Contribution of Mutual Health Organizations

To Financing, Delivery, and Access to Health Care

Nigeria Case Study

USAID/PHR, ILO/ACOPAM, ANMC, WSM

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Introduction

Mutual health organisations (MHOs) are community and employment-based groupings that have grown progressively in West and Central Africa. Their emergence has attracted growing interest from governments, NGOs and international organisations, particularly those interested in new and innovative approaches to the difficult issues of health care financing and access in the subregion.

In the light of this, several international organisations have shared efforts to collaborate from 1997 to 1998, on a research project on the actual and potential contribution of MHOs in the financing, the delivery and the access to health care in West and Central Africa.

The consultative group included the project Partnerships for Health Reform (PHR), supported by USAID, the International Labour Organisation programmes "Appui associatif et coopératif aux initiatives de développement à la base"(ACOPAM) and "Strategies and Tools against social Exclusion and Poverty" (STEP), World Solidarity (WSM) and the National Alliance of Christian MHOs of Belgium (ANMC).

The study deals with nine West and Central African counties and has lead to a database of mutual health organisations in six countries including 22 case studies: Benin, Ivory Coast, Ghana, Mali, Nigeria and Senegal. Methodological guidelines have been addressed for the selection and the analysis of MHOs as case studies.

The research has examined systematically the actual and potential contributions of West and Central African MHOs in the field of the mobilisation of resources, sustainability and the democratic governance of the health sector. It has led to recommendations aimed at the key actors in the development of mutual health organisations. The results of the study have been published and are entitled: "The contribution of Mutual Health Organisations to Financing, Delivery, and Access to Health Care: Synthesis of Research in Nine West and Central African Countries".

The study can be considered as a successful example of efficient collaboration between international organisations that have succeeded in sharing human resources, personnel and financing for the realisation of activities of common interest.

This report refers to the case studies in Nigeria. It has been produced by Chris Atim, PHR, in April 1998.

Executive summary

Nigeria contains nearly a quarter of Africa's total population. Yet, this giant country remains relatively isolated, largely because of the political character of its regime. Thus even developments in the non-governmental sector of this big country have generally gone unnoticed. It will therefore come as a surprise to many to learn that there are not only mutual health organisations (MHOs) in Nigeria but that they may even have useful experience to impart to others elsewhere.

Hence one of the useful outcomes of this mission is the fact that it helps to focus attention on this experience, and the study indeed shows that the Nigerian experience has several interesting features and a contribution to make to the body of African practice and knowledge in this field. The main MHOs studied, which offer useful lessons, are the Community Partners for Health (CPHs) promoted by USAID's BASICS programme in that country, and the Country Women's Association of Nigeria (COWAN).

The are several innovative features of the Community Partners for Health (CPHs) worth highlighting. First is that, they are organised through existing community based organisations (CBOs) of all kinds – such as local trade unions, petty traders, associations of blacksmiths, carpenters, battery chargers, other professional associations, residential and tenants' associations, church groups including spiritual or charismatic church groups, Muslim groups, traditional birth attendants. Membership of the CPH is gained not directly as an individual but through the local association which offers advantages in terms of social control and prevention of abuse and fraud, as well as the chasing up of defaulters and minimising adverse selection. It also means that control is exercised at the lowest possible level.

A second feature worth noting is the savings nature of the schemes, rather than reliance on an insurance mechanism. The idea of saving for health is apparently better understood (as an extension of traditional saving concepts such as *esusu* or *ojo*), whereas insurance is less well understood, and moreover, requires different and rather scarce skills to manage properly. This particular adaptation not only saves on administrative costs (for the CPH), but also helps avoid fraud, an ever-present danger with insurance schemes everywhere and a big problem in Nigeria. These remarks apply equally well to the COWAN Mutual Health Savings scheme too.

A third important feature is that the scheme is based on a preliminary identification of the top ten health priorities of the community concerned (the CBOs are involved in this preliminary task), which then form the focus of the interventions of the CPH's primary health care activity, i.e. the health providers in the network agree to offer 50% discount to CPH members for those defined priority areas. This is a good design feature aiding in the achievement of improved access to health care, equity and efficiency.

The CPH model and experience offer other lessons too. One of these is the formal separation of the health facilities from the CPH through contracts and negotiation (Memoranda of Understanding). This separation is essential for reasons of efficiency, effectiveness and quality of care.

Another is the setting of quantifiable objectives for the CPH to achieve (this aids the budgeting, planning, monitoring and evaluation process immensely).

One of the principal conclusions from the Nigerian case studies is therefore that the 'complex' or high participation model of community financing (i.e. the CPH type of scheme) appears well attuned to the health care needs of the communities and health sector goals of the country. Social movement based schemes such as the COWAN scheme may also have good potential, and it is no coincidence that both types (social movement and participatory community financing) share broadly similar features in so far as participation by the insured or their representatives in management is concerned. These participatory features may be the key to their relative success (or potential to do so, as arguably in the case of COWAN) but unlike the CPH, COWAN cannot negotiate terms and influence quality and efficiency of providers because it has no links with providers (except its own clinics).

The COWAN model has the advantage that it is based on a traditional institution (credit and savings) which has wide legitimacy and is easily understood. Its potential for generating resources for health care is therefore arguably quite good. However, the COWAN experience probably suffers from excessive caution in regard to the actual level of contributions and the conditions of access to the savings.

The potential indigenous institutional support for a mutuals development programme in Nigeria appears to be quite favourable. However, there is only limited external (donor and other) support available due to existing political constraints.

Technical assistance to existing MHOs to equip them better to manage their schemes (e.g. in accounting and record-keeping, with the skills to carry out monitoring and evaluation of their work, and with the skills to run an insurance scheme) is another clear area of need. The analysis shows that the Nigerian schemes would also benefit from targeted training in these areas: need for independence from the provider (CPHs), use of negotiating power, marketing, need for quality control mechanisms, and drugs' policy.

The room for MHO development in Nigeria lies in the sectors of the population that will not be covered (at least initially) by the proposed phased introduction of the national health insurance scheme (which means mostly the informal sector including rural communities).

Contents

1. Objectives, Methodology and Data Sources

The Methodological Guidelines for this research state that the "overall objective" of the project is to "study the actual and potential contribution of mutuelles to the financing, delivery and access to health care in Africa, with particular reference to WCA countries." The Guidelines go on to state, more specifically, that the research "aims to evaluate the experience with and potential for mutuelles as a health insurance mechanism."[1]

The fieldwork was aimed at collecting substantial data and information to enable some of the key questions that arose from the stated objectives to be answered in detail. Ideally, four types of non-profit mutual health organisations (MHOs) were to be selected in each country, according to the typology discussed in the Guidelines. But this could be varied if such variation would best contribute to the research objectives.

In Nigeria and Ghana, the research was conducted mainly through interviews with leading personnel of various organisations that are involved in the health sectors and in particular the mutual organisations identified as worth studying in depth.

These interviews were supplemented by literature review of the country's health and health care fields, discussions and interviews with mutualist leaders, focus group discussions, 'walk-through' visits to providers linked to the MHOs, discussions with the management of provider facilities, as well as visits to research and other support institutions that intervene in the health sectors in the two countries.

Most individuals and organisations interviewed were open and willing to give information. However, members of traditional mutual organisations were noticeably more reticent about disclosing information, particularly relating to their finances. In other cases, with non-traditional MHOs, the quality of the data was sometimes poor due to insufficient, irregular or non-existent records. However, as will become evident, reliable and sufficient data were also available from other schemes, particularly community financing types of schemes investigated. In general therefore, the quality and quantity of data were not even and much care is needed in drawing any comparisons between the various schemes.

It should also be noted that the term "health mutuelles", used in the Guidelines to refer to the mutual health organisations to be investigated, has been replaced in this paper by the descriptive English term of non-profit mutual health organisations (MHOs).

The meaning of this term, based on experience in Anglophone countries, is also wider than is commonly understood by 'mutuelle' or 'mutualité' in the Francophone countries. The organisations included in this term share the following characteristics: they are non-profit, autonomous, and based on solidarity between, and democratic accountability to, their members, with a mission to improve their members' access to good quality health care

1 Atim, C. 1997. Methodological Guidelines For PHR Field Research On Health Mutuelles In Western And Central Africa (WCA). Maryland, USA: Abt/PHR.

through any of a range of financing mechanisms including insurance, simple pre-payments, savings and credit and subscriptions.

2. The Context

a. Health Indicators for Nigeria

With a population estimated at upwards of a hundred million inhabitants, Nigeria is easily the most populated country in Africa, accounting for about a fifth of the continent's entire population. For a country containing such a sizeable proportion of the continent's people, and richly endowed with natural resources, the health indicators are quite dire, as Table 1.1 reveals.

Table 1.1: Selected Health Indicators for Nigeria

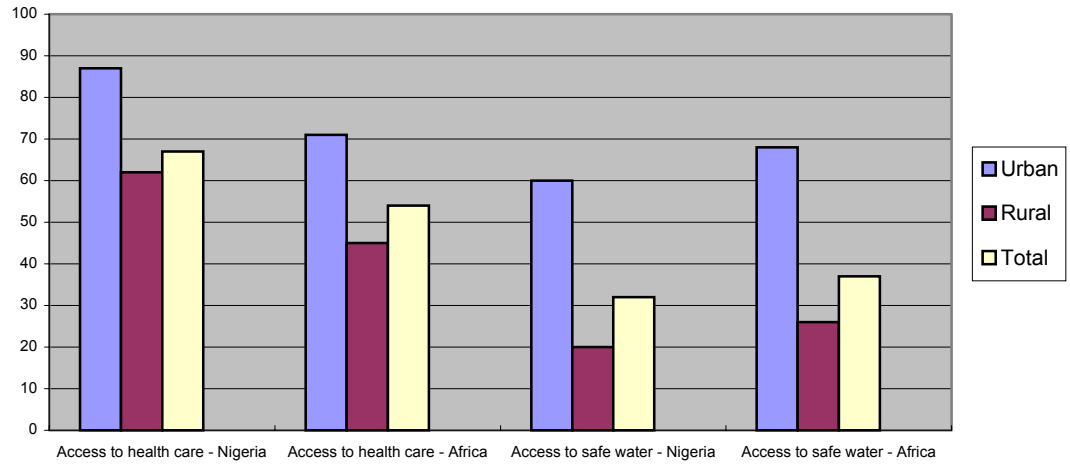
Indicator and year	Quantity	Remarks
Infant mortality rate (per 1000 population) 1992	84	Equivalent figure for Africa as a whole: 104
Female literacy rate –Secondary school enrolment (1990)	17%	Cf. For Africa: 16
Maternal mortality rate – (per 100,000 live births) (1988)	800	Cf. For Africa: 700
Life expectancy at birth (1992)	Males: 50 Females: 53	Cf. Africa M/F: 49/52; [Ghana 53/57; Cameroon 55/58; Togo 53/56]

Source: World Bank (1994). Better Health in Africa: Experience and Lessons Learned. World Bank: Washington.

Similar data on sanitation facilities show that only 30% of urban dwellers and 5% or rural dwellers had such access between 1985-90, compared to 51% and 16% respectively for all Africa.[2]

2 World Bank (1994), *op. cit.*

Chart: Urban and Rural Access to Safe Water (1985-90) and Health Care Services (1988-90) in Nigeria and the whole of Africa.



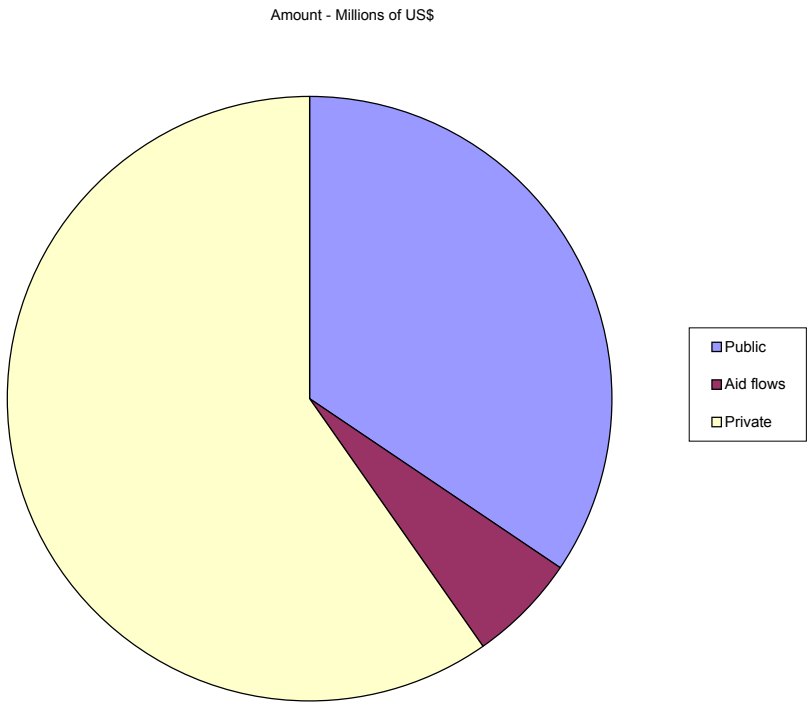
It should be noted that these data relate to a period when the Nigerian economy was undergoing an unprecedented boom. Since then boom has given way to bust and currently an austerity economic regime is in force, not the most propitious for expanding (and despite the rhetoric, not even for improving) health and social facilities.

Available data on health expenditures (US Dollars 1990, see Table 1.2) also tell an interesting story.

Table 1.2: Health Expenditures – Nigeria

	Amount	As percent of GDP
	Millions of US$	
Public	330.9	1.0
Aid flows	55.2	0.2
Private	573.7	1.7
Total	959.8	2.9 (cf. Africa 4.5)
Per capita	$10 (cf. Africa $14)	

Source: World Bank (1994), op. cit.



