COMMUNITY-BASED HEALTH INSURANCE

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Ever since the economists have taken over the health agenda, new ways of thinking about health care and its organization have been proposed and put to test. Costs of health care and its financing have since become active fronts of engagement in health policy planning. Experience from various health care financing schemes is growing but the traditional question on whether the financing schemes benefited the poor in terms of assured access to quality health care remains unresolved.

At the same time, many countries face crises in managing rising costs of health and medical care on a sustainable base. This raises another question: can community insurance schemes meet the gap in financing health care? Coverage of primary care service and provision of social security at times of illness constitute definite benefits for the poor when community-based health insurance schemes feature pro-poor safeguards.

The complexity of organizing these schemes limits ability to scale up rapidly. More examples with hard data are needed, if community health insurance is to become popular. The issue of scaling-up, nevertheless, remains a developmental challenge attempting to find resolve in intensified networking, such as the one emerging in East Africa.

However, it is important to note that diversification of sources of finance for health care is the key developmental consideration, and community health insurance is only one of the diversification avenues. It took time to grow into a dependable system in industrial economies and hence over simplification will not do justice to the subject. Taking advantage of the rapid communication of our times and people’s current need for assured access to health care, wider sharing of experiences in community health insurance should bring many faith-based health services in developing countries, new examples from which they can learn.

The risk pooling principle inherent in insurance schemes may still carry limited understanding among the elite in developing countries. Rural communities’ understanding and subsequent participation requires rigorous preparation, extensive orientation and dialogue.

For community health insurance to function, it is obvious that there has to be a working health system from which services get purchased. Complementary reform to assure quality in the health system is necessary if purchasers are to remain attracted. This is particularly the case where a number of providers are available for a suitable scene for competition. Management of schemes sometimes is vested in providers of health care and sometimes in hands of communities. Provider-based management does not facilitate the principle of provider/purchaser split but it may have its place in specific situations. Challenges often posed include stewardship, fund abuses, organization and utility control through close monitoring. Valuable lessons learned may assist to deal with these challenges. The papers presented in this edition of Contact highlight lessons as well as elaborate on some interesting experiences.

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HEALTH FINANCING
BY THE PEOPLE

With governments becoming reluctant to spend more on health, privatization of health is increasingly finding favour with many authorities. Present day economic policies dictate hospitals/health centres to be managed like any other commercial set-up which means no free medical care and if possible, aim for profits. It is therefore, no surprise that health insurance has almost become the new catchword. But developing countries with their low per capita defy such simple solutions. In such situations, formal security schemes could be complemented with community-based health insurance; cooperative health care or user-finance systems. Dr N Devadasan explains the concept of community-based health insurance and its worth.

What is community-based insurance?
Community-based insurance schemes unlike other ‘regular’ insurance is targeted at a specific community and is essentially meant for the people in the informal sector — mostly the rural and urban poor. Unlike user fees or private insurance, where one pays for oneself, in a community-based scheme the community takes responsibility for the health of its people. People from the community get together and make a pre-payment to pay for any member within the community when he/she is ill, so that there is no financial burden at the time of illness. It has great relevance in countries with a growing informal workforce and stymied economic growth.
Community-based insurance is viable in settings where the community is organized for other purposes. The common examples are the micro credit groups, women’s groups, farmers’ clubs etc. This has various benefits, ranging from a pre-existing forum to explain the concept of insurance to minimum administrative charges for collection of premium and disbursement of re-imbursements.
In an insurance scheme, there are

INTRODUCTION
Modalities of payment

Most of the schemes are financed from a combination of premium collections, government grants, donations and other miscellaneous items like interest earnings etc. Premium in most of the schemes is on flat rate basis, paid annually and payment is mostly in cash. In more sophisticated schemes, premiums are according to income. In India, many CBHI schemes have set premiums on a sliding scale according to income. Some schemes like the Sevagram scheme also allows payment in kind.

Profit or loss - not that simple

Most discussions focus on the financial gains of a CBHI. It is well known that it is difficult for a CBHI to make profits because the numbers are small and they cannot enjoy the economics of scale. But the important question is, why should CBHI be self-sustaining? Health care is a basic right, and it is the responsibility of the government to provide it to those who cannot afford. What community-based health insurance can do (and does), is reduce the subsidy needed by tapping creatively into local resources. Thus, if a community of primitive tribals contribute 20% of their health care expenditure through insurance, that should qualify as a success.

Administration

Having said that, there is no denying that one of the biggest challenges in ensuring that a community-based insurance does not derail is to make sure payments are made on time and more importantly that collections are made and accounted for. Given their erratic earnings, most people in the unorganized sector find it difficult to pay ready cash on predetermined dates. Which makes it important for the CBHI to be flexible and tailor collection dates to the periods when the community has funds.

Other than that, the administrative costs of the schemes in the NGO sector are generally low. This is probably because
the schemes do not indulge in too much marketing and most of expenditure is used for the welfare of beneficiaries. Also the NGOs and the community subsidize much of the administrative costs by taking the responsibility for collection of premiums and processing the claims and reimbursements.

Role of NGOs

NGOs who are interested in developing a CBHI have several vital roles to play.

a) They can sensitize the community to the advantages and implications of insurance.

b) They can build groups that can negotiate with insurers.

c) They can act as watchdogs to minimize abuse of the system; that false claims are identified, and delayed processing by insurance companies are rectified.

d) Streamline the administration; pay upfront, get reimbursement from company.

e) Monitor the providers and reduce the moral hazards by limiting unnecessary procedures and investigations.

f) Ensure for common illnesses (diarrhoea, malaria) and not just major ailments related to the heart/kidney are covered.

Advantages

The strength of CBHI lies in its possible use as an instrument of community empowerment.

☑ It complements existing community mobilization efforts by bringing the community together on an issue that affects all of them.

☑ The community is no longer a passive receiver of services; nor are members receiving it in their individual capacity. They now have a voice because they are contributing to the cost. And, equally important that voice is a combined voice, further reinforcing their group identity.

☑ It strengthens the process of dialogue with the community. The dialogue process increases the recipients’ understanding of the process. It also provides the opportunity and the forum to discuss about health and its causes, development, environment, social justice etc. For example, at Gudalur in South India, the community members were unhappy because though they were paying, they were not receiving any injections. This presented the opportunity to have a detailed discussion on why injections were not necessary for treatment.

In other words, CBHI builds and strengthens the entire system, while traditional health insurance is solely a financing mechanism.

