



FIRST NATIONAL CHF CONFERENCE IN UGANDA - REPORT

1st-2nd
DECEMBER
2016





Representatives of conference hosts and partners interacting with the Germany Ambassador to Uganda after the opening ceremony.



The president of Western Ankore Tweragurize (CHI) Schemes Association Mr. Bernard Mwijukye registers on arrival at the conference.

Conference host



Partners



Conference theme

Advancing Community Health Financing in Achieving Universal Health Coverage in Uganda



COMMUNITY SOLIDARITY FOR QUALITY HEALTH

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List of Abbreviations

Bftw	Bread for the world
CBHI	Community Based Health Insurance
CHF	Community Health Financing
CHI	Community Health Insurance
CORDAID	Catholic Organisation for Relief and Development Aid
DFID	Department for International Development
GDC	German Development Cooperation
ISER	Initiative for Social and Economic Rights
MBUSO	Munno Mu Bulwade Union of Schemes Organization
MDG	Millennium Development Goal
MoGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
MSCOM	Munno Mu Bulwade Schemes Cooperation Mechanism
NGO	Non Governmental Organization
NHIS	National Health Insurance Scheme
OOP	Out-of-pocket
SHU	Save for Health Uganda
UCBHFA	Uganda Community Based Health Financing Association
UHC	Universal Heal Coverage
UHI	Universal Health Insurance
UHC	Universal Health Insurance Coverage
USAID	United States Agency for International Development

Acknowledgement



On behalf of the conference hosts, I take this opportunity to immensely thank our partners who sponsored and gave credence to the first ever national Community health financing conference in Uganda. In particular, I wish to thank Bread for the World, the Ministry of Health, Uganda Community Based Health Financing Association, Uganda Insurers Association, World Vision, USAID/Uganda Private Health Support Program, Makerere University School of Public Health and Uganda Healthcare Federation.

I give special thanks to the guest of honor, H.E Peter Blomeyer, the Germany Ambassador to Uganda, Hon. Dr. Michael Yiga Bukenya, the Chairperson of the Parliamentary Committee on Health, and Mr. Benard Mujuni, the Commissioner for Equity and Rights in the Ministry of Gender, Labour and Social Development, who gave impetus to the conference opening and closing ceremonies.

The conference would not have been such a success without the candid and dedicated modeling of the local, national, regional and international experiences and content by all the presenters and session chairs. Your work will not only be echoed in subsequent CHF conferences, but will also form the core in advancing the realization of universal health insurance in the country.

In a special way, I wish to acknowledge the role played by the organizing committee which made the conference a great success. The thought of the conference theme “Advancing Community Health Financing in Achieving Universal Health Coverage” could not have been more relevant than at such a time when the country’s healthcare financing strategies are still shaping, and gearing towards the attainment of quality healthcare for all.

To all the participants, we say thank you for the insightful engagements and your heartfelt concerns and desire to drive CHF forward, reflected particularly in the conference conclusions and declarations.

The entire SHU fraternity is indeed grateful.

A handwritten signature in blue ink, appearing to read 'M. Fredrick'.

Makaire Fredrick
Executive Director
Save for Health Uganda and Conference Chair

1. INTRODUCTION

Overview

Save for Health Uganda (SHU) in collaboration with Uganda Community Based Health Financing Association (UCBHFA) and Ministry of Health organised the First National Community Health Financing Conference in Kampala, from 1st to 2nd December 2016. The conference, the first of its kind in Uganda, brought together 109 community health financing (CHF) stakeholders and experts from Uganda, Rwanda, Kenya, Tanzania and Germany. The theme of the conference was “Advancing Community Health Financing in achieving Universal Health Coverage in Uganda”. The main theme was broken into four subthemes:

- Showcasing Uganda’s achievements and initiatives in community health financing;
- Global and regional perspectives on the role of community health financing in healthcare financing;
- The proposed national health insurance scheme for Uganda and the envisaged role of community health financing /insurance; and
- Indigents and informal sector participation in universal health insurance coverage

The objectives of the conference were five:

- To raise awareness about community health financing initiatives in Uganda and achievements so far;
- To present regional and global evidence of the role of community health financing in achieving Universal Health Insurance and Universal Health Coverage;
- To present the current and examine the envisaged role of community health financing initiatives for the national health insurance scheme in Uganda;
- To derive ways in which the informal sector and indigents in Uganda can be central in universal health insurance coverage; and
- To make declarations and recommendations on how the current community health financing initiatives can be strengthened to contribute to the achievement of universal health insurance and eventually universal health coverage.

Background to the conference

The Uganda Government intends to introduce a National Health Insurance Scheme (NHIS) for all residents. The draft NHIS Bill of 2014 provides for three sub-schemes for residents to enroll for health insurance: 1) Social Health Insurance Scheme; 2) Community Health Insurance Scheme; and 3) Private Commercial Health Insurance Scheme. The NHIS is expected to contribute to achieving Universal Health Coverage (UHC) where all people will access the healthcare services they need of the highest attainable quality without anyone suffering financial hardships.

The large informal sector in Uganda and a significant indigent population both continue to challenge policy and key decision makers to define who they are, and how they will be enrolled and retained in the NHIS. Out-of-pocket (OOP) payments dominate healthcare financing and these are generally higher

among the poor. The high OOP expenditure leads to potentially catastrophic payments for health care among low income groups.

CHF, where the community pays for healthcare and is involved in the control and management of health resources has the potential to provide financial protection for the rural communities, mobilize additional resources for health and increase utilization of health services. It is a promising alternative for a cost sharing health care system which also leads to better utilization of health care services; reduced illness related income shocks and eventually leads to a sustainable and fully functioning universal health care system. This conference, therefore, sought to explore mechanisms for providing financial protection to the poor in accessing healthcare through leveraging on community resources and support by the government and other partners.

Conference structure

Three approaches were used: plenary presentations, panel discussions and exhibition. Each presentation and panel discussion was followed by a question and answer session facilitated by experts on healthcare financing. In the exhibition, CHF implementers showcased the materials and tools used in their work. The conference was crowned with a set of declarations on how the current CHF initiatives can be strengthened to contribute to the achievement of universal health insurance (UHI) and eventually UHC.

Key highlights and messages

- A sound regulatory environment for health financing, health service provision, governance and institutional arrangements is the recipe for a functional health care system that meets the needs of citizens without exposing them to impoverishing expenditures due to ill health.
- It is important for Uganda to move towards dynamic, learning, adaptive health financing systems that contextualise the population needs.
- Communities have enormous resources that should be tapped into to contribute to financing health care by supporting their initiatives.
- Equity in accessing health can be achieved when everybody pays according to capacity to pay but accesses services depending on need;
- Availability, affordability, acceptability and accessibility of healthcare services must be considered to enable rural communities obtain quality services.
- Political will coupled with financial and legal support are key to the success of CHF schemes.
- Health insurance schemes have been more successful in countries where they were implemented in a phased manner.
- Governments should allow different health insurance schemes to co-exist but cross-subsidization is important to enable the poor and indigent access the minimum health care package.
- Where CHF initiatives have been implemented, there has been an increase in the number of schemes and beneficiaries providing pooling mechanisms for health care and improving health outcomes.
- Health insurance education is important in increasing enrolment, enrolment renewal and scheme sustainability
- It is important to have effective coordination mechanisms for CHF implementing partners in order to share information
- Government should retain the duty to ensure effectiveness, efficiency and sustainability of health insurance schemes.

2.0 OPENING CEREMONY

2.1. Welcome remarks

The Chairperson of the Board of Directors of Save for Health Uganda (SHU) Mr. Zakaria Muwanga Kasirye, together with Ms Christine Makobole, a member of the Board of Uganda Community Based Health Financing Association (UCBHFA) who represented the chairperson, and Ms. Yvonne Papendorf, the Program Officer for Uganda from Bread for the World, Germany, welcomed participants to the conference. They underscored the timeliness of the conference in relation to existing plans by the government of Uganda to introduce a National Health Insurance Scheme. They stressed the need to advance CHF as a vehicle for facilitating vulnerable citizens to access quality and timely health care services as well as protecting them from catastrophic health care expenditures. They reiterated the important role CHF can play in realizing Universal Health Coverage (UHC) in the country.

Mr. Kasirye pointed out that SHU was the perfect conference host because of its vast experience in implementing CHF interventions and bringing together stakeholders to harmonize views on linking CHF to national programmes.



Mr. Zakaria Muwanga Kasirye

2.2 Opening remarks



H.E. Dr. Peter Blomeyer

His Excellence, Peter Blomeyer, the Germany Ambassador to Uganda officially opened the conference. He was dismayed by the inadequate funding to Uganda's health sector and the predicament poor people face when they fall sick due to uncertainty over paying medical bills. He appealed to the government of Uganda to explore ways of increasing funding for the health sector to improve service delivery and put the sector on a sustainable basis. He observed that health insurance is the foundation by which the risk of falling sick is shared by many and costs of health care are distributed to a great number of people. He noted that health is a decisive factor for poor people to advance and participate in economic transactions.

He encouraged conference participants to generate concrete declarations and recommendations on how the current community health financing initiatives can be strengthened to contribute to the achievement of universal health insurance and eventually universal health coverage.

3.0 CONFERENCE PROCEEDINGS

3.1 Keynote address

Keynote speaker: Dr. Francis Runumi, Independent Health Financing Specialist

Session chair: Prof. Robert Basaza, Associate Dean, Institute of Public Health and Management International Health Sciences University, Kampala



Dr Francis Runumi

The keynote address focused on the theme of the conference, ‘Advancing community health financing to achieve Universal Health Coverage’, and explored various healthcare financing mechanisms with case studies from different countries, the history of CHF in Uganda, the challenges and the need to review the country’s health care financing system. It showed that effective and integrated health financing mechanism has to be rooted under the four pillars: 1) regulatory environment, 2) health financing, 3) health service provision and 4) governance and institutional arrangements. Most countries do not finance healthcare through a single mechanism but rather use a combination of approaches that include public financing, private financing, a combination of both, as well as having multiple health plans. It is critical for countries to move towards dynamic, learning, adaptive health financing systems that contextualise the population needs given their differences in level of development, social conditions, value systems, disease profiles, effectiveness of their governance structures and institutions. Community involvement is crucial in order to mobilise local resources for sustainability.