About 60 percent of health expenditures in the country are accounted for by private spending. This could be partly a reflection of the fact that in many parts of the country, most of the available health facilities are provided by the private sector. This is for instance the case in the deprived communities of Lagos (such as Lawanson and Mushin) where the Community Partners for Health (CPH) projects that were investigated for this research are located. As these services have the additional advantage of being popularly considered as providing better quality of care than the public sector facilities, making these private facilities accessible to more people could be a good public health policy objective.

b. The private health insurance market

It was estimated from the evidence available in 1993 that about 370,000 persons, or about 0.4 percent of the population of the country at the time, were covered by private health insurance schemes, including other employer based medical insurance schemes.[3] Of the about 150 insurance companies operating in the country at the end of 1995, less than 10 offered health insurance policies among their portfolio. Of these only four operated independent schemes, while the others co-insured health risks.[4] A profile of the four underwriting independent health insurance policies is given in Table 1.3.

3 Ibukun-Oluwa Ogunbekun, Health Insurance: A viable approach to financing health care in Nigeria? (Private Initiatives for Primary Healthcare Project, 1996).

4 Co-insurance (as distinct from co-payment or cost-sharing) is defined in the insurance industry as the joint underwriting of a given risk by two or more insurance companies, the premiums – and claims settlement - being shared according to the proportion of risk borne by each company.

Table 1.3: Data on Private Insurance Market in Nigeria

Company	Location	Began marketing health insurance	Type of policy sold (individual/group)	Number of beneficiaries covered as of July 1995 (dependants included)
Industrial and General Insurance Company Ltd (IGI)	Lagos, Lagos State	1993	Individual and group	700
International Standard Insurers (ISI)	Lagos, Lagos State	1993	Group only	17,447
Newline Insurance Company Ltd (NIC)	Lagos, Lagos State	1989	Individual and group	not available
Shelter Insurance Company Ltd. (SIC)	Enugu, Enugu State	1991	Group only	7,500

Source: I Ogunbekun, op. cit. *p. 13.*

The total size of the private insurance market (in terms of gross premium income of all the insurance companies) was estimated in 1993 to be around N6.55 billion (US$379 million at 1992 exchange rates), but only a tiny portion of this reportedly came from selling health insurance. Of the companies for which data were available, Shelter Insurance Company obtained N1.85 million (US$107,000 at 1992 rates) of its premium income from health insurance policies in 1993, representing 17 percent of its gross premium income for that year. The company with the next largest health insurance portfolio International Standards Insurance (but covering the largest number of persons, see Table 1.3) drew 12 percent of its income from health insurance in 1994 (up from 1.4 percent in 1993).[5]

There are a number of problems with the health insurance industry which might have a bearing on the development of non-profit mutual health organisations (MHOs) in Nigeria. Fraud has been cited as a major factor in the escalating costs of health insurance in the country. The facts certainly indicate that the growth in claims is far outstripping growth of premium incomes leading to steeply rising medical loss ratios (claims paid out/premium income received). One company recorded an increase of 122 percent (twice the official rate of inflation) in claims from 1993 to 1994 compared to a 40 percent increase in premium incomes. The average value of claims in the industry was observed to rise by over 150 percent in less than two years.[6]

5 Ogunbekun, *Op. cit.* p. 24.

6 Ogunbekun, *op. cit.* p. 36.

By 1997, the health insurance business of one of the bigger firms in the industry, ISI, which also covered the largest number of persons, had collapsed and the firm forced to pull out of that line of business altogether, while just one new firm, Phoenix Assurance of Nigeria Ltd. had entered the health insurance market.[7]

Another problem facing the industry was what was perceived to be an image problem, i.e. the negative image that insurance has acquired in the public mind.[8] Insurance is perceived as an industry where the staff readily collect your contributions but will do anything to avoid paying your claim, and if you are fortunate to be paid, this will only be after a long tortuous process.

These factors need to be borne in mind when we will discuss the caution displayed by Nigerian health mutuals towards the notion and use of the word insurance.

c. Experience with other alternatives to user fees: general overview

Employees in the formal sector of Nigeria, like most other African countries, tend to have some form of health coverage, which means that in practice out of pocket health expenses are relatively low. Besides the situation described above where a private insurance company has a group plan with employers to cater for the health care expenses of employees in return for stated annual premiums, it is also common for employers to contract with a health care provider who will treat all the employees concerned and send the bills directly to the employer (service plan). In other arrangements, the employer, especially the larger ones, will provide a staff clinic using contracted private medical personnel to take care of the health of its employees. Cash indemnity plans, where the employee first pays the health care provider and is later reimbursed by his/her employer, also exist but are relatively rare.

Until recently, such employer based plans usually provided cover for the worker plus a spouse and up to four children.

The new development in workers' health care in Nigeria which was causing some concern in labour circles at the time of this research is that annual caps or spending limits are increasingly being placed on a family's health care expenses. For instance, an employer might specify that each worker (plus his/her family) is entitled to spend up to 15,000 naira (US$183)[9] per year on health care, any excess will then be borne personally by the worker concerned. With this capping, the previous limitation on family size and who the beneficiaries should be are removed, and it is left to the employee to ensure that the total spending of his/her family is kept within the limit, or be prepared to pay for any excess. With these new arrangements, the employer's incentive to monitor costs and quality of care by providers is also diminished.

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7 The author is grateful to Dr Ogunbekun for this updated information on the health insurance industry in Nigeria.

8 This was gleaned from the author's discussions with ordinary Nigerians with whom he came into contact during the mission.

9 Exchange rate of naira to dollar in October 1997: 82 naira to one US dollar.

On another level, the Federal Government has launched a new health insurance initiative, the National Health Insurance Scheme (NHIS), to begin with the formal sector (public sector employees and private companies with more than 10 employees) and gradually to be extended to the rest of the population though no time frame has been placed on this extension. Under the plan, the scheme (based on capitation) will be run by the private and public (health care) sectors jointly and almost autonomously of government. Management and funding at state levels will be independent of the central government and no cross-subsidies between states will be involved. The services to be covered will include primary care, ambulatory and hospitalisation care up to 21 days. Dependants to be covered will be one spouse plus a maximum of four children, other dependants will attract additional premiums.

Already fears have been raised that the scheme has been too physician led from the beginning and takes little account of other stakeholders' interests such as those of the pharmacists who are still opposed to the scheme.[10] It is also felt that in a country with a large Muslim population, the limitations of the currently proposed scheme may have adverse consequences for the health of women and children.[11]

In all of these developments, the informal sector, probably the largest sector in the country when it is remembered that almost the entire rural population is included, is the one that has had no health care cover and for whose health needs none of the plans currently on offer provide any solutions.

This is the context in which some mutual health financing organisations (MHOs) have arisen in recent years, often with the help of external donors, to fill the vacuum left by the formal sector schemes. This is also the background in which any assessment of the contribution of MHOs to the health sector in Nigeria should be viewed. We will now examine some typical examples of the MHO schemes that have evolved with a view to seeing how significant their contribution is, and equally important, what their potential contribution to this area of greatest need could be.

10 As another example of physician bias in the scheme, it is understood that the answer of the scheme designers to the potential danger of physician malpractice is to recommend malpractice insurance.

11 Views expressed during interviews with various health care professionals and health NGO activists in Nigeria, Oct 1997.

3. Case Studies of MHOs in Nigeria

a. Choice and typology of case studies

For reasons probably related to Nigeria's complex regional dynamics and attendant history of differential regional development, the western part of Nigeria, including Lagos State, appears to have been the most fertile area for the development of mutual health activities in the past. That potential also appears to have attracted promoting institutions to that part of the country earlier than the rest of it. So it is not surprising that the most well known, and probably also the best, mutual experiences have arisen in the western part of the country.

BASICS [Basic Support for Institutionalising Child Survival], a programme of USAID-Nigeria, is one of those early promoters of MHOs in Nigeria who spotted the potential for mutual development activity in the western areas. BASICS has been involved in promoting such initiatives in deprived slum areas of Lagos, known as the Community Partners for Health (CPH) projects. CPHs are informal sector mutual health insurance schemes (MHOs) involving some private primary health care (PHC) providers and community based organisations (CBOs) to finance and jointly manage the community members' primary health care needs. Six of these projects are currently being developed in and around Lagos, experience which is now beginning to be replicated in the North of the country (with five new projects around Kano).

The level of participation of grassroots associations and church/religious groups in those schemes would tend to classify them as examples of a 'complex' (or high participation) community financing model described in the Methodological Guidelines. Two of those examples around Lagos were chosen for investigation because the similarities in their design are such that the gaps in data collected from each could be partly made up by complementary data from the other, enabling more complete information for analysis of the CPH model. The main difference between the two was that one of them (JAS Community Partners for Health - JCPH) is built around a single private PHC provider and the second (Lawanson Community Partners for Health - LCPH) has been developed around a network of private PHC providers. This difference in itself did not lead to significant analytical insights.

The Country Women's Association of Nigeria (COWAN), led by Chief Bisi Ogunleye, is a women's social movement and one of the best known NGOs in Nigeria, with chapters across many of the states. After several years of operation, the movement decided, because of popular demand, to set up a Health Development Fund (HDF) which on examination appears to have the features of the social movement based mutual health financing scheme. This is therefore the second kind of scheme examined below.

For the traditional (clan or ethnic based) networks of solidarity with mutual health support activity, all the available evidence pointed to the Ibo community groups in Lagos as the best candidates for study. The third kind of case study presented below is such a group, known as the Ibughubu Improvement Union, made up of inhabitants of Ibughubu village (Umuchu town, Anambra State) resident in Lagos.

Another type of MHO was found in a database of non-formal sector health insurance schemes compiled by the WHO, but it was not possible to include an investigation of this experience during this study. This experience is situated in the Odogbolu Local Government Area of Ogun State, and is called the Ala/Idowa Community-based Health Insurance Scheme. We shall give a brief description of its main features later under section 1.3.1.

The decision matrix for selection of MHO case studies, presented in the Guidelines, is reproduced below with the appropriate annotations to show the characteristics of the chosen case studies.

Table 1.4: Nigerian MHO Case Study typology

MHO type and corresponding case study	**Urban Location**	**Rural Location**	**Informal sector membership**	**Formal sector membership**	**small to medium size**	**large size**
1. Traditional mutual aid association: Ibughubu Improvement Union	Yes	Has links with branches in rural areas	Yes	Is an informal sector organisation but membership includes formal sector employees	Lagos branch Small –but has many branches throughout country	No
2. Mutual insurance association or social movement type: COWAN's HDF	Low-income urban dwellers (market women mainly) make up c. 20% of members	Yes	Yes		Health fund small, but large social movement	Yes
3. Community financing model: 'simple' or 'complex': JCPH/LCPH (complex types)	Peri-urban	No	Yes	No, but individual members may be formally employed	No	Yes

b. The Lawanson and Jas Community Partners for Health

- ***Background and objectives***

Since 1995, BASICS has been implementing the pilot stage of a private sector integrated health project. Under this, six urban communities in Lagos are being assisted with technical advice, training and equipment to undertake Community Partners for Health (CPH) projects, with a view to reducing infant and child deaths and generally improving the quality of lives of children in the communities. The six Lagos communities involved are: Ajegunle, Amukoko, Lagos Island, Lawanson (Surulere), Makoko and Mushin. The six areas had these features in common, that though urban in location, they were deprived communities that had rural characteristics where their key health problems were concerned. Both the Jas CPH (Mushin) and the Lawanson CPH (Surulere) were started in December 1995, after sensitisation workshops animated by BASICS officials.

CPHs have eight specific objectives, nearly all of which are quantifiable[12]:

- To reduce by the end of 1998, the number of children under five years and pregnant mothers falling ill and dying from malaria
- To reduce the number of children under five years having diarrhoea and dysentery and dying from dehydration
- To reduce the number of children falling sick with cough and dying from acute respiratory infections
- To increase the immunisation coverage of children under two years old and ensure availability of effective quality vaccines
- To increase the demand for and the availability of modern child spacing/family planning services
- To increase the level of awareness of partner organisations and the community on the incidence and control of HIV/AIDS and sexually transmitted diseases
- To ensure that the project is self-sustaining to maintain its improved capacity and services, and
- To strengthen and expand the role of female decision making among members of the project and community.

This approach of defining specific objectives for the MHOs has several advantages, including a basis upon which to design benefits packages and to develop workplans and budgets.

- ***Design, Organisation and Management***

The CPHs achieve the above objectives through partnerships between interested private health facilities (for profit or non-profit) and community based organisations, with the emphasis on utilising existing community resources to solve child survival problems. Funding is obtained from membership dues, donations and support from members of the community.

There is a governing board of trustees, which manages the CPH and which is elected by members of the CPH for five-year terms. In practice, the board is made up of leaders and representatives of both providers and CBOs. The Board has all executive powers and is responsible for "planning, implementing, supervising, monitoring, and evaluating programme activities of the Association including financial accountability and sustainability of the Association".[13]

A Memorandum of Understanding (MOU) sets out the terms of the partnership and provides the framework for the collaborative effort to solve the community's leading child health problems. Two MOUs are involved: one MOU sets out the relationship, duties and

12 From Memorandum of Understanding between BASICS-Nigeria and Jas Community Partners for Health. These objectives are incorporated into the MOUs and Constitutions of all the Community Partners for Health.

13 Constitution of the Lawanson Community Partners for Health, p. 6.

obligations between BASICS and the CPH; another sets out those between the health provider(s) and the CBOs.

There are two essential aspects to the CPH. The first is the health self-financing part, described as a "pre-paid/mutual fund", which seeks to mobilise resources from the community via the CBOs to strengthen the financial capacity of the health facilities and to provide and improve access to quality care for members of the community. The second part is the managed care committee which brings all participating health facilities together in a committee that meets regularly to ensure uniform quality and pricing of health care.

The health objectives of the CPHs are achieved through a subsidised health scheme, described as "a kind of health insurance under which the community can refer a patient to the hospital for treatment with a promise to pay within two weeks if the patient defaults".[14] Each member registers at a participating hospital or clinic near where they live. On registration, a member receives a "participatory card" containing the name, address, hospital number and CBO of the member. The dates and times of clinic attendance are also recorded in the card but no passport picture is affixed.

