AFRICAN COLLABORATIVE FOR HEALTH FINANCING SOLUTIONS

Toward Evidence-Informed UHC Policy Dialogue and Decision-Making
Applying the Evidence Integration Forum Approach in Benin

January 2022

Hashim Hounpkatin, Kefilath Bello, Luc Kouwanou

Table of contents

Abbreviations

ACS	African collaborative for health financing solutions
AM-ARCH	Assurance Maladie de l'ARCH, composante assurance maladie du projet pour le renforcement du capital humain – Health insurance component of Insurance for human capital strengthening
ARCH	Assurance pour le Renforcement du Capital Humain – Insurance for human capital strengthening
CERRHUD	Centre de Recherche en Reproduction Humaine et en Démographie – Human Reproduction and Demography Research Center
CC	Consultative committee
EIF	Evidence integration forum
UHC	Universal Health Coverage

Background

Effective and inclusive policy dialogue on universal health coverage (UHC) is an iterative process that connects the technical and political aspects, introduces evidence, and involves sensitive discussions in which a wide range of stakeholders participate [1]. Ample evidence shows that effective and inclusive policy dialogue is essential for advancing UHC because it improves stakeholder coordination, reduces fragmentation of efforts, engages citizens and improves responsiveness to their needs [2]. However, despite commitments to UHC, country stakeholders and development actors face several obstacles when trying to establish effective and sustainable policy dialogue [2,3]. One of the most frequently cited barriers (along with poor inclusivity and poor leadership) is that policy dialogue is often not based on sound evidence [3]. This often results in power imbalances [4], tensions between ideas and ideologies, and decision-making processes that favor some stakeholder subgroups over others [2,5,6].

Dialogue forums that are intended to promote policy dialogue in Africa are not immune to these challenges. Because they convene stakeholders with different backgrounds, different levels of access to knowledge, different interests, and different levels of influence, it can be difficult to keep everyone aligned and moving forward productively. Conflicting positions and opinions generated by a diversity of participants can lead to positive and constructive results only if consensus is built based on evidence rather than influence. This is unfortunately not always the case. Reasons cited for poor integration of evidence within policy dialogue include an authoritarian approach taken by dialogue organizers [4], lack of good facilitation [2,7], and lack of relevant evidence to properly inform the dialogue [8,9].

To address these shortcomings, the African Collaborative for Health Financing Solutions (ACS) project piloted its Evidence Integration Forum (EIF) approach to support Benin's consultative committee (*cadre de concertation* (CC)) for health insurance, which brings together technical experts from line ministries, health district managers, health care providers, private-sector representatives, and civil society actors at the national, subnational, and district levels to support health insurance reforms. Committee members had reported that several issues were regularly emerging from discussions for which there were no clear answers. This hindered the progress of discussions and limited the quality of decision-making. The EIF approach was introduced to help them better understand their knowledge needs, find relevant and context-appropriate evidence to address those needs, and use that evidence in decision-making.

This report describes the EIF concept, presents results from its use in Benin from April to November 2021, and draws lessons for next steps.

Methodology

Benin's CC was selected to serve as a case study for the EIF approach. Based on an assessment of the needs of the stakeholders represented on the committee, experiences from committee dialogue starting in February 2020, and insights from informal key informant interviews, ACS Benin and *Centre de Recherche en Reproduction Humaine et en Démographie* (CERRHUD) – Human Reproduction and Demography Research Center - conceptualized and co-implemented the EIF approach and introduced it to the committee in April 2021.
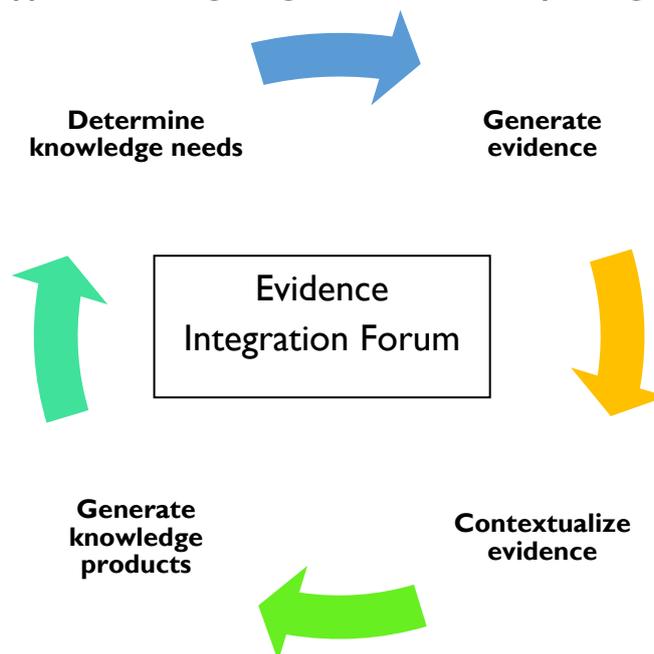
Objectives

The overall objective of applying the EIF approach in Benin was to promote the use of evidence in decision-making within the consultative committee. Specific objectives included:
- o Ensuring that all stakeholders' experiences, suggestions, and questions were valued
- o Improving committee members' capacity to seek relevant and contextual evidence throughout the policy dialogue and decision-making process
- o Promoting peer learning
- o Stimulating the use of the approach by committee members in other multi-stakeholder settings

The EIF approach

The EIF approach has four iterative steps, as depicted in Figure 1.

