



**SUPPORT TO HEALTH SECTOR REFORM  
IN THE REPUBLIC OF YEMEN**

European Commission  
Ministry of Public Health and Population



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Technical Assistance

Mission Report of Short-Term Consultancy

**DEVELOPMENT OF A PILOT SCHEME FOR  
COMMUNITY BASED HEALTH INSURANCE**

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Support to Health Sector Reform in Yemen  
European Commission - Ministry of Public Health and Population

## 1. Executive Summary

The Ministry of Public Health in Yemen decided in October 2000 to implement a far-reaching health sector reform program, including the introduction of cost-sharing and health insurance.

A first EC consultancy to assist the start up of Community Based Health Insurance (CBHI) took place in April-May 2004. A central team for CBHI was formed and trained and a pilot area for CBHI was selected. Authorities of all levels were engaged and standardized communication with the community was started.

From June to September'04 the central CBHI team, without external assistance, made good progress and accomplished a satisfactory process of community consultations (Focus Group Discussions & Rapid Family Survey). They also disseminated the results of the consultation. Late last year, the activities of the team somewhat slowed down.

During the second EC consultancy, one month in February/March 2005, the activities were picked up again:

- A draft of the Regulations for CBHI and Guidelines was prepared and discussed with district and governorate stakeholders. This draft was then adjusted into a 'second draft of the Regulations for CBHI' to be debated at Ministerial level.
- An administrative system for CBHI in Yemen was finalized. This should guarantee transparent accounting and keep track of the number of families enrolled in the CBHI scheme. Also the health services that are received by the insured members will be quantified. A methodology is proposed to ensure community participation, control and management of the scheme through a Community Management Committee.
- Good progress has been made in the analysis, stocktaking and identification of challenges in the Revolving Drug Fund (RDF) of the selected district hospital. This will allow further cooperation to seek improvements in the availability of essential drugs.
- An updated report on the views of stakeholders has been written. In fact all involved are eager to start CBHI. Understandably all parties also feel some uncertainty about this pilot experiment. Potential member-families wonder whether the quality of services they pre-pay for will be satisfactory. The selected hospital wonders whether the capitation system will not bring them deficits.

The central CBHI team has in cooperation with the consultant

- developed an activity plan for the remaining tasks to be fulfilled until the opening of the CBHI scheme, together with a proposed budget frame,
- has identified expected challenges and ways to avoid or minimize them,
- and has listed points of advice for improved team-work at the central, governorate and district level for the teams involved in the implementation of the first CBHI pilot.

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#### **Other CBHI work-documents added to the Mission Report of consultant Filip De Loof**

- 1) Draft Regulations for CBHI
- 2) Guidelines for the Regulations for CBHI
- 3) Manual for the Administrative System of CBHI: forms, registers and letters used in the administration of CBHI.

**3. Abbreviations used**

note: 1 USD = 167.5 Yemen Rials (March'05)

Acc.Mgr. = CBHI Account Manager

ANC= Ante-natal care

CBHI= Community Based Health Insurance

CBO= Community Based Organizations, incl. fishermen cooperatives, welfare agencies, inter-aid societies, etc.

DG= Director General

DHO= District Health Office

DPT= Diphtheria-Pertussis-Tetanus vaccine, often combined with Hepatitis B vaccine

EC = European Commission

EDL = Essential Drug List

EPI= Extended Program for Immunization

ESP= Essential services package (for health facilities)

EC/PCU= European Commission / Project Coordination Unit (in MoPH&amp;P)

FGD= Focus Groups Discussion

FP= family planning

GHO= Governorate Health Office

GTZ= German Technical Cooperation

HC= health centre

HI= health insurance

H.Fin.= Health Financing

HPTSU= Health Policy and Technical Support Unit (in MoPH&amp;P)

HSR= Health System Reform

HU= health unit

IM= intra-muscular drugs (injection)

IUD = Intra-uterine device (for family planning)

JICA= Japan International Cooperation Agency

MCH= Mother and child care

Mgt Ctee= District or Ministerial CBHI Management Committee

MoPH&amp;P= Ministry of Public Health and Population in Sana'a, Yemen.

OPD= Out-patient department = consultations

PH= public health

PHC= Primary Health Care

p.o.= oral drugs

POA= Plan of action (activity plan)

PRS(P)= Poverty Reduction Strategy (Program)

RDF = Revolving Drug Fund

RFS= Rapid Family Survey

RP = Resource Person for CBHI

WHO = World Health Organization

## 4. Introduction

### 4.1 Context of the consultancy

For a country background, refer to the first Mission Report of Filip De Loof, Yemen April-May 2004. The context of health sector reform has not changed over the last year. Here the main points of the text of last year:

In October 2000, the Ministry of Public Health and Population produced a strategy document proposing a far-reaching health sector reform program, based on system approach. The paper makes a critical analysis of the numerous problems in the health sector in Yemen, including health care financing, quality of care and accountability. Solutions are proposed to lift the health sector out of the deep crisis, which is reflected in declining health indicators in the past decade. The crisis in the health sector is related to the economic downturn with a rapid population growth. The health sector suffers from long-term under-funding, poor management and applying a system model, which does not fit the Yemen situation well (MoPH&P, 2000). Proposals to introduce cost-sharing in the health sector in Yemen were first suggested in the First National Conference for Health Development in February 1994. In more recent years this policy has been put in practice by the MoPH&P, through the introduction of Revolving Drug Funds, however with limited success. Recent evaluations of the health care system have sometimes criticized the slow and uncoordinated progress in the health sector reform, as proposed in 2000.

The objective is to assist the MoPH&P in Yemen to implement a pilot scheme for CBHI, to create an alternative health financing method for rural areas, where most inhabitants are self employed (informal sector). The aims of pre-payment and risk-pooling are to improve financial access to health care, poverty reduction by protecting the insured against catastrophic expenditure, enlarge coverage of health care, and improve the quality of health services in a financially sustainable way. The October 2000 strategy document of the MoPH&P "Health sector reform in the Republic of Yemen" clearly acknowledges that health care provision 'for free' or completely paid by government funding is unfeasible and undesirable. Cost-sharing or co-payment at the time of use is described as a necessary solution to achieve sustainable health financing. Cost-sharing as part of a comprehensive reform package is the best way to bring in more resources to finance essential care. In January 1999 the Cabinet passed a resolution enabling health facilities to charge legally for health services. Also in 1999, a law established the National Revolving Drug Fund. Several by-laws followed, to define the role of various stakeholders at central level and of donors and providers, including Decree No 15 of 1999 on granting of exemptions on poverty grounds.

In Yemen the total expenditure on health is estimated at 20 USD per person per year, compared to 38 USD in Egypt and 136 USD in Jordan. The expenditure on health makes up about 5.6% of the GDP in Yemen. Of this total amount of 20 USD per person per year:

- 29% is provided by government funds,
- 57% (to 75%) is provided by household expenditure,
- and 14% is from other sources such as donors, private insurance, caritas donations, etc.

The government expenditure on public health now represents 3.3% of the total public expenditure. Informal 'under-the-table' payments to health staff are difficult to account for, but may constitute an important extra out-of-pocket expense. The large amount of expenditure by households at the time of use (out-of-pocket payments) creates obvious problems for equity and financial access to health care. Poor people pay a higher percentage of their income to health care. Poor people postpone or forgo health care because of the high cost. Health expenditure is a cause of extreme poverty: poor families are tipped into extreme poverty due to 'catastrophic' health care expenditure. A system depending on high household expenditure on health at the time of use also leads to irrational use of health care, depending on the available cash: rich people tend to over-use diagnostic procedures and over-consume drugs. Poor people cut short the amount of drugs they purchase, due to limited cash. Pre-payment and risk pooling (= health insurance) has the potential to alleviate most of the above described disadvantages of large household expenditure at the time of use.

The European Commission (EC) project supports the Ministry of Public Health and Population (MoPH&P) with a mandate in health sector reform. The EC health project works from its offices in the Project Coordination Unit (PCU) in the ministry. Another unit in the ministry which gets special attention from the EC support project is the Health Policy and Technical Support Unit (HPTSU), which fulfills a key management role in health sector reform and in this function gradually takes over the management responsibility of the EC projects in health.

The first hospital to be contracted in CBHI is Khalifa district hospital, in Atturba town, in Taiz governorate. Figures of December 2004 show that the 150 bed hospital has 163 government staff and 18 locally contracted staff, plus 20 foreign staff including several Russian doctors. In total there are 26 medical doctors, of whom 12 specialists. Khalifa district hospital targets a population of 800,000. There are on average 3,321 OPD consultations and 184 admissions per month, including 103 cases with major surgery. The laboratory provides 4,290 tests per month, more

then half of them blood analysis. Seven XRay staff take on average 221 XRay's per month. Two ECG staff provide 114 ECG exams per month.

#### **4.2 Description of the objective of the consultancy and the proposed intervention**

This EC consultancy, which lasted from 9 February to 12 March 2005, was the second mission to advise the MoPH&P on the implementation of the first CBHI pilot scheme in Yemen. The first EC consultancy on the same subject was in April-May 2004, and lasted 45 days. In between these two missions, the local team (central and district level) continued the preparation of the implementation of the first CBHI pilot, and completed some activities successfully. Other proposed activities however have not yet started, and some changes have occurred in the staffing of the central team.

The objective of the second consultancy is to advise the local actors and to continue to prepare the CBHI pilot in the first district, in Shamaytain, Taiz governorate. At the start of the first scheme, the target population will be about 47,000 people spread over 46 rural villages and one district town Atturba (11,400 people). At the start of the scheme there will be only one contracted hospital, without chance of referral services that are covered by the insurance. The district hospital, Khalifa Hospital, is of exceptional capacity and size, as it was once planned to become a new governorate level hospital.

As facilitator and regulator of the new insurance scheme, the MoPH&P prepares the format of the CBHI scheme by developing Regulations for the insurance, an administrative and accounting format, and a central team to train and monitor. The daily management of the insurance scheme, will be the responsibility of a local district Management Committee for CBHI (the Arabic term is 'Community Management Committee), which will organize the collections of monthly contributions and the provider payment. The district Management Committee for CBHI has to solve problems and address issues brought forward by the members, as well as monitor the care given under health insurance. The central project team for CBHI helps the district to set up the district Management Committee for CBHI and trains all actors, including building up administrative capacity.

The EC consultant has to strengthen the capacity of the central team, advising them on how to support the district resource persons and how to develop the format for CBHI. The EC consultant is also asked to give guidelines (activity plan and budget provisions) for the coming months, up to the opening of the CBHI scheme in the district. Refer to ANNEX 1 for a copy of the Terms of Reference for the EC consultant Filip De Loof.

## 5. Description of the methodology of the consultancy

Preparations in the MoPH&P include review of the progress of CBHI implementation, review findings of the Focus Group Discussions and Family Survey of last year, and liaise with project managers and managers in the MoPH&P. With the central team for CBHI, daily discussions were held to prepare the 'first draft' of the Regulations for CBHI, together with guidelines with those Regulations. The central team also fine-tuned the administrative and accounting system for CBHI, to field-test in the district. Daily discussions also focussed on generalities of CBHI, capitation method, methodology of calculating a capitation rate and contributions. Expected challenges were discussed with the team. Long-term objectives of the CBHI program were analysed, as were the expected developments in a wider context of social security establishment in Yemen.

At this stage, the team members were proposed to start specializing and taking up individual responsibilities, to facilitate progress in the activities. This approach had mixed success, with some team members concentrating on their assigned tasks, while others did not meet the challenge, or even dropped out (temporarily?) of the team. It seems unavoidable to continue the strategy of specialization in order to implement the wide variety of activities in the district.

The central team for CBHI then designed an activity plan for action during the 10 day field-visit to Shamaytain district. Four teams were identified to work simultaneously on major subjects in the preparation of the health insurance pilot. For each team, a central member was identified as responsible, being assisted by resource persons from governorate and/or district level. A working budget was provided by the EC project.

- Team for discussion on REGULATIONS for CBHI,
- Team for finalization of ADMINISTRATIVE SYSTEM for CBHI,
- Team for analysing the situation of the Revolving Drug Fund (RDF) in Khalifa hospital,
- Team for CALCULATION of CAPITATION rate with data from the district hospital.

.See below under 6.2 for further details.

## 6. Technical Proposal

### 6.1 Description of the total process of implementing the first CBHI pilot in Taiz

Here it is useful to refer to the work plan for CBHI in Yemen, which was proposed in the first mission (April-May 2004) and which includes all activities from the very start of the preparation up to the running of the first pilot. Last year, a very ambitious and optimistic

timeframe for the preparatory phase of 7 months from April to October 2004 was proposed. In this work plan, activities are grouped under 6 headings and activities were planned week by week for the 7 month period.

Activity Group 1: System development and project setting:

- Legal issues & legal framework, Ministerial decrees to endorse pilot.
- Select central Task Force & local Resource Persons, training.
- Prepare work documents, Regulations, administrative & accounting format
- Network with other organizations
- Identify pilot district and possible health care providers to be contracted
- Hospital financing study, utilization and calculation of capitation rate

Activity Group 2: Community communication

A. Listen to grass root community

- Focus Group Discussions, surveys, statistics, ...
- Ask community to feedback on drafts of Regulations for CBHI scheme
- Involve existing Community Based Organizations

B. Awareness Building population

- Awareness Campaigns: several rounds in each target village, use media
- Pre-registration of families

Activity Group3: Engage authorities in health and administration

- Liaise with authorities, give training to all levels of health and administrative leaders. Seek endorsement, seek cooperation, ask to join management and monitoring of CBHI
- Select & train team of local Resource Persons

Activity Group 4: work with the hospitals to be contracted

- Analyze functioning of hospital: financing, information and patient flows, RDF,...
- Advise hospitals to improve services if necessary
- Train hospital leaders & staff on HI matters and running of CBHI
- Calculate and discuss % capitation split between contracted facilities (this activity was not necessary as there is only one provider selected for the start).

Activity Group 5: start-up the CBHI scheme

- Set up and train district Management Committee for CBHI
- Set up Ministerial Management Committee for CBHI
- Select and train Collectors and one Account Manager
- Print all forms, buy equipment and furniture for start-up

- Opening Ceremony: signature of CBHI contract
- Help local actors with start of every first-time activity: registration, first collections, administration, reception, first services, first Mgt Ctee meetings, first reports, etc.

#### Activity Group 6: Monitor, retrain, evaluate

- Assist scheme actors to make first reports
- Train local people (inc. local district Finance Unit) to monitor and audit the administration and accounting of the CBHI scheme.
- Evaluate the impact of the CBHI scheme on utilization, cost of services, quality, comparing insured with non-insured, protection against catastrophic expenditure, sustainability, etc.

## **6.2 Actual situation in the total process of implementing CBHI**

The team leader Dr Ragheb provided the EC consultant with a list of activities implemented and those activities still to start on the arrival day on 9 February 2005. In general those activities that were achieved were completed in a very satisfactory way, with a higher than expected quality of output. Many other scheduled activities were not yet commenced. During the last trimester before the current EC consultancy, almost no new activities were undertaken, .