The following description of how the Jas CPH works to attain its health objectives illustrates the basic principle underlying the operation of all the CPHs.

The Jas CPH

After preliminary sensitisation sessions in October and November 1995, a meeting was held between Jas Medical Services (a private local clinic in Mushin area), BASICS officials, and 8 CBOs on 12th December 1995 to launch the Jas CPH. The founding members were the following:

- Jas Medical Services
- Holy Trinity (Anglican) Church, Mushin
- Bosby Private School, Ilasamaja
- Oladeinde – Coker & Environs – Landlord/Residents Association
- Alfa-Nda Welfare Association
- Foursquare Gospel Church Ilasa II
- National Union of Road Transport Workers Union (NURTW), Ilasamaja branch
- Kayode Native Doctor, Itire Road
- Kingdom Christian Ministry

At the time of the present research, the participating CBOs had increased to 13. The new groups are: OSA Residents Association, Christ Gospel Apostelic Church, Ahoememogbe Ishan Women's Social Club and Health Care Association of Igbehin Residents. No reliable figure for the total memberhip of these organisations was available, but an estimate by the

14 See the Lagos Guardian newspaper of 2nd June 1997, "Unsung community effort to secure the child's future", p. 13.

Chairman of the CPH put this at over 10,000 members. In all probability, the great majority of these would not be active in the CPH, a good sign of this being the relatively small size of the meeting hall for general meetings. Many of the members of these organisations are involved in informal sector economic activity – such as petty traders (probably the predominant economic activity especially among the women members), vulcanisers, battery chargers, mechanics, drivers of public transport (taxis and mini-buses), carpenters, hairdressers, tailors, etc.

Jas Medical Services, which also serves as the secretariat for the CPH, is a primary health care (PHC) clinic which provides preventive and promotive health services (including family planning, immunisation outreach, promotion of breast feeding and health education), and curative care (including obstetrics and gynaecology services). Diagnostic services are contracted out to a private laboratory. It has 9 in-patient beds (7 adult and 2 child beds) and a total staff of 12 (distributed as following: 2 medical doctors, 6 qualified nurses and 4 auxiliary staff (2 cleaners and 2 receptionists). An outside auditor comes monthly to do the books.

The CPH staff and governing board consists of a chairman, vice-chairman, secretary plus vice-secretary, treasurer, the chair of the Women's Empowerment Committee, an advisor (an elderly retired educationist), financial secretary plus the ex-officio members (representatives and leaders of the CBOs). In addition, there is a fund-raising committee, a youth wing and an ambulance committee (which manages the operation of the ambulance/hearse of the CPH).

At one of the first meetings of the CPH, the partner organisations (i.e. the CBOs and the Jas Medical Services together) met and identified the key health problems of the community. At Jas, in Mushin area of Lagos, these were defined as:

- Malaria
- Diarrhoea
- ARI (acute respiratory infections)
- Lack of potent vaccines
- Fevers
- Family planning services
- Health education

In addition, it was felt that the issues of women's empowerment, sustainability of the CPH and democracy and governance were of such importance that they deserved attention among the objectives and activities of the CPH. Some strategies for dealing with these problems were also agreed on.

For malaria, for instance, it was accepted that regular clean up campaigns to remove stagnant water (the breeding place of the malarial parasites) and clean up streets and gutters would be undertaken. Each CBO is responsible for mobilising its members, while Jas and BASICS help with sensitisation campaigns to explain the importance of the clean-up exercises, and environmental sanitation materials and implements (such as wheel barrows, shovels, garden forks, rainboots, gloves, etc.) are made available by BASICS as part of its assistance package.

To improve the stock of vaccines and drugs, a financing scheme was devised which works like this. Each individual member of the CPH pays a participating fee (annual dues) of 100 naira (about US$1.20) for an adult, 70 naira (about US$0.85) for adolescents and 50 naira (about US$0.60) for children under 12 years. This is used both to run the CPH secretariat and to buy essential drugs ("essential drugs" are defined as those generic ones required to treat the common ailments identified by the community, those listed above). In effect, some of the dues are used to constitute a revolving fund for drug purchases.[15]

To achieve its health improvement and access extension objectives, some further novel and interesting features have been built into the design of the scheme. If a member's health problem falls among the key health problems identified by the community at the start, that member is entitled to 50 percent discount on their health bill (including drugs) if properly referred by the leader of his/her CBO. (Here the CBOs are playing an important community health and PHC role, one that could be discharged more effectively with some basic training.)

Furthermore, a co-operative credit society has been started by the CPH, which is open to all members. There are currently (October 1997) 138 members of the co-operative (from 11 founding members in February 1997) and each member saves either 100 naira or a multiple of this amount every month, after paying a once only registration fee of 100 naira. The highest contributor currently pays 3000 naira (US$36.59) per month.

Eighty percent of the total savings times two are available to the member (after a minimum of six months of regular savings) as a loan if he/she wishes so (at interest of 10 percent). The other twenty percent are held back as health savings, to which interest (at 5 percent) is added at the end of the year, but this is not ordinarily available for withdrawal except either when the member is resigning from the CPH, or when the member or a family member is ill. In the latter case, an interest free loan can be obtained from the health savings to help pay the hospital bill.

The clinic's gain in this respect, and therefore its ability to offer the 50 percent discounts in the appropriate cases, stems from the virtual elimination of bad debts (a big problem before the CPH) and the greatly increased numbers of patients they now attend to daily (see below).

To explain this more succinctly, then, if a member or a dependant falls ill, the concerned person or his/her relatives must first obtain a referral slip from their CBO leader. This slip entitles the patient to treatment at Jas Medical Services clinic even if they have no means of immediately paying the bill. (They will also not be asked for a deposit before being treated, which a non-member is required to do.) The patient has two weeks to pay after the treatment, and the leader of the CBO makes sure of this. In case of default, if the member is in the co-operative, money can be withdrawn from their 20 percent health saving to pay the bill.

To illustrate further by means of an example, suppose the normal or full health care bill of a person is 1000 naira (about US$12). The amount actually billed to a member of the CPH will be 500 naira (about US$6) or half that of a non-member if the ailment falls within the 10 major health problems identified by that community. If the ailment is not in the priority list,

15 It is not known to what extent the drugs' budget is subsidised by other bodies such as donors, but the participation fees certainly seem to be rather modest in relation to the real costs of drugs in particular.

they have to pay the full amount. But even in this latter case (ie ailments outside the identified health priorities), the member can have recourse to the health savings if he/she is in the co-operative. If they have been saving the minimum of 100 naira for six months, they will be able to borrow 120 naira (about US$1.5), representing 20% of their total savings of 600 naira (just over US$7). As far as the savings aspect is concerned, therefore, there is no solidarity between members.

These savings are also available for use in the case of further referral from Jas to say, Lagos University Teaching Hospital.

Quality improvements in health care for the community are obtained through the greater interaction between hospital staff and users especially in the context of regular meetings of the CPH and other elected bodies. The governing board of the CPH meets the third Wednesday of every month while the General Meeting of all members takes place every three months. In addition, the co-operative society holds meetings twice a month. Sensitisation, health education and clean-up campaigns further bring providers and community members together frequently, all helping to cement a partnership to tackle the health (and through the co-operative for instance, other) problems of the community.

In the case of Jas CPH, obviously the Managed Care Committee is simply notional since there is only one provider. However, interviews with users showed that they perceive significant improvements in quality of care at Jas clinic since the CPH was set up. For instance, the attitudes of staff are reported to be much better and waiting times have shortened with more staff employed from the increased revenues made possible by the CPH.[16] Even the Chief Medical Officer, who himself lives in the community, is said to be much more approachable than before. There are other improvements such as in the drug supply and availability, vaccinations, etc. to which we shall return below.

Lawanson CPH

The organisation and management of Lawanson CPH (LCPH) is similar to that of Jas CPH, with the following variations.

A network of four medical practices in Lawanson[17] together constitute the provider side of the partnership, and they meet within the framework of a managed care committee to agree on uniform care standards and pricing for their services, so that CPH members are assured of the same standard of care where ever they go within the network. The Royal Healthcare Hospital, one of the early pioneers of the CPH approach, serves also as the secretariat for the CPH.

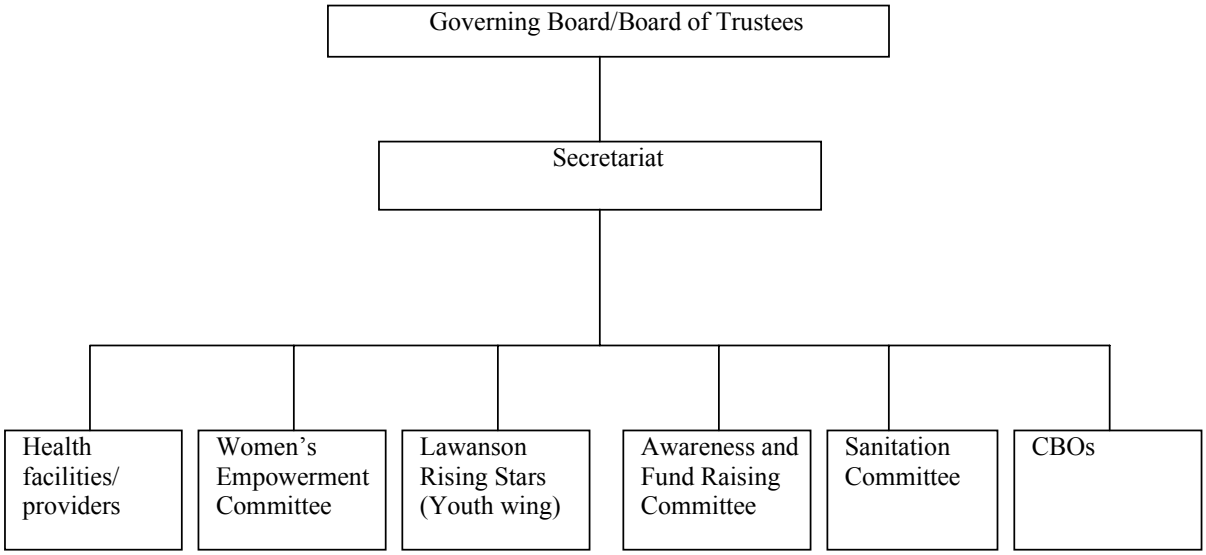
The providers offer the same health care services as noted earlier for Jas Medical Services but in addition, paediatric and surgery services are available. Again there is no in-house diagnostic service (it being more efficient to contract this service to outside labs). The Royal Healthcare Hospital has 6 in-patient beds and 12 staff including 2 doctors.

16 No specific evidence was offered to back up these assertions, and so some caution is required given only verbal statements.

17 These are: the Royal Healthcare Hospital, Pine Hospital, Rock of Ages Hospital, and Anthnie Clinic.

As at October 1997, Lawanson CPH had 21 CBO partners and 4 health facilities (see Appendix 1). This list is interesting in itself, inasmuch as it contains a wide diversity of informal sector groups that at first glance might not be expected to be involved in such initiatives. The total membership of those partner organisations was estimated at over 58,000 but the author could not verify this figure.

CHART 1.1: ORGANISATIONAL CHART OF LAWANSON CPH



The participating fee (annual dues) were previously set at 50 naira per male per month, 20 naira (about US$0.25) per female per month and 20 naira per youth per month. However, since the middle of 1997, these have been completely revised as follows: 100 naira per person per year and 150 naira (US$1.83) per family per year for the participatory card.

The co-operative credit union, organised similarly to Jas CPH, was started very recently there and has 40 subscribers. The savings attract 8 percent interest rate of which 5 percent are added to the member's savings account while the other 3 percent go to a fund set aside for bulk purchasing of drugs (revolving drug fund).

The inclusion of traditional medical practitioners in CPHs is an innovation that augurs well for quality care for the community because CPHs try to reach agreement with traditional birth attendants (TBAs) under which, first the TBAs get some training to upgrade their skills, and secondly, TBAs are encouraged to recognise and refer cases beyond their competence to the hospital or clinic. In return, the CPH has had to deal with the legitimate fears of the TBAs that their clients will be 'stolen' by the hospitals after referral. This involves assurances that clients will be sent back to the referring TBA after the clinic's staff have treated the complication that could not be handled by the TBAs. It makes for a mutually beneficial relationship and also recognises the reality that the vast majority of deliveries in the community are done by TBAs, not the modern trained midwives. However, no similar accommodation appears to have been reached with the native doctor participating in the Jas CPH which the author studied.

In the next sub-sections, we will assess the contribution of the two case study CPHs above more concretely in terms of the criteria laid out in the Methodological Guidelines.

- ***Resource mobilisation***

Information gathered from the research indicated that CPHs have contributed significantly to resource mobilisation for the health facilities involved in the following ways.

– Money for revolving drug funds was obtained from a combination of membership dues (JCPH) and interest on savings (LCPH).

– Physical resources, including environmental equipment, were obtained from foreign donors (notably BASICS-USAID as we have seen) and community members and well wishers, all of which would not have been available for improvement of health and health services without the CPH. Members of the community have donated furniture freely for use by the CPH e.g. for meetings.

– Income generating activities (again supported by external partners) engaged in by the CPHs bring in further revenue to pursue PHC objectives.

To give an idea of the revenue, in raw figures, from the above sources, JCPH received a total income of 65,120 naira (US$794 at October 1997 exchange rates) for the year ending 31 Dec 1996, of which 28,420 ($346.59), the biggest source, came from donations. Registration and participating fees together contributed just over 8,000 naira (nearly US$98).[18]

For the period to July 1997, co-operative registrations earned 8,700 naira (from 87 members, rising to 13,800 naira (about $168) by Oct 1997 with membership at 138), while total deposits of members amounted to 110,800 naira (about US$1350). This yielded 22,160 naira (about $270) or 20 percent of the deposits, for the health savings' account.[19] In this same period, LCPH, described by a private consultant as "maintaining a very good and healthy bank account", had a total of 276,813.97 naira ($3375.78) in two bank accounts. They were receiving monthly net income of 13,000 naira.[20]

– Voluntary labour is made available by community members to run the CPH and PHC activities. For example, all except one each of the staff of the JCPH and LCPH are volunteers (i.e. only one paid staff each). At JCPH, they point with pride at the invaluable voluntary work performed for the CPH and community by a retired educationist and some retired matrons (members of the community) during PHC campaigns.