CHI Schemes in Uganda

Dr. Runumi chronicled community health Insurance (CHI) schemes in Uganda as starting way back in 1994 triggered by paucity of services in the rural areas. The need to support each other as a survival instinct motivated communities to start up health financing schemes where Kisiizi Hospital in Rukungiri District was the first pilot with support from government and donors. Currently, the growth of community health insurance schemes is dependent on member contributions and the support provided by donors. CHI schemes face challenges including low premium contributions, high administrative costs, fatigue among volunteer servants, poverty and inadequate service delivery outlets.

The future

Dr. Runumi noted that the future of CHF lies in more sensitization of communities on social solidarity, improving scope and quality of services at delivery outlets, and progressive support to schemes to grow and integrate into bigger health insurance schemes.

Plenary discussion

The key note address was followed by a questions and answer session where the following issues were noted:

- The current health financing mechanisms used by government are skewed to curative healthcare services which are more reactive than proactive in mitigating out of pocket expenses.
- For CHF to effectively take root, there is need to strengthening preventive healthcare services. This will reduce preventable diseases which will, in turn, minimize curative healthcare consumption and cost. Consequently, premiums in CHI schemes will be more affordable as hospital visits reduce hence having better health care packages that address more critical illnesses.
- There is need to provide extensive health insurance education to foster community understanding about health risks and using health insurance to mitigate them. This should be built on the hitherto unexploited potentials inherent in the social capital that different communities possess.

Key issues

- An effective health financing mechanism must be founded on sound regulatory environment, clear health financing modalities, health service provision, governance and institutional arrangement.
- CHF is crucial for the informal sector workers who constitute majority of the population that carries the highest disease burden and its attendant costs.
- It is important for Uganda to move towards dynamic, learning, adaptive health financing systems that contextualise the population needs.



Save for Health Uganda staff (left) talk to conference participants at SHU's exhibition stall

3.2 Thematic presentations and discussions

3.2.1 Theme 1: Showcasing Uganda's achievements and initiatives in community health financing

Session chair: Mr. Makaire Fredrick Executive Director, Save for Health Uganda



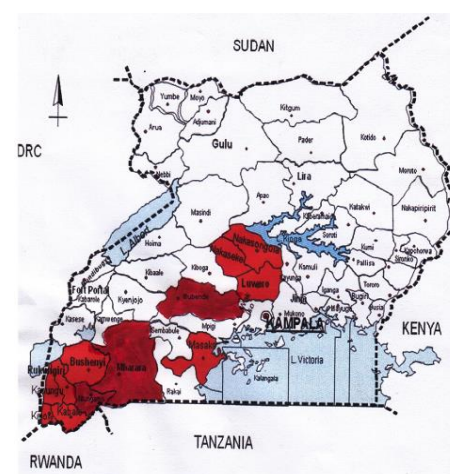
Mr. Makaire

Mr. Makaire opened the session with an overview of the history of CHF schemes in Uganda, their current geographical and population coverage, and the different models being implemented. He showed that the first scheme was launched in 1996 at Kisiizi Hospital and is still running. Other schemes emerged later covering mainly parts of western and central Uganda.

There are three types of schemes namely: 1) Member managed; 2) Service provider managed; and 3) Third party managed schemes. These cover about 150,000 people in total.

The risk management models in existing schemes include: 1) Risk sharing/spreading among members; 2) Risk transfer to the service provider; and 3) Risk retention by the family (group capitalization and emergency healthcare loan schemes, individual household health care savings schemes, patients savings schemes). CHF schemes in Uganda generally depend on external funding to start up and scale up. Major donors include Bread for the World (BftW), BftW, United States Agency for International Development (USAID), CORDAID and United Kingdom Department for International Development (DFID).

Coverage of CHF schemes in Uganda



3.2.1.1 Session 1: Achievements of various CHF initiatives in Uganda

Five representatives of CHF implementers shared experiences on their work and milestones. The presenters were:

- * Ms Juliet Nazibanja Kibirige, Head of Programs, Save for Health Uganda.
- * Dr. Edwin Birungi Mutahunga, Executive Director, Bwindi Community Hospital- Kanungu District.
- * Dr. Archibald N. S Bahizi, Medical Superintendent, Rukunyu HCIV, Kamwenge District.
- * Mr. James Mubangizi, Scheme Manager, Happy Community Health Insurance scheme - Ntungamo District.
- * Dr. Elizabeth Ekirapa – Kiracho, Lecturer, Department of Health Policy and Management, Makerere University School of Public Health.



Ms. Juliet Nazibanja



Dr. Edwin Birungi



Dr. Archibald Bahizi



Mr. James Mubangizi



Dr. ELizabeth Ekirapa

3.2.1.2 Save for Health Uganda's CHF initiatives, achievements and challenges

SHU has been promoting CHF schemes since its establishment in 2002. SHU runs four types of CHF schemes namely: 1) Pure health insurance schemes; 2) Pure health credit schemes; 3) Mixed health insurance and credit schemes; and 4) Family savings for healthcare. SHU currently operates in 10 districts.

Management models for the initiatives

The schemes are either managed by the community or by a third party (SHU). Community managed schemes are common in rural areas and members are fully in charge of day-to-day activities of the scheme. Third party managed schemes are common in urban and semi-urban areas and target organized formal and informal groups. Members collect premium but formally agree with a third party (organization with expertise) to run the scheme. In both schemes, members participate in making key decisions regarding the benefit package and service providers.

Achievements

The schemes have grown to 98 while beneficiaries are 25,665. Schemes are federated into networks to increase risk pooling and capacity to pay medical bills.

Figure 2: Increase in number of schemes since 2002

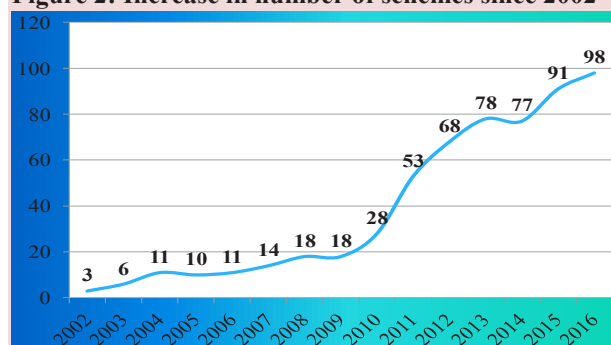


Figure 3: Growth in number of beneficiaries to 25,665

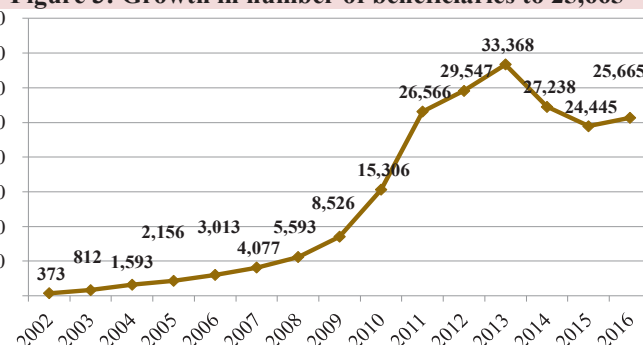


Figure 4: Local reinsurance at network level

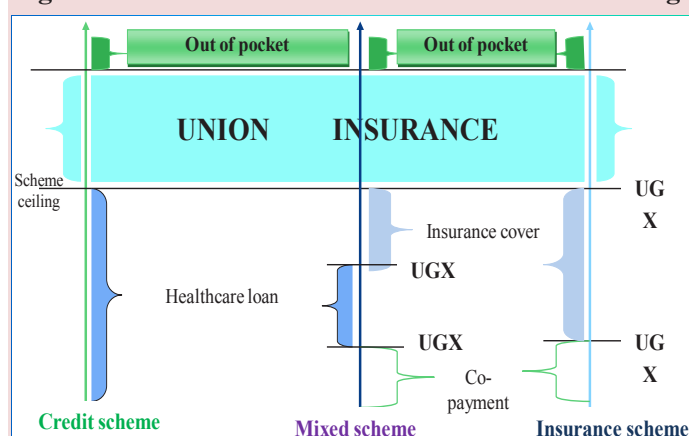
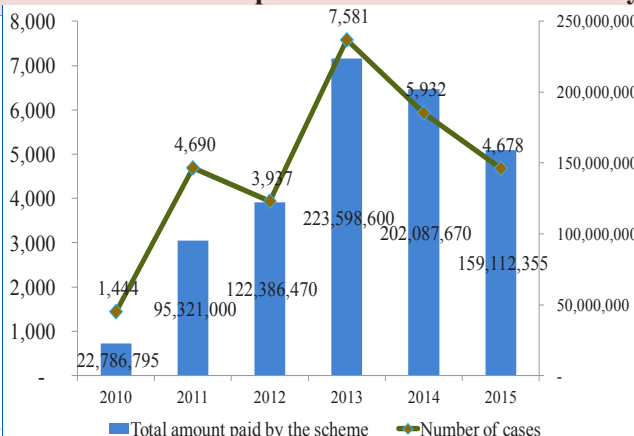


Figure 5: Schemes have paid their healthcare bills fully



Challenges

- Minimal support from government in promoting CHF as a financing mechanism;
- Limited capacity to pay premiums by majority of the target families as a result of fluctuating incomes;
- Limited financial capacity for SHU to extend to other areas to respond to the demands;
- Limited number of facilities that offer quality care to be contracted

Future plans

- Scale up the number of schemes to 300 in 5 years
- Increase the number of beneficiaries to 200,000.
- Link all CHF schemes to the NHIS when it starts.

3.2.1.3 Experiences of eQuality scheme of Bwindi Community Hospital

Bwindi Community Hospital (BCH) is a private not for profit facility under Kinkiizi Diocese in Kanungu district, western Uganda. The eQuality Health Scheme was conceived in 2010 when BCH was 95% dependent on external funding. It collaborated with International Medical Group, and drew lessons from Kisiizi and Micro-care to start the initiative.

The scheme uses existing social networks (burial society groups) to minimize costs of mobilization thus promoting shared responsibility among members. At least 60% of the households are required for a group to enroll. Leaders of local elders collect premiums for remittance to eQuality. Scheme members are allowed to pay premium in three equal installments (every four months).