Activities completed (March'04 to October'04):

- Advocating for CBHI and social health insurance, legal framework. Set up and train central team in issues about Health Financing and Health Insurance. This was mainly done during the first consultancy in April-May'04.
- Select pilot area for first CBHI scheme (Shamaytain district in Taiz). This was achieved during the first consultancy, after discussions with senior managers in the MoPH&P and two field visits to Hadramouth and Taiz governorates during the time a dozen health facilities were visited.
- Engage authorities, health care providers and local CBO's (Community Based Organizations). This activity was continued from May to October'04.
- Conduct Focus Group Discussions and Rapid Family Survey in target area, analyze findings and disseminate findings through seminars. The consultant only trained the central team and did some field tests for the FGD and RFS. The central team then did an excellent job to finish the community communication exercise in several weeks, made a good analysis and disseminated the findings.
- Draft first regulations in Arabic after many discussions with the team and EC consultant in April-May'04, which resulted in an early draft in English. Mr Thabet Baggash of

Oxfam translated the first draft in Arabic, then Mr Jamal al Serouri, legal advisor in MoPH&P, with the central team for CBHI substantially improved the Arabic version.

- A useful pamphlet to distribute in the Awareness Campaign has been developed by the central team in Arabic. It explains the basic principles of CBHI and the Regulations.

Activities still to implement in preparation of CBHI launch in Shamaytain, at the start of the second mission of the EC consultant (Feb.'05):

- Produce final draft Regulations for CBHI, discuss and adjust, propose to Minister for signing into decree. Write guidelines to the Regulations.
- Further develop and test administrative system for CBHI.
- Calculate capitation rate for CBHI and propose contribution rates.
- Conduct several awareness campaigns with population, authorities and health staff. Engage and select CBO's Train health staff to manage CBHI. Train district Management Committee for CBHI. Train Account Manager for CBHI.
- Work with selected hospital (Khalifa district hospital). Activities to improve and monitor quality of services and well functioning of the RDF.
- Set up Ministerial Management Committee for CBHI. Develop reporting and evaluation format.
- Engage Ministry of Finance and Governorate & District Finance Department.

In accordance with the workload still to implement, the eleven-day field-visit in February-March 2005 had the following agenda, to be implemented simultaneously by four teams. The purpose and technical details of the tasks were thoroughly discussed in the central team.

**a) Team FINANCE: to calculate the capitation rate.**

- Task:**
- Collect data on collection of charges (co-payments) in the district hospital and collect data on utilization,
  - Calculate unit cost of OPD and IPD, and estimate capitation rate.
  - If time available: transform capitation rate in actual contribution rates.

**Team leaders** from central level:

Dr Abdulwahid al Serouri (University of Sana'a), from 25 Feb. to 2 March'05.

Dr Jamal Nasher (head Health Policy and Technical Support Unit in MoPH&P),  
from 22 to 24 Feb.'05

**Resource Persons:** \* none from governorate level,

\* two from district level: from administration and accounting.

**Materials and budget needed:**

- clipboard, register or large notebook, A4 paper, 2 calculators
- per diems: 2 district persons for 7 days

**Detailed activity plan (see timetable in Annex 3)**

- Contact administration/accounting section of district hospital. Record from them data on collection of charges (co-payments by patients, including administrative and doctor fees, boarding fees, drug co-payments, all diagnostic charges, etc.) and collect data on utilization.
- Collect similar information in the hospital service sections: check original records and registers, where the information is recorded as the patients present. Identify the cashier points in OPD and IPD (where charges are collected). Gather data on utilization from reception Registers in OPD and IPD and maybe diagnostic services. Cover a period of several months if possible.
- Calculate unit charges of OPD (charges for one OPD visit) and IPD (charges for one patient-day). Estimate capitation rate using an expected level of utilization. Estimate allocation keys (to split charges between OPD and IPD) if necessary. For that purpose: discuss with staff, check sample of prescriptions, observe on-the-spot.
- Discuss with administration section to learn how the cash flow and information flow is organized in the hospital. Record exactly what information items are collected, passed on and summarized.
- If time available: transform capitation rate in actual contribution rates.

**Remarks on the implementation of the plan**

Unfortunately the central team members chosen for this important activity did not make it to the district for organizational reasons. The activity has thus been postponed. Only an initial study of sources of data was done by Dr Saleh Faddaq and the consultant Filip De Loof.

**b) Team REGULATIONS: to discuss and explain regulations of CBHI**

**Task:** - Conduct 4 seminars with stakeholders to explain regulations of CBHI,  
- Engage CBO's & Finance Department.

**Team leader** from central level: Mr Jamal al Serouri (jurist in MoPH&P)

**Resource Persons:** \* one from governorate level: management or policy person,  
\* one from district level: management or policy person.

**Materials and budget needed:**

- 100 copies of draft Regulations for CBHI in Arabic,
- box overheads for copy
- budget rent room and overhead 4 days,
- per diems 25 participants seminars at governorate level,
- per diems 75 participants seminars at district level,
- funds for coffee break 100 people, per diem 1 cleaner/servant 4 days,
- per diems: 1 governorate & 1 district persons for 7 days
- handout paper-pen-folder for 100 participants

**Detailed activity plan (see timetable in Annex 3):**

- Conduct 4 seminars to explain regulations of CBHI to the following stakeholders:
  - Governorate health leaders & authorities (political, CBO's, welfare, finance, ...)
  - District health leaders & district administrative authorities
  - Hospital middle management
  - Village leaders, local CBO's, local leaders
- Engage CBO's and find out more about their functioning, management structure, activities and target population. Get information on the quality of their financial management and transparency of their accounting system. Ask whether the CBO would be interested in participating in the CBHI district Management Committee.
- Engage the district Finance Department. Explain the CBHI program. Explain the reason for tax exemption. Explain the future monitoring task of the district Finance Department.

**Remarks on the implementation of the plan**

The planned activities have been fully implemented. An extra meeting was requested by the CBO representatives, to discuss many issues and to hear the team's feedback on a large document with questions and remarks on the Regulations of some of the CBO representatives.

**c) Team ADMINISTRATION: design administrative system for CBHI.**

**Task:** design administrative system for CBHI.

**Team leader** from central level: Dr Ragheb al Qarshi (team leader CBHI in MoPH&P)

**Resource Persons:** \* none from governorate level  
 \* two from district level (from administration section)

**Materials and budget needed:**

- pack A4 paper, 2 rulers, pens, scotch tape, blanc posters, 12 markers, 3 clipboards
- 3 copies Arabic first draft 'Administration System', 1 copy English,
- blanc CD rom, floppy discs, 4 plastic folders,
- funds for 300 photocopies to handout in workshop,
- per diems: 2 district persons for 7 days
- budget rent small room and overhead 1 day,
- funds for coffee break 14 people, per diem 1 cleaner/servant 1 day.

**Detailed activity plan (see timetable Annex 3):**

1. Train local resource persons on the functioning of the administrative system (information flow, consolidation, reason for data collection). Adjust first draft 'Administration System' to local situation in district hospital,
2. Test forms and registers in the real hospital situation, and adapt further (check whether requested information is available, check where and who would collect the data),
3. Conduct a workshop to present administrative forms to 10 or 15 hospital (technical) staff. Ask for their feedback.

**Remarks on the implementation of the plan**

The activities under this chapter have been fully implemented, by the EC consultant with assistance of two district hospital staff, as the CBHI team leader chose to attend the seminars on Regulations and do overall monitoring of the teamwork.

**d) Team REVOLVING DRUG FUND**

**Task:** investigate existing RDF: check inventory drugs and supply mechanism.

**Team leader** from central level: Dr Saleh Fadaq (head Health Insurance Unit in MPH&P)

**Resource Persons:** \* one from governorate level (RDF)

\* one from district level (RDF)

**Materials and budget needed:**

- box floppy discs, 10 packs A4 paper to print in MoPH&P, 3 clipboards, pens, 4 plastic folders, 2 ink cartilages printer MoPH&P (type .....),  
2 ink tubes copy machine MPH&P (type .....),
- per diems: 1 governorate & 1 district persons for 7 days.

**Detailed activity plan (see timetable):**

1. In MoPH&P prior to field visit: acquire latest official version of Essential Drug List in Food and Drug Department. Arrange list for district level only. Group according to Oral / Injectable / External Use / Vertical programs.
2. Investigate existing RDF in Khalifa district hospital: how are supplies of vertical programs managed? Integrated in the RDF? How are nominal charges for vertical programs managed?
3. Investigate existing RDF in Khalifa district hospital: check inventory drugs in central drug store and in detail pharmacies of OPD & IPD, TB and MCH program
4. Investigate drug supply mechanism: what registers? Who controls? Any orders before delivery? GHO or DHO involved? Private suppliers?

**Remarks on the implementation of the plan**

Planned activities were fully implemented. Refer to Annex 7 for a list of available essential drugs in Khalifa district hospital, and calculations on what percentage of required drugs are available at this time.

### 6.3 Views of stakeholders

#### 6.3.1. Target population of the first pilot scheme of CBHI:

The target population is enthusiastic, growing impatient, and eager to start CBHI. Of course only when registration to the scheme will start and the actual first contributions will be collected, will the team know what part of the target population is really confident enough to join. It is not uncommon that much fewer families join that earlier pre-registered. A wait-and-see attitude and indecisiveness are a common challenge to community programs. This issue should be diplomatically addressed during the Awareness Campaign.

For a review of expectations and willingness-to-pay: refer to Focus Group Discussions (FGD) and Rapid Family Survey (RFS). A 93 page very informative report with the findings was published in English and disseminated by the central-level CBHI team. This community consultation process was done from May to July 2004.

#### **Summary findings of 79 FGD's conducted in all villages, with villagers:**

- Most villagers do use Khalifa district hospital, but offer some scope for improvement: mainly related to unofficial payments, quality of staff, poor diagnostic capacity, lack of available drugs, staff attitude, waiting time, etc.
- Villagers demand more specialist staff, more laboratory equipment, cheap drugs, more polite staff, more equity for the poor, ...
- When in need of health care, most people go into debt, or sell and pawn belongings, or lend money from hospital staff. People confirm that health care leads to poverty. There is no tradition of saving money for health care. There are some traditional risk-pooling strategies and 'group-deposits' ('gameia').
- There is some knowledge about insurance: car insurance, teacher groups, cooperatives and unions,...
- Villagers indicate the following actors could be trusted as fund holders of the new CBHI scheme: village head, district head, Sheikh, NGO, elected committee, women, must be local people, but not health staff.
- Villagers had experience with community based programs: development, water or electricity projects, school and road building. As factors for success: good management, no politics, clear rules, real need, broad support, good accounting, are mentioned.

**Summary findings of the RFS of 1899 families in the target area (=27% of targeted families):**

- On average there are 1.3 families per household. About 80% of household have only 1 family. There are on average 6.7 persons per family.
- 45% of the population is less than 18 years old.
- 38% of the families has a child under 5 years. 29% of the families has an elderly over 60 years old. The dependency rate is 0.9 children per adult and 0.1 elderly per adult.
- Only 17% of the population earns an income. 12.5% of families have no earner, but only 2% of families have no income. 34% of adults are earning.
- Of those working: 40% are civil servants!!, 27% in the informal sector, 19% get formal wages, 12% irregular work, and only 2% farmers!!
- The average salary income is 17,218 Rial/month = 2,570 Rial/person/month or 13.8 USD/person/month.
- 23% of families have at least one chronic patient, 4% have more than one chronic patient. Most frequent chronic conditions are heart disease (2%) and diabetes (1%).
- 73% of families had at least 1 episode of health care in the last 6 months (only 2.4% for obstetrics and 0.8% for traffic accidents). For health seeking behavior, the choice of first contact was:
  - \* 58% to Khalifa district hospital
  - \* 15% to private clinics
  - \* 11% to private pharmacy
  - \* 8% to Sana'a or governorate referral hospital.

The choice of second contact was:
 
  - \* 38% to Sana'a or governorate referral hospital
  - \* 28% to private clinics
  - \* 16% to Khalifa district hospital
  - \* 1.3% abroad.

The choice of third contact was:
 
  - \* 38% private clinic
  - \* 35% to Sana'a or governorate referral hospital
  - \* 9% traditional medicine.
- 63% of patients paid for transport: mean 2,300 Rial, median 500 Rial. Only 5% report to have paid unofficial fees (median 500 Rial).
- 76% of families want the largest possible benefit package: OPD+ IPD+ dentist + all cost of surgery. For this the families are willing to pay 5.8 USD per person per year.

**Family size in the target area** (important for calculation of contribution rates).

| Family size | Total families | % in population | cumul % | Family size | Total families | % in population | cumul % |
|-------------|----------------|-----------------|---------|-------------|----------------|-----------------|---------|
| 1           | 6              | 0.3%            | 0.3%    | 13          | 69             | 3.6%            | 93.1%   |
| 2           | 87             | 4.6%            | 4.9%    | 14          | 32             | 1.7%            | 94.8%   |
| 3           | 112            | 5.9%            | 10.8%   | 15          | 31             | 1.6%            | 96.4%   |
| 4           | 136            | 7.2%            | 18.0%   | 16          | 18             | 0.9%            | 97.4%   |
| 5           | 168            | 8.8%            | 26.8%   | 17          | 9              | 0.5%            | 97.8%   |
| 6           | 221            | 11.6%           | 38.4%   | 18          | 5              | 0.3%            | 98.1%   |
| 7           | 203            | 10.7%           | 49.1%   | 19          | 4              | 0.2%            | 98.3%   |
| 8           | 205            | 10.8%           | 59.9%   | 20          | 5              | 0.3%            | 98.6%   |
| 9           | 179            | 9.4%            | 69.4%   | 21          | 3              | 0.2%            | 98.7%   |
| 10          | 175            | 9.2%            | 78.6%   | 22          | 5              | 0.3%            | 99.0%   |
| 11          | 117            | 6.2%            | 84.7%   | 23          | 5              | 0.3%            | 99.3%   |
| 12          | 90             | 4.7%            | 89.5%   | 24 and up   | 14             | 0.7%            | 100%    |

When calculating the number of persons (and not families): all families with up to 9 members make up half the number of people in the area. All families with up to 12 members make up three-quarters of people in the area.

**6.3.2. Khalifa district hospital as first contracted hospital, under capitation:**

The management of Khalifa district hospital has always been very kind and welcoming to the CBHI team. Constantly they have expressed full support for the pilot project, and they are eager to start the scheme. They do understand the capitation method of payment now and are not opposed to it. However, the district hospital has some insurance arrangements for employees in large private companies based on a fee-for-service system. The DG of the hospital has expressed fears that capitation payment would be difficult and that he prefers the known fee-for-service system with reimbursement of provided services according to an agreed price list. This is somewhat a challenge to the principles of CBHI, although the DG has always added he is willing to give capitation a try. One can expect the 'nervousness' of the provider to increase as the date of contracting approaches. Good communication with the CBHI central team is essential.

Then there is a charity-based insurance fund for hospital staff. This fund is more or less open-ended, with case-to-case approach and somewhat subsidized by the hospital itself. Although this is a applaudable effort in social protection, the CBHI scheme can not run on the same management practice.

The staff of Khalifa district hospital is also interested in CBHI, but less concerned. It is not clear how big is the threat of health staff who fear losing their 'private' 'unofficial' income from charges to patients, as insured patients will be told clearly they should not pay any additional fees anymore. In the future this issue should be carefully monitored. As in most countries unofficial fees are very difficult to evaluate. In the first years of

CBHI, only a minor percentage of the population (20%?) is expected to join, thus only affecting the hospital workload (and staff revenue) in a minor way. As the percentage of membership coverage increases, so should the size of the bonus package provided by CBHI increase. The potential of a functional bonus system should be explained to the staff but especially to the hospital management.

The management of Khalifa district hospital has always been open and forthcoming when the CBHI team wanted to analyze revenue, utilization, or RDF functioning. This is encouraging for future cooperation and builds hope for a straightforward discussion on capitation rate and expenditure of capitation funds.