18 Jas Community Partners for Health, Statement of Affairs, draft Auditor's Report for period ended 31 Dec 1996.

19 Oluwaseye Olalokiki, Consultant, "Community Partners for Health – Management Report and Recommendations: Assessment and evaluation report on the adequacy of Financial records, review (of) accounting books and overall funds management ability for the periods (sic) to July 1997", p. 7.

20 O Olalokiki, *op. cit.* p. 9.

- Among CPH members, defaults in payment of hospital bills are now virtually unknown, thanks to the mechanisms described earlier. Also, the existence of the CPH (and therefore mechanisms to ease payment difficulties) enables hospitals to take a tougher approach to non-members who cannot pay the required deposits and wish to be treated on a promise to pay later.
- It also follows that less time is wasted on chasing up non-compliant individuals. In fact it is the CBO leaders who are responsible for this, as we have seen, thus saving on administrative expenses for the providers. One of the novel and interesting features of the Community Partners for Health (CPHs) is that they are organised through existing community organisations of all kinds – from local trade unions, to traders and professional associations, church groups including spiritual or charismatic church groups, Muslim groups, traditional birth attendants, etc. Membership of the CPH is gained not directly as an individual but through the local association which offers a lot of advantages in terms of social control and prevention of abuse and fraud as well as the chasing up of defaulters.
- Although the precise magnitude and significance of some of the above resource generating or saving sources cannot be adequately assessed from the available data, certain further indicators were pointed out as clear evidence of the beneficial impact of improved finances (the result, the chief medical officers of Jas Medical Services and Royal Healthcare Hospital affirm, of the CPH intervention):
  - Facilities have been significantly expanded after the CPH: Jas Medical Services used to occupy one wing of a ground floor building, now it has expanded to take up the top floor as well. Technical staff has also increased – before, there was only one nurse per shift available, now there are 2 or 3 per shift.
  - Essential drugs are now more readily available (confirmed in interviews with users)
  - They are now able to offer free immunisation of children (with free vaccines from local governments, but the private health facilities used to charge for their syringes and personnel). A year ago, an exercise in the community discovered that only 26 percent of children under one year old were fully immunised against the common childhood diseases. As a result, immunisation efforts have been stepped up, with sensitisation combined with free immunisation sessions every Saturday. The evidence (see under Access below) strongly suggests a much higher uptake of this facility than before.
  - JCPH has acquired a backup generator, which enables it to store vaccines reliably on its premises (in view of frequent power cuts).

In sum, the evidence that the CPHs examined help to mobilise latent resources (from the community and external sources) to enhance the financial situation of the associated health facilities as well as to improve the community's health generally is arguably persuasive.

- ***Efficiency contribution***

Probably the two most significant efficiency contributions of the CPHs are the incentive that they give to community members to patronise primary health care facilities in their

neighbourhoods and the specific targeting of the community's most important health needs (defined in consultation with the community members).

All the health care facilities in the CPHs are primary care providers with an impressive range of preventive/promotive services. By reducing barriers (especially financial, but also psychological, see below) to access to their facilities, they encourage the community to use them more than they otherwise would have.

Also related to this, is the mobilisation of the CBOs to undertake PHC tasks (such as environmental sanitation) for the benefit of the community. Further reinforcing this point, is the use of the CBOs as in effect the first level in the PHC system, since a patient is required (except in genuine emergency cases) to obtain a referral slip from their CBO leader.

However, the role of the health facilities as gatekeepers to other higher referral hospitals is not satisfactory from the efficiency standpoint. Investigation showed that an individual is equally entitled to borrow from his/her health savings to pay the bill for care obtained at a higher referral hospital (e.g. Lagos University Teaching Hospital) even if he/she did not pass through the CPH-associated (PHC) clinic or hospital to get referred to the higher level hospital. This is a clear limitation on the efficiency of the CPH system since the benefit package is not used to reinforce the incentives to go first through the cheaper PHC facilities and be properly referred before going on to the higher levels. It also means that the first or PHC level facilities miss the opportunity to influence quality of care delivered to their patients by the referral facilities higher up.

On the other hand, the CPH approach of defining, together with the CBOs, the community's most important health problems at the outset and then specifically focusing resources and incentives on those problems/issues is potentially one of its most valuable efficiency contributions. This approach has the great advantage that it concentrates PHC resources on the areas of greatest need, and therefore promises the best possible health impact. But only a health impact assessment will be able to ascertain whether this potential or promise is actually realised and to what extent.

Social control is a strong feature in the design of the CPH system. In fact, it can be argued that the system is crucially dependant on this feature being sufficiently effective. As we have seen, one of the interesting aspects of the Community Partners for Health (CPHs) is that they are organised through existing community organisations (CBOs) of all kinds. Membership of the CPH is gained not directly as an individual but through the local association which offers a lot of advantages in terms of social control and prevention of abuse, fraud and adverse selection. Leaders of the CBOs have a better knowledge of the circumstances of their members and also have greater influence over their behaviour than the health care provider. This feature can help the provider and CPH greatly to minimise moral hazard and adverse selection. The user survey in this research however was not extensive enough to enable definitive conclusions to be made about the actual extent and effectiveness of this crucial feature of the schemes, but it can be safely accepted that CBO leaders play an important role within the CPHs.

The effectiveness of this feature (membership through associations not as individuals) also depends crucially on how democratic, transparent and well managed the local associations are. Unfortunately, these attributes may be absent or abused with little resistance in informal

sector organisations leading to loss of confidence and low participation by members, but it was not possible to confirm any of this during the research.

In fact, it would appear that the design of the CPH scheme is meant to minimise the risks as much as possible. It is not based on classic insurance mechanisms, but on savings which are better understood since traditional saving institutions such as *Ajo Ojumo* (daily savings) and *esusu* (rotating savings) are widely patronised.[21] This aspect also reduces administrative complexities associated with insurance schemes (which tend to require quite specialised skills to manage properly) and is therefore better adapted to the local milieu. Incentives for fraud are also minimised since the incentives for free-rider gains are also minimised. As an example, and further risk-minimising measure, membership of the CPH simply affords a big discount on your bill (for the defined conditions) but not free care. However free-riding is more likely with the public clean-up campaigns and similar activity that benefits all whether one contributes to it or not, but such free-riding can be minimised through peer pressure and social control, potentially strong features of the CPH system as argued above.

The structure of the membership dues (participating fees) encourages family registration since there is a graduated scale favouring women and children. A family head therefore has an incentive to register the rest of the family as well, which reduces the danger of adverse selection and improves efficiency.

The CPH is in a unique position to influence quality of care at the associated health facility or facilities. First through the regular meetings, the members of the community (in effect the users of the health facility) are brought into direct contact with the providers in a setting arguably devoid of the normal doctor-patient or provider-client relationship. At these meetings, issues of common concern are thrashed out, including quality issues such as staff attitudes and waiting times. Secondly, since the CPH mobilises resources for improving facilities at the clinic (e.g. for drug purchases), this affords another possibility to influence the quality of care. When the system works as it is designed to do, in fact the community gets quite a good bargain. For their most important health needs, they get a good discount on the bills they pay, and they can still insist on certain quality standards through the meetings and other channels open to them.

The Managed Care Committee constitute an important contribution to efficiency since it defines and enforces uniform quality standards and pricing structures that enables regular monitoring of the standards of care and pricing arrangements, to the benefit of consumers and the health care system for the community. However, it is not a managed care committee in the sense commonly understood since it is composed of the providers; it might be more appropriate to call it a peer review committee.

Finally, the practical definition of an essential drugs list (EDL), based on the health problems identified as the priority problems of the community, is a positive contribution to efficiency within the health care system. Moreover, the JCPH claims that its EDL is based on the use of generic drugs, a claim which could not be verified.

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21 The membership dues do not constitute a general pool for sharing health risks in the sense of most MHOs except when they are used to constitute revolving drug funds. The 50% discount offered by the providers is not refundable from the contributions or funds of the CPH.

- ***Equity features***

The communities served by the CPHs are, as previously explained, among the deprived areas of Lagos, and especially in terms of health provision, have more in common with rural communities than urban ones. Moreover, as we have seen in section 1.1.3 above, people in the formal sector, such as public servants and unionised private sector employees, have access to free or subsidised health care. The occupations of most of the CBOs in the CPH communities are to be found in the informal sectors. Therefore, increasing the access of members of such communities to health care as the CPHs seek to do, is a contribution to equity in Nigeria.

Within the CPHs themselves, we have seen that no relationship exists between a member's contribution (participating fee or savings) and the quantity of discount which the member receives (a fixed figure) or the quality of service rendered, which enhances equity objectives. However, we also found that a relationship does exist between the level of an individual's health savings and the amount of loan that is available for health spending (being 20 percent of the savings), which reinforces existing inequities since the savings differ from person to person. In this aspect of the scheme, therefore, no cross-subsidy takes place between the better off and the poorer members of the community.

However, since membership dues are used to purchase essential drugs that are available to all members (at half price, discount included), and if it can be presumed (not an unreasonable supposition) that the poorer members are liable to use the health facilities more than the better off, then a potential exists here for transfer of resources from the richer members to the poorer ones. This argument is also at least partly applicable where improvements to health facilities and care standards were made possible through increased revenues gathered from all members the community so long as a person did not contribute more than others on the grounds of the intensity of that person's utilisation of health services.

- ***Access to health care***

A lot of the above analysis has already clearly established that the CPH system has reduced barriers to access to health care in the communities concerned. Nevertheless, it is necessary to examine some concrete indicators of this increased access.

At LCPH, records show that immunisation (targeted at pregnant women and babies) at Royal Healthcare Hospital alone before the setting up of the CPH took place at 2 or 3 cases per week. After the CPH and its emphasis on targeting priority PHC areas, there was a huge increase in immunisations at this same hospital, aided by the fact that they were now free to mothers and children. Figures taken randomly from three consecutive days in August this year show that 115 people were immunised on the first day, 87 the next day and 91 on the third day. The weekly average was between 90 – 100.[22]

The frequency of attendance at the above-named hospital was running at 3 or 4 cases daily before the setting up of the LCPH. Attendance figures for October 1997 show an average of

22 Information obtained from records and interviews with CPH leaders and members, Oct 1997.

15 cases daily, again an increase attributed almost entirely to the greater access made possible by the CPH. Similarly, at Jas Medical services, daily attendance was said to be running at under 5 before the CPH, but since then the daily average is between 5 and 10, also attributed to the increased access.[23]

The factors responsible for this increased access have been discussed at length earlier, and include: 50 percent discount on hospital bills for the most common health problems of the community, ability to borrow interest free from health savings (for those registered in the co-operative society) to help defray hospital bills, and a maximum of 15 days after treatment to settle the bill. Moreover, it should not be ignored that the activities of the co-operative society, in mobilising savings from the community which are then made available to members to invest in small scale businesses, among other things, by enhancing the income earning potential of members, by the same token, also affords the means to pay the bills when required.

This leads to consideration of what is possibly one of the greatest attractions of the CPH to members. This is the access they get to **quality care**, since private facilities are generally (perhaps universally) reputed to provide better quality care than public sector ones. Though considered to be of high quality, they also enjoy an unfortunate reputation (among poor people) for inaccessibility due to high costs.[24]

What the CPH has done, and this is evident as soon as one visits one of them, is to enable ordinary people to think of private health facilities as being within their means. Perhaps the close interaction between community and hospital staff in the CPH is also a factor in this.

In discussions at the two CPHs in Lagos, nobody questioned the level of the participating fee (100 naira to register in the co-operative, and 100 naira minimum monthly contribution) as being too much. It is notoriously difficult to assess the income levels of persons in the informal sector, but it is safe to assume that 100 naira per month is not a major burden on the target groups here.

Access is further enhanced, as we have seen, by the good incentives that encourage the registration of family members, and also by the schemes' focus on the core health problems of the community.

23 *Ibid*.

24 This perception tends to persist even where this is not true. For instance, it is usually assumed that one reason that people turn to traditional healers is to avoid the higher costs of modern medicine. This may well be true, but an important national survey in Ghana found that "in general … traditional healers charge more for their consultations than other health practitioners". Ghana Statistical Service, Ghana Living Standards Survey, 1991/92 (Ghana Statistical Service, Accra, 1995), p. 21. There is no suggestion that all of the people who consult such practitioners face insuperable geographical barriers to access to modern facilities, suggesting that other barriers – among them probably psychological and cultural ones - also exist.

- ***Sustainability of the CPH***

The sustainability objective of Jas CPH is pursued through income-generation activities, supported by BASICS. Examples are the donation by USAID of an unserviceable station wagon in September 1996 to Jas CPH. This vehicle was rehabilitated and is now used as a private 24-hour ambulance service and also as a hearse for hire throughout the country. The CPH also rents out the environmental tools and implements obtained from BASICS to other groups and to contractors working in the community. Similarly, the megaphones that they use for their public education campaigns are sometimes rented out to generate money. Finally, Jas CPH has obtained a metal container from USAID that they are currently dividing up into rental street shops, under the women's empowerment programme. All of these are revenue-generating activities that are aimed at improving the financial sustainability of the CPH once BASICS support ends.

LCPH has also embarked on similar sustainability projects in its community. The co-operative societies are also seen as potential revenue generating institutions.

However, some of the most important issues regarding the viability of these CPHs were brought to light in the report of Olalokiki (earlier mentioned) on financial and management practices.[25] The picture painted by this report is worth summarising here.