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WHAT PLACE FOR HEALTH INSURANCE?

Free health care is an illusion. There is no such thing as free health care – the equation is straightforward: households pay for everything!… but the implication for the household (i.e. the 'burden') differs considerably according to the way of payment!

Dr Bart Criel explains...

Nevertheless, the disadvantages of user fees are clear, certainly when they are comparatively very high, which is the case in many African countries. They decrease the access to health care for poor population groups and they can even lead to total exclusion in situations where the family income is seasonal as in many rural African communities.

Insurance systems are, therefore, a technically interesting option that can also contribute to the solidarity within the community.

Types of mutual aid mechanisms

In most developing countries in particular, a number of collective mechanisms designed to face individual risks have been developed. These risks are related not only to life cycle events like birth and death but also to illness.

Insurance implies the possibility of a discrepancy between the initial investment (i.e. the costs for the insured) and the eventual result (i.e. the personal return) of this investment for the subscriber. This frequently occurs in practice. From a financial point of view this means that there will always be winners and losers: everybody pays in to compensate the damage suffered by some. Hence, the insurance principle differs from the reciprocity principle where inputs and expected outputs are more or less equivalent.

Insurance can be paired to varying degrees of solidarity. In the case of insurance, this means the (implicit) acceptance that the size of the personal return may not match the initial investment. In the case of mandatory insurance systems, as they exist in many European countries, this unequal relationship is imposed on people by law. Solidarity is then institutionalized,
but is nevertheless reversible. Whether it is reversed or not depends on the political and social choice that society makes.

**Mutual aid mechanisms without insurance**

Family and clan solidarity is based on the moral obligation – informal, but nevertheless codified – to help family members.

These systems of mutual aid are selective since those who do not belong to the family, clan or ethnic group cannot benefit from the aid. The ‘coverage’ definitely goes beyond troublesome events like illnesses or accidents, and includes happy events like births and feasts.

Next to traditional family solidarity systems, there exists in Africa a rapidly-growing lot of endogenous associative movements, which play an important role in the domain of mutual aid. These associations may gather people beyond kinship relations, they intervene in a wide range of (positive and negative) events, and they contribute to the creation and reinforcement of social networks. These associative movements can be classified according to the social features of the people that have joined the association, or according to the nature of the services the association provides.

The *tontine* or Rotating Savings and Credit Associations (ROSCAs) is one type of associative movement that constitutes a widespread aid arrangement in the whole of Africa. These arrangements are not insurance systems, but rather informal (yet not illegal) savings systems. Usually a *tontine*-consists of a limited group of people who have something in common (like for instance a same profession) or who are acquainted in one or the other way. Each participant makes regular payments to a common pool (the ‘pot’) which is then in turn allotted to each one of the participants. The investment, usually financial, is in principle in balance with the eventual individual benefit. *Tontines* are usually created in order to generate a small capital that is invested in a small business, or that is used to purchase a particularly costly item. *Tontines* are rarely mobilized to cover health care expenses, since these are difficult to determine and plan ahead.

**Pre-payment system**

In the case of pre-payment systems, a certain payment, sometimes on an individual basis, but usually on family basis, is made in advance to a health care provider or health care institution. At every consultation of the health care provider, this prepaid amount is gradually debited – according to the consultation fees charged – until the total amount is consumed. This system is actually quite rare and is usually organized to pre-finance the costs of fairly predictable health care costs, like antenatal or under-five consultations. Pre-payment is, nevertheless, an interesting option because it allows purchasing health care at a time when money is indeed, available in the household. The impact of pre-payment, however, is limited by the fact that expensive events, like a hospital admission, are more difficult to pre-finance. Moreover, in such systems the risk is generally shared amongst a relatively small group of people (a family for instance.)

**Mutual aid mechanisms with insurance**

There is a distinction to be made between the model of mandatory health insurance (especially the Bismarck-model as it exists in different European countries), and voluntary health care systems.

Systems of compulsory health insurance do exist in most African countries. In most cases, they were established in the last year of the colonial rule or in the first years following the independence of the young African states. This Bismarckian health insurance model is in fact, an imported (European) model, introduced in countries.
There are two types of insurance: "high-risk" and "low-risk." Public or private insurance systems are usually driven by a public-private rationale, such as the individual's financial risk and capacity at the government level. Today, such a capacity is not readily available in most of the sub-Saharan African countries. Moreover, it is highly questionable whether the risk and cost sharing policies employed by the rural health population enjoys sufficient popular credibility for the population, particularly civil servants.

A possible extension of these health insurance systems to the informal sector and the urban population could be distinguished with the help of health care expenditure. Protection of the family capital — savings for health — is necessary. In this perspective a British citizen would be insured as a German citizen although the health care in the United Kingdom is mainly tax-financed and health care in Germany is financed through earmarked social security contributions. While both these have their place, other factors play an important role.

1) Target population. The size of the population is inversely related to the potential for the community to participate in the scheme's management. A larger population allows for economies of scale, hence contributing to the scheme's efficiency and effectiveness.

2) Degree of overlapping: The population targeted by the insurance scheme and the population covered by existing functional entities of health care providers (e.g., a health district) often overlap. Health care financing then may be a major issue, leading to a variety of solutions.
constitute a lever to rationalize the pattern of health care delivery organization in that very functional entity (for instance, rationalizing the referral system).

3) **Intermediary institution**

An intermediary institution — a monitoring body — between the source of funding (i.e. the households) and the eventual destination of the funds (i.e. the care provider) has an active role to play.

If one combines these different variables, one can distinguish two poles of voluntary health insurance systems: on one hand, the ‘mutualistic’ or participatory model, on the other, the ‘provider-driven’ or technocratic model.

**The mutualistic model**

In the mutualistic model, the members’ association, or a Mutual Health Organization (MHO) functions as an intermediary structure between the source and the destination of funds.

The mutualistic model is often part of a larger social dynamic where solidarity and self-governance are important concerns. The insurer and the care providers confer with each other and negotiate the terms of the care that will be offered to the insured and define the financing modalities of the package of benefits. These are then recorded in a contract. In MHOs, there is a commitment (often explicit) to achieve results, i.e. to offer certain types and amounts of care at an agreed price.

The operation of such an intermediary structure obviously accounts for additional expenses to the system as a whole, but through this structure an improvement in quality and efficiency can be obtained from the health care providers. Such a structure can serve as a kind of ‘counter-force’ to the health care services. Whether or not this potential is indeed achieved, mainly depends on the objectives pursued and on the managerial capacity of the purchaser.