The scheme uses the community to identify five poorest households per village and these pay only 60% of the standard premium. Households in excess of six members pay 60% of the premium. The Batwa pygmies (considered indigents) contribute only 10% and the rest is paid by a donor (Batwa Development Program). For purposes of community participation, eQuality holds annual consultative meetings with community members (insured and non-insured). Scheme members receive general primary healthcare services including family planning and HIV/AIDS testing, care and treatment. Services which require specialized expertise which is not available at the hospital are excluded.

Achievements

- Improved quality of services at the hospital (service delivery standards are met)
- Improved community participation through annual community dialogues/consultations
- More accountability to the community
- Financed 20 % in 2010 and 45% in 2016 of facility based (curative) running costs
- Under five deaths are three times less among the insured
- Penetration (coverage) is at 45%

Challenges

- Larger families have challenges paying premiums
- Long distance to the facility (geographical access) is an impediment
- Indigents still left out and thus need other partners to cover their healthcare costs

Future Plans

- Rolling out on demand
- Considering partnering with facilities under diocese of Kinkiizi in the district to improve access and reduce drop outs
- Enrolling any other pre-existing groups other than Bataka
- Work with other CHI schemes and partners for advocacy & appropriate legislation

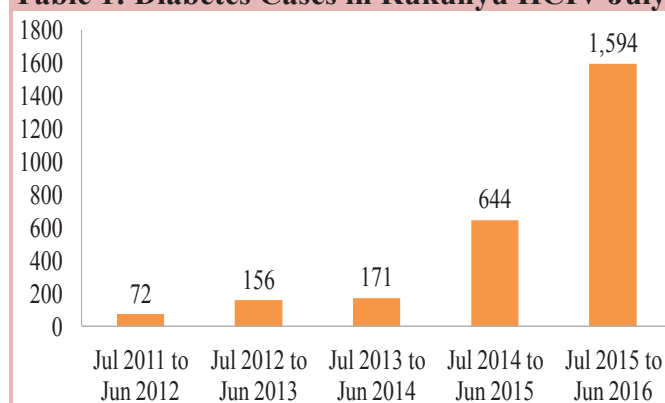
3.2.1.4 Community Health Financing Initiatives by the Diabetes Club at Rukunyu Health Centre IV in Kamwenge district

Rukunyu HCIV serves a population of about 280,000. A diabetic/hypertension clinic was started around 2005 when the health centre had primary health care finances to procure medicine and supplies from Joint Medical Stores and private pharmacies. In 2011/2012 National Medical Stores took over the overall procurement and supply of medicines. Consequently, medicines for non-communicable diseases including diabetes were less prioritized leading to high morbidity and mortality.

A team of five men and women consulted the In-charge about revitalizing the clinic. They had agreed to influence the patients to pay UGX 2,000 per clinic visit to cater for blood sugar testing. The In-charge at the time donated a glucometer and blood pressure machine. The first mobilization meeting after radio announcements raised 15 patients. Later, the number increased to 1,594 by end of June 2016.

Every clinic day, at least 2 new patients were enrolled and over 50 patients came from sister districts of Kyegegwa, Kiruhura, Ibanda and Kyenjojo. This prompted the hospital management to increase the number of clinic days from 1 to 4 in a month on every Wednesday of the week. Currently patients pay 3,000 per clinic day and have proposed to increase it to 5,000 effective January 2017 due to inadequate medicine supplies from National Medical Stores.

Table 1: Diabetes Cases in Rukunyu HCIV July 2011 - June 2016



Diabetes/hypertension clinic attendance

Good practices

- Every clinic day, they begin with a meeting and minutes are available.
- They have a committee and manage their finances.
- Money is used to buy glucosticks, procure medicines to complement what NMS supplies

Strengths

- Willingness of the community to sustain the clinic and spread over.
- Influence through a win-win situation is good in establishing systems.
- Facility meets the costs for the extremely disadvantaged using PHC grant

Challenges

- Politicization of community financing for health facility cost-sharing.
- Inadequate medicine and laboratory supplies by NMS
- Lack physician visit to review complicated cases but also for onsite mentorship for staff

Recommendations

- MoH should implement result based financing (RBF). This will address equity to prevent generalization.
- All Hospitals and Health centre IVs to establish chronic care clinics through community organised efforts (advocacy needed).
- Establish meaningful village health committees for NCD prevention

3.2.1.5 Achievements and Challenges of Happy Health Insurance Scheme in Ntungamo District

The scheme located in Ntungamo district, western Uganda, registered as an NGO in 2008 and has a total of 369 members. The idea originated from the concept that communities were forming burial associations without putting in place any mechanism to treat the sick before they die. This was a common social phenomenon in Ankole region and a form of social capital; and was instrumental in mobilizing communities to embrace Happy Health Insurance Scheme.

The scheme generates all its funding and has never received any funding from any donor. It collects premiums from its members and has a vocational training centre where students contribute premium as one of its financial risk management measures. The scheme runs a clinic where members receive general medical care.

Table 2: Membership of Happy Health Insurance Scheme

Group Code	Group Name	Male Infants	Male Adults	Female Infants	Female Adults	Total
1	Butare	1	23	0	77	101
2	Buragara	0	4	0	32	36
3	Kahunga	0	8	0	25	33
4	Nyabubare	0	3	0	9	12
5	Staff HHIS	0	7	0	7	14
6	Nyakasa	0	4	0	22	26
7	Kyamajumba	0	8	0	25	33
8	Kitondo	0	2	0	5	7
9	Ruhooko	0	3	0	6	9
10	St.Padre Pio	1	47	0	21	69
11	Kiyooro	0	4	0	16	20
12	Mobilizers of HHIS	0	7	0	2	9
Total		2	120	0	247	369

Table 3: Performance of Happy Health Insurance since 2008

Year	Scheme Members	Non scheme members	Total
2008	228	142	370
2009	920	489	1,409
2010	1,533	292	1,825
2011	978	347	1,325
2012	619	553	1,172
2013	431	466	897
2014	985	757	1,742
2015	1,100	539	1,639
2016	664	420	1,084
Total	7,458	4,005	11,463

3.2.1.6 Harnessing Savings for Improving Maternal and Newborn Health Outcomes: MANIFEST Experiences

Makerere University was implementing a three-year maternal health financing project in Kamuli, Pallisa and Kibuku districts in Eastern Uganda (MANIFEST). The project harnessed savings for improving maternal and newborn health outcomes through working with local savings groups (SGs). Community members had formed the groups to meet the following needs: School fees, social protection, access loans, pay for healthcare, improve household welfare, and earn interest, among others.

Makerere University established partnerships with the savings groups to further diversify their benefits to include saving for maternal and newborn health care. The project had two main components: 1) Community empowerment which included home visits by village health teams (VHTs), financial preparedness through saving groups, and improving access to transport by working with local providers; 2) Health systems strengthening which included mentorship, support supervision, recognition, training in management and provision of basic equipment.

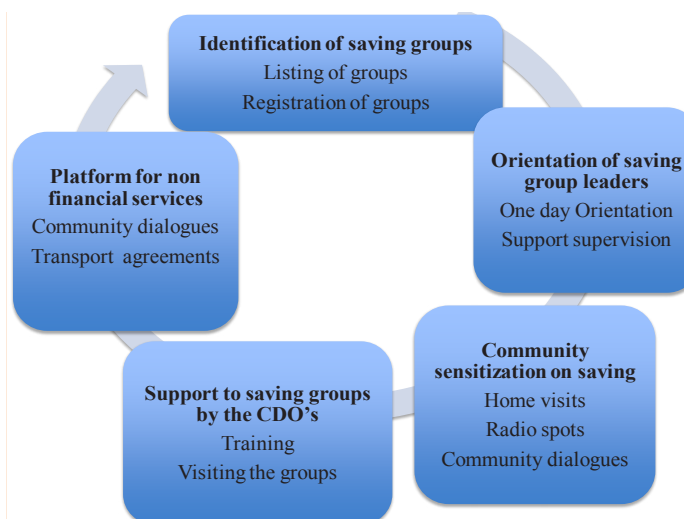
Results after 18 months

- A total of 304 groups out of 913 incorporated saving for maternal and child health while 263 had agreements for providing transport to women to access health facilities for delivery.
- Significant increase in women saving for MNH by 60% between baseline and end line (10% to 69%).
- Women saving using saving groups increased by 10 % in the intervention area (0 to 10.82 %) and by 5% (0 to 5.43 %) in the control

Key message

Saving groups can enable households to meet basic health care needs and contribute to service delivery.

Figure 7: The process of partnering with savings groups



Factors that facilitate saving with SG's

- Awareness about the importance of saving
- Poverty
- Easy access to loans
- Safer custody of money

Factors that constrain saving with SG's

- Lack of prioritization of health issues
- Poor management of SG's
- Selfishness
- Dissatisfaction with saving modalities

Policy and programme implications

- Districts, community leaders and implementing partners should increase awareness about the importance of saving for health – target men as household heads and local leaders who can influence behavior.
- SGs are essential for meeting personal costs (birth items -pregnant women and babies), transport costs, medication costs, nutrition costs, safe housing and sanitation, mosquito nets.
- Districts and implementing partners should develop sustainable methods for supporting SGs using project personnel and community development officers, and facilitate them to support savings groups.
- SGs should be supported to invest their income, so that they can grow. This will reduce inability to save due to poverty.
- Participation in SGs can be encouraged through the provision of subsidies, matching of funds, flexible paying arrangements.
- National level Policy makers should create an enabling environment that encourages the contribution of communities to meeting the costs of health service delivery.

Key issues on showcasing Uganda's achievements and initiatives in community health financing

- Where CHF initiatives have been implemented, there has been an increase in the number of schemes and beneficiaries providing pooling mechanisms for health care and improving health outcomes.
- There is limited capacity by majority of the target families to pay premiums as a result of fluctuating incomes
- There has been improved accountability of service providers to the communities they serve
- Support to CHF from government as a financing mechanism has been minimal
- The number of facilities that offer quality health care commensurate to the health care needs of scheme members is limited
- Savings groups have potential to increase resources for health care

3.2.1.5 Experiences of health care providers working with CHF schemes in Uganda

Session chair: Dr. Ronald Kasyaba, Deputy Executive Director, Uganda Catholic Medical Bureau (UCMB)



Mr. Moses Kintu Ssekidde

Mr. Moses Kintu Ssekidde, the Manager for Community Based Health Programs at Kiwoko Hospital, a private not for profit facility located in Nakaseke district, central Uganda, presented the experience of the hospital in serving members of CHF schemes since 1999. The 250-bed facility is owned by the Church of Uganda. Its catchment area includes Luwero, Nakasongola and Nakaseke districts.