Regarding the qualifications and skills of the staff in each of the two CPHs, the report concludes that JCPH "needs experienced staff" while the staff of LCPH is described as "average". On the keeping of accounting records, JCPH shows evidence of record keeping, but LCPH needs to improve upon its record keeping practices. LCPH maintained "neat and healthy current accounts", but JCPH opened its bank accounts only after the report was submitted.

On funds management, JCPH is described as "above average" but needing "education on financial regulations", LCPH displayed "proof of prudency (sic), but could perform better". On verification of their assets, the existence of the assets of JCPH were "confirmed and present condition certified good"; those of LCPH were also confirmed but there was "no keeping of assets register".

The level of participation in meetings and the keeping of such records (minutes) is an indicator of the commitment of the volunteers who run such organisations and therefore also of sustainability. On this level, the report notes that JCPH was "lively and encouraging, meets regularly on 3rd Wednesday of every month and Minutes of Meetings kept." LCPH held meetings "regularly every month with majority members in attendance. Minutes kept." However, the meetings referred to may actually have been those of the governing boards rather than the general membership, but it is precisely in the boards that one finds all the volunteers responsible for running the organisations and so their level of commitment is the crucial issue.

However, this slightly positive picture is qualified considerably by the general conclusions of the report, which admittedly relate to all six CPHs and not only the two we have been

25 Olalokiki, *op. cit.*

examining. All the same, some of the criticisms appear to have general validity and, even if they apply only to some limited degree to these two groups, they nevertheless illustrate the dangers and threats that they have to guard against if they are to achieve success and sustainability.

The first criticism of the report worth raising here is that "administrative and accounting functions are performed generally on voluntary basis without any financial rewards, hence no serious commitment or accountability." Also, "essential record books are handled by just anybody without background knowledge of simple elementary book-keeping." Thus monies "received and spent were not adequately recorded in appropriate books of accounts" resulting in "no basis for reconciliation or accountability." Indeed there is a catalogue of malpractice regarding finance and accounts which led the report writers to the overall conclusion that "funds management ability of each of the CPHs lacks sound system of internal control both in quality and quantity,"

Thus perhaps it is too early to make definitive statements on the sustainability of the CPH model but there are good grounds for optimism if the deficiencies reported by the BASICS consultant are tackled seriously. This optimism is based on the fact that the problems highlighted are mainly implementational ones and not problems intrinsic to the design of the scheme.

c. The Country Women's Association of Nigeria's (COWAN's) Health Development Fund (HDF)

- ***Background and Objectives***

The Country Women's Association of Nigeria (COWAN) was founded in 1982 by Chief (Mrs) Bisi Ogunleye in Ondo State in the western part of Nigeria. COWAN has since spread to 23 states in Nigeria: 6 in the West, 8 in the East and 9 in the North.

The main purpose behind the creation of this organisation was to empower Nigerian womenfolk economically and to promote the spirit of self-sufficiency among them, on the basis of traditional systems of communal contributions and revolving credit known as *esusu* or *ajo*. COWAN is registered as a co-operative at the state level and as an NGO with the Corporate Affairs Commission (CAC) at federal level (which gives it tax-exempt status).

COWAN's economic objectives are pursued through six key areas of activity:

Credit Scheme: This is the major focus and the core activity of COWAN. The underlying method of organisation is described as the African Traditional Responsive Banking (ATRB) approach. Credit and savings are inextricably linked within this scheme. Revenue comes from the small individual savings of members and the income obtained from investments of the funds. Credit is normally given to groups, but the money can be used to finance individual as well as group projects.

Women in agriculture: This programme aims at aiding women farmers with credit other technical assistance to improve their productivity and incomes. Credit is given to groups desiring to undertake group farming or similar joint agricultural enterprises. It can be used for

purchase of inputs such as seedlings and fertiliser, or to hire mechanical equipment such as tractors.

Technology and Food Processing: Groups can receive credit to set up units to process local foodstuffs such as maize, cassava and palm nuts into marketable products such as 'garri' (cassava flour) and palm oil. COWAN can arrange the purchase of equipment from local manufacturers who then supply the machinery direct to the groups concerned. Alternatively, the equipment can be bought from the open market and supplied on hire-purchase terms to the groups. These loans, described as 'loan in kind', are offset from the groups' monthly contributions.

Option Life Programme for COWAN Youths: Members have been required since 1994 to register all their children between 12 and 20 years old in this youth wing of COWAN. Those who are not currently in education are offered training in various crafts and trades, similar to those of their parents, for up to three months. When they have completed, each person can be offered a start-up loan of 5,000 – 10,000 naira to begin a business. This is one of the few cases where COWAN loans are offered to individuals not groups and the amounts are also larger than those per individual adult member in a group. This is justified on the grounds that such credit is supplemental to already established businesses (their parents').

Health: This programme provides family planning and health education services and also operates the Health Development Fund, further discussed below.

Training: Training is an important component of COWAN's work and is essentially a service which facilitates the work of the other programme areas. For instance, training is offered to members to become community-based distributors (CBDs) of family planning devices. Workshops and seminars are also organised on credit management, book-keeping and record keeping, as well as demonstration exercises to equip members with basic skills in the maintenance of their capital equipment such as food processing machines.

- ***Organisation and management***

Membership

Traders (especially market women) and farmers constitute the bulk of COWAN's membership. But membership is not restricted to women and there are indeed male members (attracted mainly, it is said, by the health benefits, which we shall be examining in greater detail later). However, conscious efforts are made to keep the female:male ratio predominantly in the former's favour, and there is a rule that this ratio must not fall below 4:1 in any member-group of COWAN.

COWAN is organised on the basis of small groups known as co-operative societies, each comprised most commonly of 10 to 15 members. In Ondo State (home state of COWAN, hosting its national secretariat and also the focus of this research) six such groups with 225 members took off at the start of COWAN in 1982 and by the end of 1994 there were 650 of these with total individual membership of 21,710. Only 680 of this total were male members

(see Table 1.5). By the end of 1996, the association boasted that it had 6,000 co-operative societies nation-wide with total membership of 120,000.[26]

26 1994 figures from Ibukun Ogunbekun, *op. cit.* , 1996 data from Chief Bisi Ogunleye, African Traditional Responsive Banking Approach (ARTBA): African Innovation for Poverty Eradication, presented at Micro Credit Summit, Wash DC, (COWAN, Akure, 1997).

Table 1.5: ONDO STATE BRANCH OF COWAN – Membership, Contributions and Loans, 1992-94

	1992	1993	1994
Credit Scheme			
No. of individuals enrolled - Female	17,100	19,220	21,030
Male	320	560	680
Total	17,420	19,780	21,710
No. of groups registered	572	580	650
Total contributions or savings in naira	342,548	1,360,800	3,067,200
No. of loan applications approved (to groups)	171	189	426
Value of loans disbursed	513,824	945,000	2,130,000
Loans as percent of total contribution	150.0	69.4	69.4
Average value of loan per application (naira)	3,005	5,000	5,000

Source: *Adapted from Ogunbekun,* op. cit. *Tables 3 & 4.*

Where loans as percent of total contributions exceed 100 percent (1992), this indicates the use of other funds (mainly external donations e.g. from Ford Foundation's seed grant) to support the credit programme.

How the credit scheme (ATRB) works

To join COWAN, a group (or co-operative society) must pay 200 naira (representing the share capital) and 50 naira registration fee in order to receive the registration approval. Before 1993, monthly dues of 60 naira per group were also collected. This amount was allocated as follows: 30 naira or 50% was earmarked for programme administration and office expenses, 20 naira or 33% for the co-operative's Trust Fund and 10 naira (or 17%) went to the Health Development Fund (HDF). The Trust Fund is an interest bearing account held in the name of COWAN at the local branch of the Co-operative Bank. These deposits attract an interest of 1 percent per month.

In 1993, however, the monthly dues were replaced by 'Daily Savings' of 600 naira per group per month, while a separate amount of 20 naira per month was deposited in the Trust Fund for the group. The 'Daily Savings' were increased to 1,200 naira per month in 1995, on the grounds that each individual member of the group should be able to save 8 naira per day without difficulty (hence the term 'daily savings', used chiefly because of its resonance with a similar, well-known traditional institution (*Ajo Ojumu*)). These daily savings are held in an account with a commercial bank.[27]

In equivalent daily savings terms, the monthly dues before 1993 translated into: 50 kobo (0.50 naira) per day in 1982, rising to one naira in the early 1990s, and later to 2 naira between

27 Ibukun Ogunbekun, *op. cit.*

1992—93, 4 naira in 1994, and 8 naira in 1995. In 1997, the minimum daily saving amounted to 12 naira per member.[28]

The group savings are collected by the group leader, who usually collects the monies weekly. This leader will normally hand the money over to a COWAN staff member who attends the regular monthly community meetings.

After six months of COWAN membership and three months of contributions, a group is eligible for a loan of 10,000 naira ($122) per annum. The group identifies the investment project in any area it prefers but COWAN's Programme Officer will assess it for profitability before the loan is granted. Individuals may also apply for consumption loans for non-medical expenses such as children's school fees. These loans, which can be up to 20,000 naira ($244) each, are made from the Trust Fund.

Loan repayments are spread over 12 months with no moratorium except for loans acquired to purchase technological equipment. In the latter case, a moratorium of three months and a repayment period of up to 18 months are allowed due to the larger amounts involved. To illustrate, a group of 5 saving 8 naira per member per day (or 1,200 naira each month) in 1995 could apply for a loan of 10,000 naira for a productive project. (Note that for a group having contributed for only three months, the value of the loan is much higher than what they would have accumulated by then.) This productive venture must assure enough profits to repay the monthly interest on the loan (at 2% below the current bank rate). The group is required to continue its monthly savings after receiving the loan. Therefore, it should have a saving of 14,400 naira by the end of the year to pay the principal and still have 4,400 naira in its savings account after deduction of the initial credit.

Personal loans, however, are payable within six months, at a monthly interest of 2.5 percent.[29] Loans from the HDF are considered to be a separate category, as we shall see.

Default rates are reported to be extremely low, not least because of the strong social control exercised by traditional leaders in COWAN.

Organisational structure

The group or society level. The functional unit of COWAN is the group or co-operative society. Its membership varies from 5 to 25 individuals, more commonly 10 – 15. The members must be bound by some common bond – e.g. same family, age-mates, profession or trade- but the bond is usually economic. A society is headed by its president.

To form a group or society, COWAN's leaders first approach the village or community leader (or church or mosque head, as the case may be). This latter person summons the ten or so women in whom he/she has complete confidence to listen to the COWAN mission. Thereafter, they are empowered to go and form five to ten groups. These groups will obtain

28 Data from Chief Bisi Ogunleye, African Traditional Responsive Banking Approach (ARTBA): African Innovation for Poverty Eradication, presented at Micro Credit Summit, Wash DC, (COWAN, Akure, 1997), p. 32; and from interviews with COWAN staff in Akure, October 1997.

29 From interviews with COWAN staff at Akure, Ondo State, Oct 1997 and Ogunbekun, *op. cit*.

registration, begin their savings and start development projects with COWAN's assistance, advice and technical input.

The role of the village or community head is therefore crucial, not only during the setting up, but also in the running of COWAN's societies. As the National Executive Director, Chief Bisi, explains, "the ATRB [African Traditional Responsive Banking Approach] involves everybody in the community, including the Royal Father and Mother [traditional chief and wife]. The community leaders play central roles in monitoring and evaluating the faithful operation of ATRB initiative activities. They constitute arbitration courts to curb indiscipline *and prevent defaulters*." (emphasis added.)

Some of the most potent tools deployed to prevent loan defaults come from traditional customs related to the religious position and social esteem of the traditional rulers: For instance, among the Yoruba peoples, it is considered taboo for the staff (a symbol of office) of the *Alares* or religious leaders to stay overnight outside the palace. Therefore the religious leader has only to "allow their staff of office to visit the defaulters. … (and) all the neighbors would prevail on the defaulter and help her look for the money and pay promptly".[30]

Similarly, among the Ondo communities, "if one defaulters, the group would go to the defaulter's house with a basket and a keg of water. As soon as the group gets to the front of her house, she would be called upon to come and see what would happen to her by putting the water into the basket at that stage, no defaulter would come out to them, rather, neighbors would rally round to make sure that the money is given to the group. The fear is that if the group should be allowed to pour the water into the basket, it will drain, and that is how the wealth and prosperity would drain away from that community."[31]

The community level. The next level up is the community level, made up of 5 societies from the same community, and coordinated by a facilitator. Community level meetings are held monthly to discuss finances, projects, problems and solutions.

Zonal/Local Government level. A zone is made up of societies and communities in 3-10 local government areas. Zonal meetings are also held monthly with society presidents, community facilitators, the zonal coordinator and field marshals from each village where COWAN exists, in attendance.

State level. The state level consists of all rural women presidents, facilitators and coordinators from different zones, and marshals. They meet bi-monthly to resolve problems from the zones that could not be solved at zonal level.

National level. The national level consists of COWAN's national headquarters in Akure, Ondo State, plus:

- Executive members from each state chapter of COWAN

30 COWAN, Poverty Anti-clockwise: COWAN's experience. African Traditional Responsive Banking; undated publication, p. 13.

31 COWAN, Poverty Anti-clockwise, *op. cit.*

- The financial executive committee (the National Co-ordinator, national secretary, treasurer and financial secretary)
- The Board of Directors (15 in number: 13 rural women presidents, the National Co-ordinator and COWAN Matron)
- The national body meets quarterly to consider issues arising from the state chapters. It is also the forum where programmes and major projects are initiated and carried by members to individual states for implementation.

- ***The Rural Integrated Health and Family Planning Programme***

In the early years of COWAN, it was observed that frequent child birth (little or no spacing of children) contributed to the poor health of women and adversely impacted on their participation in COWAN (for instance, problems with loan repayments and low productivity were some of the consequences). The family planning programme, supported by the Planned Parenthood Federation of Nigeria (PPFN), was therefore launched to help check this problem. The PPFN assisted with the training of community-based distributors (CBDs) and the supply of family planning goods (oral pills and barrier devices). By the end of 1994, 370 CBDs had been trained to dispense these items. CBDs also played an essential primary health care role by referring clients seeking other forms of contraception (such as IUCD and injectables) as well as complications arising from contraceptive use, to private and public health facilities. They are also equipped with first aid skills.

