Annual Narrative Report
For
Community Based Health Insurance (CBHI) for Rural Poor in Banteay Meanchey and Oddar Meanchey provinces Cambodia

1.Summary

This report is presented achievements of the Community-Based Health Insurance (CBHI) in Oddar Meanchey province made for the period covering from 1st January to 31st June 2013 (6 months). By June 2013, CBHI has reached up to 26,205 insured represented about 14.28% of whole population in Samrong OD.

2.Descriptions

Project Number	
Country	**Cambodia**
Project title	Community Based Health Insurance (CBHI) for Rural Poor in Banteay Meanchey and Oddar Meanchey provinces
Project Location	327 villages in 5 administrative districts (Samrong, Chungkal, Banteay Ampil, Anlong Veng and Trapeang Brasath districts), Samrong Operational Health District (OD), Oddar Meanchey province (covering the whole province).
Reporting period	1st January-June 2013
Implementing Organization	**Cambodian Organization for Assistance to Families and Widows (CAAFW)**
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Name, Signature of the accredited official of the Agency of the project and Date:.....

Chhin Phalla	**Dann Chhing**
Executive Director	**BHI Program Manager**

3. Scheme design in brief

3.1. Premium:

In response to an increasing of user fee among the contracted health facilities, CAAFW decided to increase premium from $ 2.5 to $ 3 per insured member as per year. Maximum premium is $ 15 for those households which exists more than 6 members. From May 2012, the service providers across Otdar Meanchey started increasing user fee up to an average around 100% of the existing utilization cost. The increasing took place every health facility. This factor affected by standard benefit package introduced by URC for pre-identification households in the province.

Main purpose of increasing was to stabilize medical and non-medical benefit of the scheme. Thought an increasing happened, the premium or contribution, which needs to pay by insured people were remained at moderate scale as compare to other schemes in Cambodia. Since the start up of scheme, our premium was designed toward ability to pay by rural voluntary people that why CAAFW CBHI got broadest coverage.

3.2. Benefit packages

Insured households using their health insurance card can make free use of the services at health centre as well as the referral hospitals. Complicated and surgical cases are referral to the higher level care hospitals. Apart from user fees, insurance covers the cost of transport by ambulance or alternative emergency transport to the hospitals and basic social assistance such as transportation of dead body from hospital to home village; funeral costs. Detailed benefit packages shown in table below:

Services	Support by CBHI	
	Thmar Pouk	Samrong
User fees at HC reimbursement	100%	100%
User fees at RH reimbursement	100%	100%
Transportation between home to HC-RH (only IPD)	100%	100%
RH ambulance fees reimbursement	100%	100%
Cost for food for the IPD patients	Yes	Yes
Transportation of death body	Yes	Yes
Funeral cost (50,000 Riel or US$12 per cases)	yes	yes
Cost for referral & admission at higher level care, Mongkol Borei or Siem Reap	100%	100%

Due to gap between poor and near-poor of the population in the areas is so close, the CAAFW CBHI provided very comprehensive benefit package assistance to insured people. We try to offer health-handled benefits for all insured members who have joined the scheme. Majority of beneficiaries expressed satisfaction on the insurance benefits granted by CBHI because they were aware that it really protected them from catastrophic financial loss due to ill health. More importantly, they felt confidence of having less spending, but greater reimbursement they get at facilities in time they had health problems.

3.3. Target beneficiaries:

Main beneficiaries for CBHI are for near-poor and informal sector group who are living in rural areas. It intervenes to all women, children and dependent (disabled, elderly) members,

who were obtained equal opportunity to receive medical treatment and necessary social supports. This kind of services were designed to protect near-poor households while the poor in this OD protected by Health Equity Fund (HEF). The schemes is enhancing insurance services to informal economic sector and intended to involve health financing services to them as well as improving insurance service in the areas. However, the scheme in Oddar Meanchey is the one where introduced for voluntary. We do strong hope that people will be more active in joining the scheme. Near-poor is the group that we specially focused on to be final beneficiaries.

