

MHOs and Reproductive Health

Using Mutual Health Organizations to Promote Reproductive Health

In developing countries, a large proportion of maternal deaths linked to pregnancy and childbirth could be prevented by improved access to and use of reproductive health (RH) services. These services include family planning (FP) to reduce unplanned pregnancy, post-abortion care, prenatal interventions, training of birth attendants, and emergency obstetric care. Despite the fact that the advantages of RH programs are well known, expanding the use of RH and FP services remains a challenge.

Since the introduction of user fees in many countries in sub-Saharan Africa – a practice adopted to generate funds for desperately underfunded public health systems – ensuring access to acceptable quality health care, particularly among poor communities, has been a key issue for policymakers and communities. Community-based health financing (CBHF) schemes, which involve risk pooling and allow members to prepay for services, have been proposed as one way of reducing economic barriers to care, and, consequently, have emerged as a promising means of increasing utilization of priority health services.

Proponents of CBHF schemes, called *mutuelles* (mutual health organizations, or MHOs) in West Africa, believe that MHOs have the potential to increase access to RH services, both by offering these services in their benefits packages and promoting their use among MHO members.

This PHR_{plus} brief provides an overview of MHOs, describes findings of a study in Senegal that examined current MHO coverage of RH services, and recommends how MHOs can be used to promote these services.

What is the role of MHOs in West Africa?¹

Mutual health organizations began to develop in Africa in the 1980s and 1990s, in response to various changes in national health systems. MHOs provide a form of insurance, especially to people working outside of the formal sector, to protect against unforeseen health costs. Based on concepts of mutual aid and social solidarity, MHOs help communities to meet their health financing needs by collecting premiums and making resource allocation decisions as a community.

MHOs have many different financial structures: They may be member-based and contract with providers, or they may be provider- or facility-based, where providers or facilities both provide care and manage membership. They collect premiums on an individual or household basis. Premium payment schedules can range from once-per-year – for example, at harvest season – to a small monthly fee. Premiums can be less than the cost of user fees; more importantly, premiums are paid when people have funds and not when they are ill and seeking care.

MHO benefits packages depend on local resources, needs, and availability of services. Some MHOs focus on primary health services and offer limited coverage for hospital care, while others begin with hospital care and later expand into primary health care coverage.

Benefits packages commonly include regular outpatient consultations, maternal care (including pre- and post-natal care), vaccinations, ambulance services, hospitalization, laboratory tests, and

¹ Section excerpted from Bennett and Gamble Kelley 2004.

education on health issues. MHOs can also cover other costs incurred in the seeking of health care, such as transport and medication, which can otherwise be major barriers to care.

By lowering out-of-pocket spending at the point of care, MHOs have the potential to increase utilization of health services and reduce delay in seeking care. MHOs also lessen the risk of household debt that can result from paying for health services. MHOs can contribute to the overall quality of care in a health system by improving accountability of providers and facilities to communities grouped in MHOs – by contracting with a particular provider or facility, MHOs can stipulate certain standards of care as a condition of the contract. Facilities in turn can use regular income from MHOs to maintain a stock of drugs and other supplies, thereby also contributing to improved quality of care.

It is important to note that MHOs are community-born and managed; thus, the selection of services covered in the benefits package is made by the community and often reflects needs not addressed by the public sector. For example, an MHO might cover a high-demand service, such as prenatal care, that is not provided free of charge in the public health system, or it might enable members to obtain the higher quality care available in the private sector.

While MHOs differ in structure, what is standard is that they can contribute to better health through improving financial access, utilization, resource mobilization, and quality of health care services.

How widely do MHOs currently cover reproductive health services?

In many of the countries where the MHO movement is strongest, the need for RH services is high as evidenced by high maternal mortality, high fertility rates, and low contraceptive prevalence (see Table 1). This points to the urgency to identify ways to leverage MHOs to increase access to these services.

Some MHO schemes in Rwanda, Ghana, and Senegal currently include RH services in the benefits package though the extent to which these services are covered varies. In a survey of 47 MHOs in Ghana, PHR*plus* found that a majority (71.4 percent) cover the full cost of complicated deliveries (Atim et al. 2001), but normal deliveries are covered by only 28.6 percent and none cover family planning.² In a follow-up survey of 159 MHO schemes undertaken in 2002, PHR*plus* found that only four schemes cover family planning.

In Senegal, many of the existing MHOs cover some RH services, such as pre- and post-natal care and deliveries. In Thiès, Senegal, nine of the 27 currently

operating MHOs cover family planning. PHR*plus* carried out a qualitative study in Thiès to better understand the factors involved in the inclusion (or exclusion) of RH services in MHO schemes and to examine the role that MHOs play in the promotion of these services. The research findings suggest that MHOs increase members' access to health care, and that MHOs are created out of a concern for ensuring that communities have access to affordable care when needed. The findings also demonstrate that women's groups are the initiators of many MHOs that offer FP services and products in their benefits packages; of the nine MHOs that cover FP services, six are women-run. The study also concludes that, while the majority of members of the 27 MHOs are satisfied that their schemes cover the most essential health care services, many would like to see RH and FP benefits expanded. They acknowledge, however, that financial constraints limit such expansion.

A lack of public education about family planning also appears to be a significant constraint to increasing inclusion of these services in MHO benefits packages. Members do not articulate a demand for FP services, and many people are not aware of the advantages of child spacing or have unaddressed concerns about side-effects of contraceptives. Many women perceive family planning narrowly, as a matter only of contraceptives, while neglecting its contributions to issues such as reduction of unintended pregnancy and abortion, and prevention of sexually transmitted infections including HIV. Many women also confuse reproductive health with non-RH problems such as malaria, vaccinations, and chronic illnesses. Without further information, education, communication (IEC) and training, MHO beneficiaries are not likely to demand RH and FP services and products.