**Corporate and non-corporate MHOs**

A dynamic of mutual insurance systems exists in Africa, especially in the French-speaking part even though this ‘movement’ is still recent and poorly structured. There is a distinction between corporate and non-corporate MHOs. The corporate model is targeted at individuals and their relations. The non-corporative type is aimed at a more mixed population, but which as a group shares other characteristics: for instance, people who live in the same neighbourhood or social movement. The corporative system usually has many more members than the non-corporate system as the latter often remains small-scaled, at the most a few hundred people. This obviously will influence the financial sustainability of the latter.

Mutualistic dynamics enjoy important technical and institutional support. Many mutualistic initiatives, however, struggle with problems in the institutional design and management of the system. The financial viability of African mutualistic associations remains, on the whole, limited due to lack of economies of scale.

**The provider-driven or technocratic model**

This is also a voluntary health care insurance system without, however, an intermediary structure between the payer of funds and the health care provider: in other words, the care provider is also the insurer.

Such an institutional construction bears a resemblance to the HMO (Health Maintenance Organization) model that is widespread in the United States. In Africa, this model is found in situations where the District Management Team is responsible for the organization and the management of an insurance system. The target population is then the population for which the district is explicitly responsible. It can be the population of the whole district or the population living in the ‘area’ of a health centre. Generally, the insured patients are then required to consult a well-
defined care provider. The health care provider is then the financial risk-bearer. This model can substantially increase access to health care when the district team is lead by a public finality and when it possesses the necessary managerial capacity. The insurance system for hospital care developed in 1986 in the Bwamanda district in the Democratic Republic of Congo is a well-documented example of this model. An important limitation of this model, however, is a lack of a ‘counter-force’ to the health services. The risk that the health professionals actually dominate the decision-making process is real indeed. This was clearly illustrated in the case of the Bwamanda scheme.

**Conclusion**

The different arrangements discussed cover a range going from very informal systems to very formal ones. Mutual health organizations as well as centrally managed and mandatory social health insurance systems all co-exist in Africa, although they are independent of each other. This is not the case where the dynamic of mutual health organizations have gradually evolved. Consequently one system is the historical outcome of the other.

Obviously there are intermediate forms between the two above-mentioned models of voluntary health insurance. Such an intermediary model is not only possible, it is perhaps even desirable. It would, indeed reconcile the transparency and participatory potential of the mutualistic model with the effectiveness and efficiency of the more large-scale provider-driven or technocratic model. In this way, a better synthesis between people’s priorities on one hand and the technical know-how of health professionals on the other could be achieved. This is only possible if there is a continuous dialogue between both partners.

This intermediary model seems coherent with the philosophy of Primary Health Care as formulated by the World Health Organization in the Alma Ata (WHO 1978). The philosophy of Primary Health Care advocates consumer participation in the management process of the health system as well as the pursuit of an optimal accessibility of the health services.

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Hospitalization - a privilege of the rich?
VITAL LINKS: GOVERNMENTS, NGOS AND INTERNATIONAL ORGANIZATIONS

Community-based insurance schemes, primarily for people in the informal sector, can have great relevance in countries with poor growth prospects and a growing informal workforce. Dr Christoph Benn examines the situation in sub-Sahara Africa and focuses on some of the challenges, which include ways and means in which accessible care of good quality can be organized by using non-government resources along with government support, in a transparent and accountable manner.

Introduction

Many countries in sub-Saharan Africa are facing an acute crisis in the delivery, management and financial sustainability of their health care services. The main health care providers are governments, voluntary agencies (mainly church-based institutions) and to a lesser degree, private or profit organizations.

The distribution of services varies between different countries but in countries like Kenya, Uganda and Tanzania, the churches provide 30%-45% of the overall number of hospital and bed capacity.

The government plays a role, both as a direct provider and as a financial contributor, as they support health institutions of voluntary agencies with financial subsidies. Therefore, these institutions get financial support from different sources: tax revenue, direct patient fees and donations from international partners. This model is becoming increasingly inadequate, as tax revenue generation in poor countries is rather low and its use not very efficient.

The payment of user fees by poor patients is limited and discriminating against the poorest sections of society. With international donations decreasing, there is a need to look for new and innovative ways of health care financing.

The concept of community-based health insurance

An attractive alternative seems to be the community-based health insurance model. It is based on risk sharing and resource pooling and has worked fairly well in many industrialized countries. In recent years several pilot projects have been initiated in sub-Saharan Africa, trying to translate this concept into reality.

Many international organizations like WHO, ILO and the World Bank showed great interest in this approach. Several existing schemes were evaluated so that lessons could be learnt from the ongoing experience.

The lessons learnt for community-based health insurance are:

☞ Insurance schemes need a clear government policy and legal framework.
☞ The framework needs to be adapted to the local and national situation.

Successful immunization programmes are good examples of government/NGO and international organization cooperation.

The payment of user fees by poor patients is limited and discriminating against the poorest sections of society.
Pilot projects can help to develop a national policy on health insurance. Insurance schemes cannot replace a national health system; they can only contribute to it.

The introduction of health insurance might have negative effects for those people who for different reasons cannot join any of the schemes. Therefore, mechanisms should be introduced to reduce inequities and ensure access for the poorest sections of communities (sliding scale fees, exemption policies and subsidies).

The potential for cost-recovery in rural areas is limited. Insurance schemes cannot solve the financial problems by themselves.

Insurance schemes should rather be seen as an additional instrument for financing essential health services.

Government subsidies will be required even for well-designed and efficiently run insurance schemes.

Insurance schemes are not only instruments for getting additional funds but can improve the sense of community participation, ownership and responsibility.

A split between provider and purchaser of health services is preferable for any community-based scheme but depends on the availability of different providers so that the consumers have a choice.

There is a need for a detailed understanding of people’s preferences, needs, ability to pay etc., before a scheme can be designed. This can be achieved through feasibility studies.

Communities need to be well informed about all aspects of insurance schemes before they can be initiated.

Well-designed schemes need to be marketed so that the highest possible number of purchasers can be motivated to join.

There are many different health insurance schemes. Basically we have to differentiate between health insurance for the formal and the informal sector, between provider-based (usually hospital) and community-based, between prepayment schemes with direct benefits for the payer and true risk sharing with benefits only for those who are in need of services.