4. Project Objective:

The **Project objective** is to improve access to appropriate health care for the poor and prevent them from catastrophic health expenditure, thereby contributing to poverty reduction through an increase in social health protection coverage of poor rural population in Cambodia.

4.1. Specific objective is to promote insurance coverage in Thmar Pouk and Samrong ODs and encouraging progressive and sustainable uptake of health insurance by the poor.

a. *Thmar Puok OD: the scheme in Thmar Puok OD is being waited for the response from Ministry of Health, it meant that during the first six months 2013 it has been under postponed situation. Historically, Thmar Puok OD has not been covered by Health Equity Fund for poor1 & poor2. In 2011, poor 1 &poor 2 were covered by ICCO and the Ministry of Health also promised to support this group from 2011-2014. In 2012, CAAFW used subsidy fund from HBV reserved fund to support poor1&poor2 in Thmar Puok OD that could make scheme run for whole 2012 including subsidized and voluntary members which we hope that the Ministry of health will provide support based on their promised. And in 2013 to avoid shortage of funding in we think we should better to wait until the Ministry of Health will provide support, the way that most secure of funding.*

   Again early 2013, Ministry of Health promised to support poor1&poor2 through integrated/linkage CBHI and HEF business plan. Since then, we still not yet get any support from it. The postpone of CBHI scheme in Thmar Puok OD due to the poor1&poor2 in Thmar Puok is about 50% of whole CBHI members. Without subsidies from Ministry of Health, we could not start running scheme while large amount of the poor which needs huge amount of money to cover.

b. *Membership targeting for 2013 in Samrong OD was planned up to 40,000 insured people; actual achievement as of reporting period is 26,205 insured persons; all of them are voluntary. This figure is covered around 14.28% of whole OD population. It reached about 65.50% of targeting in the first six months of the year.*

5. Achievement of Implementation by Result and Activity

5.1. Activities done and achievement as per result 1:

Result 1: The CBHI have enrolled and insured up to 95,000 persons (53,000 persons about 35% coverage in Thmar Pouk OD and 42,000 persons about 25% coverage in Samrong OD)

Both schemes covered in 465 villages of 7 administrative districts, 2 provinces with services through 29 Health Centers (HC), 3 referral hospitals.

In Samrong OD, the membership coverage has reached 26,205 insured presenting about 14.28% of OD population of which indicated that 65.50% achieved against planned. Coverage trend is different from the coverage figure of 2012. At that time, our enrolment coverage was up to 84% of annual plan. The trigger of decreased due to in 2013 scheme in Samrong OD decided to increase premium from $2.5 to $3 as per insured per year. Besides, the expansion of Health Equity Fund (HEF) in the province was widely coverage to health centres. Some of pre-identification households who used to be CBHI members decided to drop insurance out because they could be able to use poor card at health centres as well. The root cause of increase premium was by double increase in user fee at all health facilities in whole ODs.

5.1.1. Project planning and preparation meeting

Prior to new member enrolment and renewal activities, a 2-day meeting workshop for team was organized to all involved staff in order to target coveraged membership of the year. Moreover, the meeting also set out and discussed about some technical taskes that need to be done in purpose to improve quality of enrolment and promotion approaches. New approaches and strategies for promotion and enrolment were deeply discussed with recommendation from all those involved staff who already deployed at health centers. On the other hand, the meeting was also to review all activities need to be done the year especially project logical frame work. More importantly, lesson learn from pervious year had also taken for future improvement.

5.1.2. Establish service contracts with health facilities for provision of health care to CBHI membership;

The service contract, up to the reporting period CBHI has contracted with 19 health centers and two referral hospitals. Those facilities are being functioned in the province. In the contractual agreements, there are clear clauses mentioned about benefit packages and general conditions to ensure mutual benefit between service users, providers, and purchaser.