Since the year 2000, the hospital has been serving 15 different CHF schemes in Nakaseke district with a total of 7,963 members in addition to members of schemes in neighboring districts. Kamuli scheme created in 2003 by SHU is among the oldest with a membership of 859 with 381 males and 478 females.

Benefits of the scheme

The Hospital has benefitted from timely payment of medical bills and there is a reduction in the number of patients who fail to pay since many are now scheme members. It is assured of steady and predictable income from the scheme membership which currently stands at 7,963. The scheme members enjoy 10% discount on every visit for medical care. The administrative costs of tracking patients who leave hospital without paying the bill are minimized through engaging the CHF groups to recover the money. In 2014-15, scheme members made 1,090 outpatient visits and 598 inpatient admissions where the cost of providing care to members was UGX 92 million. The scheme union cleared all bills in time.

In collaboration with SHU, the Hospital established a “Customer care center” to proactively handle communication between the hospital administration, staff, and clients.

Challenges

- Majority of scheme members are subsistence farmers whose income fluctuates seasonally. As such, they are unable to join the schemes or renew their membership.
- New scheme members usually expect special attention at the hospital when they fall sick yet patients are served on the basis of severity of illness.

Lessons Learned

- Transforming a society is possible as long as one is patient, willing to listen to people’s concerns and then applies the appropriate method of intervention
- Providing health insurance education is important in increasing enrolment, enrolment renewal and scheme sustainability
- Schemes have enabled hospital staff to appreciate the importance of being patient and listening to the needs of clients and health care partners.
- Although some clients are unable to renew membership every year, the spirit of scheme ownership and importance continues to exist.

Key message: Let’s continue following the river - - we shall reach the sea

3.2.1.6 Current policy, legal and regulatory framework for Community Health Financing

Panel discussion

Chair: Ms. Allana Kembabazi, Head of Health Rights Program, Initiative for Social and Economic Rights (ISER)

Panelists:

- * Mr. Aliyi Walimbwa, Senior Health Planner, Ministry of Health, Uganda
- * Ms. Lydia Nabiryo, Senior Program Officer Capacity building & Social Inclusion, Expanding Social Protection Programme, Ministry of Gender, Labor and Social Development, Uganda;



Ms Allana Kembabazi



Mr Aliyi Walimbwa



Ms Lydia Nabiryo

Key issues

The panelists were of the view that CHF can be treated as a social protection issue and as such, there is currently no specific policy or law in Uganda that regulates it. The laws and policies that regulate health insurance activities implicitly provide the foundation for regulating CHF. The Constitution provides for the right to health under which CHI can be premised. In addition, the Health Sector Development Plan provides for UHC and CHI and reduction of out-of-pocket expenses. This is further expounded in the Health Sector Financing Strategy 2015/16 to 2019/20.

At international level, Uganda is a signatory to many conventions including the International Covenant on Economic, Social and Cultural Rights (ICESCR), which provides for the right to the highest attainable standard of physical and mental health. The Universal Declaration on Human Rights (1948) which provides for everyone's right to social security in the event of unemployment, sickness, disability, widowhood, old-age or other lack of livelihood in circumstances beyond one's control. Other treaties which contain provisions critical for the protection of health include the Convention on Elimination of all forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), the Convention on the Rights of Persons with Disabilities (CRPWD), the African Charter on Human and Peoples' Rights (ACHPR), the African Charter on the Rights and Welfare of the Child (ACRWC), and the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Women's Protocol).

Like other states parties, Uganda is presumed to have willingly signed and ratified these treaties and should therefore be bound by the obligations therein. These treaties are part of Ugandan law and serve as a guide to the interpretation of the Constitution. However, like other legislation, they are subsidiary to the Constitution, which is the supreme law of Uganda.

The National Social Protection Policy approved by Cabinet in November 2015 and launched in March 2016 recognizes CBHI as being part of the NHI initiatives intended to be addressed under the NHIS Bill. As a social security measure, CBHI is the model that can best be applied to the vulnerable groups of people targeted by the National Social Protection Policy. Under objective one on expanding the scope and coverage of social security, strategy 4 is to enhance access to health insurance services; Priority area of focus 5 provides that in an effort to alleviate the burden of healthcare costs on households, government shall introduce affordable health insurance schemes. The Ministry of Gender, Labour and Social Development (MoGLSD) considers health insurance as a social security issue since ill-health poses risks and vulnerabilities which social protection seeks to address. It was agreed that there is need to strengthen the partnership between MoGLSD and MoH.

It was noted that enacting specific legislation regulating CHF was a challenge since schemes were operating in limited geographical coverage which makes it difficult to convince parliament to provide legislation. This calls for implementers to generate convincing evidence to engage in national dialogues for relevant legislation. Currently the Health Sector is pushing for the NHIS Bill where CHI is a component and once passed, this will provide the regulatory mechanism. It was reported that the NHI Bill is taking long because there is no perceived urgency and that government does not want to make mistakes by expressly introducing health insurance.

The draft Bill also provides for accreditation and minimum standards for healthcare providers, and the national taskforce was identifying capacity gaps within the private and public sector for effective scheme management. It was, however, noted that client identification was not explicitly provided for especially identification of indigents.

The identified priorities for policy makers in developing the regulatory framework for CHF included the following:

- Once the NHI Bill is enacted into law, it will be important to expedite the process of developing clear guidelines on community health initiatives. Currently each initiative seems to have its own model.
- It is important for government to subsidise premium for the poor given the high levels of poverty in order to address adverse selection.
- The initial cost of implementing the NHI was perceived as very high thus requiring adopting a phased approach as was done in Kenya and Tanzania.
- In the meantime, the Insurance Regulatory Authority can review the current regulatory framework to include CHF as the country waits for the NHI Bill enactment into law.
- There is need for Government to make extensive research on the existing CHF mechanisms to inform policy development.
- It was also noted that the possibility of having government review the social assistance grant for the senior citizens and integrate a health financing component was beyond reach. This was on account of the health sector having the mandate on health financing which was beyond the MoGLSD.
- Sustaining CHF goes beyond putting in place laws and policies. It has more to do with health insurance education and tapping into the existing social capital which varied with the different cultural set up in the country.

3.2. 2 Theme 2: Global and regional perspectives on the role of CHF in healthcare financing

3.2.2.1 International perspectives on the role of Community health financing in healthcare financing

Panel discussion

Chair: Ms. Robinah Kaitiritimba, Executive Director, Uganda National Health Consumers Organization (UNHCO)

Panelists

- * Ms. Cynthia Macharia, GIZ, Kenya
- * Ms. Yvonne Papendorf, Program Officer, Bread for the World Germany



Ms Robinah Kaitiritimba



Ms Yvonne Papendorf (left) and Ms Cynthia Macharia speaking to SHU Executive Director Mr Fredrick Makaire at the conference

Panel discussants pointed out developments in recent years on the international scene and efforts by different development agencies to push for UHC. These particularly include the World Health Assembly resolution of 2005 which called upon countries to move towards UHC, where all citizens have access to appropriate promotive, preventive curative and rehabilitative services at affordable cost. The resolution also highlighted the need to ensure that health systems are funded through mechanisms that allow risk pooling and cross-subsidization. The 64th WHO Assembly in May 2011 reiterated the urgency of implementing sustainable health financing structures. In 2012, the United Nations Assembly called on governments to urgently and significantly scale up efforts to accelerate the transition towards universal access to affordable and quality health care systems.

a) Role of German Development Cooperation (GDC) in supporting coverage of people at the bottom of the pyramid

The German Development Cooperation (GDC) is working with governments and civil society organisations in Tanzania, Rwanda and Kenya, among other countries, to develop health policies, health financing strategies, and implement CBHI. In Kenya, GDC in partnership with the World Bank, GIZ and KfW is supporting scaling up of existing health insurance schemes to cover the entire population. The draft health financing strategy for Kenya proposes a single fund for both health insurance contributions and government subsidies.

b) The role of Bread for the World, Germany

Since 1999, Bread for the world has been financing community health financing initiatives in Eastern Africa. Currently, Bftw is supporting CHF projects in Kenya, Tanzania, Uganda, the Comoros islands and Togo. The objective is to give poor and marginalized groups access to quality health care. The groups are pre-payment schemes in which the poor and marginalized practice solidarity and saving among themselves. The schemes offer adapted forms of small contributions by the target group, pay costs for health expenses when they occur and distribute the risks among the members. Ceilings for costs and different packages are applied according to different needs and possibilities of different groups.

Community involvement from the beginning of the formulation of the scheme is needed in order to make members feel part of the initiative. If members are more involved, the potential for membership fees to be set at an affordable rate is much higher and the benefit package will be clear to all members, avoiding the possibility of over expectations of the benefits package.

A good indicator of satisfaction of the target groups and adequacy of the concept are renewed subscriptions. If many people drop out and do not renew their subscription, the package should possibly be realigned. The number of dropouts alone does not say much hence the need for a qualitative analysis to identify other underlying causes.

Health care for those not covered in schemes is funded largely through out-of-pocket payments. This is an inequitable form of health financing that can push households into poverty. It also acts as a barrier to accessing health services, and can promote informal payments.

Perspectives of success

Drawing examples from various countries such as Ecuador, India and Senegal, discussants showed that CHI reduces out of pocket expenditure and increases financial risk protection for members. In Rwanda and Tanzania, CBHI schemes increased access to health care coupled with improvements in the quality of services due to performance monitoring of facilities.

Challenges of CHI schemes

- Income in these schemes is often irregular, seasonal and unpredictable; it is difficult to achieve financial sustainability of the schemes
- Expenses for illness or accidents are equally unpredictable
- Cost intensive chronic diseases
- The informal sector is usually not well structured making it difficult to systematically enroll them into existing schemes.
- Lack of support from outside, public subsidies or integration in a general health insurance scheme.