#### 6.3.3. Taiz Governorate Health Office:

The GHO in Taiz has equally been enthusiastic about the coming CBHI scheme. Senior managers have always attended meetings and seminars as requested, and added to the debate in a constructive way.

An interesting – and unresolved – question is how much the GHO should be involved in the management and supervision of the CBHI pilot scheme in the district. For example, the GHO is not (yet) represented in the district Management Committee for CBHI. Neither is there a governorate level committee or board for CBHI. In my personal view, this is satisfactory for the time being, because there is only one district scheme in preparation and the insurance will not cover referral to the governorate hospitals. In the future, when CBHI expands in Taiz and when governorate hospitals will be contracted, it would be appropriate to involve the GHO more officially. Meanwhile, in order not to make the management structure too heavy, the current situation in which the GHO is informed and asked for advice, and in which GHO staff are always involved in field activities, should be satisfactory.

#### 6.3.4. Ministerial team for implementation of CBHI:

It seems that the ministerial team for CBHI is somewhat the limiting factor in the speed of progress of the CBHI program. Good intentions are there, and surely the senior managers in the MoPH&P are very supportive. Budget is no constraint at all. Technical capacity to design and monitor CBHI development has been built up. The main challenges have been the availability and replacement of central team members, the coordination between the members and the clear hierarchy and positions in the team. Hopefully, some attention and skillful management will solve these constraints and improve the team spirit. It would be good progress if the team would cooperate spontaneously in planning, executing and fully reporting on progress in the field. Additional capable and active staff would be welcome, especially if the MoPH&P hopes to expand the CBHI program once it proves to be successful.

6.3.5. Local authorities (in health and administration, political and traditional leaders, and CBO's)

**Summary findings of the 2 FGD with local authorities in the target area:**

- Local authorities described experience with existing welfare systems: some governmental, some NGO, some religion based, the family structure, etc. Overall dissatisfaction with the existing exemption system in the hospital. There is some knowledge about the principles of insurance.
- Pre-payment will only be accepted if the quality of health services improves: qualified staff, better laboratory, more drugs available, attitude of staff, need to build trust. Problems can be expected with regular and continuous contributions. Attendants only know the fee-for-service reimbursement system in insurance. There is a general expectation that the government should subsidize health care or insurance. All want a very comprehensive benefit package including referrals. Some only want to cover big (expensive) risks.
- There is a good understanding of community based action (there were Local Community Councils from the 1980's), and the threats and strengths. Advise to avoid failure: good management, honest people, clear rules and hierarchy, good government support.
- Any fund holder committee should represent a wide range of stake holders: villagers, NGO, local authorities, ...
- The poor should be subsidized by the rich (caritas).

CBO's have from the start been very interested in CBHI, and several times the willingness by the CBO's to monopolize the management of CBHI has been expressed. Although this shows great and welcome interest, giving the CBO's too much leverage in the scheme should be avoided. Analysis of the working methods and the membership they cover has shown that the management style of CBO's is not entirely desirable in the future CBHI. With a third of the members of the CBHI Management Committee reserved to CBO representatives, the CBO's will have sufficient influence to contribute positively to the CBHI program.

It is not sure whether the CBO's and other potential members of the district Committee fully understand the voluntary and unpaid characteristic of their function. Neither will any of the Management Committee members have direct access to the CBHI capitation funds. This last issue will have to be explained again during the meetings to prepare the selection of the district Management Committee for CBHI (see implementation plan under point 7).

6.3.6. Other stakeholders (private pharmacies, drug supply companies to the hospital, other public health facilities that are not contracted by CBHI):

A newly introduced health financing system influences the stakeholders covered by the new scheme. However, it also affects those not covered by the scheme:

- patients not covered may be provided better care or may even have to pay more in over-prescription and in unofficial fees to compensate for the loss from insured patients. This is unlikely to be an issue at the start.
- Private pharmacies may be unhappy that insured patients no longer buy their drugs outside the hospital. This may become a challenge in the future.
- Drug supply companies will probably not be effected, as indeed the district hospital will make an effort to improve its RDF stock. However, supply of generic drugs, rather than more expensive commercial brands, will be stimulated.
- Other public health facilities that are not contracted by CBHI may lose some patients. Especially the Health Centers may observe that insured members now go to the district for even primary health care. Therefore, a priority in the expansion plan should be the inclusion of Health Centers in the CBHI network. Earlier investigations have shown that a lot of progress remains to be done in the financial management of the Health Centers, before being able to contract for insurance.

At this time it remains difficult to appreciate the effects CBHI will have on the 'other' stakeholders. Careful monitoring and observation of these issues will be part of the follow up of the CBHI program.

#### 6.4 Opportunities and obstacles to be anticipated and exploited

6.4.1. The CBHI program should take full advantage of the current positive attitude, support and endorsement from the many stakeholders at different levels of society (refer to 6.3 'Views of stakeholders', above). The target community, the selected district hospital, the health authorities at district and governorate level, the local administrative authorities, as well as the MoPH&P are urging to move on with the implementation of the first CBHI pilot scheme.

6.4.2. Project managers should make full use of the existing team, many of whom have been trained in theoretical concepts and implementation techniques, and built up significant field experience. At central level there are now three to four members active and two who could be stimulated to restart their participation (refer to Annex 2: 'Central members of CBHI team'). At governorate level there are half a dozen staff who have been participating in fieldwork in the past. At district level there is a team for community work with a dozen quality resource persons and half a dozen staff to assist work in the district hospital. The senior CBHI program managers and team coordinators should manage these human resources skillfully and try to give the team members full work satisfaction. The central team should take good professional care of their resource persons, delegate and build ownership, so that in the future after the CBHI pilot project there is a ready pool of candidates to take up more official posts in the CBHI network.

6.4.3. At this stage, with only one CBHI district in Taiz, it may be sufficient to involve the governorate level through informing managers at governorate level and taking governorate resource persons to the district for field work (refer to point 6.3.4. above). Preparing a good coordination board or committee at governorate level (or any other management structure) should start now, by carefully training resource persons and building ownership.

6.4.4. Project managers should never forget the wider picture and the place of CBHI in a wider development of social security and social protection in Yemen. The ultimate aim is to have a nationwide universal coverage of primary health care and other social security benefits, with equitable financial access. At this point in time, a community based approach for the informal rural sector is chosen as strategy for best success and best credibility. It is normal that experts who develop a framework for the formal sector and for the civil servant social security schemes, will propose a completely different strategy: e.g. compulsory, building reserves, contributions according to income, a formal & professional management structure rather than community based, etc. This alternative strategy is in no way contradictory with the different approach of CBHI, in view of the very different target populations. Thus, care should be taken when other

experts or organizations propose a very different national framework for health insurance, as for example GTZ is invited to do later this year. Senior CBHI program managers should communicate the aims and choices of strategy for CBHI to these experts who are undertaking policy studies. In a best scenario, CBHI and other insurance schemes should merge in the far future. Refer to remark 'Vision for future expansion and integration of CBHI' on the last page of "Guidelines with the Regulations for CBHI".

6.4.5. With regard to the technical details for the implementation of the CBHI pilot scheme, there is often a choice of approach and several ways an implementation could be executed. However, the team should be careful not to change the approach or the characteristics of the current proposal, without due reflection on the impact. It is to be expected that hospital management or groups in the community or leaders in the MoPH&P propose alternative work methods, as they have done in the past. For example: - to change from capitation to fee-for-service,

- to make the system less community based,
- to start fund-building in the district Management Committee,
- to change from a large benefit package to only covering IPD,
- to make CBHI compulsory,
- to abolish the waiting periods,
- to list all diseases or interventions that are covered, rather than defining the benefit package in more 'general terms of principle',
- to demand extra funding from government or donors to directly subsidize health care under insurance, etc..

These proposals should be openly discussed. The central team should understand (as most of them do now) the principles of health financing and the advantages and threats of different approaches and share them with parties who wish to debate change.

## **7. Implementation plan: Activity plan from April to August 2005**

The following 20 pages describe a proposal for activities to be implemented by the central team for CBHI (Community Based Health Insurance), with assistance from resource persons at governorate and district level. These activities should result in the opening of the first CBHI pilot scheme in August 2005. This chapter 7 has already been submitted to the central CBHI team as a work document end March'05.

The activities are grouped according to logic steps, which themselves have a logic sequence. In past activities, many team members have already gained particular expertise in their field of work, linked to the implementation of CBHI. In this text activities are grouped as:

1. Produce Regulations for CBHI
2. Calculate the capitation rate and contribution rates
3. Set up an administrative system for CBHI
4. Awareness Campaigns in the target population
5. Assist the formation of a district Management Committee for CBHI
6. Opening Ceremony for CBHI
7. Work with Shamaytain district hospital to prepare for the start of CBHI
8. Other activities to prepare for the start of CBHI in Shamaytain district

Usually under each point a similar approach is followed in the text:

- a) a review of past achievements under this specific activity,
- b) listing of expected challenges and some hints on how to avoid them,
- c) guidelines for a budget estimate,
- d) suggestions for a timeframe for the above activities.

This whole text is summarized in a timesheet (Excel format, 2 pages) where the activities are ticked in on a weekly schedule up to August 2005, and can be found in Annex 8.

### **Activity plan for implementation of CBHI in Shamaytain, Yemen** **From April'05 to August'05**

In order to work efficiently the activities should be divided into specialized teams, with one person named responsible for each group of tasks. Of course, as central team members are very limited in number, each member of the team should be willing to assist and help another team in any way possible. In March-April 2005, four teams have been formed already, with some success. This approach should be reinforced and improved. It is unrealistic to expect that any team member is a specialist in understanding and implementing every detail in such a diverse range of activities. In the following activity plan, we retain the existing teams and add more groups of activities.

#### **7.1. Produce Regulations for CBHI**

##### **7.1.1. Former accomplishments and description of future tasks**

Regulations for CBHI have been discussed for a year. An Arabic and English version, with guidelines included, have been produced. In Feb.-March'05 this 'first draft' has been presented to and discussed with a large number of stakeholders at district level, i.e. hospital management and staff representatives, district health leaders and district administrative/political leaders, representatives of the population (CBO's) and the governorate health and administrative leaders. After four seminars, the team adjusted the Regulations (into 'second draft'), mainly to make the text more clear and

comprehensible. No major changes to the Regulations were needed, following the discussions with the stakeholders.

Now the CBHI ministerial team has to present the 'second draft' to several levels in the Ministry of Public Health. This will require several seminars for actors in the Ministry, after which the ministerial team for CBHI should produce a 'final draft' of the Regulations for CBHI to propose to the Minister for signing into a decree.

We propose four seminars in the Ministry of Public Health (each with about 25 attendants): For example:

- Seminar with members of the EC team for Health System Reform, other donors interested in the development of CBHI (Oxfam, GTZ, WHO, World Bank and others), and members of the Health Policy and Technical Support Unit in the MoPH&P.
- Seminar with heads (DG's) and Deputies of every Department in the MoPH&P.
- Seminar with top management of the MoPH&P (Minister and Vice Ministers) together with leaders of other relevant state bodies (Ministry of Finance, Ministry of Public Service, Ministry of Justice, etc.)
- Seminar with other stakeholders at central level: national representatives of CBO's, representatives of the Shura, representatives of the Assembly who are involved in the national discussion on the development of social security in Yemen.

The 'final draft' of Regulations for CBHI and the accompanying Guidelines should be edited and reviewed, and put into a suitable legal text, with reference to previous legal documents and decrees. The signature of the Regulations by the Minister is an important milestone in the implementation of the first CBHI scheme. The signed document should be printed in a handy format (for example half A4 size booklet, with cover and shiny paper). Considering there is a target population of 7,000 families and more stakeholders at central, governorate and district level, the Regulations should be printed with at least 5,000 copies! The Regulations should be distributed during the Awareness Campaigns, and during the training of hospital staff. Guidelines to the Regulations can be printed in A4 format, with cover and on normal A4 paper. The Guidelines can be printed by less than 1,000 copies.

#### **7.1.2. Challenges anticipated**

In general, the finalization of the process towards a Decree on Regulations is expected to be smooth. Strong points are the good understanding at district level (by leaders in health and administration, and to lesser extend by representatives of the population), and the strong backing by top leaders in the MoPH&P.

| Description challenge  | Likelihood of occurrence                                   | Gravity of challenge                                 | Action to take to counter challenge  |
|--|--|--|--|
| At the last minute team members agree to challenge key characteristics of the CBHI system.                   | Unlikely if the team follows a rational path.              | Confusion, delay, complete derailing of the process. | Manage the process well, good public relations and advocacy.   |
| Endless repeating of consultations at lower levels, e.g. restart discussions with local CBO's and villagers. |  |  | Involve many stakeholders in the process, so that all understand this is a product of long consultation. |
| In the final stages, the Decree on CBHI takes many months to be signed.                                      | Unlikely if the Ministry is briefed regularly on progress. | Delay.   | Stress the importance for action and not delay.  |

### 7.1.3. Budget provisions for the activity 'Produce Regulations for CBHI'

| Description budget line  | Calculation  | Total budget |
|--|--|--------------|
| <u>4 seminars for central level:</u><br>- per diem attendants ( <u>or</u> lunch)<br>- rent room<br>- rent equipment (LCD, overhead, ...)<br>- handouts Regulations<br><br>- handouts stationary for attendants<br>- 2 times coffee break<br>- 2 cleaners/assistants meeting room<br>- stationary 4 seminars: blanc posters, markers, overheads, scotch tape, budget for 500 copies, A4 paper, etc. | - 1 day x 4 times x 25 people x ...Rial<br>- 1 day x 4 times x ...Rial<br>- ... Rial<br>- 100 copies 'second draft' Regulations & Guidelines (normal A4)<br>- 100 sets: folder, pen, notebook<br>- 2 x 100 persons x ... Rial<br>- 2 people x 2 days x .... Rial<br>- ... Rial |              |
| Budget for professional text processing and translation of Regulations and Guidelines, before giving to Minister.  | - ... Rial   |              |
| Arrange meeting with Minister and Deputies to present final Regulations and ask for signature  | - Coffee and sweets for 10 people<br>- 10 Copies of 'Final draft' Regulations and Guidelines   |              |
| Print Regulations (after proper bidding process)   | 5000 copies, half A4 format  |              |
| Print Guidelines (after proper bidding process)  | 1000 copies, A4 format   |              |
| <b>TOTAL BUDGET PROVISION FOR ACTIVITY</b>   |  | Rial         |

**7.1.4. Timeframe**

- 4 seminars in 2 weeks
- edit final text before submission to Minister: 1 week
- present to Minister and signature: 1 week
- produce 5000 copies of Regulations and 1000 copies of guidelines: 2 weeks, including collecting quotations.

## **7.2. Calculate the capitation rate and contribution rates**

### **7.2.1. Former accomplishments and description of future tasks**

Principles of health financing and alternative options have been explained to stakeholders since April 2004, through a series of flagship seminars 'Principles of Health Financing, Health Insurance and Capitation'. The reasons for choosing capitation payment, and not fee-for-service reimbursement as provider payment has been explained, discussed and generally well accepted. Methodology of calculating the capitation rate, has first been explained in April/May 2004. More detailed descriptions of the methodology and the challenges to expect have been discussed with the team in March 2005. A document describing the technical details on how to do a calculation is available in English and has been discussed with the central team.