In general, the contract duration is limited in one year due and both contracting parties could propose revising or amending if there is necessary clause to be considered which would ensure mutual interest of both parties. The contract could maintain quality and performance of health facilities to meet the need of clients. And we can utilize many clauses of the contract to monitor day-to-day service providing of provider side and also use them for advocate for services even at health centers and referral hospitals.

To ensure the contract to be observed by contracted facilities, CAAFW has been utilizing some mechanisms to evaluate its improvement and effectiveness. After contract got into effect, CAAFW field Monitoring Officer and Health Financing Manager conducted monitoring at health centers and hospitals through collecting patient satisfaction in order to assess quality of care, the respect for benefit package, and finding unofficial payment at those contracted facilities.

5.1.3. Enrolment of CBHI members

Within the reporting period (January-June 2013), CBHI promotion and enrolment were broadly carried out in 327 selected villages in Samrong OD. These activities were hosted by CBHI promoters, field monitoring officer with actively assist by VIVs or CVIAs, village chief, and some key persons in the communities. The way in doing enrolment, promotion and social marketing strategy mostly managed through village meeting, small group mobilization, house-by-house visit, and joined promoter campaign. The enrolment period starts from January to June of the year. Resulting from enrolment is shown on table A below:

Table A: CBHI membership- January-June 2013 (Samrong OD)

No	Health Centers	Renewal members		New Enrolled Members		Total	
		HH	IND	HH	IND	HH	IND
1	Samrong	389	1,892	99	391	498	2,329
2	Kon-Kriel	280	1,382	159	598	464	2,109
3	Bossbov	217	947	89	279	313	1,257
4	O'Smach	48	222	13	43	62	270
5	Chong-kal	427	2,146	141	507	620	2,930
6	Pong-Ro	276	1,567	53	164	357	1,875
7	Anlong-Veng	181	1,058	56	248	246	1,343
8	Trapaing Prey	334	1,761	88	368	457	2,350
9	Trapaing Prasat	154	784	128	583	290	1,415
10	Tumnob-Dach	265	1,397	75	296	341	1,695
11	Trapaing-Tav	105	653	34	166	144	845
12	Rum-Chek	7	38	1	6	11	59
13	Chhuk	50	222	46	152	100	390
14	kok-Khposh	89	410	36	134	148	644
15	Ampil	330	1,220	251	786	586	2,021
16	Kok-Moun	313	1,273	144	437	466	1,740
17	Beng	147	586	278	892	425	1,478
18	O'kroch	42	228	66	301	110	544
19	Phaav	130	722	45	174	177	911
	Total	**3,784**	**18,508**	**1,802**	**6,525**	**5,815**	**26,205**

5.1.4. Prepare CBHI insurance card and distribution

The insurance card officers have been taking account for producing insurance card for new insurance subscriber households. The insurance card had comprised much information to confirm such composition of household members, code number, obtained/expiry date, photo, signatory of issuer, and thumb print of head of household. Prior to have produced insurance card, the promoters have to fill out all key information in the application forms with combined socio-economic, health seeking behaviour, and CBHI perception. While everything has been ready, the promoters oblige to distribute all those insurance cards to insured households. During distribution of those cards, CBHI promoters always added more information about important of insurance card, services where available, benefit package, and how present the insurance cards to health staff contracted facilities.

And during this reporting period, **3,784** new insurance cards distributed to new insured households in Samrong OD, Oddar Meanchey which equal to **18,508** insured people. For

those who already entitled insurance cards could access free of charge health services among contracted health facilities. The insurance cards were so crucial to be presented to health staff during visiting point of services.

5.1.5. Reviewing and updating data base for CBHI monitoring

The functions and indicators of the database is running smoothly. All needed information from CBHI is well enough that would ensure quality of data monitoring. Therefore, within this report period, the database was not adjusted. We keep the existing one as normal.