Figure 1 : The EIF Approach to Integrating Evidence into Policy Dialogue

Determining Knowledge Needs

One or more committee members volunteered to serve as notetakers during committee meetings. They committed to attentively following the dialogue and not actively engaging in discussions; instead, they documented all unresolved issues that arose, such as hardships and frustrations expressed, differing opinions on the best way to deal with a problem, or issues for which no member suggested a solution. After the discussions ended, the notetaker volunteers worked together to compile a consolidated list of knowledge needs based on their notes. The list was presented to the other participants, who amended the framing of issues or added items. This resulted in a final list of agreed-upon knowledge needs arising from that committee meeting, which were included in the meeting's overall minutes.

Generating Evidence

From the list of knowledge needs, the committee members selected one top-priority knowledge need in a WhatsApp discussion. Two to three committee members volunteered to form a task force to shed light on that identified knowledge need, with the aim of identifying potential solutions. They were coached by researchers from CERRHUD and ACS to not only generate sound evidence but also learn

how to do so independently. The task force members changed from round to round, while the CERRHUD and ACS coaches stayed the same.

Contextualizing Evidence

The task force findings were shared at the next committee meeting. New discussions were thus informed by evidence-based findings. Committee members reported being better able to build on or substantiate their ideas based on reliable evidence, and because that evidence was appropriate to the local context, committee members found it more convincing to guide their dialogue and decision-making.

Generating Knowledge Products

The task force generated knowledge products in different formats, ranging from a simple report to an evidence synthesis from a literature review.

Results

First Round

The EIF approach was first introduced to the consultative committee at its April 2021 meeting. In the first round, one person volunteered to be a notetaker: a health care provider from a pilot site for AM-ARCH, the health insurance scheme within the country's flagship Assurance pour le Renforcement du Capital Humain (ARCH) program. He was supported by two researchers from CERRHUD. The three of them followed the discussion and identified unresolved questions and needs. They pooled their notes at the end of the session and came up with 13 unresolved issues:

1. How can technical support and communication tools help promote use of AM-ARCH services?
2. How can the content of the AM-ARCH benefit package be better communicated?
3. Why is the list of vulnerable people eligible for AM-ARCH not made public?
4. Should a complementary identification of beneficiaries (poor and extreme poor) be performed for social justice reasons?
5. What are the strategies to hold people accountable for the implementation of recommendations made during consultative committee meetings?
6. Why are the evaluation results of the AM-ARCH pilot phase not available to stakeholders for validation?
7. How and where can funds be raised for social mobilization?
8. How often should the beneficiary database be updated?
9. How can delays in reimbursement of health facilities be reduced?
10. **What are the causes of low use of services in AM-ARCH pilot sites?**
11. How can strong partnerships for AM-ARCH be built (through town halls, mutual aid societies, pilot health districts, private/faith-based providers)?
12. What did we learn from the pilot phase of AM-ARCH that would support scale-up?
13. What is the role of the complaints management system in the whole process?

ACS facilitated a discussion among committee members over WhatsApp to identify the top-priority issue to address. They selected question 10, "What are the causes of low use of services in AM-ARCH pilot sites?"

To answer that question, the task force met with key informants at all AM-ARCH pilot sites. More specifically, the local ACS team that was already supporting field actors for the AM-ARCH implementation collected insights from hospitals managers, social promotion center managers, and

beneficiaries who were reluctant to use the services. A [report](#) with key findings was presented to the committee at its July meeting. The firsthand insights from the field stimulated a lively and rich discussion.

Second Round

The second round began at the July 2021 committee meeting and kicked off with a light refresher on the EIF approach. Two people volunteered to be notetakers: a civil society representative from an organization for aged persons and a health provider. A third person, a researcher from CERRHUD, joined them in that task. The notetakers followed the discussion, pooled their notes after the session, and identified five unresolved issues:

1. What are the causes of delays in reimbursement of health facilities and possible solutions?
2. Does the label "extreme poor" influence demand for health care?
3. What is the best way to update the AM-ARCH target beneficiaries?
4. **How could a public-private partnership work for AM-ARCH implementation?**
5. How can the gap be reduced between private health facilities' service delivery costs and the minimum reimbursement from AM-ARCH?

Through discussion, the committee chose question 4, "How could a public-private partnership work for AM-ARCH implementation?"