A time schedule and a central team for calculating the capitation rate based on data from Khalifa district hospital was proposed. Due to organizational obstacles, the identified team did not make it to the district and the calculation exercise that was planned to last for 10 working days, did not realize during the mission period of the EC consultant (Feb.-March'05). Only the very initial steps to study what kind of financial data is available at different points in the hospital were initiated.

In the future, a renewed effort will have to ensure that the identified team or a new team goes to the district and does the data collection and subsequent calculations. Technical advice on how and where in the hospital to collect financial data and data on utilization, has been provided by the EC consultant. Several central resource persons are capable to do this technical task (f.e. Dr Jamal Nasher, DG of HPTSU ; Dr Abdulwahid Al Serouri of Sana'a University ; Dr Ragheb Al Qarshi, team leader CBHI), but they should be mobilized.

### **7.2.2 Challenges anticipated**

| <b><u>Description of challenge</u></b>   | <b>Likelihood of occurrence</b>                               | <b>Gravity of challenge</b>  | <b>Action to take to counter challenge</b>                       |
|--|---|--|--|
| The team leaders are satisfied with an estimate of capitation rate, based on documents on national health expenditure. | It has already been proposed that this would be satisfactory. | This approach would severely undermine the credibility of the capitation method. * | EC team leader and HPTSU leaders should stimulate the CBHI team. |

|  |  |  |   |
|--|--|--|---|
| Some hospital leaders will always try to change the system of capitation back to the known system of fee-for-service. Likewise they will try to make the calculation method to be based on unit costs and after-service reimbursement. | Although most of the management agrees to give capitation a try, some still show mistrust. | A reimbursement system of fee-for-service will be too costly and unworkable.                   | Explain again and again the principles of health financing and capitation method.   |
| The data on charges and utilization in the hospital is not rational or transparent.  | This is surely the case.   | This would lead to a wrong calculation of the capitation rate.                                 | Skillful and meticulous analysis of data at different levels (collection points, in administration units, in service units, etc.) |
| A lot of data is missing, because currently many patients buy their drugs outside the hospital (in private pharmacies).  | This is probably the case.   | The capitation rate would be wrongly under-estimated if this lack of data is not incorporated. | Make an informed estimate on the size of the missing data.  |
| Hospital data is not nicely allocated to OPD and IPD services.   | This is surely the case.   | This would lead to a weak methodology for calculations.  | The team has to develop allocation keys based on observation and informed guess.  |

\* Capitation payment system is a completely new method of provider reimbursement in Yemen. Everywhere in the world the introduction of capitation mechanism is feared and easily misunderstood. Especially the health care provider fears making deficits, loss of unofficial income by private-acting doctors in the health facility, and over-utilization by insured members ('moral hazard'). Therefore, when advocating for a capitation mechanism and working on a pilot scheme, the central team should utilize the opportunity to increase the strength of their understanding and arguments when doing the calculations of the capitation rate:

- doing a calculation based on data collection in the field will help confidence building on the side of the hospital management and the central team as well, and help all stakeholders to accept the system of capitation.
- While collecting data in the district hospital, the central team for CBHI may well come across interesting information. For example discovering an existing practice of over-prescribing one or another diagnostic procedure, ... which then should be addressed when discussing with the hospital about managing capitation funds. Having on-hand information about non-rational practices strongly increases the negotiating power of the central team.

- To implement a functional simple administrative system for CBHI, and in order to be able to monitor functioning and reporting about utilization, the central team must know the hospital information flow in great detail. It is normal that in the future, when CBHI has started, the provider will try to inflate the reported expenditure on insured members, to negotiate for a higher capitation rate. When the team has a strong experience about the existing hospital administration, they will be much more at ease to enter these discussions.

All the above advantages and strengths would not be available to the CBHI team if the calculation of the capitation rate would be based on national health expenditure figures and done inside the MoPH&P.

Refer to the flagship seminar 'Principles of Health Financing, Health Insurance and Capitation' for the definitions of capitation, the advantages and dangers of the capitation method of provider reimbursement, the meaning of 'population based risk rating', etc.

### 7.2.3. Budget provisions to calculate the capitation rate for CBHI.

| Description budget line   | Calculation                                      | Total budget |
|---|--|--------------|
| Air ticket 2 central team members to Taiz governorate + travel to district  | 2 tickets x ..... Rial<br>+ taxi fare            |              |
| Per diem 2 central team members   | 2 people x 12 days per diem x<br>..... Rial      |              |
| 1 governorate team member from Taiz travel to district  | ..... Rial                                       |              |
| Per diem 1 governorate team member from Taiz to district  | 1 person x 10 days per diem x<br>..... Rial      |              |
| Per diem 2 district team members from Khalifa hospital administration   | 2 people x 10 days per diem x<br>.... Rial       |              |
| Lump sum for completing the work to write up and edit a report on calculation of capitation rate and contribution rates for families. | ..... Rial                                       |              |
| Budget for seminar to explain the capitation rate at ministerial level (15 attendants) + give print-out                               | (copies, overheads, coffee break )<br>..... Rial |              |
| <b><u>TOTAL BUDGET PROVISION FOR ACTIVITY</u></b>   |  | Rial         |

(Note: a small budget to buy calculators and paper and notebooks for the team has already been provided before leaving for the district in February 2005).

#### **7.2.4. Timeframe**

- 1 day workshop to review the methodology of calculation in the MoPH&P,
- 1 day workshop to review the methodology of calculation with the governorate and district resource persons,
- 8 days data collection in Khalifa district hospital:
  - in the service units (in pharmacy, XRay department, echography, etc.)
  - in the administrative department of the hospital, to get figures on: total collection of charges, total number of OPD visits and IPD days, and find allocation keys (= estimate of % charges to OPD and IPD).
- 4 days analysis of data and decision of the capitation rate
- 1 day to work out several scenario's of contribution rates according to the family size, on the basis of the found capitation rate.

### **7.3. Set up an administrative system for CBHI**

#### **7.3.1. Former accomplishments and description of future tasks**

A simple and robust administrative system for CBHI has been developed by the team. A manual in Arabic and one in English, with comments on each form used, has been produced. Every actor (Collectors, Account Manager, Reception staff) who has to collect and consolidate data has been identified, including the time this action requires. This manual should be reproduced. Just before the start of the CBHI scheme, the different actors in the administration of CBHI have to be selected and trained separately:

- Collectors, one for each Uzla. They will need two days training, and a day on-the-job assistance by the project team at the start. Then monitoring the first month is necessary.
- The Account Manager is key to the administrative system. This person will need 2 weeks full-time training and then regular support by the project team during the first months.
- Members of the district Management Team for CBHI have to be trained for two days, to understand the CBHI system and get repeat training in health financing principles. They only need basic training in the administration of CBHI, just to be able to monitor and be able to understand the monthly reports.
- Hospital staff have to be trained to understand those few CBHI documents they will come across (CBHI membership card, monthly list of eligible members). A few staff will need extra training to be able to do the small extra work in the hospital reception as well as to do the monthly ATD report (Admission/Transfer/Discharge report on utilization by insured members).

### 7.3.2. Challenges anticipated

The administrative system is expected to run smoothly without too many difficulties in implementation. Regular monitoring during the first months of implementation will be crucial.

| Description challenge   | Likelihood of occurrence   | Gravity of challenge   | Action to take to counter challenge  |
|---|--|--|--|
| Unsuitable candidates for administrative positions are selected.                                  | This is unlikely if the team manages the process well.           | If the administration is not functioning, reports will be useless, money may disappear, hospital may under-service, and members will drop-out due to dissatisfaction. Without proper administrative system it is not possible to monitor and evaluate the success or problems of CBHI. | Meticulously follow the developed system. Do not think too fast to change the system without proper investigating the consequences.<br><br>Some double-checks are built in the system: do not remove them to 'facilitate' the functioning. |
| Training is poor. Monitoring is poor. Actors that drop-out are not replaced and trained properly. | It is also important the local team and provider take ownership. |  |  |
| The monthly reports are of poor quality and not fully used as management tool.                    |  |  |  |

### 7.3.3. Budget provisions for the set-up of the administrative system for CBHI

Together with the training costs for administration, we put here the starting-up costs for the administrative system for CBHI. These seeding funds include a one-time provision by the EC project of all furniture, equipment and a first set of all books, forms and registers. This should be enough to last for 6 months to one year service. After that the administrative system should be self-sustained, taking funds from the administrative budget of CBHI.

| Description budget line   | Calculation   | Total budget |
|---|---|--------------|
| Print in Arabic 20 complete sets of 'Administration system for CBHI', to give project, governorate and when teaching district actors. | 20 copies x 80 pages + plastic coverpage = ..... Rial |              |
| Print 60 limited sets (only those few forms handled by Collectors and hospital staff) to use in their training.                       | 60 copies x 20 pages + plastic coverpage = ..... Rial |              |
| Air ticket 1 central team member to Taiz governorate + travel to district   | 2 air tickets x ..... Rial<br>+ taxi fare ..... Rial  |              |
| Per diem 1 central team member for  | 12 days per diem x                                    |              |

|   |   |  |
|---|---|--|
| Administrative task (train Collectors & Mgt Committee + Account Manager)  | .... Rial   |  |
| Per diem 2 district team members from Khalifa hospital administration to assist central team member (Admin.)  | 2 people x 10 days per diem x<br>.... Rial  |  |
| Rent a car in the district for the CBHI team to travel to the Uzlas   | 10 days rent = ..... Rial   |  |
| Per diem for Collectors + Account Mgr during training on Administrative system  | 9 Collectors x 4 days (2 day class + 2 days on-the-job) x ..... Rial<br>1 Account Manager (2 weeks) =<br>10 days x ..... Rial |  |
| Per diem for training district Management Committee   | 2 days x 19 members x .... Rial   |  |
| Stationary for all trainees in administration (pens, notebooks, paper, plastic folders, ...)  | 25 sets x .... Rial   |  |
| Half day training for <u>all</u> hospital staff (split in 3 groups) to repeat generalities and show them the few CBHI forms they will ever see (Col 1, Acc 4, stamp, Mgt 1, Hosp 1 & 2, etc.)   | - 3 groups x coffee-break for 50 P x<br>..... Rial<br>- rent room: 3 half days (incl. cleaning)                               |  |
| Per diem 1 central team member for Administrative task to FOLLOW UP Collectors & Mgt Committee + Account Manager = 3 trips of each 4 days work  | 3 air tickets x ..... Rial<br>+ 3 x taxi fare ..... Rial<br>+ 3 x 5 days per diem x .... Rial                                 |  |
| Per diem 2 district team members from Khalifa hospital administration to assist central team member (Admin.) to FOLLOW UP Collectors & Account Manager  | 3 x 4 days per diem x .... Rial   |  |
| Initial set of <u>furniture</u> for the Account Manager of CBHI:<br>- office desk + chair, desk lamp<br>- 3 extra chairs + bench for waiting<br>- shelf to put 30 box files (no doors)<br>- metal cupboard 3 drawers with lock<br>- white board big size for office Acc Mgr<br>- publicity board to hang outside Reception (wood frame covered with glass window, to hang 8 pages A4)<br>- signboard CBHI (no logo yet) to hang at the Reception(s).<br>- Small 'suggestion/complaint box' with lock, to hang near the Reception. | expensive   |  |
| Initial set of <u>office stationary</u> for the Account   |   |  |

|   |   |      |
|---|---|------|
| <p>Manager of CBHI:</p> <ul style="list-style-type: none"> <li>- pens, pensils, rulers, carbon paper, white board markers, corrector, gum, scissors, 10 packs A4 paper, post-it, empty envelopes, etc.</li> <li>- 30 empty boxfiles, plastic folders,</li> <li>- perforator, stapler and staples, ...</li> <li>- full set of all forms, registers, membership cards and notebooks for one year functioning of CBHI.</li> <li>- 2 different CBHI stamps, inepad, blue ink (enough to supply Collectors),</li> </ul>  | <ul style="list-style-type: none"> <li>- ..... Rial</li> <li>- ..... Rial</li> <li>- ..... Rial</li> <li>- expensive!<br/>(Pre-printed Registers will take weeks to produce!)</li> <li>- ..... Rial</li> </ul>  |      |
| <p>Initial set of <u>office stationary</u> for each Collector for CBHI: (no furniture)</p> <ul style="list-style-type: none"> <li>- each collector receives an 'office bag' to put all his material (with zipper and 2 compartments).</li> <li>- pens, pensils, ruler, carbon paper, gum, 30 pages of blanc A4 paper, scissors, post-it, empty envelopes, ...</li> <li>- one empty boxfile, 2 plastic folders,</li> <li>- perforator, stapler and staples, ...</li> <li>- small amount of forms the Collector uses: Form Col 2, Col 3 &amp; Col 5.</li> <li>- 1 Collector stamp, inepad</li> </ul> <p>(Collectors will be supplied by the Account Manager when running out of forms or equipment)</p> | <p>expensive</p> <ul style="list-style-type: none"> <li>- ..... Rial x 9 Collectors</li> <li>- ..... Rial x 9 Collectors</li> <li>- ..... Rial x 9 Collectors</li> <li>- ..... Rial x 9 Collectors</li> <li>- ..... Rial x 9 Collectors</li> <li>- ..... Rial x 9 Collectors</li> </ul> |      |
| <u>TOTAL BUDGET PROVISION FOR ACTIVITY</u>  |   | Rial |

Note: All equipment remains property of the CBHI scheme. If a collector stops his job, he/she must return all equipment to the Account Manager, who will provide it to the new Collector after training.

#### 7.3.4. Timeframe

- reproduce manuals on the 'Administrative System for CBHI'
- help the district to select Collectors and one Account Manager
- 2 days training of all Collectors + 1 day in-the-field training per Collector at the start of the first collections ( 3 teams x 3 days = 9 Uzla).
- 2 weeks training of the Account Manager before start of the scheme.
- Follow up of Account Manager and Collectors after the start of CBHI.
- Train hospital staff after the start = during the one month waiting period.

## **7.4. Awareness Campaigns in the target population**

### **7.4.1. Former accomplishments and description of future tasks**

Several activities with the community in preparation for CBHI have been accomplished. Even the Focus Group Discussions and the family survey can be considered as some kind of awareness campaign. Later a first round of real Awareness Campaign has been done: the team went to each Uzla and explained the system of CBHI (generalities about the Regulations).

In the future, as soon as the Minister has signed the Decree on Regulations, and after the calculation of the capitation rate has allowed to calculate the contribution rates for families of different sizes, the Awareness Campaign can begin in full earnest. Then the Awareness Campaign should be an informative forum as well as a real business-like campaign to attract future members for the insurance. If the pool is less than 300 families, the CBHI scheme should not even begin. We estimate an initial membership of 500 families should be achievable at the start. This would represent hardly 7% of the population in the target area.

In the future, we estimate two big Awareness Campaigns should be sufficient to mobilize the community to join CBHI. A list of names of all families who attended, per village, should be kept in order to manage and monitor the process properly (e.g. what % of the target group showed up? What % of the families pre-registered?).

We propose the following contents for the Awareness Campaign: always start with a review of the general aims and characteristics of CBHI, then review the Regulations and stress they are now signed by the Minister, explain the contribution rate (no need to explain the capitation rate!), explain well the waiting periods, explain the future possibilities of extension and referral if CBHI works well, explain the Community Based aspect and community ownership and responsibility. Explain the necessity to contribute regularly and promptly, and not to over-utilize (careful: the responsibility to manage over-use is mainly in the hands of the prescribers, not the community!). Special aspects of each round of Awareness Campaign are:

ROUND 1: ask the attending population to discuss CBHI with the adults in their family and to join also the next round of Awareness Campaign, with an answer whether they are likely to join.