Examples of NGO-related insurance schemes

These two schemes are located in rural areas serving mainly people in the informal sector of society. Both these programmes were initiated and run by the respective church-related hospitals and are not truly community-based. These are closely related to the community, Bwamanda through its extensive Primary Health Care Programme and Kisizi through the involvement of traditional burial societies.

The Bwamanda Health Insurance Scheme in Democratic Republic of Congo (Zaire)

The insurance scheme in Bwamanda was founded in 1986 and is, therefore, one of the schemes in Africa with the most extensive experience. It is located in a district in Northwestern Congo with a population of 158,000. Up to 1997, 61% of the population were enrolled in this scheme which amounts to about 100,000 people. The health provider is a mission hospital with 138 beds supported by the Roman Catholic church. Due to the current political situation, there is no support whatsoever by the central government but there is a good cooperation with the district administration.

Members of the insurance pay a very small annual premium of not more $0.50 per person. However, to restrict the risk of moral hazard, several components have been introduced:

- Members have to contribute a co-
payment of 20% of the actual costs.

2 There is a strict referral system. Only patients seen at one of the 23 health centres and referred to a higher level are eligible for insurance services.

To reduce the risk of adverse selection, the following mechanisms have been arranged:

1 Only complete families can join the scheme,

2 People are allowed to join the scheme only once a year after the harvest.

Given these precautions, the scheme runs very well and has enabled the people to have access to appropriate health services. It has helped the health provider to survive even in a period of extreme political and economic hardship.

**The Kisiizi Hospital Society in Uganda**

Introduced in Western Uganda in 1996, it was initiated with the support of the Anglican church’s 200-bed mission hospital. The community around Kisiizi had already experience with a kind of solidarity fund, the traditional Enigozi society. This fund to which 96% of the community was contributing was used for burials and other unexpected events.

It was now extended to cover periods of illness and to provide access to the services of Kisiizi hospital. Annual premium is about $ 3.00 per person. A co-payment of 25% was agreed upon. Any Engozi society can only join the health scheme once 60% of its members have agreed to subscribe. Currently there are 6000 members and the scheme contributes a considerable amount to the running cost of the health provider.

Of course, there are also projects that have failed or are still in the early stages of implementation. But the examples of Bwamanda and Kisiizi show the considerable potential to establish viable health insurance schemes in rural Africa.

**Closer cooperation between NGOs and governments**

Health insurance schemes are meant to be an additional instrument to provide access to quality health care. In many East African countries a close cooperation between governments and NGOs already exist and there are several reasons why this kind of cooperation is required for the initiation of well-functioning insurance schemes.

Both governments and NGOs have an indispensable role to play in this effort.

**NGOs can help:**

1 Identifying communities for pilot projects.

2 Initiating feasibility studies with the full participation of the communities.

3 Providing technical support and training for communities and their representatives who want to start a new scheme.

4 Facilitating exchange and co-ordination between existing schemes.

5 Ensuring equitable access for the poorest sections of a community.

Uganda is a good example for this kind of cooperation. Voluntary agencies provide a considerable part of the national health services. They cooperate with the government in the formulation of health policies and
“THIS IS NOT A MONEY GENERATING SCHEME....”

Stephen Mutyaba, Executive Secretary at the Uganda Protestant Medical Bureau (UPMB) is well known and respected for his research and commitment to community-based health financing (CBHF). In an interview with Reena Mathai-Luke at Tübingen, he advocates for CBHF but unlike most people who are spurred by passions, Stephen is critical and rational about the initiative.

Contact: Much as we all like to vote for community-based health insurance, do you really see it as a sustainable option for health financing?

SM: After many years of experience in this field I would advocate for it on one condition, and that is, this scheme should be supported by some external support either from the government or from some donors.

The point is, most people make the mistake of comparing community-based health insurance with other commercial insurance schemes or health financing schemes. And this is where we go wrong. We have to be very clear about the fact that community-based health insurance is not intended to be a money generating scheme. It, therefore, cannot sustain itself unless it has some kind of financial cushioning or back-up. Otherwise, it can prove to be a very frustrating experience.

Contact: There is an element in it that makes the scheme a little bit Utopian, do you agree?

SM: I am not sure what you mean when you say it’s a bit Utopian. But, it certainly has a lot of good points, for it is pro-poor and ensures equity.

And as earlier stated, we start on wrong premise if we evaluate it only on economic indicators.

Contact: But since it is known to have failed more than succeeded, do you think geo-political factors play an important role?

SM: Geo-political and social factors, I think, do influence health financing. For example, in Germany health insurance is an accepted norm,
whereas in many developing countries this is still a dream.

Coming back to community-based initiatives, the Burundi scheme is known as a success story. Another example is the Bwamanda initiative. So it is not that there are too few success stories and too many failures. I would think there are too few initiatives and too many procrastinators.

**Contact:** If you were to list the strengths and the limitations of community-based health insurance what would they be?

**SM:** The list is a little long, but it is worth elaborating. I will start with the strengths. Firstly, it ensures community participation. Next, it promotes gender equity and ensures women have direct and an easy access to health centres, even though they may not be the earning member in society.

Then premiums can be set on the community’s purchasing power. Communities can also determine exemption mechanism. Finally health risks are shared by both the healthy and the unhealthy, which actually helps to promote community solidarity.

There are also some added advantages. For example, some donors are often more willing to support CBHF initiatives. The international community and many African governments are looking for alternatives to finance health care and in some countries government subsidies to church NGOs can be utilized for the CBHF exemptions.

To shortlist the limitations of CBHF, this scheme is not comprehensive. Rural communities have low capacity to meet premiums on time, which is further compounded by the fact that income from subsistence farming is unpredictable.

The programme is limited to primary health care and needs a good referral back up. Also it is compelled to be just ‘curative’ because of illiteracy and client reluctance to primary health care.

Another important point is that there are very few success models from which one can learn. In addition, problems like irregular accounting or embezzlement make matters worse. And last but not the least, the misconception that CBHF should be commercially viable is wrong.

**Contact:** What is the single factor that makes you advocate for it?

**SM:** I think it is an excellent platform for community participation and gender equity. It has a feel-good factor besides meeting the health needs of the poor.

**Contact:** Do you see any clear-cut role for the church in this?

**SM:** The church, I think, is placed in an ideal position to steer this scheme. The church as an NGO has excellent credentials as well as outreach. Its geographical location in underserved areas, flexibility at management and policy-making levels, devoted staff, ability to tap resources and experience in handling user-fee projects, allows it to have an advantage over other governments. Also since the community comes together every Sunday, the church has the opportunity to mobilize the initiatives without too much effort.

