Research brief: Assessment of the ASSP project's Community Health Endowment Strategy in the Democratic Republic of Congo

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Background

In the Democratic Republic of Congo (DRC), the health system is heavily under-financed resulting in limited availability and quality of health care services. The Community Health Endowment (CHE) intervention, a component of the DFID-funded ASSP project, was designed to generate additional funding via community-based income-generation activities for health centers. At the beginning of the project, these structures were expected to be agricultural activities. However, communities were allowed to choose other types of income generation approaches or participants could make cash contributions. The purpose of this study was to investigate: whether village leaders and households were willing to participate in the CHE strategy, whether the expected changes were occurring (i.e. income generated for the health centres, lower user fees, and increased use of services), and to identify the factors that contributed to the success or failure in the initial stages of the CHE program.

Study Methods and Design

The study employed a mixed methods research design. Qualitative data were collected in two phases. The first phase, which was carried out between June and July of 2014, involved key informant interviews with health officials and actors involved in project implementation, in-depth interviews with male and female CHE participants, and focus group discussions. The second phase of the qualitative data collection process, which was carried out between March and May of 2015, was designed to get input on the initial study findings from key informants involved in project implementation at the provincial, health zone, and community levels. The quantitative component of the study was performed by analyzing data from ASSP's routine program monitoring system.

Key Findings

The CHE intervention was introduced in three provinces: Kasai Occidental, Maniema, and Equator (which are now the provinces of Kasai, Kasai Central, Maniema, and North Ubangi). A total of 1,625 distinct community groups in 26 health zones enrolled in the CHE program.

Village leader and household participation in the CHE strategy

The total number of active CHE groups continued to grow over the study period, providing evidence that there was a strong interest in the CHE strategy at the community level. However, only 17 percent of all households living in communities where CHE is active participated in the CHE program, and the program only reached 2 percent of households within the 26 health zones where CHE has been introduced. Village leaders and their family members in Kasai and Kasai Central played an active role in project activities. In Maniema on the other hand, involvement of leaders was limited to endorsing the project. The community members' primary motive for participation was the reduction in health care cost.

Expected changes

Nurses from health centers considered CHE revenue to be income and held and managed it like all other forms of revenue. Although three sites transferred a portion of the harvest to the local health center, none of the participants from those community received a reduction in health care costs. Health facility staff explained that they had not received authorization from government health officials to reduce fees, or that the monetary sum received for the harvest transferred from group members was insignificant in relation to the cost that would be involved in reducing treatment fees for participants and their family members. Delays in receiving the fee reduction and shortages of medications were reported to cause discontent among participants and contribute to a decrease in service utilization.

Factors that contributed to the success or failure in the initial stages of the CHE program

At the time of the study the CHE strategy had not yet led to the anticipated changes in the mobilization of community health care financing, financial protection against out of pocket spending, and improved use of services by community members. The results appear to be due to problems related to the rapid scale up of the project, limited capacity at the community level to properly lead and manage CHE groups, social and contextual factors impacting the cooperation, trust and transparency needed for communal activities, low levels of support from government, and the perception of poor quality of care due to medicines not being adequately available.

Lessons Learned

In response to the initially low rates of enrollment, the project shifted focus away from promoting community-based agricultural schemes. Instead, more traditional community-based income generation models based on cash contributions were encouraged. This study suggests that, at the community level, there is an appetite for community-based health insurance models in the DRC. However, these schemes face significant barriers that need to be addressed for them to be successful, including dissatisfaction with the quality and reliability of health center services, limited understanding of the benefits of participation, limited managerial compacity, inability of some community members to pay direct contributions, a largely undeveloped sense of community ownership, and government engagement with the project. In order to improve their chances of success, programs should consider developing a strong communication and capacity

building strategy for communities and government, conducting formative research to ensure that the selected model fits the context in which it is introduced, and improving the quality of health services offered at health centers.

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