ROUND 2: same contents as Round one, but now also 'pre-registration'. Pre-registration for CBHI means writing down names of families who say they are likely to join (but not compulsory). This is very important for the team to know whether the public is ready to start registration or whether another Awareness Campaign (Round 3) is necessary. The lists of pre-registered families also come in handy when real registration by collectors begins: they can first visit those families who said they are likely to join, rather than go door-to-door blindly.

Note: as always: the central team members should train the 12 to 15 district team members for one day on how to do a good Awareness Campaign (methodology and contents). Then in the field, the central team members should show the practice, but then as soon as possible delegate the activity and supervise. It would make no sense if only central team members would do all the talking in the villages. The 15 plus team members involved in this activity should split in small groups of about 3 team members when going to villages = 5 teams working simultaneously. Estimate that each team can do 2 sessions per day (incl. preparations, invitations, travel to village, etc.):

- a day or two for training, making schedule and invite first villages,
- Atturba town: may need 2 days for all 5 teams,
- 46 villages with 5 teams: 5 days work.

Note that some villagers may demand to do the Awareness Campaign in the evening for their convenience.

The Awareness Campaign also includes further 'repeat'-seminars for advocating with all leaders of the community, the administrative leaders (do not forget the Finance Department) and leaders in health. The way of communication and the content of the message has to be adapted to the public that has been invited.

Note: Sometime just before (if you are very confident) or just after the second Awareness Campaign the team should organize an OPENING CEREMONY for CBHI. See below under point 6.

#### 7.4.2. Challenges anticipated

| Description challenge   | Likelihood of occurrence   | Gravity of challenge   | Action to take to counter challenge  |
|---|--|--|--|
| The Awareness Campaigns are too short, with few villagers attending.          | This is unlikely to occur if the team prepares well and sticks to the laid-out plan. | Low membership at start or no start of CBHI at all.  | Prepare well. Careful invitation procedure. The teams must take time to implement. |
| Too much top-down approach. People have no time to ask questions and discuss. |  | Low credibility, many misunderstandings which will need time and energy to correct once the scheme is running. | Attitude of central team to train and delegate to local team                       |

|   |  |   |  |
|---|--|---|--|
| The Governorate team and local team take no ownership. All the campaigning is done by the central team. |  | Risk of low sustainability if for each additional awareness the central team has to travel to the district. | Good attitude by central team: first show and explain, then supervise local teams. |
|---|--|---|--|

### 7.4.3. Budget provisions for Awareness Campaign with the target population

One round of Awareness Campaign to cover all 46 villages (in 9 Uzla) + Atturba Town can take easily 2 weeks (10 working days). The CBHI team must do a real effort to give every family the chance to send an adult representative to listen to the message. One Awareness Campaign session should take no less than 2 hours per village or per Uzla (depending on the size), with time to answer questions from the public.

| Description budget line  | Calculation   | Total budget |
|--|---|--------------|
| Awareness Campaign for the population:<br>ROUND 1:<br>- air ticket + taxi fare for 2 central members of the CBHI team<br>- per diem for 2 weeks for 2 central members of the CBHI team<br>- taxi fare & 10 days per diem for 1 governorate member of the CBHI team<br>- 10 days per diem for 12 to 15 district members of the CBHI team (already well trained) | - 2 x air ticket + 2 x taxi fare<br><br>- 2 x 13 days per diem<br><br>- 1 x taxi fare + 1 x 10 days per diem (governorate to district)<br>- 15 x 10 days per diem for local district team |              |
| Awareness Campaign for the population:<br>ROUND 2: same budget as row above  | Same as above   |              |
| Awareness Campaign for the population:<br>ROUND 3: Prepare budget. If not necessary before the start of CBHI: keep budget for later rounds of campaigning to address special issues such as drop-out or over-utilization. (same budget as row above)   | Same as above   |              |
| Rent 3 cars in the district for 10 days = one car per team of Awareness Campaign   | 3 cars x 10 days= ..... Rial  |              |
|  |   |              |
| <b>TOTAL BUDGET PROVISION FOR ACTIVITY</b>   |   | Rial         |

### 7.4.4. Timeframe

ROUND 1: as soon as the contribution rates are calculated and the Regulations are signed and printed in large number for distribution: duration 2 weeks.

ROUND 2: three weeks after Round 1 (not too much later, otherwise the momentum is lost): duration 2 weeks including pre-registration.

## **7.5. Assist in the formation of a district Management Committee for CBHI**

### **7.5.1. Former accomplishments and description of future tasks**

In the past year only general outline, function and importance of the district Management Committee for CBHI have been discussed with local stakeholders. Many interesting remarks and questions have been put forward. In general, the concept of a local board responsible for the daily management of the CBHI scheme is well accepted. Local representatives and CBO's are very interested and enthusiast about the proposed format.

After the regulations have been made official, the process of installing a functional district Management Committee for CBHI must be assisted. In a diplomatic way a middle line must be chosen between completely free choice by the locals to man the district Management Committee versus a guided process where suitable candidates are appointed according to pre-set criteria. The Regulations propose a set of members form different group of stakeholders. It is important that the member population keeps the majority, but that other stakeholders remain present in the Committee.

The following activities will be necessary:

- Organize a set of meetings specially addressing the issue of creating a district Management Committee for CBHI. The meetings should start with a review of the principles of CBHI and generalities of the regulations. The main focus should then go to the function and importance of the Management Committee, it's monthly tasks and time input. It should be stressed this is a voluntary unpaid position, and members should join out of engagement and believe in the development of social protection.
- Engage and select representatives of CBO's and other representatives of the Community. Note that only 5 of the 9 or more existing CBHO's should be selected to represent in the Management Committee. Diplomatically choose only those CBO's which are functional and efficient. Engage and select representatives of the Health sector and the administration.
- After candidates have been endorsed by the chair of the district Management Committee, there should be some training to prepare them for the function.
- Once the CBHI scheme is running, the central team should assist the first couple of monthly meetings of the district Management Committee for CBHI, in order to assure a smooth process, but also to help answer technical questions regarding CBHI regulations.

### 7.5.2. Challenges anticipated

| Description challenge   | Likelihood of occurrence  | Gravity of challenge  | Action to take to counter challenge   |
|---|---|---|---|
| Stakeholders want to increase the number of representatives in the Committee to accommodate more members. | Unlikely if the central team explains well the function and the needs for efficiency. | Too large Committee unable to function well.                                  | Patiently explain over and again the needs for a functional and representative Committee.<br><br>Refer to the Regulations signed by the Minister. |
| Some argue to exclude f.e. the Collectors or the health leaders from the Committee.                       |   | Committee without partners to discuss and solve problems.                     |   |
| Committee votes itself to get extra power, f.e. to start fund building to be managed by the Committee.    |   | Great danger to create internal conflict and lose the trust of the community. |   |
| Committee votes itself to get per diems or allowances for meetings.                                       |   | Running cost of the CBHI scheme becomes too high.                             |   |
| Committee has quick turn-over of members without proper training, or meetings are not regular.            |   | Non-functional Committee and loss of trust by population.                     |   |

### 7.5.3. Budget provisions for setting up a district Management Committee for CBHI

| Description budget line   | Calculation   | Total budget |
|---|---|--------------|
| Air ticket 1 central team member to Taiz governorate + travel to district | Air ticket = ..... Rial<br>+ taxi fare                            |              |
| Per diem 1 central team member  | 12 days per diem x ..... Rial                                     |              |
| 1 governorate team member from Taiz travel to district                    | Taxi fare ..... Rial  |              |
| Per diem 1 governorate team member from Taiz to district                  | 1 person x 10 days per diem x .... Rial                           |              |
| Per diem 2 district team members from Khalifa hospital administration     | 2 people x 10 days per diem x .... Rial                           |              |
| Meeting 3 persons per Uzla about selection members Mgt Committee          | - 1 day rent room<br>- coffee break<br>- per diem 27 participants |              |
| Meeting hospital leaders and  | - 1 day rent room   |              |

|   |   |  |
|---|---|--|
| DHO about selection members Mgt Committee   | - coffee break<br>- per diem 15 participants  |  |
| Meeting district administration & political leaders about selection members Mgt Committee | - 1 day rent room<br>- coffee break<br>- per diem 15 participants   |  |
| Meeting CBO's about selection members Mgt Committee                                       | - 1 day rent room<br>- coffee break<br>- per diem 15 participants   |  |
| Train selected members of Mgt Committee: 2 days   | - 2 days rent room<br>- coffee break<br>- per diem 19 participants for 2 days                             |  |
| Repeat one time the flagship seminar 'Health Financing, Health Insurance and Capitation'  | - 1 day rent room<br>- coffee break<br>- per diem 15 participants (who did not participate in April 2004) |  |

#### 7.5.4. Timeframe

- 1day meeting 3 persons per Uzla about selection members Mgt Committee (= the Collector of each Uzla)
- 1day meeting hospital leaders and DHO about selection members Mgt Committee
- 1day meeting district administration & political leaders about selection members Mgt Committee
- 1day meeting CBO's about selection members Mgt Committee
- 1day flagship seminar 'Health Financing, Health Insurance and Capitation'
- 2 days training of selected members of Mgt Committee

## 7.6 Opening Ceremony for CBHI

### 7.6.1. Aim of the Opening Ceremony for CBHI

The Opening Ceremony for CBHI is an event to mark the official start of the CBHI scheme in a district. The most important event (after the speeches) is the signing of the CBHI contract (or agreement) between health provider and the CBHI Community Management Committee.

The aims of the ceremony are:

- Public Relations and further publicity to make CBHI known to the public and to leaders. Let everybody know that finally after more than one year preparations, the scheme will really start. Encourage everybody to join.

- Confidence building for the public (and even further building of the legal framework, as dignitaries witness the signing of the CBHI contract): when people see the officials in health and administration endorse the scheme, they may be more eager to join.

It is up to the EC project and the CBHI team (and according to the expected success at the start) to decide whether to hold a very big ceremony or a very sober event. A big ceremony would invite the Minister of Public Health and dignitaries from the Governorate and District. Of course the population and the Management Committee should be prominently represented in the Opening Ceremony.

### 7.6.2. Challenges anticipated

| <b>Description of challenge</b>  | <b>Likelihood of occurrence</b>  | <b>Gravity of challenge</b>               | <b>Action to take to counter challenge</b>   |
|--|--|---|--|
| At the last minute the district hospital refuses a contract with capitation method | Very unlikely if the central team regularly feeds back about regulations | Unimaginable, Major scandal, end of CBHI. | Team and senior MoPH&P staff should contact hospital management regularly each month |

### 7.6.3. Budget provisions for the Opening Ceremony

The expectations about the size of the event will define the budget needed for the Opening Ceremony. It could be done very cheaply, in a room with 15 invitees, taking no more than one hour. It could be a mass reception with hundred people attending, speeches, buffet, media and music, and several dignitaries from Sana'a and Taiz.

| <b>Description budget line</b>                                       | <b>Calculation</b> | <b>Total budget</b> |
|--|--------------------|---------------------|
| Transport for dignitaries from Sana'a to Shamaytain + per diems      | expensive          |                     |
| Transport for dignitaries from governorate to Shamaytain + per diems |                    |                     |
| Rent premises or tent  |                    |                     |
| Rent tables and chairs   |                    |                     |
| Buffet or snacks, soft drinks  |                    |                     |
| Invitations, print, post, petrol to invite                           |                    |                     |
| Per diem local team to organize                                      |                    |                     |
| Rent microphone & music system                                       |                    |                     |
| Transport and per diems central team                                 |                    |                     |
|  |                    |                     |
| <b>TOTAL BUDGET PROVISION FOR ACTIVITY</b>                           |                    | Rial                |

#### **7.6.4. Timeframe**

The Opening Ceremony is best done in the first half of the month, then the rest of the month can be used to register and collect the first contributions. For example: Opening Ceremony on 4<sup>th</sup> of August. Then 6<sup>th</sup> to 24<sup>th</sup> August doing the first collections. These collections are considered as payment for September = waiting period. Then the first (OPD) health service under insurance on the first of October 2005, and first hospitalization possible on 1<sup>st</sup> December 2005.

The Opening Ceremony is best done just before or after the last Awareness Campaign, shortly before the first collection of contributions (to get best use of the publicity effect).

### **7.7. Work with Shamaytain district hospital to prepare for the start of CBHI**

#### **7.7.1. Former accomplishments and description of future tasks**

In the past there have been several seminar and continuous discussions with hospital staff and hospital management to explain the principles and working of CBHI. The existing RDF and adherence to the Essential Drug List of the MoPH&P has been analyzed. The flow of drugs and patients, the money flow and information flow has been studied.

In the future, further discussions with governorate and hospital leaders to promote improvements of the RDF must be held. To bring the RDF in Khalifa hospital up to standards will take several meetings spread over months. A new inventory of the RDF stock should be made shortly before the opening of the scheme, hopefully showing improvement in the availability of essential drugs.

The central team must undertake activities to improve the quality of services. At this stage meetings with all staff is the best tool. The following list of contents can be used as guide:

- Demonstrate evidence of what improvements can be made: sample of prescription errors, complaints and suggestions from the public (refer to Focus Group Discussions and Family Survey), waiting times, hygiene, friendliness, etc.
- Discuss medical ethics and code of conduct.
- Discuss the problem of over-utilization ('moral hazard') and over-prescription (very common in the existing fee-for-service system). Tell the solution lies with the prescription behavior of doctors.

- Explain the link between pre-payment, good services, increasing membership and subsequent improvement of hospital financing and staff bonus.
- Explain the bonus system of CBHI (use of CBHI Form Hosp 3) and link between good functioning and higher bonus.
- Specific training on technical issues of CBHI, such as recognizing the CBHI stamp, knowing the flow of insured patients.

Train hospital management how to follow up on expenditure of CBHI capitation funds in the hospital (use of CBHI Form Hosp 3). Explain how to monitor prescription behavior towards insured members. Explain how a successful CBHI scheme can be very beneficial for the hospital and staff income.

### 7.7.2. Challenges anticipated

| Description challenge  | Likelihood of occurrence                          | Gravity of challenge   | Action to take to counter challenge |
|--|---|--|-------------------------------------|
| Training hospital staff to manage CBHI is neglected, in the believe that all will go smooth automatically. | Unlikely if team sticks to plan and is available. | Poor management of capitation funds and deficit, poor services for insured, poor reporting, drop-out | Follow plan of activities           |

### 7.7.3. Budget provisions for preparing Khalifa district hospital to start CBHI

| Description budget line  | Calculation  | Total budget |
|--|--|--------------|
| Discussions with hospital to improve RDF and available essential drugs | No budget required   |              |
| Divide hospital staff in three = 3 times half day meeting              | - Rent room 3 days<br>- coffee break 150 people<br>- no per diems? |              |
| Per diems central team<br>(air tickets linked with other activities)   | 4 days per diem  |              |
| Per diems governorate resource person                                  | 4 days per diem  |              |
| <b>TOTAL BUDGET PROVISION FOR ACTIVITY</b>                             |  | Rial         |

### 7.7.4. Timeframe

- several meetings with hospital managers, spread over several months, to improve RDF

- 3 days meeting with hospital staff
- meeting with hospital managers to explain management of capitation funds.