Recommendations

- Administration and charging premium should be done by professionals because volunteers are not sufficient in the long term.
- There is need for a compelling system for different income groups including the affluent and those in informal working situations and subsistence farmers to achieve insurance for all.
- CBHI schemes need to be integrated into national health insurance schemes.
- CBHI should be complimented with activities such as training of the target groups on health issues or income generating projects.

2.3.2.1 The East African experience on the role of community healthcare financing in broader healthcare financing



Mr. Douglas Opio

Session Chair: Mr. Opio Douglas, Deputy Executive Director, Federation of Uganda Employers (FUE)

Presenters

- * Mr. Pascal Amato Birindabagabo, Health Insurances Policies Specialist, Rwanda
- * Dr. Amani Anaeli, Senior Lecturer Department of Public Health Muhimbili University of Health and Allied Sciences, Tanzania
- * Mr. Stephen John Africa, Director, Health Insurance Management Organization, Mbeya, Tanzania

The three delegates from Rwanda and Tanzania made presentations on the role CHF is playing in their countries. They highlighted its history, models, achievements particularly in linking CHF schemes to national health systems, challenges and lessons learnt along the way.

a) The Rwandan Experience

Low levels of utilization of healthcare services and the precarious financial situation in health centers and hospitals due to unpaid bills provided the foundation for Rwanda's CBHI. The CBHI objectives were to improve financial access to healthcare and protect households against financial risks associated with ill health. The CBHI law makes it mandatory for family members to make contributions. CBHI was introduced in phases beginning with three districts in 1999.



Mr Pascal Birindabagabo

Figure 8: Rwanda CBHI in different phases

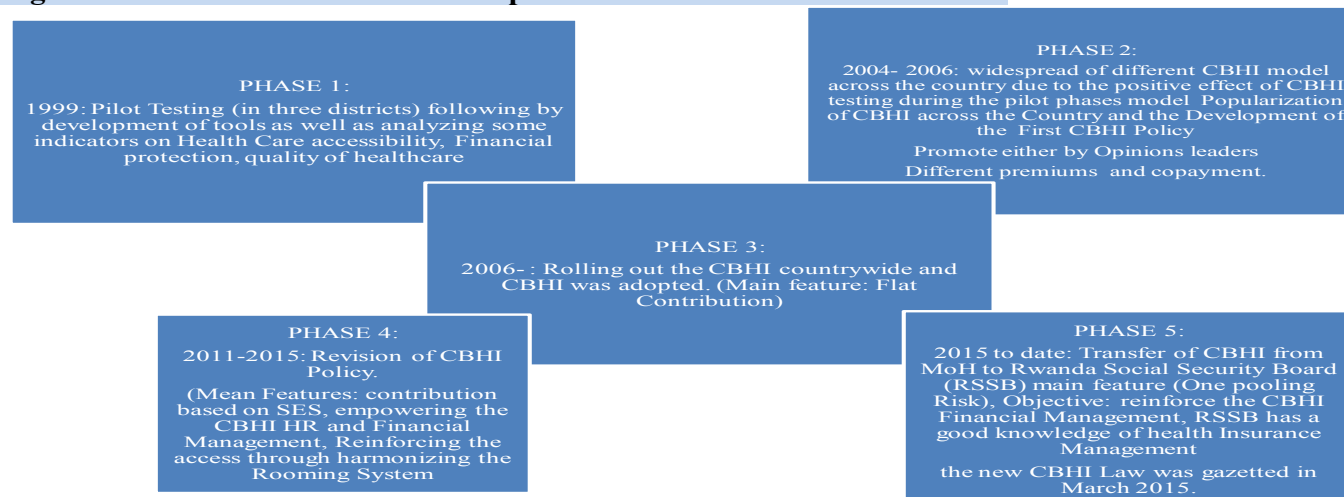


Figure 9: The structure of Rwanda's Health Insurance

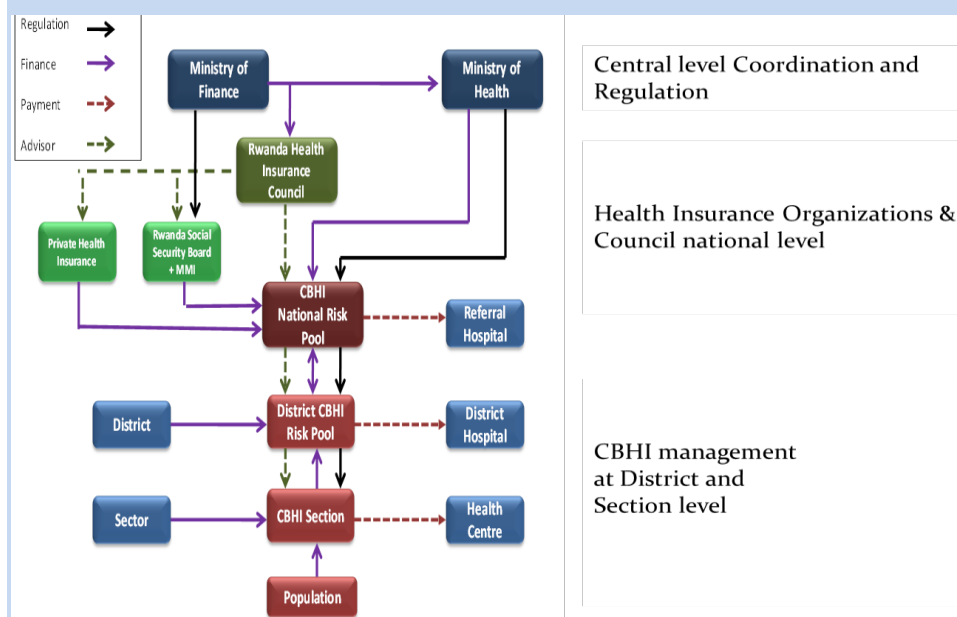


Figure 10: CBHI sources of revenue

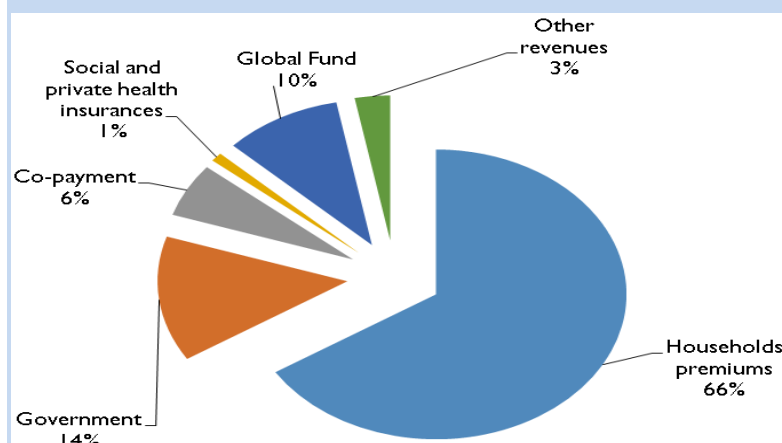


Table 5: Evolution of membership rate (2003-2015)

Year	Coverage	Utilization
2003	7%	30.70%
2004	27%	39%
2005	44%	46.80%
2006	73%	60.70%
2007	75%	72%
2008	85%	76%
2009	86%	91%
2010	91%	95%
2011- 2012	90.70%	79%
2012-2013	80.80%	90%
2013-2014	74.3	93%
2014-2015	76.3	95%

Achievements

- Population coverage and enrolment into CBHI: 90 percent of the population in 2011/2012 and 80.3 percent in 2012/2013.
- Reduced household financial hardships: 23 % of total health expenditure in 2006 to 11 % in 2009/10.
- Increasing healthcare utilization rate at all levels of the health system
- The quality of health care has also improved as CBHI has integrated a system of quality control and performance indicators.
- Reducing the household or Individual delay to seek the health service when ill
- CBHI has contributed to great changes in the health sector. It is possible to have policies and doctors, but if people cannot afford health services, all of these efforts are in vain."

Figure 11: Lessons learnt so far



Challenges

- The capacity of the population to pay premium contributions is still low.
- The youth are less willing to enroll for CBHI.
- Health facilities payment may take longer due to uncomputerized system
- Some cases of moral hazard do occur on the side of members and providers

b) The experience of Tanzania at national level



Dr. Amani Anaeli

Background

The Health sector reforms in Tanzania were initiated in mid 1990's and included introduction of user fees in health facilities, private practice and health insurance. Currently, healthcare financing in Tanzania is from taxation, out of pocket by households, health insurance and donor funds. Health insurance has five major components namely: 1) National Health Insurance Fund (NHIF) initiated in 2001; 2) Community Health Fund (CHF) started in 1996; 3) Social Health Insurance Benefit (SHIB) which commenced in 2005; 4) Private insurance which started in early 2000 and 5) Micro –insurance schemes.

Tanzania implemented CHF in a phased manner starting as a pilot scheme in 1996 in Igunga district. In 1998, it was rolled out to nine more districts. In 2001, the policy decision was reached to cover all districts through an Act of Parliament and regulations issued in 2004. The CHF model uses decentralized systems where the district councils play an important role in regulating health insurance operations.

CHF is a voluntary pre-payment scheme, which offers a household the opportunity to acquire a “health card” after paying a contribution. The insurance card is renewed after every 12 months. The scheme targets low income earners from the informal sector in rural and urban settings. It is financed through annual membership contributions and a matching grant from the government. The contribution is tied to a specific benefit package provided through a network of public facilities. The current coverage is 144 out of 168 councils under Local Government Authority and a total of 1,112,874 households that translate to 6,677,244 beneficiaries have been enrolled.

c) The experience of Tanzania at community level



Mr Stephen Africa

In setting up CHF schemes, feasibility studies are conducted to establish existing capacities and community willingness to pay. The process of scheme initiation also addresses frequency of premium payments, formation of steering committees and mobilization of members to constitutive general assembly. Once the structures are constituted, service providers are identified and contracted to deliver health care.

CHF has improved over time through public private partnerships, formation of sections and associations, unification of health insurance schemes, co-management and splitting of funds. The ultimate aim is to transfer CHF professional management to the Districts councils and strengthen members control/participation via the CHF users Association.