**Contact:** Are you optimistic about CBHF becoming a norm rather than an exception?

**SM:** I think it might take some time. But I am sure, with a bit of impetus, it will gain momentum like the movement against slave trade.

Government will soon realize that in order to ensure good health for its citizens, one has to support the poor and help them to find sustainable options which would increase their access to basic health care.

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FOR WOMEN, OF WOMEN, AND BY WOMEN...

THE SEWA EXPERIENCE

The Self-Employed Women’s Association (SEWA) in Ahmedabad (Gujrat, India) is an association of more than 153,000 poor self-employed workers. Registered as a trade union in 1974, it started a community-based insurance scheme in 1992. Its members are largely women labourers without regular salary. Committed to Gandhian values, it has evolved to become both an organization and a movement. Widely recognized for their pioneering work for the under-privileged, their secret to success is their comprehensive vision of empowerment.

Health insurance is one component
— A report by Reena Mathai-Luke

Mission

SEWA Insurance provides social protection for the economically weak and exploited section of women workers. It encourages poor women to become members, so that they are covered for the various risks they face through an insurance organization in which they themselves are users, owners and managers of all services.

SEWA members are economically active and make a significant contribution to the national economy. Their work, however, is not recognized. They are poor, exploited, illiterate and have little or no access to legal protection. SEWA’s objective is to empower these women.

Empowerment

SEWA has three broad-based categories of self-employed workers:

- Providers of services and labour like head loaders, handcart pullers, agriculture workers, salt quarry workers etc.
- SEWA operates mainly through joint action of labour unions and cooperatives. The economic ventures include an all women’s bank, the SEWA bank, child care and health care through health cooperatives, housing, legal aid and insurance.

Creating Awareness

The concept of a risk pool was virtually unknown to SEWA members till 1992. In their struggle to survive, the concept of risk sharing and supporting each other in times of crisis was difficult to comprehend.

“I haven’t been sick this year, so will I get my money back?” was a common question. It took time, patience, intensive counselling to get the message across.

They also learned to carefully preserve the various bills, certificates and case cards which were essential documentation for the process of obtaining claims.

Principles
SEWA’s insurance programme is based on the following core principles:

- Mutual Help: The scheme is meant for SEWA members (and their families) and is based on the principle of mutual help and solidarity.
- Self-Help: SEWA Insurance is run as a women-run and women-owned cooperative.
- Participatory/Contributory Scheme: Members of the insurance scheme have to contribute their premium every year either through annual premium payments or by establishing a fixed deposit account at the SEWA bank.

Financial viability

SEWA’s aim is to ensure a long-term, sustainable insurance programme. It runs on sound insurance principles and the limits of coverage are modest and appropriate in SEWA’s market. Insurance products are priced with ample margin for reserve and contingencies. Underwriting procedures have also been worked out and results are monitored by a consulting actuary. The management monitors claims-loss ratios and other key indicators on a monthly basis.

Premiums

Premiums are set annually at the policy anniversary (July 1st). Premiums are either collected annually in advance or members may opt for a Fixed Deposit Scheme.

There are three ‘package offers’ and members can use the interest from these fixed deposits to pay the annual premium.

Eligibility and Underwriting

For all coverages, only SEWA members and their husbands are eligible. Husbands cannot enroll unless their spouse is an enrolled SEWA member. Coverage for children is added at a later date. Women must be between 18 to 58 years of age to enroll for annual membership. Life insurance coverage terminates at age 58. However, the other coverage is in force so long as the member pays the premium and is in good standing with SEWA. Enrollment is open only once a year on July 1st, except that members who select the fixed deposit premium option may enroll at any time. Pre-existing conditions are excluded for hospitalization coverage. There is one year waiting period for maternity benefits as well as for hysterectomy and cataract surgery. Additionally, benefits are paid for only a single episode of illness for chronic conditions (e.g. TB) that develop after enrollment.

Hospitalization and Maternity

Hospitalization and maternity coverage is offered to SEWA members to reimburse their hospitalization and related medical charges resulting from illness. The maternity benefit is a lump sum payment at the time of birth to assist the member with extraordinary expenses and loss of income.

Impact

With SEWA’s help, many of these
illiterate women have now realized the power of economic independence and more importantly, the value of community support.

Says a grateful beneficiary of the health insurance scheme, “Normally when any one of us in the family is sick or hospitalized, it is a dark time for us. This time when I was hospitalized for cerebral malaria, my family was worried but at least we didn’t have financial worries.”

Planning for the future

With the inception of the insurance scheme, workers have been learning to plan for the future. The premium they set aside each year bears testimony, to their planning for the unexpected and to cover their risks. In 1992, 7000 women chose to plan for their future through insurance. This figure had risen to over 20,000 women in 1996 and it continues to be popular.

Change in attitudes

Women typically placed their own health and wellbeing as a low priority and spend on the health of husbands, children and other family members.

One positive impact of this health insurance scheme was that women who were sick had to have themselves hospitalized so as to obtain benefits from the scheme. Many who needed hospitalization ordinarily would not have done so or would have admitted themselves to hospital as a last resort. The conditions for reimbursement of medical costs in the scheme included hospitalization; hence women had to seek such health care for themselves.

Another positive outcome of this health insurance programme is that women have overcome their inhibition to visit doctors and hospitals. This has established stronger links with local doctors as well as municipal hospitals, thus strengthening referral services for SEWA members, regardless of whether they were enrolled for the insurance programme or not.

Difficulties

Local village hospitals and doctors are often not recognized by insurance companies thereby making it difficult for users.

Lack of knowledge about requirements of documents leads to submission of incomplete paperwork and information which ultimately results in rejection of claims by the insurance company.

In addition, the insurance company has specified hospitals with a minimum number of beds and a specific kind of certificate to be included for coverage. Often in villages there are small hospitals that do not fit into this definition and genuine cases are rejected for this reason.

Finally, poor people sometimes get ‘cheated’ by doctors. In villages and other small towns, often ‘doctors’ have no formal training or registration. Insurance companies do not recognize such treatment and therefore, the claimant who goes to the doctor in good faith does not get the reimbursement.
SOLIDARITY AND SHARED RESPONSIBILITY

The Philippines is one of the few countries that has recorded success stories in community-based health financing. The population of Guimba, Nueva Ecija, for example, encouraged by their rich experience in managing community health, started the Lunas Damayan Health Project — a community-managed social health insurance project.