These experiences reveal several challenges to promoting RH services through MHOs:

- ▲ When use of modern contraception is low among the target market, demand to include RH and FP services in the MHO benefits package is also low. Even when the services are included, members may not automatically use them without adequate IEC efforts to promote use.
- ▲ Women of reproductive age may not represent a significant portion of the target market for MHOs or of membership. Members may perceive coverage of RH services as less important than, say, coverage of treatment for malaria or of drugs. MHO managers may be reluctant to add services that are not a high priority for a majority of members.
- ▲ If RH services are offered free of charge at government facilities, there is no incentive to include the services in the MHO benefits package. When RH services are not in an MHO's benefits package, they presumably also are excluded from MHO promotional activities.
- ▲ MHO providers with a religious affiliation may be unwilling to offer FP services. For example, Lacor Catholic Hospital in Uganda refuses to offer such

² In Ghana, FP services are offered free of charge through the public health care system, which may explain why these services are not included in MHO benefits packages.

Table 1. Need for Reproductive Health in Selected Countries with CBHF Schemes

Country	Maternal Mortality Rate ^(a) per 100,000 live births	Contraceptive Prevalence Rate ^(b)	Total Fertility Rate ^(b,c)
Ghana	540	22	4.4
Ivory Coast	690	15	5.2
Senegal	690	12.9	5.7
Rwanda	1400	13.2	5.8

a) Figures are adjusted based on reviews by UNICEF, World Health Organization, and U.N. Fund for Population Activities to account for underreporting and miscalculations. Source: U.N. Development Program (2004).

b) Source: ORC Macro (various dates).

c) Total fertility rate represents the average number of children a female would bear during her lifetime if she experienced current age-specific fertility rates at each age of her reproductive life.

services (Feely 2003). In Senegal, the deeply religious character of society influences attitudes even about public discussions of family planning. As long as FP is segregated from other public health issues, it will likely be stigmatized and women will not voice their interest in MHOs covering it.

- ▲ The comprehensiveness of benefits packages must be weighed against premium levels. Schemes that promise an extensive package of services will need to set higher premiums that may deter people from joining. Most members prefer a limited package of priority services that keeps payments low.

How can MHOs promote reproductive health services?

While there are challenges to expanding RH service provision through MHOs, there also are strategies to address those challenges. Where expressed demand for services is low, demand-creation efforts need to be at the core of a strategy to promote utilization of a broader set of RH services through MHOs. Similarly, where demand for services is low but demand for information is high, MHOs are well placed to provide that information. Where MHOs with a religious affiliation are reluctant to provide all FP methods, they can promote natural FP methods as well as other RH prevention activities such as information and screening. Following are several specific steps that MHOs can use to promote the provision and utilization of RH services:

- ▲ Make RH and FP a central theme for discussion and reflection among MHO managers – administrative professionals, health workers, and community members.
- ▲ Develop a policy of education and training on RH and FP topics, particularly for MHO administrators. Involve health workers in the design, conduct, and evaluation of such programs.
- ▲ Integrate the promotion of RH services into existing IEC efforts for members. Link education and

sensitization programs to local and international non-profit groups that conduct FP education projects.

- ▲ Engage providers in educating clients about prevention because – in addition to other benefits – prevention activities lower provider costs.
- ▲ Increase enrollment of women of reproductive age by marketing MHO coverage of maternal health services, for which there is demand, and include prevention in the total delivery package.
- ▲ Contract with providers trained in RH service delivery, communicate to providers that these services are covered, and structure provider payment to encourage provision (e.g., adequate fees for RH services when providers are paid on a fee-for-service basis).
- ▲ Involve women of reproductive age in MHO management (e.g., on the MHO steering committee or at MHO assemblies that make decisions). In Senegal, it was found that women-initiated MHOs offered the most extensive packages of RH services.
- ▲ Partner with organizations committed to RH goals, such as women’s advocacy groups, to assist with IEC efforts or contract with a nongovernmental organization that delivers FP services.
- ▲ Partner with donors that support the inclusion of RH services in benefits packages.

More broadly, more and better information is needed on existing MHO coverage of RH services. Lessons learned from research should be used to articulate strategies to overcome barriers to incorporating a wide range of RH services into MHO benefits packages and to promote their use by MHO members. Donors that support reproductive health programs also need to be sensitized to the potential of MHOs to serve as information brokers, regardless of whether the MHOs include RH services in their benefits packages. *PHRplus*’ vast experience in West Africa shows that applied research also is needed to develop innovative models that are effective in increasing access to and utilization of RH and other priority services.

Future PHRplus work on MHOs and priority services

PHRplus recognizes the need for additional information in order to fully address the question of how MHOs help meet RH and other priority health service needs. With support from USAID's Global Bureau and Missions throughout the developing world, the project is undertaking work aimed at teasing out information and providing it to policymakers in an accessible format:

- ▲ PHRplus has already conducted a qualitative study of MHOs in Senegal, examining specific factors that influence the decision to include RH and FP services and commodities in benefit packages and/or health promotion activities. Based on the study's findings, interventions will be designed for use by technical assistance personnel to help MHOs expand the coverage and promotion of such services and commodities.
- ▲ PHRplus plans to leverage household surveys already planned for Senegal, Mali, and Ghana to measure the impact of MHOs on utilization of family planning and reproductive health services. These surveys will provide data on: 1) the impact of MHO membership on utilization of RH services; 2) differences in RH service utilization patterns by the type of MHO (provider- vs. community-owned, women run, donor supported or not, etc.); 3) utilization patterns of MHO members and non-members by geographic locations (rural, peri-urban, urban, distance to providers).

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