A window of opportunity opened when the president of Benin's Private Sector Health Platform asked the ACS Benin lead to organize a session at the platform's upcoming annual forum on how best to include the private sector in AM-ARCH. The session was set up as part of [Bénin Santé week](#), which was organized by the platform under the co-sponsorship of the Ministry of Health and the Ministry of Social Affairs and Microfinance and drew the participation of a wide range of stakeholders. The expected outcome was a knowledge synthesis on mechanisms for engaging the private sector and on levels of private sector integration into health insurance delivery system in African countries. The outcome aligned with the priority question that emerged during the second round of the EIF cycle. CERRHUD and the ACS Benin team collaborated on a literature review to answer the question. The report is available [here](#).

Lessons Learned

After the two EIF rounds with Benin's consultative committee, several lessons emerged:

- The EIF approach can help systematically extract and document unresolved issues without interrupting the flow of discussion, thanks to unobtrusive notetaking by dialogue observers. All concerns were included in the session report and in the development of the list of unsolved issues. Participants felt that their voices were heard during the full committee sessions and during the prioritization process.
- When the EIF approach is well communicated to participants before they use it, they are induced to participate.
- In its current format, EIF cannot realistically address all issues. Choosing one issue per round is recommended. It may be helpful to think about strategies for addressing more issues without diluting the attention devoted to each one. African UHC hubs could play a critical role by providing sustainable support to policy dialogue forums such as the consultative committee in Benin.
- The process of prioritizing issues is not yet adequately codified, even though stakeholders are involved in the choice of top-priority issue.

- Although task force members seemed excited during the committee meetings, they invested little time in actual evidence generation after the meetings in which they received coaching from researchers. Most of the work was ultimately performed by the ACS/CERRHUD team, which means that the intended evidence generation handover barely happened.

Conclusion

For policy dialogue forums to be inclusive and effective, they need facilitation approaches that engage and value stakeholder contributions. The EIF approach tested in Benin combines continuous needs assessment and user empowerment to generate evidence and strategies to respond to identified needs. However, additional support is needed to ensure that Beninese national counterparts can autonomously integrate evidence into their policy dialogue.

Recommendations

For future rounds of EIF and for other organizations that might be interesting in using the approach, we offer the following recommendations:

- A catchier name for the approach may facilitate its uptake and use.
- A permanent technical working group should be established to address remaining crucial issues and should be supported by stakeholders who have participated in a round of EIF. Incentivizing stakeholder participation in EIF rounds and the task force will be important. Another strategy for dealing with remaining issues is to link the EIF approach to a country learning agenda.
- Selection of task force members could be based on criteria that ensure representation of certain stakeholder profiles.
- A form is needed to facilitate selection of priority issues by participants. Criteria should be developed and vetted with stakeholders, such as frequency, importance, cost, time, potential benefits, ease of implementation, and feasibility. A prioritization matrix would be a helpful tool to inform voting and issue selection.
- A user-friendly knowledge management platform or shared folder is needed to give stakeholders easy access to evidence and documentation on previously resolved issues.

References

1. Rajan D, Adam T, El Husseiny D, Porignon D, Ghaffar A, Schmets G. Policy dialogue: what it is and how it can contribute to evidence-informed decision-making. 2015.

2. Nabyonga-orem J, Dovlo D, Kwamie A, Nadege A, Guangya W, Kirigia JM. Policy dialogue to improve health outcomes in low income countries: what are the issues and way forward? *BMC Health Serv Res* [Internet]. 2016;16(4). http://dx.doi.org/10.1186/s12913-016-1450-2.

3. Dovlo D, Monono ME, Elongo T, Nabyonga-Orem J. Health policy dialogue: experiences from Africa. *BMC Health Serv Res* [Internet]. 2016;16(4). http://dx.doi.org/10.1186/s12913-016-1447-x.

4. Nabyonga-Arem J, Ousman K, Estrelli Y, Rene AKM, Yakouba Z, Gebrikidane M, et al. Perspectives on health policy dialogue: definition, perceived importance and coordination. *BMC Health Serv Res* [Internet]. 2016;16(4). http://dx.doi.org/10.1186/s12913-016-1451-1.

5. Mwisongo A, Nabyonga-Orem J, Yao T, Dovlo D. The role of power in health policy dialogues: lessons from African countries. *BMC Health Serv Res*. 2016;16(4):337–46.

6. Atim C, Koduah A, Kwon S. How and why do countries make Universal Health Care policies? Interplay of country and global factors. 2021;11:1–12.

7. Makadzange K, Radebe Z, Maseko N, Lukhele V, Masuku S, Fabudze G, et al. Implementation of Urban Health Equity Assessment and Response Tool: a case of Matsapha, Swaziland. *J Urban Health*. 2020;95(5):672–81.

8. Edwards A, Zweigenthal V, Olivier J. Evidence map of knowledge translation strategies, outcomes, facilitators and barriers in African health systems. *Health Res Policy Syst*. 2019;17(1):16.

9. Oliver K, Innvar S, Lorenc T, Woodman J, Thomas J. A systematic review of barriers to and facilitators of the use of evidence by policymakers. *BMC Health Serv Res* [Internet]. 2014;14(1). https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-14-2.