Dennis B. Batangan throws light on this People-Managed Health Services and Multi-Purpose Cooperative project

Introduction

The Lunas Damayan Health Project was established in 1996 by the People-Managed Health Services and Multi-Purpose Cooperative (PMHSMPC). It aims to develop alternative models of financing health services in the rural areas. The PMHSMPC does this by assisting community organizations in developing a more socialized scheme for financing health services in the community. The pilot project for this Social Heath Insurance scheme is the Lunas Damayan Project in Guimba, Nueva Ecija, Philippines.

Lunas Damayan means “mutual assistance for healing.” This was derived from the Filipino term lunas, which means ‘curing’ or ‘healing,’ and damayan means mutual care and assistance.”

The project seeks to establish and maintain a social health service delivery and financing system involving the rural community by adopting the features of a social health insurance. It is intended to make health services accessible and inexpensive to the rural populace. The scheme is also aimed at the increased involvement of participants in managing their health services and financing requirements. One of the key strategies in the implementation of the project is the adaptation of the project to existing practices and schemes already present in the community. And the use of the local term Lunas Damayan, has facilitated people’s understanding of the project’s concept and mechanics.

Support Groups

The Lunas Damayan Health Project’s technical inputs were provided by the Social Health Insurance Networking and Empowerment Project (SHINE), a Department of Health bilateral assistance programme. While Evangelische Zentralstelle fur Entwicklungshilfe (EZE), a German development agency, provided the funds to support the project from September 1996 to September 2000, and in 2001 the Canadian International Development Agency (CIDA) supported the strengthening of the municipal-level Lunas Damayan Council.
Currently, it is being integrated into the National Health Insurance Programme with the assistance of the Department of Agrarian Reform and the Philippine Health Insurance Corporation.

**Administration**

Implementation of the scheme started with the community organization entering into an agreement with PMHSMPC for the establishment of Lunas Damayan in the organization. This was followed by enlisting organization members who wanted to participate, promulgating and adopting its own membership policies, and determining systems and procedures for financial and management policies as well as the ceilings or maximum amount of benefits. Members agreed on the amount of contribution and kinds of benefits to be provided. The organization manages its own health funds and collects the membership contributions. It administers the day-to-day operations of the system, and engages and negotiates with Health Service Providers (HSPs). PMHSMPC works in cooperation with the organization. It advises the group on basic management policies and provides policy makers with training on policy considerations. The membership is educated on the philosophy and mechanics of the health financing and service delivery system. To ensure efficient system administration, the operational staff is given training on the important related skills. PMHSMPC ensures that all participants are guided in the appropriate policies. It further trains the organization in cost-saving measures such as preventive health and primary health care. Initially, it also helped them to maintain and administer their network of HSPs and facilitated the delivery of health services to the members. To formalize these agreements, PMHSMPC and the participating organization signed a memorandum of agreement. The organization also formally issued a policy manual on membership policies, benefits, amounts of contributions, and system operation and procedures. The members will use these policies as a basis for deciding on whether or not to join. Those who are willing to join, sign an agreement with the organization detailing the rights and obligations of both parties.

**Operational systems**

Whenever a member gets sick and needs medication, he goes directly to the project physician with his membership card. After verification, the project physician renders the required treatment. If the patient needs hospitalization, the physician issues a letter of authority (LOA) after verifications. The patient is then brought to the PMHSMPC accredited hospital/HSPs. The project’s coordinator attends to the needs of the patient. In emergency cases, the member may be brought directly to the hospital. After treatment, the bills are prepared keeping within the ceiling and sent to PMHSMPC. Members are notified and collect the contribution.

Dennis B. Batangan, Chairperson, People-Managed Health Services and Multi-Purpose Cooperative (PMHSMPC), Phil. Research Associate, Institute of Philippine Culture, Ateneo De Manila University, Quezon City, Philippines Email: dbatangan@yahoo.com
THE SECRET OF THIS SUCCESS STORY

Lunas Damayan works around the following characteristics:

**People’s participation:** The scheme requires as much participation from the leaders as well as the members of the organization. They decide on most of the policies and procedures, and on the amount of ceiling and contributions. They use their own mechanisms for collecting membership contributions.

**Viability of the scheme:** Under the scheme, the number of participants is immaterial as far as viability is concerned. The organization can be viable on its own as the amount needed to be raised per incident can be covered by the membership contribution.

**Sustainability**

The participating organizations are considered as partners that take active and decisive roles in managing the social health insurance enterprise in the area. Recognizing that the project is their own and works for their own benefit, they are enthusiastic about learning the policies and mechanisms of the enterprise.

**Simplicity/efficiency**

Since the partner organization already exists, members have a bonding with the organization. They are familiar with one another. They have long been engaged in common activities. All PMHSMPC has to do is to introduce the concept of the social health insurance scheme and establish the health management systems, orient them on the important aspects of the scheme, and train them in the administrative requirements of health service delivery and financial systems.

**Social acceptability**

The system is not difficult for members of participating organizations to understand and accept. In fact, it is an ongoing practice in the community. Under the prevailing practice in mortuary aid programmes for example, once a member dies his/her family automatically and immediately receives a fixed and predetermined amount from the mortuary fund. The members then contribute a certain amount to replenish the fund.

**HEALTH FINANCING BY THE PEOPLE**

**Sustainability**

That depends on how one views sustainability:

Financial sustainability is usually not possible but as a community initiative it is viable, provided the insurance scheme is integrated into and complements other community empowerment efforts.

**Problems**

Inherent problems in these schemes are low coverage and limited ability to protect the interest of the poorest, both in terms of access and financing. Also, these schemes are based on the demand for those services/facilities for which there is local demand and not on professionally perceived needs.

Lastly, unless quality health care is guaranteed, there will be few takers for community-based health insurance.

**Conclusions**

Today insurance is gaining popularity. The government, the companies and the providers are all talking about insurance. Unfortunately the standard insurance packages are not at all user-friendly and has not been acceptable to the people. Even less for the poor who are even further marginalized. In this context, community-based insurance schemes offer a window of opportunity for the poor to protect themselves from the massive burden of health care. However, CBHI needs to be developed carefully and nurtured for it to be viable. Along with providing insurance cover, CBHI also provides an opportunity for empowering the community.