5.1.6. Manage CBHI premium fund and subsidies for reimbursements

The collected premium has been well managed by project administrator with good management system. The management of it has been done through important accounting software, Quick Book and Microsoft Excel controlling system. More importantly, the supervision by chief accountant of CAAFW is a core part to ensure well performance of premium management. An expenditure of premium was through financial procedures with adequate supporting documents for annual financial audit.

By June 2013, US$ 58,280.00 was collected and kept for reimbursement to only health care and travel costs for insured patients. The collected premium directly managed by project administrator with firmly supervision from CAAFW accountant. Based on CBHI guideline, premium could not be spent for administrative and or other operational cost. It is strongly recommended to use for direct and direct medical benefits.

Result 2: Health expenditure in insured households has been significantly reduced

CBHI has been providing comprehensive benefit package to cover user fee at health centers and referral hospitals, travel cost, funeral grant, transport of dead body back home. The insured people enjoy greater benefits from CBHI rather than they contributed premium to the scheme. Huge cost reimbursement during they got illness is an effective financial mean to protect from bigger damage due to catastrophic expenditure on health care.

Therefore, CBHI mechanism is to reduce expenditure burden among CBHI members as well as enhancing opportunity for those to have gained income in the occasion of they are being insured by CBHI scheme.

In Thmar Puok OD: No result at this reporting period.

-In Samrong OD: The OPD utilization at all 19 contracted health centers plus two refferal hospitals were totally 28,087 cases through January-June 2013. And admissions by CBHI members at Anlong Veng district referral hospital were 508 cases/patients and admission at provincial referral hospital Samrong 745 cases/patients. Total spending for direct benefit to those service users were;

1-Medical benefits (health care cost) reimbursement $ 53,218.53

2-Non-medical benefit (travel cost, funeral grant, transport of dead body) $ 10,751.46

5.2. Activities done and achievement as per result 2:

5.2.1. Collecting information on economic conditions of CBHI members

The information regarding to the economic condition of CBHI members were collected from every registered household. This was gathered by project promoters and VIVs in time of registration at village level. It is convenient that the related information already existed in an application so that we have been able to acquire multi-information in such related to what we needed for the project data base. For example, the information that possessed in the application mostly respective to family composition/ bio-data, health care expenditure, health care seeking behavior, CBHI perception, main sources of income, and expenditure

As result, until the reporting period, **3,578** sets of information were collected from **3,578** registered households. This collected data will not be utilized only for economic measuring but also for assessing an improving and changing in health status of the insured households as well as economic indicators comparison. An economic data can be useful tools for assessing information relevant to economic status growth from the beginning of joining CBHI and after.

5.2.2. Annual review and final evaluation

This activity has not yet been done during this reporting period.

Result 3: Health services have improved in quantity and quality through increased use by insured, communities and responsive care

Quality of health services among the contracted facilities were much better improved. CAAFW has still constantly worked with quality improvement through advocate for services with the contracted facilities where necessary.

During the reporting period (January-June 2013), the monitor of increase of mobilization was regularly happened weekly, monthly, quarterly by promoters, social workers, database officer, field monitoring officer and project manager. Many methods have been used within the monitoring, promoters used weekly and monthly check utilization report up at health centers; social workers used daily, weekly, and monthly check managed the utilization at referral hospitals; field monitoring officer and project manager did monthly and quarterly monitor at health centers and referral hospital and recording utilization from health facilities. At meantime, the responsive care from health care providers is much more responsive to service users. This includes quality of services, staff attitude changes, coordination from CAAFW, and services improvement action taken by health authorities all level. Other thing is that awareness about using public health services has been raised among insured people through our promotion and encouragement. In the mandate of our work is to change people attitude toward better health seeking care behaviors and make them use public health services in order to avoid bigger financial loses or waste money on health treatment.

Patient satisfaction survey also conducted at two referral hospitals which it is called as exit interview which focused only on the services satisfaction during the stay. And we do the same interview with community people after they used health center. Besides, feedbacks

and complains from patients through phone call and directly collection have been brought and solved with service providers through extraordinary meeting, HCMC meeting, steering committee meeting, and informal discussion with the providers in the manner of disclosure.