From this beginning, COWAN's family planning programme expanded to incorporate other observed health needs. COWAN now has visiting nurses attached to state chapters as consultants and the organisation runs a few rural clinics such as the newly-opened one at Bamikemo village (Ile-Oluji) in Ondo State and a longer established one in Plateau State. COWAN's health programme also involves training of traditional birth attendants (TBAs) to improve their skills.

However, certain health problems that impacted adversely on COWAN's economic empowerment programmes continued to be observed frequently among the members. For instance, continuing high rates of mortality and morbidity among members, occasioned frequently by inadequate maternal care and child nutrition and self-medication. In turn, many of these problems could be related to high medical fees and lack of funds to pay the bills. A way to integrate health care funding into the credit programme was sought and this led to the establishment of the Health Development Fund (HDF) in 1989.

- ***COWAN's Health Development Fund***

Contributions to the HDF ('savings for health') are compulsory and are fixed at 10 naira per group per month. These savings are held in a separate account from other contributions to the credit scheme. This contribution entitles a member or any close relation who falls seriously ill and lacks the means to pay for their health care, to apply for a soft loan to help the family meet the expenses involved. In other words, the loan is available only in cases of 'catastrophic illness' and since no means testing is actually involved, the onus lies on the

family to decide how much assistance is required, but the amount cannot exceed the actual costs of care.[32] There is no waiting period and loans can be guaranteed by relatives.

Table 1.6: COWAN's Health Fund – Basic Data for Ondo State Branch, 1992-1994

	1992	1993	1994
Total contribution to HDF (naira)	68,640	69,600	78,000
No. of loan applications received	20	30	45
No. of loan applications approved	15	20	33
Percent of loan applications approved	75.0	66.7	73.3
Value of loans disbursed (naira)	55,000	72,500	60,000
Average value of loan per beneficiary (naira)	3,667	3,625	1,818
Where patient was treated			
a. private facility	4	4	7
b. public facility	10	16	26
No. of loan defaults	0	0	0
Shortest repayment period (months)	3	3	3
Longest repayment period (months)	10	13	12
No. of states operating health fund	10	10	10
Health Fund contribution as percent of total (Credit Scheme) contribution (see Table 1.5)	20.0	5.1	2.5
Health Fund loan disbursement as percent of total loans disbursed (see Table 1.5)	10.7	7.7	2.8
Health Fund loan disbursement as percent of Fund contributions	80.1	104.2	76.9

Source: *Adapted from Ogunbekun,* op. cit. *Tables 3 & 4.*

Data from Table 1.6 indicate that only a few loan applications (in relation to the number of members) are received annually for health expenses (eg 45 applications out of 21,710 members in 1994), and around 70 percent of these were approved. Part of the reason for this is the stipulation that only serious (defined in practice by members as life threatening) illnesses will qualify for loans, as well as the requirement (not enforced) that the family should not be able to pay for care from its own resources. Though this latter condition is not enforced, psychologically it can have a deterrent effect because of the stigma that might attach to an applicant as an indigent, but this argument is speculative. More certain is the point that, since the loan has to be repaid, even if on soft terms, people in need must factor in their ability to repay before applying for the loan. Indeed whether means testing is explicitly applied (by the fund's staff) or implicitly done (by the sick persons themselves) should make little difference to this situation since rigorous loan recovery mechanisms exist, as we have

32 Ogunbekun, *op. cit.*

seen. This fact alone must have a dampening effect on demand for assistance, and by the same token, also on health.

Another aspect to this mechanism, which can only further dampen demand for assistance, is the *group* nature of the contribution. Because, at least in theory, the savings belong to the whole group and will be available for withdrawal with interest if no member of the group borrows from the fund for 10 years, it is probably safe to presume that healthier members of a group will tend to apply social pressure on less healthy ones not to apply for the loan even in time of need but to look elsewhere, with the hope of preserving the health savings as a 'nest egg'.

On the other hand, it may also be argued that these features help to make the scheme acceptable to the vast majority of members who are not beneficiaries of health loans but do contribute into the fund.[33]

Reasons for rejecting an application include where amount sought is too small and the illness is not considered serious. In a few cases, it is said that Programme Officers were the ones that identified very ill members and packaged the necessary loan assistance from the HDF.[34] More usually, the visiting nurses and CBDs have been known to recommend a case for HDF assistance subsequent to a referral.[35] This information tends to buttress the above point about the possible deterrent effect of some of the loan conditions.

Table 1.6 also shows that health fund contributions as a proportion of total savings contribution continued to fall in the period 1992 (when they stood at 20 percent of the total) to 1994 (when they fell to 2.5 percent). The main reason appears to be that, as total savings contributions per individual and per group rose each year, the contribution to the HDF (health savings) remained constant at 10 naira per group per month. The adequacy is this latter amount is brought into question by two facts: firstly, disbursements averaged 87.1 percent of contributions for the three years (a relatively high figure if unavoidable administrative costs are taken into account) and secondly, in at least one year (1993), funds had to be transferred from other credit funds to make up the shortfall in loan requests for health expenditure (104.2 percent disbursement of loans relative to HDF contributions).

Loan repayments effected within three months after recovery from illness are interest free, but thereafter, interest at 2 percent per month is charged. The data indicates zero default rates for the three years shown.

33 It should be noted, in this connection, that a major and oft-heard complaint among leaders and promoters of MHOs all over Africa is the tendency of healthier persons to withdraw from schemes on the grounds of not having benefited from their contributions, implying therefore that the insurance concept is not fully accepted by the subscribers. The credit approach may give such individuals the notion (probably illusory in the COWAN case) that their contributions are 'still there', a 'saving' for the rainy day, and not 'used up' by others.

34 Ogunbekun, *op. cit.* p. 38.

35 Interview with COWAN staff at Akure, October 1997.

Though the health contributions are considered nominally as savings, in practice the fund's operation (with the crucial exception of the loan aspect) has similarities to an insurance fund since no interest is normally paid on the 'saving' and stringent conditions make it virtually impossible to reclaim it. For example, any group withdrawing from COWAN after 2-3 years can take its other savings but the health savings cannot be withdrawn till after 10 years. Resigning *individuals* cannot claim anything from the fund. However, as a small incentive, a group, which has not withdrawn from this account for 10 years, will be able to obtain interest of 1 percent monthly after the 10-year period has elapsed. These conditions protect the health fund from depletion and make it possible to use the accumulated funds to help the sick or needy members, although not only on the basis of their need since their ability to repay is also a relevant factor.

- ***Resource mobilisation potential of COWAN's HDF***

The data from the above table (1.6) indicate that resources mobilised for the health sector by this scheme are relatively small. Some possible reasons have been touched upon above, including the low level of the health savings required and the nature of the conditions required to gain access to the funds.

Some indication that COWAN may not be fully tapping its own resource mobilisation potential in this regard can be gleaned from analysis of impact on each member of the 10 naira uniform contribution per group, irrespective of the size of the group. As shown below under 'Equity', this leads to some members paying 2 naira each (if their group size is 5) and others paying much less per head. The argument here is that if members of some groups can afford to pay 2 naira per head, then presumably those in the larger groups (potentially also the wealthier groups due to higher income generation capacities) can equally afford this amount. By not taking this into account, the movement denies itself this further contribution to the fund. However, set against this argument is the fact that a flat fee per group has the virtue and attractiveness of administrative simplicity.[36]

However what is small in relation to the potential and size of COWAN may not necessarily be so for a small hard-pressed health facility seeking cost recovery in an isolated, poor rural community, and it is possible that on occasion, COWAN health savings have made some difference to the finances of such institutions, though no hard evidence is available to support such a view.

More importantly, though, is the fact that what COWAN has been able to do in this small way has potentially far-reaching significance. In other words, the potential for health sector resource mobilisation through this mechanism is possibly much greater than may be realised since the integration of mutual health activity into what is essentially a micro credit institution appears far easier for the community to accept because of the relationship to existing traditional savings concepts. In the case of COWAN itself, the very large numbers of people subscribing to the movement means that a properly designed 'health savings' scheme based

36 A flat fee per member may also have this attraction if there is an up to date register of all members, the task of collection need not be nay more complex than the current system of collecting individual contributions to group savings through group leaders.

on that model could release greater resources for health sector and have a noticeable impact on community health at the same time.

What may be true for COWAN, can be said equally for the many other credit and savings clubs, unions and movements dotted all over Africa. To the extent that these are successful in attracting many people to subscribe (and many of these have memberships running in hundreds of thousands and more) then they could make a tremendous contribution to health in their communities if they can learn positive lessons from the COWAN model and adapt these to their contexts.[37] The model itself may therefore be the real contribution of COWAN's HDF in so far as resource mobilisation for health is concerned.[38]

It should be borne in mind however, that the COWAN falls short of what the health sector would consider its ideal resource mobilisation too, i.e. health insurance. The fact that the scheme is principally a credit scheme means that it has features that deter individuals in need from calling upon its resources. Hence its resource mobilisation potential will be somewhat reduced than if it was a full fledged insurance scheme.[39] If people have to repay the amount spent on their health care, albeit on soft terms, they will think carefully before applying for assistance in time of need, and this will tend to reduce demand.

- ***Efficiency contribution***

Similarly, because of the way that COWAN's health fund is currently designed, it is not able to make any significant contribution to efficiency in the health sector.

The lack of a waiting period is probably not of great significance, and such a measure would in all likelihood have served no useful purpose since the money lent has to be paid back, and this by itself will act as a check on moral hazard.

However, the fact that the HDF operates a cash-indemnity system, with no direct interaction between the fund and the providers, means that the fund is deprived of the most potent means of influencing the quality of care given to its beneficiaries, and also on the pricing of this care. A fund such as COWAN's, if it had been designed differently, could have used the power of the organised consumers represented by the fund to negotiate agreed fee schedules with the providers (obtaining possible discounts for members in the process) and quality standards which the providers must adhere to, thus reinforcing a drive for efficiency in the health sector. But this is patently not the case for COWAN's health fund, with the possible exception of a few cases where the fund has reached an 'understanding' with public hospitals

37 To give just one instance, the Self Help Foundation (SDF) in Zimbabwe, a rural credit movement with membership of well over 300,000, is currently seeking to learn from just this kind of example in order to design a health fund for its members. Clearly, they could learn something useful from the COWAN experience.

38 But to learn useful lessons from this model, a group would have to study its shortcomings as well, some of which have been highlighted here.

39 However, there is, at least in principle, some solidarity between members here since, unlike in the case of the CPH schemes, a member can borrow beyond what they have personally saved.

so that the latter accept COWAN's membership card as a kind of 'credit card' to treat a member who will then reimburse the hospital later from her/his loan. There is no vetting or checking of bills from providers and the choice of provider (and therefore also quality and cost issues) is left entirely to the patient. Indeed, to compound the situation, it is said that efforts are made not to disclose the involvement of a 'third party' payer to the care provider so as not to provoke price inflation by providers armed with this knowledge.[40]

Other potential efficiency benefits that are not available for the same reason are the ability to enforce use of drugs that are generic and from the essential drugs list. Additionally, the scheme has no incentives to encourage or enforce a policy based on the PHC approach (e.g. gate-keeper system) although COWAN's health programme as a whole places much emphasis on primary care including preventive and promotive services.

Due to the scheme's credit features and the absence of interaction with providers, not much significance can be placed on the evolution of health care expenses per member (the average value of loan per application shown in the Table 1.6).

No data is kept regarding morbidity and mortality patterns among members, and so it is not possible to assess the health impact of the fund on those criteria.

Since contributions to the fund are compulsory for COWAN members, adverse selection cannot take place in the scheme. This improves risk management.

- ***Equity***

As COWAN's HDF operates principally in (relatively deprived) rural areas, its health fund has the potential to contribute to equity in the use of health care institutions where it enables poor people in those communities to seek timely health care where they might not otherwise have done. Such a contribution, however, is somewhat reduced by the loan mechanism involved which, as previously argued, will tend to discourage poorer people (those in most need) from applying for assistance if they assess their ability to repay as poor, leading to inequity in utilisation of health services.

COWAN's health programme has led to the setting up of health facilities in rural communities where there were none before, examples being the Bamikemo clinic and another one in a remote village in Plateau State. This is also a contribution to equity in health care provision in Nigeria.

In so far as the health fund is available for the use of the sick members only, and practical difficulties mean that in practice the funds are not 'there' for the original contributors whenever they want them, it can be argued that this represents a cross-subsidy between rich and poor in the scheme (hence equity in the financing of the health services). This argument would however be more sustainable if the sums advanced did not have to be paid back, however generous the repayment terms which, especially in the current context of high inflation in the country, are indeed quite good.

40 Ogunbekun, *op. cit.* p. 40.

Another factor that detracts from equity is the uniform 10 naira per group contribution, irrespective of group size. This means that a 5 member group obviously pays more per head (2 naira each) into the fund than say a 25 member one (which pays only 40 kobo or 0.40 naira per head). Thus in addition to the inequity in the *utilisation* of the fund (hence health services) mentioned earlier, there is also inequity in the *financing* of health care.

Finally, the regulation that a group that has not withdrawn money from the health fund for 10 years will obtain interest creates disincentives to the use of the fund, however small the interest and distant the reward, and therefore detracts from equity considerations. Earlier we stated that the presumption in this case has to be that healthier members of a group will apply pressure on less healthy ones not to make use of the fund, in 'everyone's' interest. This is another case of potential inequity in utilisation of health services.

- ***Access***

The figures on the number of beneficiaries of the HDF each year are not large enough, in relation to the overall size of COWAN in Ondo State, to justify an assertion that the fund has significantly increased access to health care for its members.