Dr N Devadasan has had considerable experience in implementing a CBHI. He currently works with WHO, India. Address: WHO, Nirman Bhavan, New Delhi 110 001 Tel: +91 11 301 8955 E-mail: devadasann@whoindia.org

Disclaimer: The above comments are his own and do not reflect any WHO position on the matter.
RAHA—THE WAY TO GO

In 1969 the Catholic church founded the Raigarh-Ambikapur Health Association (RAHA), in an effort to encourage the normally reticent local tribal population to take control of their health. For nearly 18 years RAHA remained an informal set-up until Fr Charles Van Besouv gave it a new direction by registering it as a society. Today it is in every aspect a people’s movement and now covers four large districts — and a population of four million.

Sister Elizabeth reports:

Introduction

RAHA is tucked away in the remote eastern belt of the rugged central plateau of India. Inhabited mostly by tribals, this area has been traditionally looked after by the Catholic diocese of Raigarh and Ambikapur. The tribals form 52% of the total population and live in remote and isolated villages. These tribals belong to Oraon, Kawar, Gonds and Kural tribes. They are peace loving people and enjoy their life by dancing and singing. They live in mud houses roofed with locally baked tiles. Women hold an honourable place in the society and move around freely. They work in the fields and forests along with the men.

This region has very few schools and government-run primary health centres. To reach a hospital or school is one of the biggest challenges for these tribals, as they are not only few but they are also far from their inhabitation.

The locals, therefore, depend more on their village doctor — a herbalist with some respectful knowledge about the curative properties of roots and leaves. However, in life threatening situations or serious emergencies, they offer little assistance as they have no quick remedies.

It was in this scenario that RAHA stepped in to bridge the gap. The project area at present has extended to cover over four districts in 41 blocks covering 2000 villages.

Medical Insurance Scheme

The existing 85 rural health centres provide both curative as well as preventive health care services in rural areas. But given the low economic status of people and the additional expense incurred to reach these centres, most of these tribals shied away from these health centres. Under these circumstances, RAHA which was already working for the tribals, hit upon the idea of providing a medical insurance scheme to subsidize the medical care given to the most needy persons.

Objectives of the scheme

❖ To subsidize the medical care of the members at primary, secondary and tertiary level.
❖ To encourage people’s participation in health care services.
To encourage people to be a caring community and contribute towards the medical care of their fellow beings through membership fees.

To reduce exploitation from money-lenders.

To make medical facilities available in the village itself.

The membership fee

Any person desirous of becoming a member of the scheme shall pay annually a membership fee in kind or in cash equivalent to two kg of rice. The scheme is open for new membership between October and January (harvest season). Benefits can be availed from April to March the following year. The membership is valid for one year and has to be renewed annually (any male or female irrespective of age, caste, qualifications or creed). Students may enroll in June-July each year.

Terms of membership

A person suffering from chronic (long-term) illness or through unnatural events (eg. suicide attempts) at the time of aspiring for membership shall not be eligible for membership.

For availing health care services at rural health centre, the patient needs to first report to the voluntary health worker of the village or area.

In case of emergency or unavailability of the local health worker, the patient can directly approach the rural health centre for treatment.

At the rural health centre it is the nurse in-charge who decides on the treatment and medicine to be given.

Privileges

a) At the village level: The health worker attends to minor ailments and gives free treatment. No syrups, antibiotics and injections are supplied at this level. For minor ailments the first line of treatment is home or herbal remedies.

b) As out-patients at the Rural Health Centre level:

A member enjoys the following privileges:

Free consultation, free medicines up to Rs.100/- per year.

Patients contribution towards hospital services shall be as follows:

<table>
<thead>
<tr>
<th>Travelling Distance from the Hospital</th>
<th>Patient’s Contribution</th>
<th>Student’s Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 25km</td>
<td>Rs. 250/-</td>
<td>Rs. 50/-</td>
</tr>
<tr>
<td>Up to 50km</td>
<td>Rs. 200/-</td>
<td>Rs. 50/-</td>
</tr>
<tr>
<td>Up to 75km</td>
<td>Rs. 150/-</td>
<td>Rs. 50/-</td>
</tr>
<tr>
<td>More than 75km</td>
<td>Rs. 100/-</td>
<td>Rs. 50/-</td>
</tr>
</tbody>
</table>

Ordinarily, MIS member patients will be admitted in the General Ward.

At the rural health centre, a patient needing syrup and injection will be required to bear the cost of the same.

c) As In-patient:

Free consultation and a 50% rebate is given on the total bill. In addition a pregnant mother who is a member, if admitted at the rural health centre, will be expected to pay only Rs.50/- towards the entire cost of delivery charges.

d) At the hospital level:

A rebate to the extent of Rs.1,250/- is given on the total treatment per year.

Organizational structure

RAHA does not have a rigid organizational structure. The Executive Director works with the Health and Development Coordinators of Kunkuri, Ambikapur and Raigarh areas, assisted by a strong team of nurses from different congregations. The grassroots-level workers comprising of a cluster of village health workers, traditional birth attendants and school health guides, are members of the core team.

RAHA is a people’s movement, therefore, rigid bureaucratic and hierarchical approach is not relevant for RAHA. Instead it believes in team work, people’s participation, democratic/situational leadership, identifying and nurturing people’s participation, developing local leadership, mobilizing local resources and ensuring the sustainability of the programme.

Sr Elizabeth, Executive Director, Raigarh Ambikapur Health Association (RAHA)
BIT Chowk, PO Pathalgaon – 486 118, Dt. Jashpur Chattisgarh, MP, India.
A survey conducted by Christian Connections for International Health and the Ecumenical Pharmaceutical Network highlights some of the grey areas about the Global Fund — Excerpts from the survey

Background

The Global Fund to fight AIDS, Tuberculosis, and Malaria, recently established, with the strong support of the Secretary General of the United Nations, Kofi Annan, is an attempt to expand resources available to governments, national agencies, and community-based organizations to address the major infectious causes of mortality in developing countries, AIDS, tuberculosis and malaria. The Global Fund is mandated to seek participation from all the major stakeholders. The Global Fund Board has recommended that Coordinated Country Mechanisms (CCM) be established in each country as the structure through which country proposals are submitted for their review. Its board is clearly seeking CCMs that promote partnerships between government ministries, NGOs, the private sector, and multilateral institutions.

Since Christian and other Faith-based Organizations (FBOs) have contributed greatly to the process of addressing these diseases, we believe that the performance of the Fund, and the countries submitting funding proposals to the Fund should also be monitored, with regard to these organizations. To this end, Christian Connections for International Health (www.ccih.org) and Ecumenical Pharmaceutical Network sent out a survey to several hundreds of the FBOs that were eligible to apply for funding.