#### **7.8. Other activities to prepare for the start of CBHI in Shamaytain district**

a) Set up Ministerial Management Committee for CBHI. This will require several individual meetings with senior managers in the MoPH&P, surely with those people who will be member of the Committee. Print pages with the Regulations concerning the Ministerial Management Committee for CBHI (Articles 4 and 10). Arrange then an official meeting with all concerned to declare the start of the Ministerial Management Committee.

b) Engage Ministry of Finance, Governorate Finance Depart. & District Finance Department. The aim is a good understanding and cooperation, avoiding conflict in the future (for example taxing or demanding transfer of funds).

c) Work with RDF at ministerial level (after seeking backing from senior managers in MoPH&P). Explain the situation and that a good RDF as condition for success of CBHI. Ask for special attention for the supply off Khalifa Hospital. Ask for permission that Khalifa Hospital is allowed to take supplies from Aden and private sector for those drugs the RDF store in Sana'a cannot supply.

d) Appoint a Local Coordinator for CBHI at district level, to help with the implementation of the first CBHI pilot. The ToR proposal has been drafted by the central team.

e) Produce one or two more campaign leaflets or posters to distribute during the Awareness Campaign for CBHI.

f) Open a bank account for the CBHI Management Committee and Account Manager. Assure the bank requests two out of three signatories (members of the Mgt Committee) before the Account Manager can withdraw money. Ask the hospital to open a bank account for the capitation funds to be transferred.

g) Follow-up visits from the central team to Shamaytain district during the first month of functioning of the CBHI scheme, to assist the district hospital and Management Committee with the following:

- At the end of the first month 'waiting period': assist the Account Manager with the second time closing of accounts and transfer of capitation funds. Assist the first real

Management Committee monthly meeting. Be present in the OPD reception at the start of the first services under insurance.

- At the end of the first month OPD services under CBHI: assist the Account Manager with the third time closing of accounts and transfer of capitation funds. Help the assigned hospital staff to produce the first ATD report. Assist the Management Committee monthly meeting.

h) Organize the first Ministerial Management Committee for CBHI after 6 months functioning. Prepare a six month compilation report on the functioning of CBHI to present in this meeting. Three compilation forms (CBHI Form Rep 1 to 3) have been proposed for this purpose.

i) Further follow-up visits from the central team to Shamaytain district once the CBHI scheme is running, to monitor the functioning and address specific issues as they arise (accounting, membership, functioning of the Collectors, Account Manager and district Management Committee, and management of capitation funds by the hospital). Audit the accounts of CBHI (a auditing manual has been drafted). Involve the Finance department of the district in the monitoring and auditing of the CBHI accounts. Retrain actors in the CBHI administration as necessary. This follow-up falls outside the scope of this Activity Plan and should be organized later.

#### **Conclusion:**

The proposed timeframe is indicative, and could be implemented faster or slower by postponing an activity. Dates can be adapted to local conditions and according to availability of staff. However, we think it is not possible to cancel any of the main activities in the preparation of the CBHI scheme.

The sequence of activities is also logical: f.e. signing of the Regulations should be after the calculation of the capitation rate ; likewise the signing of the contract (opening ceremony) can only happen after the Minister has endorsed the Regulations. Collection of contributions can only be done after the hospital has committed itself to the CBHI scheme.

From the proposed activity plan, it is clear that still many time-consuming activities remain to be implemented, in order for the CBHI scheme to start successfully. The central team for CBHI will need all support and stimulation to bring this series of activities to a fruitful end. Introducing for the first time in a country a social protection scheme, based on prepayment of health services is indeed a major undertaking, as many concepts and methods are completely unheard of. This interesting challenge should not be underestimated.

## 8. Conclusion / Summary of Recommendations

For recommendations on technical issues: refer to the above advice on how to avoid or counter expected challenges (chapters 6.4 and 7.1.2., 7.2.2., 7.3.2., 7.4.2., 7.5.2., 7.6.2 and 7.7.2).

8.1. The most urgent technical task to fulfil is calculate the capitation rate and subsequently the contribution rates, depending on the family size. It would be difficult to continue the implementation of other tasks, like awareness campaigns or discussions with the hospital, without knowing the price of the proposed benefit package.

8.2. The RDF system should be strengthened nation-wide. Temporarily it is satisfactory if special attention is given just to the RDF of Shamaytain district hospital, for the sake of the CBHI pilot scheme there. For future expansion of CBHI to other districts, and indeed for successful health financing in general, the whole RDF system should get renewed attention and support.

It must be recognised that the RDF implementation has encountered some major challenges:

- The central purchase store and purchase/distribution mechanism could improve, in speed, adherence to the Essential Drug List, transparency and regulations.
- Regarding the financial management, the law stipulates that funds collected from co-payment are to be managed at the health facility itself, to purchase and replace drugs that have been sold. In reality the finance section of the MoPH&P and even the Ministry of Finance has in several cases ordered the transfer of all collected funds, under the promise that they will settle the bills with the central RDF purchase store, when the health facility orders new drugs. This mechanism failed, and left several health facilities with loss of finances. This scenario should absolutely be avoided in the CBHI schemes, by good networking with the Ministry of Finance and MoPH&P.
- Several health facilities reported that no standard accounting format or drug management guidelines have been issued together with the implementation of the RDF system. It seems that it is left to the health facilities to create their own accounting format, transfer methods, ordering forms, inventory forms, internal deliveries, etc. The RDF would be much stronger if central level would propose a standard format for RDF management. Efficient manuals for this purpose are available from other developing countries that have recently implemented a nation-wide RDF system.

- Sometimes inside the hospital, funds from the RDF are used to support purchase of medical equipment or pay for general running costs of the facility. This should be better regulated.

Lessons should be learned from the challenges faced by the implementation of the RDF in Yemen, so that similar difficulties do not arise with the CBHI program. Constant good co-operation and engagement with the Ministry of Finance and the Finance Department of the MoPH&P are essential. Refer to Annex 6: general findings about the RDF in Khalifa district hospital.

8.3. Team building inside the MoPH&P to strengthen the CBHI team is necessary. Clear responsibilities, capacity building, availability and dedication of resource persons, long-term commitment and hard work are necessary for success of the CBHI program. Senior managers should search for additional human resources to strengthen the CBHI team.

8.4. Step by step there should be capacity building at governorate level. Resource persons from the Governorate Health Department should be further trained and involved in the implementation process. Ownership should be stimulated, eventually leading to the creation of a Governorate Unit for CBHI. At district level a Local Co-ordinator will be appointed to support the pilot project, especially when the central CBHI team is not present. A job description has been written by the central CBHI team, see Annex 7.

8.5. Building of a broader vision for social security development in Yemen, more particularly development of health insurance, has to continue. The role of CBHI in this process must be shared with other leaders and policy makers. In the absence of health insurance for civil servants and for the formal sector, CBHI would be the first attempt to organise non-profit health insurance for the community. This is a grand task. As other sectors attempt to organise formal (and compulsory) health insurance schemes, many experts will give their advise and vision. Soon GTZ will undertake a major feasibility study and offer policy advise. Senior managers of the CBHI program should brief those external experts on the role and vision of CBHI. Refer to the last page of the "Guidelines for the Regulation for CBHI", draft 10/3/2005, (below Article 26) "Vision for future expansion of CBHI". Also refer to the similar point 6.4.4 above.

8.6. As suggested by Dr Jamal Nasher, DG of the HPTSU, in a personal communication on 11/2/2005, it would be very useful to create a forum to discuss issues on Health Insurance for all sectors and promote the nation-wide expansion. The forum at central level could unite stakeholders in the relevant Ministries, as well as senior professionals from EC, WB, WHO, GTZ and NGO's interested in the advancement of health insurance and social protection in Yemen.

**END OF TEXT OF MISSION REPORT**

## List of Annexes

### **ANNEX 1. Terms of Reference of EC consultant Filip De Loof**

Support to Health Sector Reform in the Republic of Yemen  
European Commission, Ministry of Public Health and Population  
Project No. YEM/B7-3000/IB/98/0710

#### **TERMS OF REFERENCE:**

#### **DEVELOPMENT OF A PILOT SCHEME FOR COMMUNITY BASED HEALTH INSURANCE**

International short-term expert under EC Technical Assistance for the Programme Support Stage (PSS) 2005

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#### **Objective and context of the consultancy:**

The objective of the consultancy is to continue support to the Ministry of Public Health and Population in the development of a pilot scheme of Community Based Health Insurance (CBHI), which was started in the district of Shamayatayn in 2004

The Ministry recognizes that for any CBHI scheme to be sustainable the scheme must be truly owned and administered by communities themselves through suitable Community Based Organizations (CBO) or local authorities under the regulation and supervision of the Ministry. In order to secure higher success rates of the schemes, participating CBOs need to be well organized, have sufficient administrative capacity, and be recognized by all stakeholders (Local Government, health authorities, population) as legitimate representatives of the community they are serving. Communities with a high degree of social coherence, which are already running CBOs (e.g. farmers and fishermen cooperatives, local charitable societies, etc) are to be preferred over communities which don't show these characteristics.

The Ministry sees itself mainly as the facilitator and where necessary as the regulator of these community-owned health insurance schemes, without exercising direct control over the schemes. It is envisaged that the schemes will eventually act as independent purchasers of health services from selected public and possibly even private health facilities in their neighbourhood.

#### **Expertise needed:**

One international **Expert in Community-Based Health Financing** with hands-on experience in developing countries, is required to support the Health Sector Reform Project in the development of a trial programme "Community Based Health Financing".

The expert should have at least 10 years professional experience as a public health expert, with a strong background in health financing and hands-on experience with the design and implementation of community based health insurance / financing schemes.

#### **Description of the consultancy:**

The assignments will take place in Sana'a, in Taiz and in district of Shamayatayn. The total duration of the assignments will be 30 days to take place in February / March 2003.

The international expert will work closely with and support the Ministry's CBHI Team, which has been established in 2004, as well as a local short-term expert.

**Tasks of the consultant:**

## 1) Train the Ministry's CBHI Team (2 days)

- Conduct an intensive two-day training course in advanced principles and practice of CBHI for the Team members

## 2) Review the progress of the CBHI Workplan activities (4 days)

- Carry out a thorough review of the progress of the CBHI Workplan activities implemented since March 2004 at all three levels (Ministry, Governorate, District)
- Identify specific achievements and constraints, pay specific attention to the following:
  - o Staffing and capacity of the CBHI team at central level
  - o Staffing and capacity of the CBHI focal points at Governorate and District level
  - o Commitment, capacity and current expectations of the CBOs in the District
  - o Sate of preparations and capacity of the District Hospital in Shamayatayn for implementation of the CBHI scheme
  - o Integration of the scheme with other pilot scheme (i.e. Oxfam, World Bank project)
- Based on these findings make practical recommendations for action to the Ministry / project management with the aim to strengthen capacity for implementation of the CBHI Workplan.

## 3) Support CBHI Team in implementation of selected activities of CBHI Workplan (18 days):

- Carry out costing exercise of health services in Khalifa Hospital, determin the applicable capitation rate for the CBHI scheme
- Complete the institution of the proposed administrative system for the CBHI scheme at Khalifa Hospital; define roles and responsibilities, as well as relevant management tasks like accounting, patient registration, reporting, etc; train relevant hospital staff in these procedures.
- Decide on the final selection of CBOs for participation in the scheme. Train CBOs on applicable administrative procedures.
- Provide further assistance to the CBOs to mobilize community acceptance and sufficient membership enrolment in the scheme.
- Finalize legislation relevant to CBHI at central level
- Support the CBHI Team in any other relevant Workplan activity

## 4) Update the CBHI Workplan and monitoring system (2 days)

- Assist the CBHI Team in updating the CBHI Workplan based on the findings of activity 1 to 3 above

## 4) Report on the findings and results of the consultancy (4 days)

- Prepare a comprehensive consultancy report following the TA standard format and present it to the relevant stakeholders
- Brief the Minister of Public Health and Population and the project management on the overall progress and outlook of the trial scheme, and make practical recommendations for further strengthening of the scheme

## **ANNEX 2. Members of the central and local team for implementation of CBHI**

### **Ministerial team for CBHI**

Dr Ragheb al Qarshi (dentist, member Health Policy and Technical Support Unit, team leader CBHI team)

Dr Jamal Nasher (Director Health Policy and Technical Support Unit)

Dr Saleh Faddaq (Director Health Insurance Division in MoPH&P)

Mr Jamal al Serouri (Jurist, Deputy Director Legal Department in MoPH&P)

Dr Abdulwahid al Serouri (docent PH in University of Sana'a). Then temporary leaving CBHI team over discussion ToR and short-term contract.

### **Local Resource Persons for CBHI activities**

(Note that there are already some 15 local Resource Persons in Shamaytain district who have been trained to implement activities to engage the local community, and who preformed in a very satisfactory way, in doing the Focus Group Discussions in each village, conduct the Rapid Family Survey and do the first round of awareness campaign. They were not re-activated for the current hospital-based activities, but they will be contacted again in the future for many more activities with the community, such as awareness campaigns, pre-registration, training and assisting Collectors, recruiting members of the Management Committee for CBHI, etc.)

# Two local Resource Persons in the Team for finalization of ADMINISTRATIVE SYSTEM for CBHI:

- Mr Abdullah Noman Ganen: manager of the pharmacy finances in Khalifa district hospital + secretary for the DG of the district (good English).
- Mr Mansoor Rashid Abdulmalik: manager of hospital accounting.

# Two local Resource Persons in the Team for discussion on REGULATIONS for CBHI:

- Mr Gibril Ar Rouwasi: CBO member from Ar Rabeysah Uzla, teacher.
- Mr Abdullah Abdul Jabar: Khalifa district hospital legal affairs section.

# Two local Resource Persons in the Team for analysing the situation of the Revolving Drug Fund (RDF):

- Dr Abdul Rahim Mohammed Salem: Head of RDF department Taiz Governorate Health Office + head District Health Office of Taiz.
- Abdullah Abdul Kader: pharmacist, Deputy Head Medical Store in Khalifa district hospital.