However, other aspects of its integrated rural health programme appear to have benefited many more people, according to Table 1.7 showing the movement's achievements up to October 1997.[41]

Table 1.7: Data on achievements of COWAN's Integrated Rural Health Programme

COWAN Activity	Number of beneficiaries to date (October 1997)
Community-based distributors (CBDs) trained for family planning activities	520
Traditional birth attendants (TBAs) trained	50
Advocacy mission with traditional rulers, community and religious leader	1,500
Family planning acceptors generated	251,560
Clients referred for more permanent methods	23,142
Received awareness and education services on family planning	1,655,923
People were reached for maternal and child health care	142,143
People received awareness and prevention education on STDs/HIV/AIDS	52,903
Total	**2,129,738**

Source: Data provided by COWAN national secretariat at Akure during field visit in October 1997.

41 Great care is required in interpreting these figures. In particular, data derived from self-reporting (i.e. by the organisers themselves) of the number of people present at large gatherings or meetings, such as numbers who 'received awareness and education services on family planning' (1.65million in the table), and people who "were reached for maternal and child care' (142,143), are subject to several kinds of error.

Also, the level of the contribution involved (10 naira per group) is so low that this amount by itself could not possibly be a barrier to any member participating in and benefiting from the scheme, i.e. financial barriers are somewhat reduced when the level of this initial fee alone is considered. However, as pointed out earlier, in removing this initial barrier, other formidable ones may also have been created including psychological and social (peer pressure) ones due to the design of the fund.

- ***Sustainability***

Despite all the critical remarks made about the design of the COWAN health scheme above, its sustainability (in financial terms at least) cannot be doubted. This is mainly because of the way it is integrated into a credit and income generation programme. COWAN operates in such a way that the means to afford payment of the contribution is constantly being generated through income generation ventures that members are involved in. The low level of the fee also aids this process.

Other relevant factors in this regard include: the mandatory character of contributions and the use of powerful and very potent tools of social control to enforce loan payments, which mean that there is little danger of non-compliance and depletion of funds on grounds of defaults in contributions. Of course, such depletion can occur from other sources, the chief one being the small size of the contributions and hence the overall size of the fund in relation to demand from members.

From various COWAN meetings that took place during the field visit, there was good evidence that this is a highly motivated movement in which member participation in meetings is fairly high. Again this derives from its character as an essentially credit and savings movement, which has to do with people's livelihoods, an area in which people generally do not show indifference.

As can be seen from Table 1.5, there was a 25 percent rise in membership between 1992 and 1994. Such continuing growth in membership seems to indicate evidence of a dynamic movement. Data on resignations were not available for a fuller assessment of the extent of this dynamism to be made.

The movement also appears to enjoy good support from promoting institutions including external donors, which potentially further enhances the sustainability of its programmes including the health ones.

No data were available to permit an assessment of COWAN's staffing levels and capacities, the ratio of volunteers to paid staff, and whether regular monitoring and evaluation exercises are carried out.

d. The Ibughubu Improvement Union

The format for presenting this section will be modified to take into account of factors. First, the traditional social network kind of social institutions are generally less complex in their organisational structure and functioning than the other organisations we have been examining. Second, a general difficulty with obtaining reliable information from such organisations (a

problem of transparency) means that sufficient data on some crucial areas were not available to allow the same level of detailed discussion as the other case studies.

- ***Background and Objectives***

Ibughubu is a village of around 15,000 persons in Umuchu, a town in the Agoata Local Government Area (LGA) of Anambra State, Eastern Nigeria. Agoata LGA has a population of 341,000 and Umuchu inhabitants are estimated to number in the region of 100,000.

Social solidarity, or the spirit of a shared sense of destiny and of mutual caring for each other, is particularly strong among the Ibo ethnic group, to which Anambra State citizens belong. One view expressed to this author says that this spirit arises chiefly from the civil war in the late 1960s and its aftermath. Immediately before and during the war, which was fought between the Eastern part of Nigeria on the one hand, and the rest of the country (North and West) on the other, the Ibo communities felt under siege and this, together with the act of war itself (like in nearly every war situation) drew people closer together for mutual survival and support. After the war, in which the Ibo-dominated East was defeated, this spirit seemed to have survived and turned into a positive force for self-upliftment and community development, a spirit of self-reliance and self-help probably unequalled elsewhere in Nigeria.

Ibughubu Improvement Union (IIU) was established in May 1972 (significantly, this was soon after the end of the civil war).[42] The main objective was to serve as a forum for indigenes of Ibughubu resident in the village and elsewhere to meet and discuss issues of common concern and take decisions affecting the welfare of the village and to contribute to its development. Each branch also had a mission to seek the welfare of its members wherever they were. The Lagos Branch, especially its women's wing, was investigated for this study.

The Lagos Branch of the IIU has over 300 members, including a women's wing of about 140 members. The women's wing has divided Lagos into five welfare zones, with a woman welfare officer present in each one and whose principal responsibility is to maintain contact with the women and children in the zone and to monitor their health and other welfare concerns, for example, they will monitor instances of burglary affecting members, fire or natural disaster, bereavement, hospital admission, weddings and new births so that they can decide whether and how the union should intervene to support the member concerned. The welfare officer reports to the general meeting on any situation calling for potential intervention and the meeting decides the nature and scale of the support or intervention required.

- ***Organisational structure***

The IIU has two major organisational structures, consistent with what we previously stated about the relative simplicity of these kinds of movement: the Executive and the General Meeting. The Executive consists of a Chair and Deputy Chair, Secretary and assistant, a

42 Most of the data for this discussion comes from interviews with the Chair of the women's wing of this movement, and her spouse who is also a leading member of the organisation.

financial secretary (who keeps documentation of income and expenditure), and a treasurer (who collects monies, takes it to the bank and keeps the imprest account). The Executive is elected by the General Meeting for a three-year term, and its members are eligible for only one more term each after that. The General Meeting is the body of all the members who meet monthly to decide on policy and take decisions, which the Executive is required to implement.

Decisions are made at General Meetings by democratic discussion and simple majority voting after exhaustive discussion. Decisions taken are binding on all.

Besides these two main organs, the union makes frequent use of ad hoc committees to accomplish specific projects. For instance, an ad hoc committee will be charged with following up the case of a member who is before court for some alleged offence, or to take charge of an infrastructure project back in the village.

Membership of the union is open to all Ibughubu citizens over 18 years old. Though no precise figures were available for male members, the women's wing is known to demand 5 naira per woman per month as dues. The corresponding amount for men is said to be quite high, which means that only those in gainful employment can realistically be expected to be able to pay. Therefore, two categories of membership are defined: 'financial members', who are full dues-paying members, and 'non-financial members', who, being unemployed, are non-dues paying. The duties and benefits of the two categories of member are different, as we shall see below.

Apart from dues, funding is obtained through donations (possibly the largest source of funds) on special occasions, and fund-raising events.

Social control is very strong and rigorously exercised not only in regard to matters relating to the union itself, but also in respect of members' behaviour at home and in public. There is a strong disciplinary code which all members agree to abide by, or in default to pay the appropriate fine or suffer such other penalty as is prescribed by the union.

For example, it is a punishable offence for a member to conduct him/her-self in public in such a way as to bring disrepute on the community. This includes engaging in fighting or brawls, stealing (an offence which leads to dismissal) and dishonesty. Women are under an even stricter social regime. It is not acceptable for a married woman to dress 'improperly' in public or to display 'bad manners'.

With such a strong social regime, it is not difficult to understand why accountability is easily enforced in the union. Officers are under powerful social pressure to perform their duties as required, as unsatisfactory performance or dereliction of duty attracts strong group sanctions.

All IIU members are automatically members of the Umuchu Improvement Union, which holds meetings in alternate months. The Lagos branch of the latter umbrella union notably funded the building of a paediatric ward at Umuchu town's general hospital back in the mid 1980s.

- ***Welfare and health interventions***

Services to members are many and include loans for business ventures or consumption loans. Loans are guaranteed by a financial member who will be responsible for repaying the loan in case of default. It also includes areas as moral and material support through a court case (arranging bail, court attendance, financial help with lawyers, etc.).

In case of the death of a member or a relation in Lagos, the IIU is responsible for transporting the body of the person back to the village for burial, including all expenses (coffin, mortuary fees, burial plot) if the member is a dues-paying one (financial member). The union will also present money to the surviving relations.

To make things clearer, the different obligations and benefits of financial and non-financial members are presented in Table 1.8:

Table 1.8: Ibughubu Improvement Union – Obligations and Benefits of Members

Obligations/benefits of a Financial member	**Obligations/benefits of a Non-financial member**
Pays dues	Pays no dues
All expenses of transporting and burying the member or a relation in case of death outside village	Union only pays for coffin and burial-related expenses such as mortuary fees; no transportation
Financial assistance to surviving relatives in case of death	No assistance to relations
Entitled to health care expenses, limited only by group's resources	Gets help with health care expenses but likely to be limited compared to a financial member
Help with other social and economic problems	Limited help with other social and economic problems

As far as the health financing aspect of this movement is concerned, following procedure is foreseen. If a woman or a child of a member is admitted to hospital, the welfare officer will report it. This also constitutes a process of verification in itself. A fixed and annually agreed amount of money is then automatically payable towards the expenses of such a person. A delegation from the union will also visit the sick person in hospital.

The situation is different with male members,. In this case, the union will only intervene if there is a specific request from the family, to the effect that the cost involved is too much for the individual or his family. This process can be as anonymous as possible. Only the President and Secretary need to know the name of the individual concerned, the general membership will be told that a 'brother' or 'sister' in need has asked for some assistance of this or that amount. But it is likely that this anonymity only protects the pride of the well off (or 'financial') members since the dignity of the non-financial members has already been breached by the different membership categories.

The union will then grant the sick person financial assistance to the extent possible, taking into account the actual costs of treatment and the soundness of the union's finances. If

necessary, though, an appeal will be made for special voluntary contributions. Eventually however, the details will have to be made available to the auditors (appointed from among the members annually to examine the books). The union will still organise hospital visits to cheer the person up.

An example is cited of a couple who just got married and got involved in a bad accident while travelling home afterwards. The IIU helped the family to pay the full amount of 40,000 naira ($488) for hospital expenses (including surgery and orthopaedic bills). In addition, a group was asked to visit the hospital not less than twice a week to monitor the progress and help comfort the family. In such circumstances, an emergency meeting will be called and special contributions asked for to help meet the expected expenses without depleting the union's funds.

There is also a health education role where the union organises talks at the monthly meetings on health-related issues, such as AIDS, family planning and hygiene. Members who have special skills will be called upon on those occasions to assist. For example, the health education sessions are led by the chair of the women's wing because she is a principal nursing officer (PNO) with the Federal Ministry of Health in Lagos. (Similar talks involving other lead persons take place on issues as diverse as home economics, trading, and livelihood skills).

- ***Analysis of the health contribution of the IIU***

From a **resource mobilisation** viewpoint, it is arguable that the IIU is one of those informal, and largely unacknowledged, sources of health care funding particularly for individuals who have large hospital bills and no means of meeting them from their own resources alone. To the extent to which this is funded from prior contributions of the members, it is a form of health insurance but its true scale and significance for the health care system cannot be assessed without more data.

And this is where such movements fail. There is a lack of transparency, closely linked with a distrust of those who are not members of the target community, which makes this barrier a difficult one to break.

However, it can also be argued that one of the main contributions of such movements is to enable people who would otherwise have no other means of gaining **access to quality health care** in time of need, to obtain this via their membership of the movement. Such movements are particularly effective in the breaking of non-financial barriers to access such as the psychological ones mentioned in earlier analysis here. This is derived from the unusually strong influence and control which they exercise over their members, a degree of influence and control which no other institution, certainly not state institutions, can rival. A possible exception will be a church organisation, but the relationship between the traditional social network and the church usually tends to be close, complementary and mutually reinforcing, rather than competitive. This happens usually because all the members tend to belong to the same church (a carry over from the village) and have the same pastors officiating at their family events, etc.

In terms of **sustainability**, these are probably among the most sustainable type of institution in Africa because of their strong roots in tradition and culture (sometimes also religion as mentioned above) combined with a focus on personal economic advancement and concern for the well-being of each one which makes their appeal irresistible to the majority of the populace. Certainly these movements tend to attract loyalty and commitment from their members, as well as systems of internal accountability which would be the envy of many modern organisations.

Another health sector area where organisations like the IIU may make a significant contribution is that of **governance**, hitherto not found to be a significant area of intervention of any of the previous Nigerian MHOs examined. The IIU has powerful links with local development authorities back in the village (indeed it has a strong presence on the development scene at home) and so is in a pole position to be consulted and asked for opinions on proposed development projects, including health sector ones. At any rate, it has influence with local politicians and bureaucrats who are involved in decision-making affecting such areas, many of its leading members are themselves local politicians or notables in their own right and so the channels of communication and consultation are varied and likely to be exploited to the full.

For the rest, however, the IIU (and many movements like it) makes little or no contribution to advancing other health sector objectives. The IIU has no interaction with health care providers, and so cannot make any significant **efficiency** contribution (for the reasons previously discussed in regard to COWAN). In terms of **equity**, its impact may be at best a mixed one, or even possibly perverse. In contributing to the development of health infrastructure back in the village, and if the village is relatively deprived one, as most villages in Nigeria (and Africa) are, a movement like IIU makes a positive contribution to equity in health provision. But it is well known that such organisations tend to appeal best to the elite of the community concerned (and the IIU's distinctions between financial and non-financial members is a good example of what makes such an organisation less appealing to the poorer members of the community). Differential access to benefits based solely on one's contributions is not a policy to promote equity.