Table 6: Weaknesses in performance of CHF (after 5-10 yrs)

Weakness	Explanations/details
Lack of competence in health insurance management	- Lack of qualified human and other resources dedicated to CHF - Problem of data availability and reporting - Weak capacity to analyze the CHF situation - Low efficiency in funds utilization - High adverse selection jeopardizing the fund
Lack of participatory governance	- Lack of CHF members participation in management - Low commitment of HFGC and CHSB - No complaint mechanism
Low attractiveness of the CHF	- Lack of medicines - Limited package of services - Limited portability (within a facility vicinity) - The low price of user fees
Low interest for the health facilities	- No incentive for Providers to treat the beneficiaries

Lessons

- HIMSO and other partners are now influencing the structure and set-up of the new government CHF planning towards Universal Healthcare coverage;
- CBHIS/CHF are evolving towards UHC
- Public Private Partnership (Govt, FBO, NGOs, Private companies) is key in managing CHF
- It is important to have effective coordination mechanisms among partners

Key issues on the East African experience on the role of CHF in the broader healthcare financing

- CBHI has contributed to great positive changes in the health sector.
- Community awareness and involvement are key to the success of CHF.
- Phased implementation provides evidence for scaling up CHF.
- The capacity of the population to pay premium is still low thus affecting sustainability of CHF.
- Inadequate management skills pose a challenge given the high rate at which CHF is expanding .
- Effective coordination mechanisms for CHF implementing partners are very important.

Day Two

3.2.3 Theme 3: The proposed national health insurance scheme for Uganda and the envisaged role of community health financing /insurance

3.2.3.1 Universal Health Coverage and Sustainable Development Goals

Presenter: Dr. Juliet Evelyn Bataringaya, Country Advisor - Health Systems Development, World Health Organization, Uganda

Session chair: Dr. Charles Okiria, Senior Lecturer, Institute of Public Health and Management, International University of Health Sciences



Dr. Charles Okiria



Dr Juliet Bataringaya

Dr. Bataringaya's presentation focused on UHC in relation to the Millenium Development Goals (MDGs), the unfinished MDG agenda as well as Sustainable Development Goals(SDGs) and the necessary national action.

What is Universal Health Coverage?

This is when all people are able to use needed health services (including prevention, promotion, treatment, rehabilitation, and palliation), of sufficient quality to be effective. The use of these services does not expose the user to financial hardship (World Health Report 2010, p.6). UHC means addressing the health needs of the poor on equal footing with the rich

without any citizen suffering catastrophic expenditures on health. Ill health under SDG 3 is both a cause and a consequence of poverty which can effectively be addressed by UHC. UHC is premised on the principles of health as a right and that health is socially determined and contributes towards development of a nation.

UHC has basically three performance objectives namely: improving the health status of the citizens; customer satisfaction/responsiveness of the health system; and financial risk protection.

Three ways to move towards UHC

For UHC to take root, there must be a population that is covered thus underscoring the need to increase the share of the population that benefits from pooled financing; Secondly, there must be health services that are covered which should be expanded in scope to meet the needs of the population and paid for with pooled funds; Thirdly, the proportion of direct costs that are covered in order to reduce the amount of out-of-pocket payments through increased financing with insurance (pre-paid risk pooling) and general government revenue.

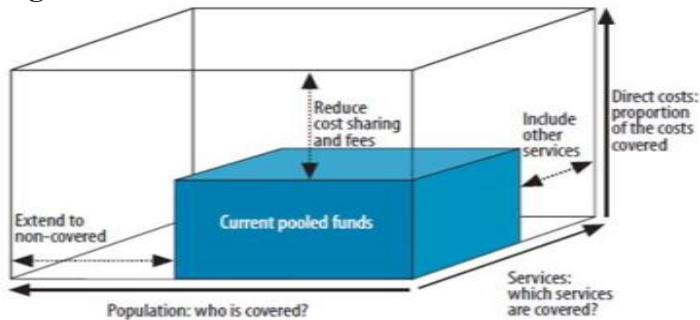
Linking UHC to Sustainable Development Goals

The SDGs are a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. These 17 Goals build on the successes of the MDGs (unfinished MDG agenda), while including new areas. Sustainable Development Goal 3 is to: ensure healthy lives and promote well-being for all at all ages. Target 3.8 is to achieve UHC, including financial risk protection, access to quality health care services, medicines and vaccines for all.

SDGs, UHC and National Action

The SDGs are mainstreamed in Uganda’s National Development Plan II and the Health Sector Development Plan 2015/16-2019/20. The goal of the Health Sector Development Plan is to accelerate movement towards Universal Health Coverage with essential health and related services needed for promotion of a healthy and productive life. Partners and stakeholders are also committed to supporting Government of Uganda towards UHC.

Figure 12: Health Insurance and UHC



“Universal coverage is relevant to every person on this planet. It is a powerful equalizer that abolishes distinctions between the rich and the poor, the privileged and the marginalized, the young and the old, ethnic groups, and women and men. Universal health coverage is the best way to cement the gains made during the previous decade. It is the ultimate expression of fairness. This is the anchor for the work of WHO as we move forward,” Dr Margaret Chan, address to the World Health Assembly, May 2012.

An illustration of one of the draft NHIS scheme models that SHU approves and believes is fair and best represents the needs of all Ugandans.



“National solidarity for equitable access to quality healthcare by all”

3.2.3.2: How to achieve a fair National Health Insurance Scheme (NHIS) in Uganda

Panel Discussion

Chair: Mr. Dennis Odwe, Executive Director, Action Group for Health human rights and HIV/AIDS Uganda (AGHA)

Panelists:

- * Dr. Sam Kamba, Ministry of Health, Uganda
- * Ms. Hannah Baldwin Technical Advisor, Program for Accessible Communication and Education (PACE)
- * Mr. Pascal Birindabagabo, Health Insurances Policies Specialist, Rwanda
- * Mr. Fredrick Makaire, Executive Director, SHU
- * Ms. Allana Kembabazi Head, Health Rights Program, Initiatives for Social and Economic Rights (ISER)
- * Ms. Grace Kiwanuka Ssali, Executive Director, Uganda Healthcare Federation



Left-right: Mr. Dennis Odwe, Ms Hannah Baldwin, Dr. Sam Kamba, Ms Allana Kembabazi and Mr. Pascal Birindabagabo

The discussion focused on various aspects of fairness which panelists felt deserve special attention as the government of Uganda designs the National Health Insurance Scheme. Some of the aspects of fairness highlighted included: the benefit package (universal package); population coverage; contributions (capacity to pay, joint pools instead of sub-scheme pools); access to health care services (network of providers); coordination of sub-schemes; and representation in governance and management of the NHIS.

Key issues raised on how to achieve a fair NHIS in Uganda

- The government should consider reforming health sector financing because: Out of pocket expenditure for health has increased to about 40%; catastrophic health expenditure has risen from 5% to 30% between 2001 and 2010; and the quality of healthcare continues to decline.
- One of the presidential election campaign promises of the ruling government was to introduce universal health insurance. It is one of the performance indicators on fulfillment of its commitments to the electorate.
- Key stakeholders like the Cabinet, Parliament, Civil society and the private sector need to agree on the need for health sector financing reforms and the timelines for introducing them. The objective of the reforms is to extend health care services to the entire population through improving service delivery and to extend financial protection to all Ugandans.
- There is need for concerted efforts to advocate for the NHIS Bill to be enacted into law.

- The NHIS law should have provisions that focus on all segments of the community and recognize that people have different capacities to pay. As such, a minimum health care package should be designed to provide services from an equity point of view.
- Implementation of the NHIS should be phased allowing for drawing lessons learnt to gradually scale-up thus avoiding pitfalls characteristic of large scale intervention.
- The NHIS law should be flexible to accommodate other schemes by different players rather than Government running the show as a monopoly. This will provide for competition and improvement of quality of services.

Fairness is about cost and not prices; provision of a wide range of services based on need; addressing geographical access.

- A single pool for a universal package: citizens should pay according to capacity but access services according to need.
- In order to cater for cross subsidization, private health insurance and social health insurance should contribute to the solidarity fund for the rich to subsidize the poor; Government must be a major provider of resources.
- It should compel everybody to participate as opposed to promoting voluntary contributions.
- Consider affirmative action in the implementation. CHI (for informal sector) should be included in the governance and in any phasing approach taken (e.g. phasing by region, benefits, etc); the minorities and marginalized communities, persons with disabilities and the indigents should be covered.
- Financing for health care goes beyond paying for services at the point of service delivery but also includes transport cover for the patient and attendants, feeding while in hospital e.t.c. In this respect, the NHIS law should have provisions for addressing access issues given the long distances that communities have to trek to health facilities. This was identified as one of the barriers to enrolment into CBHI schemes in many countries. Some service packages should be delivered through outreaches for hard to reach communities.
- Fairness will be realized when the rich subsidize the poor, and when services are accessible to those in the rural poor communities depending on their needs.
- The NHI law should have provisions for health providers to deliver appropriate range of products and services needed to address the health issues faced by the user population.

How Rwanda ensures inclusion of all citizens

Rwanda has a number of health insurance schemes. They vary from social, community based to private health insurance. Social and community based health insurance are mandatory while private health insurance membership is voluntary. In Rwanda, having health insurance is mandatory by law, although only 85% of the population are covered by a health insurance, of which 80% are CBHI members.

Two social health insurance schemes were introduced, one for civil servants and the other for military. For instance, La Rwandaise d'Assurance Maladie (RAMA) and Military Medical Insurance respectively. In RAMA, the premium is 15% of the member gross salary, where the government contributes a share of 7.5% and the member provides 7.5% of his salary as personal contribution. In CBHI, the contribution is by each individual but the membership is household based. This is for reducing the moral hazard which may result from factors such as gender, age, health status or financial ability.

There is cross subsidization of social and private health insurance to CBHI. By the Health Insurance Law of 2015, the contribution of the social and private schemes to the CBHI is 5% of their quarterly or annual income. This contribution to CBHI promotes equity in health care, where the better off and those who are less at risk of health shocks such as civil servants, the military, policemen and businessmen contribute to healthcare for the worse off.

Members of these schemes receive health care in public facilities, some private clinics and pharmacies based on contracts. The copayment varies from 10% to 15%. CBHI members follow a referral system while seeking health care services (Health center, District and Provincial, then Referral Hospitals).