### ANNEX 3. Activity Plan for the field visit during the consultancy of Filip De Loof

Community Based Health Insurance, Taiz governorate, Yemen

#### Review1: Activity plan: visit Shamaytain district to prepare CBHI, February'05

- Team FINANCE (Dr Abdulwahid, Dr Jamal Nasher): calculate capitation rate.
- Team REGULATIONS (Mr Jamal al Serouri): 4 seminars to explain regulations of CBHI and engage CBO's & Finance Department.
- Team ADMINISTRATION (Dr Ragheb): design administrative system for CBHI.
- Team RDF (Dr Saleh): investigate existing RDF: check inventory drugs, supply mechanism.

| <u>Date</u> | <u>Team</u>  | <u>Activity</u>   |
|-------------|--|---|
| Sun 20 Feb. | All (except FIN)   | 9am: fly Sana'a – Taiz, immediately drive Shamaytain district<br>Meet in Khalifa hospital: show activity plan., seek cooperation, identify challenges<br>pm: teamwork: Regulations, bonus system, generalities.   |
| Mon 21 Feb. | Team REG:<br>Team ADM:<br>Team RDF:                              | Train Resource P., invitations seminars, interview 3 CBO's<br>Teach 2 resource persons about regulations & admin system<br>Interview hosp.adm.&RDF& vertical program: drug-flow.  |
| Tue 22 Feb. | Team FIN:<br>Team REG:<br>Team ADM:<br>Team RDF:                 | Dr Jamal Nasher: prepare work calculation capitation rate<br>Meet several CBO's: 'interested? structure? accounting?'<br>Adjust all forms, think about location forms and registers.<br>Inventory central drug store.   |
| Wed 23 Feb. | Team FIN:<br>Team REG:<br>Team ADM:<br>Team RDF:                 | Dr Jamal Nasher: prepare work calculation capitation rate<br><u>Seminar</u> in district: 20 hospital middle management.<br>Walk in hospital, see reality, check availability staff&data.<br>Inventory OPD pharmacy + discuss.   |
| Thu 24 Feb. | All teams  | Teamwork: brief, plan, technical sessions.  |
| Fri 25 Feb. |  | Dr Abdulwahid arrives in Taiz   |
| Sat 26 Feb. | Team FIN:<br>Team REG:<br>Team ADM:<br>Team RDF:                 | Dr Abdulwahid: interview hospital admin./accounting.<br><u>Seminar</u> in district: 25 village leaders, CBO, politicians.<br>Walk in hospital, see reality, check availability staff&data<br>Inventory IPD pharmacy + discuss.  |
| Sun 27 Feb. | Team FIN:<br>Team REG:<br>Team ADM:<br>Team RDF:                 | Check real registers (cashier & reception registers), calculate, maybe have to estimate allocation keys.<br><u>Seminar</u> in district: 20 Health Leaders & distr. Authorities<br>Adjust forms and make good copies for workshop.<br>Interview actors in drug supply: what mechanism? Problems? |
| Mon 28 Feb. | Team FIN:<br>Team REG:<br>Team ADM:<br>Team RDF:                 | Check real registers (cashier & reception registers).<br>CBO's + Visit distr.finance office: engage & future task.<br><u>Workshop</u> : propose draft admin. system to 15 hosp.staff.<br>Reporting, produce tables drug inventories.<br><br>(all teams to Taiz)                                 |
| Tue 1 Mar.  | All in Taiz:<br>Team FIN:<br>Team REG:<br>Team ADM:<br>Team RDF: | Calculate unit cost (OPD&IPD)<br><u>Seminar</u> in Taiz: 25 GHO& admin./political authorities<br>Join team REG seminar<br>Join team REG seminar   |
| Wed 2 Mar.  | All teams  | Debrief GHO: brief past & next steps<br>12:45 noon return flight Taiz to Sana'a   |

#### **ANNEX 4. List of meetings held and people met**

- 9/2/05: initial briefing by team leader Dr Stephan Pahls, Dr Ragheb al Qarshi and Dr Jamal Nasher.  
19/2/05, 5/3/05 and 6/3/05: team meetings with new team leaders of EC health sector projects Dr Hans-Uwe Wendl-Richter and the CBHI team.
- 19/2/2005, 13:30pm: Meet Deputy Minister of Planning and Development (MoPH&P): Dr Holeydi Abdullah Majeed. Discuss past activities and planned activities for this month. Discuss principles of community health insurance and several technical issues.
- 19/2/2005, 14:30pm: Greet Deputy Minister for Primary Health Care (MoPH&P): Dr Majeed al Guneid (the CBHI project is also under his responsibility, and he was former DG of the HPTSU). Courtesy short talk.
- From 20/2/05 to 2/3/05: work in Shamaytain district: regular meetings with Khalifa hospital director and deputy director. Close co-operation. Daily seminars with stakeholders.  
27/2/05: the Khalifa hospital Director meets our CBHI team and expressed his concern that the capitation system of CBHI will make the hospital loose money. We highlight the necessity of good management of capitation funds and prescription behaviour. The Director proposes a fee-for-service system with reimbursement of service fees according to an agreed price list. Finally the Director agrees to give capitation a try.  
1/3/05: large seminar at Taiz governorate level. with leaders in the health sector and other sectors linked with the future CBHI program.
- 5/3/2005, 13:00pm: Brief new EC Team Leader for 'Support to Health Sector Reform in Yemen' Dr Hans-Uwe Wendl-Richter. Inform about past and future activity plan, achievements and challenges. Discuss ToR of new post for local coordinator for CBHI in Shamaytain district. Discuss how to form a team (who and when) to do 'calculation of capitation rate' in Shamaytain district hospital.
- 6/3/2005, 13:00pm: team meeting with Dr Uwe, Dr Jamal, Dr Ragheb, Dr Saleh and Filip. Discuss how to form a team (who and when) to do 'calculation of capitation rate' in Shamaytain district hospital. Discuss option to 'contract out' the work of the CBHI ministerial team, but then decide to keep normal project budget activities.
- 9/3/2005: 10:00am: long meeting with Deputy Minister for Primary Health Care (MoPH&P): Dr Majeed al Guneid.

**ANNEX 5. Target population for the start of the first CBHI pilot scheme in**  
**Shamaytain**

One small district town At Turba and 46 villages around Khalifa district hospital, Shamayatayn district, Taizz governorate, Republic of Yemen:

These 46 villages and district town house about one third of the total district population.

| 9 Uzla = hamlet<br>(group of villages) | nbr villages     | nbr families<br>(1994 sensus) | nbr population<br>(1994 sensus) | nbr population<br>(estim.2004) |
|--|------------------|-------------------------------|---------------------------------|--------------------------------|
| At Turba                               | 1 town           | 1,139                         | 8,054                           | 11,361                         |
| Dubhan                                 | 14               | 1,181                         | 7,462                           | 10,526                         |
| Bani Ghazi                             | 4                | 293                           | 1,504                           | 2,122                          |
| Jabel Sabaran                          | 3                | 155                           | 762                             | 1,075                          |
| Al Mushariqah                          | 6                | 264                           | 1,802                           | 2,542                          |
| Ar Rabeyseh                            | 3                | 132                           | 1,035                           | 1,460                          |
| Sharjab                                | 4                | 471                           | 3,371                           | 4,755                          |
| Al Assabeh                             | 6                | 1,114                         | 7,144                           | 10,073                         |
| Madahej                                | 6                | 394                           | 2,729                           | 3,848                          |
| TOTAL                                  | 1 town + 46 vill | 5,143                         | 33,863                          | 47,762                         |

**ANNEX 6. Drugs form the Essential Drug List available in Khalifa hospital**

See attached file in Excel, 8 pages.

## **ANNEX 6: Drugs from the Essential Drug List available in Khalifa hospital**

### **Summary of the findings after doing the drug store inventory in Khalifa district hospital and interviewing several staff responsible for the RDF**

Task completed by the CBHI team for RDF under leadership of Dr Saleh Fadaq (head Health Insurance Unit in MoPH&P) from 21 to 28/2/05. Refer to chapter 6.2 point d) in this Mission Report.

The inventory gave satisfactory results, insofar that two-thirds of the Essential Drugs are already available. This will facilitate the work of the CBHI team for RDF improvement. According to the CBHI contract, the hospital will have all essential drugs readily available at all times, without ever running short. This is necessary for a successful implementation of health insurance under capitation, and gaining confidence of the population.

The detailed list of the drug inventory is attached in the following pages. The list will permit to quantify the progress in the availability of essential drugs. It will show impartially that the introduction of CBHI improves the quality of health care, even for the non-insured, which can be considered as a 'spill-over' advantage of CBHI.

### **Summary of Essential Drugs available in Khalifa hospital, at the first stock-taking (24/2/05):**

| type of drug     | nbr in EDL | nbr in Khalifa | % available | extra, not in EDL | total nbr drugs in Khalifa |
|------------------|------------|----------------|-------------|-------------------|----------------------------|
| oral drugs       | 65         | 38             | 59%         | 7                 | 45                         |
| injectable drugs | 33         | 26             | 79%         | 17                | 44                         |
| external use     | 18         | 8              | 44%         | 2                 | 10                         |
| <b>TOTAL</b>     | <b>116</b> | <b>72</b>      | <b>62%</b>  |                   |                            |

65% of the oral and injectable drugs from the EDL are available

For Family Planning: All items on EDL are available:

- Condom
- IUD copper
- Oral Contraceptive (150 or 250 mg)
- Spermicidal

### **General findings about the functioning of the RDF in Khalifa hospital: stock-keeping, purchase procedures, fund management**

\* There are only two vertical programs implemented in Khalifa hospital: tuberculosis and family planning.

- TB has 5 hospital staff: 1 coordinator, 2 medical doctors (OPD and IPD), 1 labo technician, 1 registrar and drug supplies. All TB drugs are free.
- Local TB teams work around the district and in 20 rural Health Units.

Family Planning has 4 hospital staff: 1 coordinator, 2 nurses and 1 assistant.

Now all drugs available (after more than one year no supply at all!)

- condoms: charge 2 Rial (including 0.5 Rial staff bonus)
- IUD copper: charge 60 Rial (including 10 Rial staff bonus)
- oral pill: charge 20 Rial (including 10 Rial staff bonus)
- hormone IM-vial 3 months: charge 30 Rial (including 10 Rial staff bonus)

\* The drug supply mechanism in Khalifa hospital:

History: the RDF started in 2002 and restarted in 2003, with a central government start-up budget of 11 million Rial. Khalifa hospital got permission to order drugs from the governmental in Aden too, and not only from Sana'a, because the store in Aden functions better. Orders are placed every three months. Khalifa hospital RDF has an internal-order mechanism between the hospital store and the detail pharmacy. There is one detail pharmacy for the whole hospital, which runs 24 hours a day. In fact the detail pharmacy is split in three similar stores according to the shifts to facilitate accountability.

Drugs are sold at 15% surcharge. This surcharge is used as hospital staff bonus, according to a percentage split, with the prescribing doctors receiving 30% of the bonus if they restrict to Essential Drugs prescription.

\* Problems identified by the RDF staff:

- Finance Department in MoPH&P and the Ministry of Finance have tried in the past to ask that Khalifa hospital send all its revenue from the RDF to central level. This is contrary to the strategy proposed by the MoPH&P stating that 'revenue from cost-sharing should remain in the health facility where it was generated in order to avoid losses on its way through different administrative levels (MoPH&P, Oct.2000). Khalifa hospital has however maintained control.

The central drug store in Sana'a tries to keep a monopoly in supply to Khalifa, but they often have not all drugs available.

Some drugs (e.g. oxygen and nitrogen) are more expensive in the central drug store.

- Aden government supply store is also not perfect. E.g. amoxicillin is only available in syrop, not tables. E.g. no vitamins at all available.

- Prescribing doctors like to prescribe drugs to purchase outside the hospital, even when those drugs are available in the hospital, as they receive a commission of up to 100% on the sale.

- The administrative section of Khalifa hospital has sometimes used funds of the RDF for other purposes: purchase of equipment and running costs.

- The purchase mechanism could improve in transparency, with more comparison between drug prices and clear quotations.

- Drugs that are not available from the government store in Sana'a nor Aden must be purchased in the local private market, which is much more expensive

\* Recommendations from Khalifa hospital Directorate:

- The Aden government supply store should have all essential drugs available.
- In Khalifa hospital an effort should lead to better accounting practices and transparent spending of the RDF revenue.
- The prescribing doctors in Khalifa hospital should follow the Essential Drug List more strictly and stop sending patients outside for purchasing drugs.
- During the implementation of CBHI, the central CBHI team should liaise with the central RDF and ask special attention for the supply of Khalifa hospital, to ensure the success of CBHI.

\* In general Khalifa Directors and RDF staff have been very open and forthcoming during the collaboration with the central CBHI team. There is an honest desire to improve further the hospital RDF. The general situation of the RDF, both the central management and supply as well as inside Khalifa hospital, can be considered as an environmental risk, or as an assumption (using a term of the Logical Framework analysis).

**ORAL DRUGS FROM EDL AVAILABLE IN KHALIFA HOSPITAL (23Feb'05)**

|    | Name                         | form     | dose                  | store Sana'a | store Aden | pharma |
|----|------------------------------|----------|-----------------------|--------------|------------|--------|
| 1  | Acetylsalicylic acid         | tab      | 300mg                 |              |            | X      |
| 2  | Al/Mg hydroxide              | tab      | 500mg                 | X            |            | X      |
| 3  | Albendazole, chewable        | tab      | 200mg                 | X            |            | X      |
| 4  | Amoxicillin                  | tab      | 250mg                 |              |            |        |
| 5  | Amoxicillin                  | syrup    | 25mg/ml               | X            |            | X      |
| 6  | Atenolol, scored             | tab      | 50 mg                 | X            |            | X      |
| 7  | Bisacodyl                    | tab      | 2mg                   | X            |            | X      |
| 8  | Calcium lactate              | tab      | 300mg                 |              |            |        |
| 9  | Carbamazepine                | tab      | 200 mg                |              |            |        |
| 10 | Chloramphenicol              | caps     | 250 mg                | X            |            | X      |
| 11 | Chloramphenicol              | syrup    | 25 mg /ml bot -100 ml | X            |            | X      |
| 12 | Chloroquine phosphate        | tab      | 150mg base            |              |            | X      |
| 13 | Chloroquine phosphate        | syrup    | 10mg/ml base          |              |            | X      |
| 14 | Chlorphenamine maleate       | tab      | 4mg                   |              |            | X      |
| 15 | Cotrimoxazole                | susp.    | 40/8mg/ml             |              |            | X      |
| 16 | Cotrimoxazole, scored        | tab      | 400/80mg              | X            |            | X      |
| 17 | Diazepam, scored             | tab      | 5mg                   |              |            | X      |
| 18 | Digoxin                      | tab      | 0.25mg/ml             |              |            | X      |
| 19 | Diloxanide furoate           | tab      | 500mg                 | X            |            | X      |
| 20 | Ergometrine maleate *        | tab      | 0.2mg                 |              |            |        |
| 21 | Erythromycin                 | tab      | 250 mg                |              |            | X      |
| 22 | Erythromycin                 | syrup    | 25 mg/ml bot.100ml    |              |            |        |
| 23 | Ethosuximide                 | caps     | 250 mg                |              |            |        |
| 24 | Ferrous sulfate              | tab      | 200mg (65mg iron)     | X            |            | X      |
| 25 | Ferrous Sulfate + Folic acid | tab      | 60mg base+0.25mg      | X            |            |        |
| 26 | Folic acid                   | tab      | 1mg                   |              |            |        |
| 27 | Fursamide, scored            | tab      | 40mg                  | X            |            | X      |
| 28 | Glibenclamide *              | tab      | 5mg                   |              |            |        |
| 29 | Glyceryl trinitrate          | sub tab  | 0.5 mg                |              |            |        |
| 30 | Hydrochlorthiazide, scored   | tab      | 25 mg                 |              |            |        |
| 31 | Hyosine N-butylbromide       | tab      | 10mg                  |              |            | X      |
| 32 | Ibuprofen, scored            | tab      | 200mg                 |              |            |        |
| 33 | Indomethacin                 | caps     | 25mg                  |              |            |        |
| 34 | K-Chloride                   | tab      | 600 mg                |              |            |        |
| 35 | Methyldopa                   | tab      | 250mg                 | X            |            | X      |
| 36 | Metronidazole                | tab      | 200mg                 | X            |            | X      |
| 37 | Metronidazole                | susp.    | 200mg/5ml             | X            |            | X      |
| 38 | Miconazole                   | oral/gel | 25 mg /ml             |              |            | X      |
| 39 | Miconazole                   | pessary  | 100 mg or eq.         | X            |            | X      |
| 40 | Multivitamin (as placebo)    | tab      |                       |              |            |        |
| 41 | Niclosamide                  | tab      | 500mg                 | X            |            | X      |

|    |                                 |        |                       |   |  |   |
|----|---------------------------------|--------|-----------------------|---|--|---|
| 42 | Nitrous Oxide (medical quality) | inhal  |                       |   |  |   |
| 43 | Oral Rehydration Salt / ORS     | powder | dilute to 750ml water |   |  | X |
| 44 | Paracetamol                     | syrup  | 24mg/ml               | X |  | X |
| 45 | Paracetamol, double scored      | tab    | 500mg                 |   |  |   |
| 46 | Phenobarbital, scored           | tab    | 30mg                  |   |  | X |
| 47 | Phenoxymethyl penicillin        | susp.  | 25mg/ml               | X |  |   |
| 48 | Phenoxymethyl penicillin        | tab    | 250mg                 | X |  | X |
| 49 | Phenytoin sodium                | tab    | 50mg                  |   |  |   |
| 50 | Praziquantel                    | tab    | 600mg                 | X |  | X |
| 51 | Prednisolone                    | tab    | 5mg                   |   |  |   |
| 52 | Prednisolone                    | tab.   | 5 mg                  |   |  |   |
| 53 | Primaquine                      | tab    | 7.5mg                 |   |  |   |
| 54 | Promethazin HCL                 | elixir | 1 mg /ml bot. 100 ml  | X |  | X |
| 55 | Promethazine sugar coated       | tab    | 25mg                  | X |  | X |
| 56 | Propranolol                     | tab    | 40 mg                 |   |  | X |
| 57 | Propranolol, double scored      | tab    | 40 mg                 |   |  |   |
| 58 | Rantidine                       | tab.   | 150 mg                |   |  |   |
| 59 | Retinol (vit. A)                | cap    | 100,000 IU            |   |  |   |
| 60 | Salbutamol #                    | tab    | 4mg                   |   |  |   |
| 61 | Salbutamol #                    | syrup  | 2mg/ml                |   |  |   |
| 62 | Senna                           | tab    | 7.5mg                 |   |  | X |
| 63 | Simple linctus BP               | syrup  | BP                    | X |  | X |
| 64 | Sulphadoxine/pyrimethamin       | tab    | 500/25 mg             |   |  | X |
| 65 | Theophylline #                  | tab    | 200mg/SR              |   |  |   |