5.3. Activities done and achievement as per result 3:

5.3.1. Monitor implementation of service contracts and benefit packages with RH and HC

The service contract has been monitored regularly by promoters at health centers. They spent time visiting all contracted health centers weekly and monthly basic. Besides, they have always join monthly meeting and HCMC meeting to review what has been implemented regarding to the clauses of contract and benefit packages agreed by the scheme. Other way of monitoring was through households visit and interview the service users who are CBHI members and some non-CBHI members related to satisfaction while those users came to utilize health services. The interview wanted to know about the performance of health center staff and user fees charged for each service whether those contracted HCs respected for services contract and benefit packages provided by CBHI scheme or not. The monitoring at health center found that the implement of service contracts and benefit packages was much better. The both contracting parties follow and respect for the service contract agreements.

At referral hospitals, the social workers have been performing key roles in monitoring the implementation of service contracts and benefit packages as daily activity. They have coordinated the service contract and benefit packages routinely with RH staff and solve the problems timely. One more, the social workers have also monitoring the contracts implementation through patients exit interview relevant to the performance of health staff during the stay of each patient. The functioning of social workers helped improve the implementation of service contracts and benefit package implementation. Apart from the monitoring by promoters and social workers, field monitoring officer and project manager have always periodically follow up on this activity health center and referral hospital visiting or extra ordinary talk or meeting with those providers.

5.3.2. Monitor increase of mobilisation and quality of care for further improvement

The monitor on increase of mobilization has been done regularly by promoters at health centers and social workers at referral hospitals. On the other hand, database officer also plays important roles in monitoring the increase of mobilization through data analysis after data entry transaction. All these mechanism would provide enough sense toward monitoring system even mobilization and quality of care. Checking up utilization registration and record at contract facilities was one method for the project to measure and surveillance the increase of mobilization and quality of care. Moreover, the collection of feedbacks and concerns of service users was also conducted in the way to gather concrete cases from what have been faced and experienced by those users. The utilization record by facilities evidenced that the utilization of health services at public providers is getting increase and the quality of cares has also improved.

In response to this activity, the project manager and field monitoring officer, within this quarter, had visited health centers and referral hospitals in order to meet with patients who come to use health care services. During that time, we had interviewed the patients related to quality of service, attitude of health staff, and the frequency of service using. Also at

health center and referral hospital, we monitored all utilization report in purpose to make sure and compare the cases from CBHI and non CBHI. And related to the quality of care at health center we also constantly discuss during bi-monthly of HCMC meeting.

Table B: CBHI member utilization at health centers January-December 2012 (Samrong OD)

No	Health Centers	Utilization CBHI members at health centers January-June 2013			
		Overall Contacts	CBHI	Non-CBHI	% CBHI covered
1	Chung Kal	**4,576**	2,393	2,183	52.29
2	Pongro	**5,158**	2,903	2,255	56.28
3	Bosbow	**4,553**	1,000	3,553	21.96
4	Samrong	**5,221**	1,622	3,599	31.07
5	Kon Kriel	**4,974**	1,526	3,448	30.68
6	O'smach	**6,900**	630	6,270	9.13
7	T. Prey	**3,302**	1,058	2,244	32.04
8	Anlong Veng	**4,818**	852	3,966	17.68
9	T. Prasath	**6,318**	791	5,527	12.52
10	T. Dach	**7,975**	1,191	6,784	14.93
11	Tr. Tav	**2,651**	431	2,220	16.26
12	Rumchek	**3,706**	102	3,604	2.75
13	Chhouk	**3,567**	1,097	2,470	30.75
14	Kok Kpos	**2,637**	928	1,709	35.19
15	Beng	**4,668**	2,333	2,335	49.98
16	Kok Morn	**8,471**	2,968	5,503	35.04
17	Ampil	**5,065**	2,330	2,735	46.00
18	O'kroch	**2,742**	564	2,178	20.57
19	Phaav	**3,522**	622	2,900	17.66
	Total	**87,749**	**25,341**	**62,408**	**28.88**

As illustrated in table D above, number of contacts by CBHI members were covered up to 22.88% of overall contacts at all contracted health centers. This also made huge amount of contacts. We also went detailed about the classification of utilization made by OPDs at health centres it came to figure that the OPD visits at health centers; 29% were men, 55% were women, and 16% were children under 5 year old.