All in all, for the CBHI to play a role and enlarge room to contribute efficiently and integrate effectively in the whole national health insurance system, a comprehensive national insurance legal and regulatory framework should be put in place.

Key issues on how to achieve a fair national health insurance scheme in Uganda

- The national health insurance law must make health insurance mandatory.
- Government has a duty to ensure effectiveness, efficiency and sustainability of insurance schemes.
- Cross subsidization is necessary to ensure that no one is left behind regardless of their economic status / category.
- There is need to consider accessibility, affordability, availability and acceptability of services particularly for rural communities.
- The NHI Bill should be flexible to accommodate other schemes by different players thus providing for competition and improvement of service quality.
- Government must be a major contributor of resources to sustain the scheme.



Front row: Mr. Isaiah Bagyenzi and Mr Asaph Mwesigye from Ishaka Adventist Hospital are some of the participants who represented health facilities serving CHF schemes.

3.2.3.3 How Community Health Financing /Insurance can operate in synergy with NHIS based on local and international experience

Panel Discussion

Chair: Dr. Baine Sebastian, Senior Lecturer Department of Public Health Makerere University

Panelists:

- * Prof. Robert Basaza, Associate Dean, Institute of Public Health and Management, International Health Sciences University, Kampala;
- * Mr. Robert Kabaale, National Coordinator, Uganda Community Based Health Financing Association;
- * Mr. Pascal Birindabagabo, Health Insurances Policies Specialist, Rwanda;
- * Dr. Amani Anaeli, Senior Lecturer Department of Public Health, Muhimbili University of Health and Allied Sciences, Tanzania
- * Mr. Aliyi Walimbwa, Senior Health Planner, Ministry of Health, Kampala



Dr. Sebastian Baine, Mr. Aliyi Walimbwa, Mr. Pascal Birindabagabo and Dr. Amani Anaeli, Mr. Robert Kabaale and Prof Robert Basaza

The panel comprised discussants from Uganda, Rwanda and Tanzania. They approached the topic basing on the experiences of their countries while drawing case studies from the rest of the world. Those from Uganda reflected on the situation of existing CHI schemes in Uganda, the draft NHIS Bill and lessons picked from other countries.

Experiences of other countries

Discussants highlighted case studies showing attempts in different countries to link CHI to national systems and results achieved. In Francophone African countries, mainly in West Africa, countries such as Senegal, Mauritania, and Burkina Faso had started with mutual health long ago, but some ran bankrupt, others did not develop and consequently the coverage rate did not exceed 5 to 10% of the catchment area. In China, the Chinese government introduced the new rural health financing which was both financed by the central, local governments and households compared to the Rural Cooperative Medical System (RCMS) which failed in the early 1980s because of lack of political support. The positive influence of the political will was also seen in Rwanda CBHI, Ghana and recently in Senegal. In Ghana, the mutual was being integrated in the national health insurance with impressive results. This is one of the best practices in community health financing which can be cited in addition to Rwanda. In East Africa, Uganda, Tanzania and Kenya initiated different schemes. However, being scattered limits their effectiveness as well as their visibility.

The winning motto is “**The bigger the pool, the better; One joint pool is always better than many**”.

Good practices identified in Rwanda:

- The way the community behaves towards CBHI depends on how government accounts to the people.
- CBHI is one of the key political promises made in Rwanda and it was delivered which indicates political will and commitment.
- UHC is the concern of many ministries such as the transport and social development sectors to provide other components of the NHIS thus requiring a multi-sectoral approach.

Good practices in Tanzania:

- Mandatory deductions are made from the pay roll under the SHI; the NHI fund had the advantage of accumulating a lot of money that was used to improve the quality of health care
- District Councils are responsible for managing the CBHI schemes, providing health services and also engaging Private Health Insurance schemes to provide technical assistance. Being the service providers, the District Councils are not mandated to collect premiums from the communities. Trusted community health workers enroll households and collect premium which they remit to the NHI fund account using mobile money. They get a commission of 10% of collections as an incentive. The premium is USD 15 per year and they have registered over 20% of the population. The government provides a matching grant commensurate to the collections made, which, in itself, is an incentive to increasing enrolment.

The debate on Uganda's proposed NHIS

Mr. Walimbwa argued that the NHIS Bill states that all Ugandans shall belong to any of the insurance schemes provided thus indicating the synergies inherent within the Bill to progress towards UHC. The provisions of the Bill will be operationalized through regulations. However, there was anxiety expressed by the UCBHFA Coordinator on how CBHI schemes will work within NHI since the provisions in the Bill were not explicit. This was likely to create antagonism and therefore required explicit clarification on the linkages between the different forms of health insurance. It was further noted that the NHI scheme should build on the current networks under UCBHFA to create synergies especially using their structures to mobilize communities and identify indigents. The CHI schemes can be mandated to conduct health insurance education and act as focal points for premium collection. In terms of increasing enrolment into CHI schemes, it was important to consider designing health care packages that address transportation concerns.

Key issues on how Community Health Financing /Insurance can operate in synergy with NHIS

- The power and success of CHI is assured by the extent to which it is supported politically.
- It is so imperative that the government takes lead in supporting CBHI legally, financially, in advocacy efforts and in developing ownership strategies.
- The roles of CHI and its linkage to local councils and central government organs must be clearly stated.
- Accountability centres for CHI must be clear, accessible and accountable to the people.
- Enhancing efficiency in public resource allocation may be a solution to integrate CBHI in the whole NHIS system.

2.33.4 How to scale up Community Health Financing/ insurance to reach the entire population in Uganda

Panel discussion

Chair: Dr. Elizabeth Ekirapa – Kiracho, Lecturer, Department of Health Policy and Management, Makerere University School of Public Health

Discussants

- * Dr. Ronald Kasyaba, Deputy Executive Director, Uganda Catholic Medical Bureau;
- * Dr. Aloysius Ssenyonjo, Study coordinator, Supporting Policy Engagement for Evidence-based Decisions (SPEED) project Makerere University School of Public Health;
- * Dr. Sam Kamba, Ministry of Health, Uganda
- * Mr. Nicholas Lutakome, Head of Corporate Relationships, Sanlam Life Insurance (U) Limited



Dr. Elizabeth Ekirapa -



Mr. Nicholas Lutakome, Dr. Sam Kamba and Dr. Ronald Kasyaba

Discussants considered the experiences of CHF implementers and private health insurance providers to make recommendations for scaling up CHF/I in Uganda. Key issues that emerged from the discussion were:

- The NHIS law will regulate CHF and provide an opportunity for increased enrolment but this will require political support at national and district levels, and building trust at community level.
- The NHIS law should have provisions for mandatory enrolment, where every individual must belong to one of the health insurance schemes. This will make premiums more affordable.
- There must be clear accountability mechanisms which should provide for community participation in decision making processes.
- The schemes should deliberately invest in mothers through affirmative action and health insurance education; women have better health seeking behaviour compared to men.
- There should be equilibrium between the premiums paid and the quality of services provided in order to secure and maintain the community trust in the health insurance schemes.
- There is need for more advocates and health insurance education activists to create awareness about risk pooling as a measure of mitigating catastrophic health expenditures.
- Government should provide subsidies to cater for the losses occasioned by service providers on account of indigents especially among PNFP health care service providers.
- There must be clear separation of roles where health service providers should not run an insurance scheme.

3.2.4 Theme 4: Indigents and informal sector participation in universal health insurance coverage

Chair: Dr. Owembabazi Wilberforce, PMS – Health systems strengthening, Office of Health and HIV
U.S Agency for International Development

Presenters

- * Mr. Pascal Birindabagabo, Health Insurances Policies Specialist, Rwanda
- * Mr. Patrick Opolot A. Supervisor, Service Management Domestic Taxes Uganda Revenue Authority;
- * Ms. Proscovia Nnamulondo, Communication and Advocacy Officer Save for Health Uganda
- * Ms. Esther Nasiky, Communication and Campaigns Coordinator, World Vision
- * Ms. Beatrice Okillan, Coordinator, Policy and Advocacy, Expanding Social Protection Programme, Ministry of Gender, Labour, and Social Development



Left-right: Mr. Pascal Birindabagabo, Mr. Patrick Opolot, Ms Proscovia Nnamulondo, Ms Esther Nasiky and Ms Beatrice Okillan



Dr. Wilberforce Owembabazi

This session was intended to explore ways of reaching the informal sector and indigents to participate in development programs including obtaining health insurance. Presenters shared the experiences of the organizations they represented in targeting the informal sector.

a) Rwanda's experience in targeting the indigent for CBHI

To ensure that everyone, mainly the poorest people have access to healthcare, the CBHI uses Ubudehe program which is managed by the Ministry of Local Government. Ubudehe concept means “mutual help or mutual assistance among people for solving problems in the community”. The Ubudehe is an ancient traditional practice in Rwanda, which has been used to help people in need and mostly with no any form of assistance (orphans/ widows/old and sick people) in different socio economic activities (agriculture, building, wedding, etc.). Currently, Ubudehe concept is used to determine the nature and levels of poverty through categorization and a social mapping “stratification” system. The “Ubudehe” Socio-classifications are used for different programs aiming at accelerating community development.

In the pilot phase of implementing CBHI, indigents were not targeted thus creating a need for targeting them which was the main focus of the second phase. In 2010, when the CBHI used Ubudehe data for the first time, the population was categorized into 6 socio-economic classes: 1) Abject poverty; 2) Very poor;

3) Poor; 4) Resourceful poor, 5) food rich and 6) Money rich. The categorization in Ubudehe has been conducted 5 times: (2005-2006, 2007-2008, 2010, 2012 and 2015). The first four exercises had the same indicators while the last one (2015) considered only 4 categories.

Categorizing households into one of the six categories relied on two methods: Bottom up and Top Down. The Bottom Up method is where community members at village level map all existing households. They then identify the social category of each household in that village. Data about those who are really poor and rich is captured and if a household feels it has been wrongfully categorized, there is a redress mechanism in place. This categorization is often done during the Umuganda (community village work) which happens once every month.