Those who responded to the survey included organizations from 54 countries. Of these 139 are based in Africa; 22 from Asia; four from Latin America; three from Europe; four from South America; and one from North America. All of the surveyed organizations had some religious affiliation.

The survey also indicated that there seems to be a general lack of any knowledge concerning the Global Fund and CCMs amongst Faith-based Organizations. Many of the organizations are also dissatisfied with the level of information they received about the CCM’s process.

Fifty percent of the respondents felt that there is a need for more consultation across a broader base. Forty-five percent wanted more information from government; thirty-one percent believed that there should be more time to gather data; 40% were seeking more coaching on how to write better proposals; and 27% wanted better proposal guidelines.

The results of the survey show that:

➢ there is a general lack of knowledge about the Global Fund among Faith-based Organizations
➢ the FBOs that are aware of the Global Fund are generally not satisfied with the degree to which they are able to participate in the Coordinated Country Mechanisms (CCM)
➢ government attitudes toward Faith-based Organizations make a difference
➢ faith-based organizations are very interested in working with their CCMs and the Global Fund.

For more details, see:

Dr Christoph Benn, Global Fund Board Member would appreciate your comments and feedback.
E-mail: benn@difaem.de
“BEING PREPARED FOR THE FUTURE”

GENESIS 41:33-36

The importance of planning ahead cannot be over emphasised. It wasn’t raining when Noah built the ark. Dr Christoph Benn elaborates on this theme with reference from the Bible.

Life is variable. Sometimes we are feeling well and happy, sometimes we are down and depressed. There are times in our life when we are strong and healthy and all of us experience times of weakness and ill health. At times we feel close to God and spiritually enriched and sometimes we feel deserted and dry. This is a common experience for all human beings in all cultures and places. The question is: what do we do to prepare for those more difficult times. Can we use the vibrant experiences, the times of abundance to nurture ourselves, to build up a storage for times of scarcity and want?

Joseph’s wisdom

There is a very encouraging example in the Holy Scriptures telling us about similar experiences. In the well-known story of Joseph, we hear how he suffered all kinds of hardships. He was misused by his brothers, sold into slavery, brought into a foreign land and put into prison without proper charges. Yet God was to use him in a special way and gave him the gift to interpret dreams.

Joseph said to Pharaoh

“And now let Pharaoh look for a discerning and wise man and put him in charge of the land of Egypt. Let Pharaoh appoint commissioners over the land to take a fifth of the harvest of Egypt during the seven years of abundance. They should collect all the food of these good years that are coming and store up the grain under the authority of Pharaoh, to be kept in the cities for food. This food should be held in reserve for the country, to be used during the seven years of famine that will come upon Egypt, so that the country may not be ruined by the famine.”

Joseph helped the Pharaoh to prepare for the future, to make plans and to use the abundance of the good years for the time of scarcity that was definitely to come. A similar idea forms the basis for any kind of insurance. We contribute to an insurance scheme in times of health when resources are available so that we might benefit in times of sickness. It is good to prepare for it in advance so that we might not be caught in a desperate situation. In addition, it is good when many people pool their resources so that all might benefit. Joseph did not ask each Egyptian family to put something aside in their own store. He asked the whole country, rich or poor, civil servant or farmer to pool their resources in big storehouses so that everybody got a share when the situation became harsh. This kind of cooperation is not only an act of prudence but also of solidarity and mutual support.

Take a cue

The whole story makes for extremely valuable reading when we hear how this plan worked out so that not only the Egyptians were saved from famine but even people from neighbouring countries came to benefit from Joseph’s wisdom entrusted to him by God, including his own family coming all the way from Israel.

God provides us with resources of different kinds: material resources as well as natural and spiritual resources. We must use them wisely looking at the immediate needs and the future, including our next of kin as well as the larger community. It is the blessing we receive from God and the lesson is as valid today as it was at the time of Joseph in the foreign land of Egypt.
DATA ON COMMUNITY-BASED HEALTH INSURANCE

Conceptual studies:

Large scale comparative studies (5 schemes)

Case studies – AFRICA

Case studies– ASIA

Equity and Health: Views from the Pan American Sanitary Bureau. The concept if equity has emerged as a primary principle for the work of the Pan American Sanitary Bureau. This bureau has been gathering information on and examining issues related to disparities in health in the Americas, especially as they relate to socioeconomic factors. The authors have attempted to highlight how equity (or the lack of it) impacts health and other factors. PAHO, 2001,169pp (E.S.P) ISBN: 9275 12288 1. Price: Sfr.44, US$22.00 In dev countries Sfr. 30.80. Order no 1630008.

God, Faith and the New Millennium This book by Keith Ward, explores about a new and positive interpretation of living in harmony with Christian faith and science. He tackles questions as “Does being a Christian in the modern scientific age require intellectual suicide?” Sfr 27, 218 pp Published by Oneworld.

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3. Liu Y 1996. Is community financing necessary and feasible for rural China?

Case studies - LATIN AMERICA AND THE CARIBBEAN

Case studies - MIXED REGIONS
1. Ron A 1999. NGOs in community health insurance schemes: examples from Guatemala and Philippines.
ANNOUNCEMENTS

World Health Assembly 2002 (WHA) May 13 –17, Geneva
This is an event that is generating a lot of interest. The WHA session for ‘NGO forum for Health’ will include a symposium on ‘Partnership in Action for Health’.

XIV International Conference on AIDS at Barcelona, Spain. July 7-12, 2002: The conference will provide a platform for the latest update on the HIV/AIDS. For more details, please contact: UNAIDS.


Working together — Networking a Pan-African HIV/AIDS Christian Response, June 21 to 24, Gaborone, Botswana: This conference is being organized by the Botswana Christian Aids Intervention Programme (BOCAIP). Christians from across Africa are welcome. A good opportunity for supporters and workers of HIV/AIDS to participate and network. Contact: Katrin Taylor E-mail: Taylor@botsnet.bw

LETTERS

Dear Reader,

Thank you for your interest in Contact. While we get a lot of letters from our readers appreciating the contents/lay-out etc., we would like to encourage our readers to update us with information, local experiences and short articles on the following themes:

- 175 Community-based rehabilitation
- 176 AIDS orphans
- 177 Problems of the Aged – special emphasis on parenting grandchildren.

While we do not promise to print every article we receive, your response will motivate us to make the edition more relevant.

Editor

Contact deals with various aspects of the churches’ and community’s involvement in health, and seeks to report topical, innovative and courageous approaches to the promotion of health and healing.

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