The IPD visits in table E indicated that 36% were men, 38% were women, and 26% were children under 5 year old.

Table C: CBHI member admitted at RH and PH January-June 2013 (Samrong OD)

No of cases admitted/referred to	Overall admission	CBHI	Non-CBHI	% CBHI coverage	CBHI admi./ 1000 insured
Anlong Veng referral hospital	2187	508	1679	**23.23**	**19**
Oddar Meanchey referral hospital	2711	745	1966	**27.48**	**28**
Mongkol Borei provincial hospital		41			

At the same time, IPD admission at hospital in table F showed that 40% were men, 48% were women, and 12% were children under 5 year old. Percentage of CBHI patients hospitalized in Anlong Veng referral hospital was indicating about 23.23% of total admissions while admission in Oddar Meanchey referral hospital (provincial hospital) figured out around 27.48% of overall admissions for the period covering January-June 2013.

Table D: Deliveries by CBHI members at health centers-January-June 2013 (Samrong OD)

No	Health Centers	Utilization CBHI members at health centers January-June 2013			
		Overall	CBHI	Non-CBHI	% CBHI
1	Chung Kal	86	57	29	66.28
2	Pongro	65	35	30	53.85
3	Bosbow	72	36	36	50.00
4	Samrong	142	27	115	19.01
5	Kon Kriel	139	38	101	27.34
6	O'smach	98	6	92	6.12
7	Trapaing Prey	84	22	62	26.19
8	Anlong Veng	87	18	69	20.69
9	Trapaing Prasath	146	11	135	7.53
10	Tumnob Dach	130	16	114	12.31
11	Trapaing Tav	81	17	64	20.99
12	Rumchek	61	3	58	4.92
13	Chhouk	73	37	36	50.68
14	KokKhpos	39	20	19	51.28
15	Beng	66	33	33	50.00
16	Kok Morn	138	91	47	65.94
17	Ampil	124	100	24	80.65
18	O'kroch	81	17	64	20.99
19	Phaav	73	15	58	20.55
	Total	**1785**	**599**	**1186**	**33.56**

5.3.3. Promoters manage CBHI members at HC and link with communities;

Promoters are front line worker. They are not only promoting and enrolling CBHI members, but also play a lot of keys responsibilities concerning collecting utilization report from HCs, collecting feedback information from service users, recording and meeting with stakeholders at HCs and community level. Related to utilization at HCs, they always collect the data monthly and doing controlling work such as examining cases of utilization, amount reimbursement in order to make sure that everything is correctness. This is to ensure the problem of service overcharging and to minimize the risk on budget expenditures. Tasks of promoters as mentioned above become daily and routine works that they have always fulfilled to meet quality of project implementation. With the support from field monitoring officer and project manager, every task which is under their responsibility has been effectively organized by the promoters.

5.3.4. Social workers manage CBHI members at RH, advocate service improvements and settle reimbursements

A presence of 3 social workers at referral hospital is an integral part of coordination of CBHI patients while they are admitted. From day-to-day the social workers have fulfilled their important responsibility in visiting patients, advocate for services with hospital staff, health service improvement through regularly attending hospital monthly meeting, give feedback health staff and solve problems for patients during their admission in the hospital. Moreover, they have many tasks to implement reimbursement travel cost and admission fee to patients and referral hospital. At the same time, they have taken duties to produce monthly report, daily bookkeeping record, and collect and verify utilization report with hospital staff in order to ensure correctness.