4. Institutional, policy, legal and regulatory framework

We will now look at some macro issues affecting the development of MHOs in Nigeria. We will explore briefly the institutional environment and the legal/regulatory and policy framework in order to see where the gaps are as well as the areas where possible donor and external intervention could have a useful impact. In the final section on Conclusions and Recommendations, we will then make a similar analysis of gaps and possible areas of intervention based on the previous case study analysis.

a. Institutional framework

In the Western part of Nigeria, where this study was carried out, the institutional environment for the promotion, development, and support of MHOs appears to be quite good. Examples of institutions found to be capable of playing such a role abound: not only USAID (particularly its BASICS programme), but also UNICEF, WHO, the Christian Health Association of Nigeria (CHAN), Ford Foundation, the MacArthur Foundation, the Association for Reproductive and Family Health (ARFH), and the Women's Health Organisation of Nigeria (WHON). Of these, however, only USAID, WHO and UNICEF were actually actively working to develop MHOs on the ground (UNICEF supports such initiatives at least in the North). As we have previously stated, WHO has been involved in giving technical assistance to a scheme in the Ogun State, and we shall return to discuss the main features of this scheme at the end of this sub-ection. The rest (including many others not listed here) clearly have the capacity (infrastructure, qualified trainers, motivation, etc.) to play similar roles, if properly sensitised and with appropriate technical and logistic assistance.

But Nigeria, as previously noted, is a complex country and different areas of the country have different experiences and levels of need. Therefore what obtains in the West, a largely rosy picture, does not necessarily exist elsewhere, and indeed the evidence suggests that this is far from being the case as far as MHOs are concerned.

In the North, modern MHOs are just beginning to take off. BASICS has extended the experience in Lagos to Kano State, where five pilot CPHs have been launched. UNICEF has also provided assistance for a mutual health insurance (community financing) initiative in Kano.

The context of the North is very different from the West (or South in general), being basically Muslim (where the West is more Christian/animist) with all that this implies in terms of culture and social organisation. For example, the definition of the boundaries of the family will be a crucial issue here for the viability of a MHO since polygamous marriages are more likely to be prevalent. Similarly, promoter and support organisations are not as abundant as in the South (generic term used for the West and the East) of the country. Other relevant factors are the fact that education is much less advanced in the North, and that poverty is more widespread. All are factors which will affect the design of schemes for that part of the country, and in the absence of a good local network of support or promoting institutions with requisite skills and experience, this will probably require intervention of a different kind from the South. Such a programme for the North is likely to involve more external institutional support than for the South.

In the East, as has been noted, a strong tradition of self-reliance and mutual assistance already exists and may provide a fertile ground for the development of MHOs. It would be interesting to know what the experience on the ground in this area is, and the UNICEF-sponsored Directory of NGOs in Nigeria mentions a women's organisation called Women's Health and Economic Development Association (WHEDA) whose list of activities includes "running a small health insurance scheme." Attempts during the mission to get some documentation or other information concerning this initiative however proved abortive. But a potential obviously exists there, and moreover, like the West, the local institutional environment is likely to be reasonably good. In such a case, sensitisation seminars and workshops could serve to unearth any hidden potentials and construct the foundation (organisational networks and contacts) for a MHO programme there.

The Ala/Idowa Community-based Health Insurance Scheme mentioned earlier has its origins in the findings of a WHO sponsored multi-country Research and Development project which studied alternative sources and mechanisms of ensuring adequate financing of services. The researchers recommended the formation of a local health insurance scheme around the local health centre. A lecturer at the University of Lagos, Nigeria, has been the driving force behind the Scheme.[43]

According to the WHO mutuals database, the Ala/Idowa Health Centre is a "typical modest rural primary health centre with a full complement of community health workers, headed by a medical officer. ... The centre provides basic health services including a full range of maternal and child health services. ... Ala and Idowa are rural communities seperated by a trunk B road, but share a common historical, linguistic and cultural heritage. ... The major occupation of the people is subsistence farming, supplemented with some handicraft and trading activities."[44] All services provided at the health centre are included in the scheme's benefits, but referral to secondary/tertiary level is not covered.

The scheme is formally owned by the Ala/Idowa Health Society and the management is carried out by the Ala/Idowa Health Society through the Governing Board.The secretary of the board is always the health worker in charge of the Ala/Idowa Health Centre, or his representative.

The Ala/Idowa scheme is a further example that institutional support for MHOs in Nigeria, by those health sector donors and international agencies still working in the country, is not lacking but perhaps requires reinforcing.

b. Legal, regulatory and policy framework

The legal framework for the development of MHOs in Nigeria is somewhat deficient. All NGOs in the country are required to register with the Corporate Affairs Commission (CAC) in Abuja, in order to obtain corporate (legal person) status and also to qualify for tax exemption and other benefits e.g. assistance from the Petroleum Trust Fund (PTF), set up to help local development efforts. No distinction is made concerning the purposes and nature of

43 See WHO Database of Health Insurance Schemes for the Non-Formal Sector. Geneva: WHO, 1998.

44 WHO Database, *op. cit.*

the NGO. Hence the special sectoral concerns and needs of the MHOs for instance are not addressed by the registration process or requirements. These sectoral needs include what constitutes a MHO in Nigeria (as opposed to other kinds of organisation involved in health or other social sectors), model rules and regulations drawn up by or in consultation with the MHOs and made available for new organisations to adopt and adapt to their own needs, regulations concerning the running of non-profit insurance schemes,[45] protection for members who are paying their subscriptions on trust, etc.

The only new initiative of the Nigerian Government in this direction is a draft policy document for the regulation of NGOs. While most of it is benign, some key sections have been opposed by the local NGO community because they are perceived as having a potentially pernicious impact. There is concern, for instance, at proposals in the document that, in the "interest of national security", NGOs should be subjected to certain regulatory controls including mandatory disclosure of all sources of funding to appropriate government agencies. Under this draft document, NGOs will also be required to set their objectives within the framework of the Nigerian Government's priorities. And at the state level, the office of the Governor is to be mandated to "establish an Inter-Ministerial Committee to monitor, document, register and evaluate programmes and activities of NGOs in the state."[46]

Finally, the issue that is going to radically affect the regulatory and institutional contexts as well as the policy environment for development of MHOs in Nigeria in the future is the proposed National Health Insurance Scheme (NHIS) being piloted now in some states.

There is need for clarification as to what will happen to existing MHOs when the national scheme is fully operational. As currently proposed, the NHIS will concentrate on the formal sectors, hence urban areas mainly for the foreseeable future. Though there is provision to extend this to the rural population, possible difficulties migtht arise with the running of the formal sector. Budgetary constraints, inherent difficulties of collecting subscriptions from informal sector workers (evidenced by the poor track record of existing tax systems in collecting tax revenue from that sector) and poor rural health infrastructure are likely to delay that aspect for a long time. The question then is what arrangements are to be put in place for the rural folk left out of the NHIS? Clearly, this is the area where the comparative advantages of MHOs come in, especially in their superior ability to mobilise the necessary resources from the informal sector. Even within the framework of an eventual public sector scheme for the informal sector, could MHOs come to be seen as serving as a vital transitional institution or as a crucial partner with the public scheme? Could they eventually become carriers of official health insurance as happens in some European countries notably Germany, Holland, Belgium? The possibilities are endless, but the success of existing MHOs will make it more difficult to ignore their potential, given the almost insuperable difficulties that the NHIS will have in being extended to the informal sector.

45 This concern was expressed notably by COWAN's Executive Director, who believes that the law forbids NGOs from running insurance schemes, so that they can never call their health savings scheme an insurance one even if they wished to. At the very least, there is vital need for greater clarity on the matter.

46 Federal Government of Nigeria, National Policy on Non-Governmental Organization (NGOs) – draft, Federal Ministry of Women's Affairs and Social Development, Jan 1997. A Press Release signed by a number of Nigerian NGOs including the Civil Liberies Organisation described the document as intending to "cage the activities of vocal groups."

5. Conclusions and Findings on MHOs in Nigeria

1. Nigerian experience in the area of mutual health organisations (MHOs) is not generally well known in the outside world. Additionally, because of the country's relative political isolation in recent times, there has been a tendency to ignore even developments in the non-governmental sector of this big country (which contains nearly a quarter of Africa's total population). This mission may help to focus more attention on this experience, and our analysis shows that the Nigerian experience has several interesting features and a contribution to make to the body of African practice and knowledge in this field.

2. One of the novel and interesting features of the Community Partners for Health (CPHs) is that they are organised through existing community organisations of all kinds – from local trade unions, to traders and professional associations, church groups including spiritual or charismatic church groups, Muslim groups and traditional birth attendants. Membership of the CPH is gained not directly as an individual but through the local association which offers advantages in terms of social control and prevention of abuse or fraud as well as the chasing up of defaulters. It also means that control is exercised at the lowest possible level.

3. Another feature that is worth noting is the savings nature of the schemes, rather than an insurance mechanism as such. The idea of saving for health is apparently better understood (as an extension of traditional saving concepts such as *esusu* or *ojo*), whereas insurance is less well understood, and moreover, requires different and rather scarce skills to manage properly. This particular adaptation not only saves on administrative costs (for the CPH), but also helps avoid fraud, an ever-present danger with insurance schemes everywhere and a big problem in Nigeria. These remarks apply equally well to the COWAN Mutual Health Savings scheme too.

4. Other lessons that can be drawn from the CPH model and experience are:

    - The formal separation of the health facilities from the CPH through contracts and negotiation (Memoranda of Understanding). This separation is essential for reasons of efficiency, effectiveness and quality of care. However, in practice this separation is sometimes illusory since the Chief Medical Officer who played the crucial part in the initiation of the CPH scheme does tend to become the dominant personality (aided by the prestigious status of the doctor in the community).

    - The setting of quantifiable objectives for the CPH to achieve (aids the budgeting, planning, monitoring and evaluation processes immensely).

    - The identification of the community's key health problems in the initial stages as the special focus of the CPH's targeted intervention. This is a good design feature aiding in the achievement of improved access to health care, equity and efficiency.

    - The focus on PHC, child and mother survival.

2. Some of the design weaknesses of the CPH include poor or non-existent referral mechanisms from the PHC clinic or hospital to higher level referral health facilities.

3. Implementational problems of the CPH arguably include poor or inadequate accounting and financial skills and practices.

4. The COWAN model has the advantage that it is based on a traditional institution (credit and savings) which has wide legitimacy and is easily understood. Its potential for generating resources for health care is therefore arguably quite good. However, the COWAN experience probably suffers from excessive caution in regard to the actual level of contributions and the conditions of access to the savings.

7. Finally, the potential indigenous institutional support for a mutual programme in Nigeria appears to be quite good. However, there is only limited external (donor and other) support available due to existing political constraints.

- ***Recommendations***

Areas of intervention which have been highlighted by this study and which will add some value to the experiences of the MHOs in Nigeria include:

1. In every country, co-ordination between donors and other interested parties will be useful in order to map out the areas of unmet needs and to match available resources to the areas of greatest priority. In this case, USAID, UNICEF and WHO could help establish the nucleus of such a network.

2. The analysis of the CPH experience shows that specific training is required for managers in administrative and accounting procedures; as well as record keeping and funds management.

3. Concentration on the health activities and sectors of the population which will not be covered (at least initially) by the proposed phased introduction of national health insurance scheme (which means mostly the informal sector including rural communities) will be the right direction in which to develop MHO interventions in the future.

4. Technical assistance to existing MHOs to equip them better to manage their schemes (e.g. with the skills to carry out monitoring and evaluation of their work, and with the skills to run an insurance scheme) is another clear area of need. The analysis shows that the Nigerian schemes would also benefit from targeted training in these areas: need for independence from the provider (CPHs), use of negotiating power, marketing, need for quality control mechanisms, and drugs' policy.

5. In the area of technical assistance and mutual promotion, it may be useful to bear in mind one of the principal findings of the Nigerian case studies, namely that the 'complex' or high participation model of community financing (ie the CPH type of scheme) appears better attuned to the health care needs of the communities and health sector goals of the country than either the 'simple' (low participation) type or traditional social network scheme. Social movement based schemes may also have great potential, as the COWAN scheme shows, and indeed it is no coincidence that both types (social movement and 'complex' community financing) share broadly similar features in so far as participation by the insured or their representatives in management is concerned. These participatory

features may be the real key to their relative success (or potential to do so, as the COWAN example arguably shows) but one further advantage of the participatory community financing or CPH type is the fact that it is directly linked to the providers and therefore potentially at least, can negotiate terms and influence quality and efficiency of provider care. COWAN is not able to do this because it has no links with providers (except its own clinics).

6. Attention needs to be paid to the critical issue of the legal and regulatory framework in which MHOs operate. There is need for MHO-specific legislation to enable mutuals to acquire a legal or corporate status through registration, to offer protection for members who subscribe and pay dues, to regulate financial management and administration, and may be some model rules and regulations (drawn up in consultation with existing mutuals) which new organisations can adopt or adapt to their own needs. But the proposed policy framework for NGOs by the Nigerian government has potential to be used to harm the interests of such organisations and does not address adequately the specific needs of MHOs.

7. The proposed national health insurance scheme has several shortcomings, in particular, the way it appears to ignore the interests of important stakeholders and the lack of public debate or discussion of the key design features. These shortcomings need addressing to ensure that an inappropriate and perhaps unworkable scheme is not imposed on the country.

6. Appendix : Lawanson CPH partner members – List

Health Facilities:

1. Pine Hospital, Ijesha
2. Rock of Ages Hospital, Suru-lere
3. Anthnie Clinic, Mbonu-Ojike St.
4. Roysl Health Care Hospital, Lawanson

CBOs

1. Omobola Residents Association
2. Obele-Kolade Residents Association
3. Mbonu-Ojike Residents Association
4. Obele-Oniwala Residents Association
5. Women's Empowerment Committee
6. Photographers Association
7. Carpentary Association
8. Vulcanizer Association
9. Sis Mulumbar Catholic Church, Lawanson
10. Market Women's Association
11. CCC Ibujeran Parish Itire
12. National Union of Road Transport Workers (NURTW)
13. Onilegogoro Residents Association
14. Goldsmiths Association
15. Battery Chargers Association
16. Duro Oyedoyin Residents Association
17. Lawanson Rising Star (Youth Wing)
18. Traditional Birth Attendants Association
19. Ansar-ud-deen Clinic (herbalist?)
20. Tailoring Association
21. Hairdressers Association