38 drugs available in list of 65 = 59%  
+ extra 7 oral drugs not on EDL

### **ORAL Drugs NOT in the Essential Drug List, but available in Khalifa Hospital**

|    | Name           | form  | dose   | indications      | in store only |
|----|----------------|-------|--------|------------------|---------------|
| 66 | Allopurinol    | tab   | 10 mg  | gout             |               |
| 67 | Cloxacillin    | syrup | 125 mg | AB               |               |
| 68 | Hydralazine    | tab   | 25 gm  | hypertention     | not in pharma |
| 69 | Metoclopramide | tab   | 10 mg  | nausea, vomiting |               |
| 70 | Nalidixid acid | syrup | 300 mg |                  |               |
| 71 | Nifedipine     | cap   | 10 mg  | angina pectoris  |               |
| 72 | Sulfasalazin   | tab   | 500 mg | arthritis        |               |

## INJECTABLE DRUGS FROM EDL AVAILABLE IN KHALIFA HOSPITAL (23Feb'05)

|    | Name  | form    | dose                   | store Sana'a | store Aden | pharma |
|----|---|---------|------------------------|--------------|------------|--------|
| 1  | Aminophylline                               | inj     | 25mg/ml                | X            | X          | X      |
| 2  | Ampicillin                                  | inj     | 500 mg / vial          |              |            |        |
| 3  | Atropin Sulphate                            | inj     | 1 mg/ml                |              |            | X      |
| 4  | Benzathin benzyl penicillin                 | pow inj | 1.2 mill .IU           | X            |            | X      |
| 5  | Benzyl penicillin (crystalline penicillin ) | pow inj | 1 million . IU         | X            |            | X      |
| 6  | Chloroquine phosphate                       | inj     | 40 mg ml base 5ml      |              |            |        |
| 7  | Chlorphenamine maleate                      | inj     | 10mg/ml                | X            | X          | X      |
| 8  | Chlorpromazin HCl                           | inj     | 25 mg /ml - amp<br>2ml | X            |            | X      |
| 9  | Dexamethason (sodium phosphate)             | inj     | 4 mg /ml               | X            | X          | X      |
| 10 | Dextrose 2.5% + Sodium chloride             | inj sol | 0.45%                  |              | X          | X      |
| 11 | Diazepam                                    | inj     | 5mg /ml                | X            | X          | X      |
| 12 | Diclofenac sodium                           | inj     | 25 mg /ml              |              |            |        |
| 13 | Epinephrine (Adrenaline)                    | inj     | 1mg/ml                 | X            | X          | X      |
| 14 | Ergometrine maleate                         | inj.    | 0.2 mg /ml-amp-1<br>ml | X            | X          | X      |
| 15 | Fursamide                                   | inj     | 10mg/ml                | X            | X          | X      |
| 16 | Glucose 5%                                  | inj     | 50 ml – amp            |              |            |        |
| 17 | Hydrocortison ( sodium succinate)           | pow inj | 100 mg -vial           | X            | X          | X      |
| 18 | Hyosine N-butylbromide                      | inj     | 20mg/ml                | X            | X          | X      |
| 19 | Insulin(intermediate-acting) #              | inj     | 100 IU/ml              |              |            |        |
| 20 | Insulin (soluble) #                         | inj     | 100 IU/ml              |              |            |        |
| 21 | Insulin Mixtrad (30/70) #                   | inj     | 100 IU/ml              |              |            |        |
| 22 | Lidocaine + adrenaline 1/100,000            | inj     | 2%                     | X            | X          |        |
| 23 | Lidocaine HCl                               | inj     | 2%                     | X            | X          | X      |
| 24 | Oxytocin                                    | inj     | 10 IU /ml – amp        | X            | X          | X      |
| 25 | Pethidine HCl                               | inj     | 50mg                   | X            | X          | X      |
| 26 | Procaine benzyl penicillin                  | inj     | 1.2 mill. IU           |              |            | X      |
| 27 | Rabies immuno-serum                         | inj     | 200 IU /ml             |              | X          |        |
| 28 | Rabies vaccine                              | inj     | single - amp           |              | X          |        |
| 29 | Snake venom anti serum                      | inj     | polyvalent             |              | X          | X      |
| 30 | Sodium chloride 0.9%                        | inj sol |                        | X            | X          | X      |
| 31 | Sodium compound                             | inj sol |                        |              | X          |        |
| 32 | Suxamethonium chloride or bromide           | pow.inj | 50 mg -vial            |              |            | X      |
| 33 | Water for injection                         | inj     |                        | X            | X          | X      |

26 drugs available in list of 33 = 79%  
+ extra 17 injectable drugs not on EDL

**INJECTABLE Drugs NOT in the Essential Drug List, but available in Khalifa Hospital**

|    | <b>Name</b>                | <b>form</b> | <b>dose</b> | <b>indications</b>     | <b>in store only</b> |
|----|----------------------------|-------------|-------------|------------------------|----------------------|
| 34 | Calcium gluconate          | amp         | 1g/10ml     |                        |                      |
| 35 | Cloxacillin                | vial        | 250 mg      | AB                     |                      |
| 36 | Dexiraze                   | vial        | 20 ml       |                        |                      |
| 37 | Dopamine chloride          | amp         | 1ml         | shock                  |                      |
| 38 | Halothane liquid           | bottle      | 250 mg      | general anesthe        | not in pharma        |
| 39 | Hydroxycobalamin           | amp         | 1mg/1ml     | Vit B12                |                      |
| 40 | Ketamine hydrochloride     | vial        | 50 mg       | anesthesia             |                      |
| 41 | Manitol 20%                | bag         | 250 ml      | diuretic               |                      |
| 42 | Metoclopramide             | amp         | 10mg/2ml    | nausea, vomiting       |                      |
| 43 | Morphine                   | amp         | 10mg/1ml    | pain                   |                      |
| 44 | Neostigmine                | amp         | 2.5 mg      | migraine, intest.atony |                      |
| 45 | Promethazine hydrochloride | amp         | 50 mg       | cough                  |                      |
| 46 | Quinine                    | amp         | 600 mg      | malaria                |                      |
| 47 | Sodium amidotizoate 6%     | amp         | 0.1 g       |                        |                      |
| 48 | sodium stibogluconate      | vial        | 100 mg      |                        |                      |
| 49 | Thiopental sodium          | vial        | 1 mg        | general anesthesia     |                      |
| 50 | Vit B complex              | amp         | 2 ml        |                        |                      |

**EXTERNAL USE DRUGS FROM EDL AVAILABLE IN KHALIFA HOSPITAL  
( inventory 23 Feb '05)**

|    | Name                                       | form      | dose                     | store Sana'a | store Aden | pharma |
|----|--|-----------|--------------------------|--------------|------------|--------|
| 1  | Antihemorrhoidal ointment + hydrocortisone | oint      | manufacturer composition | X            |            | X      |
| 2  | Benzoic acid + salicylic acid)             | oint      | 6% + 3%                  |              |            |        |
| 3  | Betamethason valerate                      | oint.     | 0.1% -tube ,30 g         |              |            |        |
| 4  | Calamine                                   | lotion    | 5%                       | X            |            |        |
| 5  | Chlorhexidine digluconate                  | sol       | 5% to dilute             | X            |            |        |
| 6  | Gamma benzene hexachloride                 | lotion    | 1%                       |              |            |        |
| 7  | Gentamycin sulphate                        | eye drops | 0.3 % -bot. 5 ml         | X            |            |        |
| 8  | Gentian violet                             | powd.     | for dilution             |              |            |        |
| 9  | Hydrocortisone acetate                     | cream     | 1%                       |              |            |        |
| 10 | Methylated spirit(ethanol)                 | liq       | 90%                      | X            |            |        |
| 11 | Peroxygen & Organic Acid                   | powd.     | 1% to dilute             |              |            |        |
| 12 | Potassium permanganate                     | powd.     | for dilution             |              |            |        |
| 13 | PVP iodine                                 | topic sol | 10%                      | X            |            |        |
| 14 | Silver nitrate applicator                  | pencil    |                          |              |            |        |
| 15 | Silver sulfadiazine                        | cream     | 1%                       |              |            | X      |
| 16 | Sulphur in petrolatum                      | oint      | 6%                       |              |            |        |
| 17 | Tetracycline HCL                           | eye oint. | 1%                       |              |            |        |
| 18 | Zinc oxide                                 | oint      | 10%                      | X            |            | X      |

8 drugs available in list of 18 = 44%  
+ extra 2 external use drugs not on EDL

**EXTERNAL USE Drugs NOT in the Essential Drug List, but available in Khalifa Hospital**

|    | Name               | form | dose  | indications | in store only |
|----|--------------------|------|-------|-------------|---------------|
| 25 | Dexamethasone oint | oint | 0.10% | eye-ear AB  |               |
| 26 | Glutazaldehyde     | sol  | 2%    |             | not in pharma |

**ANNEX 7. Vacancy announcement: Local Coordinator for CBHI in Shamaytain District, Taiz governorate.**

**General background of CBHI project:**

The CBHI project, is a pilot experience in non-profit voluntary Health Insurance, focusing on the informal sector. If the pilot is successful, the CBHI model may be extended to cover many more districts in Yemen. The aim of pre-payment and risk-pooling is to improve financial access to health care and protect families against catastrophic expenditure for health. A capitation method will ensure regular predictable income for the hospital and give opportunity to improve the quality health services.

**Activities completed (March'04 to October'04):**

- Advocating for CBHI & social health insurance, legal framework. Set up and train a ministerial team in issues about Health Financing and Health Insurance.
- Select Shamaytain district in Taiz as pilot area for first CBHI scheme.
- Engage authorities, health care providers and local CBO's (Community Based Organizations), at central, governorate and district level.
- Conduct Focus Group Discussions and Rapid Family Survey in target area, analyze findings and disseminate findings through seminars.
- Draft first regulations in Arabic (Mr Thabet-Oxfam, then Mr Jamal al Serouri, with team).

**Activities still to implement at district level in preparation of CBHI launch in Shamaytain, from April 2005:**

- Calculate capitation rate for CBHI and propose contribution rates.
- Conduct several awareness campaigns with population, authorities and health staff. Engage and select CBO's to take part in the district Management Committee. Train district Management Committee for CBHI. Train Account Manager for CBHI.
- Work with Khalifa district hospital. Activities to improve and monitor quality of services and well functioning of the RDF. Train health staff to manage capitation funds from CBHI.

**Required Qualifications:**

- Yemen national, with post-secondary studies, preferably in the medical sector (MD, Assistant, Nurse or Pharmacist) because part of the task will be intense cooperation with the hospital (RDF, prescription behavior, attitude, hospital functioning, ...).
- The candidate should be very dynamic, able to work in a team, possessing good communication skills, be able to address groups of people from the community, discuss with community leaders and negotiate with hospital leaders and talk to hospital staff.
- The person should be trustworthy, and able to manage and hold small working budgets, to spend according to a developed activity plan.
- Assist in secretarial tasks such as preparing meetings, inviting people, writing minutes of meetings, etc.
- To have professional experience involving inter-person skills, such as teaching or awareness building.

**Terms of Reference: Local Coordinator for CBHI in Shamaytain district**

**Tasks before the start of the CBHI insurance scheme:**

- Function as focal person with full authority from the Ministry of Public Health and Population, and with endorsement of the GHO (Governorate Health Office) to promote, assist implementation and monitor the CBHI pilot program.
- Work full time on the CBHI program, any time a team from the Ministry of Public Health and Population visits Shamaytain district to assist the preparation of CBHI. When the ministerial team for CBHI returns to Sana'a, the Local Coordinator for CBHI should ensure the planned activities continue to be implemented.
- Monitor all activities related to the preparation and implementation phase.
- Coordinate and monitor local resource persons for CBHI to ensure that proposed tasks are executed in a proper manner.

- Specific tasks will include:
  - Work with the community, through Awareness Campaigns, meetings with local leaders, and disseminating promotion materials (folders, leaflets,...)
  - Assist in the creation of the Community Management Community for CBHI, following guidelines from the ministerial team for CBHI. Assist in the proper training of the Community Management Community for CBHI, training of the Collectors and training of the Account Manager for CBHI.
  - Liaise and work with the Khalifa hospital to prepare for the best possible situation to start CBHI, including organizing workshops with hospital staff to train them in improved rational prescription, good reception of insured patients. The RDF in Khalifa hospital has to be upgraded in order to fulfill the contract obligations under capitation (which is to have all Essential Drugs available according to the ministerial list). Assist in training hospital managers about 'management of capitation funds'.
  - Advise in the selection of a suitable Account Manager and assist with the training. Assist in securing a suitable workplace for the Account Manager.
- Invite the ministerial team for CBHI to come to Shamayatain district, when it is deemed necessary, to solve any problems, address issues or introduce a next step in the implementation of CBHI.

Tasks after the start of the CBHI insurance scheme:

- Monitor the well functioning of the CBHI program, including the administrative system, the accounting, the collection of contributions and payment of capitation funds to the contracted hospital.
- Monitor the quality of provided services and the whole information system developed by the CBHI team. Ensure the monthly reports of the Community Management Community for CBHI are sent to the ministerial team for CBHI, and check on the quality of the information.
- Liaise and work with the Khalifa hospital to improve management of capitation funds and good quality of services to the insured members, including state of the RDF.
- Attend the monthly meetings of the Community Management Community for CBHI.
- Invite the ministerial team for CBHI to come to Shamayatain district, when necessary.

**ANNEX 8.** Activity Plan for the period April'05 to August'05

See attached file in Excel, 2 pages.





**ANNEX 9. References / Bibliography**

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