To improve social worker performance, they have been advised to be more active in providing faster services to all patients in term of reimbursement of travel cost and other social assistances. Furthermore, the social workers are recommended to check, do patient visits and patient exit interview more effectively. Within this quarter, the social workers have duties to check the validation of insurance cards in order to verify an expiry date of the cards which were being used at referral hospitals by members. Additional explanation to patients benefit packages at RHs is the main activity of social workers due to some patients claimed the services beyond benefit packages provided and agreed by the scheme. They have also handled any issue confused by patients during their stay.

5.3.5. Quarterly review meetings of the CBHI steering committee (CBHI-sc meeting)

CBHI steering committee meeting has not been conducted. It is plan to be done by August this year. Reason why we delayed this meeting due to waiting results of project achievements during first six month 2013.

6. Implementation:

6.1. Organisational structure and team for implementation of the project

The technical advisors (Iyong Suor and Por Ir) will provide technical advice and coordination in the implementation activities where was necessary need for technical inputs such ensuring the donors requirement, responsible for reporting to the donors and link the project to the national policies dialogues .

The CAAFW executive management such as; Executive Director, administration and accountant staff were worked in a supporting role for technical facilitation, finance and logistic, preparing financial accounting report, preparation of internal and external audits and administrative affair.

The project staff who were direct involved in the implementation and management of these CBHI scheme and their function and primary responsibility was describing below;

6.2.Staffing: Totally 19 staffs were directly responsible in implementation and management both CBHI schemes in Thmar Pouk and Samrong. But during the first six month the team involve in Thmar Pouk was postponed due to the waiting result of the subsidy scheme for the Poor 1 and Poor 2 from the Ministry of Health.

The staffs were divided by categories as;

Management level: there were 4 staffs include; director of CBHI, Program Manager, Accountant, Assistant admin and cashier. The management level are mainly based in the

head office and frequently travelling to each of the project site for at least 2-3 times per months to provide technical supervision and monitoring of the activities.

Monitor and follow up: The monitoring conducted periodically mostly monthly and quarterly basic. This activity conducted by Program Manager and Executive director. Key indicators to be monitored respectively on quality of enrolment, premium collection, promotion, service contract, benefit package, and utilization at health centers and referral hospitals. The activity was undertaken through site visits in order to meet with beneficiaries, service providers, and local authorities. The purposes of these were to identify and assess the progress of the project and any problems encountered. During that time the collection feedback and recommendation was also taken from the stakeholders. More importantly, the program manager always conducted financial review and oversee the transaction of expenditure. On the other way, CAAFW use the data base to monitor membership, premium collection, reimbursement, case of utilization, and health expenditure within the scope of project.

7. Challenges

- High cost of user fee at health facilities across Oddar Meanchey remained the concern of CBHI scheme when original budgeting just compute over lower user fee based year 2011. From May 2012, HC contracted providers increased user fee up around 100% of original cost. This may create over expense on direct medical benefits, therefore, financial gap on this may happen.
- Migration for job among insured household is still factor that produced drop out for the second instalment of premium collection.
- Poor infrastructure in the areas could be a difficulty to promotion and enrolment.

8. Conclusions

The CBHI member coverage for the period of January-June 2013 is 26,205 insured people which equal to 14.28% of OD population. The coverage amount is smaller than last year due to;

1. CBHI has increase premium from S2.5 in 2012 to $ 3 in 2013 per member per year. This was happen because of the health provider has increased user fee up to 100%
2. The HEF coverage also increases in the areas due to the present pre-identification of the Poor 1 and Poor 2.

However, those active members are still being enjoyed in utilizing public health service where contracted by CBHI. They exactly benefit from user fee reimbursement according to the scheme policy. Through medical and non-medical benefits, the insured people have got an ease in reducing out of pocket money for health treatment.

9. Financial report

The financial report for reporting period is enclosed.