The Top Down approach involves centralization of all data from cells, sectors, districts and provinces for subsequent submission to the centre. At the centre, quality data audit is conducted on all indicators across the country to ensure accuracy after which it is integrated into Ubudehe database for use by different programs. All these processes can take more than 6 months.

Criteria for categorizing households

Category	Description
Cat 1	HH has shelter insecurity and lacks basic necessities or is food insecure (<i>spare for children and eat in rotation</i>)
Cat 2	HH reduced quantity of food and HHM gets part time job (rural) HH reduced quantity of food (urban)
Cat 3	HH has sufficient food and has basic necessities or HHM is an ordinary employee or HHM has informal trade
Cat 4	HH member is employed at Management level or has big enterprise or consultancy or wholesaler, import and exports

Challenges

- Uncategorized people mainly in urban areas and township (internal migration)
- Unfair categorization (cases of some housekeepers), as they have periodic jobs and a higher rate of movement
- Households may be classified in a higher /lesser category because of lack of accurate measurement
- Uncertainty over lasting longer in a certain category
- Higher rate of shifting in category 1 and 2 as there are many programs which empower and improve the socio-economic status of poor households.

b) Experience of Save for Health Uganda (SHU) in enrolling low-income families in community health financing schemes

i) Intervention 1: A project to improve maternal and child health in Sheema District

Save for Health Uganda (SHU) implemented a three-year project in Sheema district aimed at increasing access to timely and quality maternal, child and reproductive health care services. The 2012 baseline showed that women who completed four ANC visits were only 47% and health facility delivery was 36.3% due to:

- Lack of funds to access the available quality healthcare;

- Long distances to quality healthcare service providers;
- Negative attitude towards maternal and child health and other healthcare services;
- Poor patient -centered care services.

SHU intended to address the financial barriers particularly lack of cash to pay medical bills. The project targeted women aged 14 – 49 years; 1,433 newborn babies and children below 1 year in 25 parishes. The intervention focused on pooling resources locally to enable all women aged 14-49 and children below 1 year to benefit from quality healthcare services regardless of the economic status.

Identification and enrolment of beneficiaries

All residents in the 25 parishes were registered in a census which captured their age, sex, income levels among others. The key findings of the census were:

- There were 21,663 women aged 15-49 years and 1,260 children aged 0-1 year
- Major source of income was from sale of matooke and coffee
- At a premium of UGX 10,000 per head for a year, about 50% of the population could not afford.
- At UGX 5,000 per head per year, about 30% said they could not afford.
- Up to about 40% of the population could not afford paying UGX 5,000 per head per year.

How the initiative was implemented

Basing on the study results, SHU determined a village premium and meetings were held with residents to explain the initiative. The village premium was divided among all households to determine a minimum to be contributed. Scheme leaders were responsible for collecting the premium and those identified as indigents were not asked to pay. All money collected from each village was pooled into one fund at parish level (scheme level). Households with target beneficiaries, whether paid up or not, received health care access cards.

Results after 3 years

- 15,076 women aged 14-49 years benefitted; only 5,641 of these were paid up in schemes – this shows that majority of beneficiaries had not paid.
- 1,123 infants benefitted.
- Proportion of pregnant women completing at least 4 ANC clinics increased from 47% in 2012 to 91.8% by 2015
- Institutional delivery increased from 36.3% in 2012 to 82.6% in 2015.

Challenges

- Some residents (between 5-10%) who could afford refused to pay premium.
- After 2 years, some beneficiaries stopped cooperating and participating in scheme activities which annoyed those who were paying premium.
- Non-beneficiaries (other population categories) felt left out e.g. the elderly and men.
- There was sabotage of the scheme by traditional birth attendants because utilization of their services by women was reducing.

ii) Intervention 2: Reducing financial barriers to utilizing quality health care services

- In the districts of Luwero, Nakaseke, Nakasongola, Masaka and Bushenyi, every household enrolling into a CHI scheme is required to pay a premium. However, the capacity of many families to pay premium is limited/low.
- SHU had to think about initiatives to enable low income earners enrol into schemes so that they don't sink further into poverty due to paying high medical bills.

Initiatives to ease premium payment by low income earners & informal sector

- The project focuses on a large number of people to keep the premium affordable (at least 350 people per scheme).
- Paying premium is done in instalments over a period of 3 months.
- Scheme members are linked to microfinance institutions for loans which are used as premium and these are in two categories; pure premium loans and premium loans linked to other loans.
- Village health saving and loan associations are currently integrating CHF into VSLA activities
- For employed members, premium is deducted from their salaries by employers

Challenges

- Some indigents lack collateral to access loans for income generating projects and premium e.g. animals, sales agreements, stocks (produce/merchandise)
- Intermittent income makes it difficult to continuously pay into Village Health Savings and Loan Associations (VHSLAs).
- Low levels of voluntarism of leaders who are supposed to collect money for premium from households.

Lesson learnt

- Linking premium payment to micro-financing institutions and VSLAs eases enrolment into the schemes.

c) How Uganda Revenue Authority targets the informal sector

Revenue mobilization is key to the growth and sustainability of developing countries' economies. The illicit financial flows in the informal sector which operate the "shadow economy", is a major hindrance to revenue mobilization. In Uganda the informal sector is relatively large estimated at 49 percent of GDP, yet it contributes minimally to revenue. The players in this field include: professionals, non-professionals, educated, none educated, multi sectoral in the economy-agriculture, wholesale and retail trade (drug shops, pharmacies, clinics, medical consultants, doctors, lawyers,). These are non registered businesses which predominantly use cash as opposed to traceable payment means. The players are nomadic in nature and do not have the desire to operate with the formal tax system.

In order to formalize the informal sector players, URA came up with a Tax Payer Register Expansion Program (TREP) in collaboration with Uganda Registration Services Bureau, Kampala Capital City Authority and the Ministry of Local Government. TREP involves opening up one stop shops for registration and tax education, and joint enforcement. Up to 9 one-stop shops were established in Kampala and 34 others in municipalities. Other components of the program include:

- Receipt Campaign
 - For accountability -Demand and Issue Proper Receipt/Invoices with TINs, quantity & amounts
 - Deal with only registered clients other than final consumers
- System Improvements.

- Online Registration, simplified self assessments & Payments (e.g. presumptive), objections
- Payments using Apps on Phones, Pay way etc
- Policy Improvements and adjustments
 - To encourage business f-W/Tax Exemptions, Deemed VAT on donor contracts, Outsourced Services etc. to encourage Business formalization
- Data analysis
 - backward and forward Linkages to identify and make compliance visits
- Stakeholder engagements with strategic Partners
 - Save for Health , NWSC, Kwagalana Group, OSSUP Coffee Dev. Authority, AUTO etc.
- Taxpayer education and Demos
 - Educate and demonstrate the HOW, WHEN, and WHY
- Publicity and awareness/Public Sensitizations
 - Talk Shows (Radio/TV) News Papers, Tax materials etc

This strategy can be tapped into for premium collection under CHF. This will require carrying out extensive tax and health insurance education.

"If everyone pays a little, then no one has to pay too much."

d) How world vision works with communities to improve health and education services

World Vision Uganda implements health programs that cover over 46 districts in the country. These programs are multisectoral in nature including education, health, livelihood and child protection

Entry into a district is based on needs assessment informed by national statistics especially on poverty indices. The choice of a Sub-county is based on required social services and priorities indicated in the district plans. World Vision conducts community needs assessment targeting women, men, children and community leaders. The needs assessments are carried out per sector i.e. agriculture, education and health using the social accountability approach referred to as citizen voice and action. They involve community education and sensitization on relevant sector policies, conducting community gatherings using a community scorecard, interface meetings for feedback and dialogue between the community and government leaders (duty bearers).

Results

- In Kole ditrict, Opeta Health Centre was upgraded from level II to level III. The community contributed local materials like bricks, sand, cement to construct the maternity ward.
- In Mpigi district, community members contributed sand, cement, bricks and labour to construct a maternity ward at Nindye Health Centre III.
- In Kiboga district, midwives were recruited at Nalinya Ndagire Health Centre III and education and child protection ordinance passed.
- In Kyankwanzi the community influenced policy and public health ordinance was passed.
- In Amuru, the community contributed land and labour for constructing a fence and a placenta pit at Otwe health centre
- At Myene Sub-county in Oyam district, World Vision bought an ambulance but the community contributes fuel and driver's salary.



Left: One of the health centres constructed; Right: ambulance for Myene sub-county

Other initiatives

- Linking communities to livelihood options through projects or government programs.
- Introduced Village Savings and Loan Associations to motivate and sustain the VHT.
- Advocacy for improved financing at district and national level.

Challenges

- Drawing action plans raises public expectation yet interventions are not immediate.
- Institutionalization of social accountability in government structures is difficult because leaders do not want to be held accountable and are reluctant to involve the public.
- Community based structures (CBOs) are limited in terms of scope and public policies
- Access to public information is difficult

e) Government policy proposals for reaching the poor and informal sector

The Uganda Vision 2040 and the National Development Plan recognize the role of social protection in wealth creation and inclusive growth. Social Protection is an important development strategy spearheaded by government to address risk and vulnerability, fight poverty, reduce inequality and promote inclusive economic growth. Its main purpose is to enhance the resilience and productive capacity of vulnerable persons for inclusive growth.

The National Social Protection Policy defines Social Protection as “**public and private interventions to address risks and vulnerabilities that expose individuals to income insecurity and social deprivation, leading to undignified lives**”. In the Ugandan context the social protection system comprises two pillars, namely: Social security and Social care and support services.

Social security focuses on protective and preventive interventions to mitigate factors that lead to income shocks & affect consumption and it has 2 components:

- i. **Direct income support** - non-contributory regular, predictable cash and in-kind transfers that provide relief from deprivation to the most vulnerable groups in society (e.g Senior Citizen grant, Disability Grant, Public Works Scheme)
- ii. **Social insurance** - contributory risk pooling arrangements that seek to mitigate livelihood risks & shocks arising from ill-health, retirement, disability (e.g. Public Service Pension Scheme, NSSF, health insurance , informal self help schemes)

Who are the indigents/informal sector workers?

- Indigents are those not registered in any of the categories of social insurance
- The informal sector are people working in firms not registered; these constitute 80% of firms and 92% of active working population.
- Income levels also substantially vary across these groups.

Targeting the informal sector

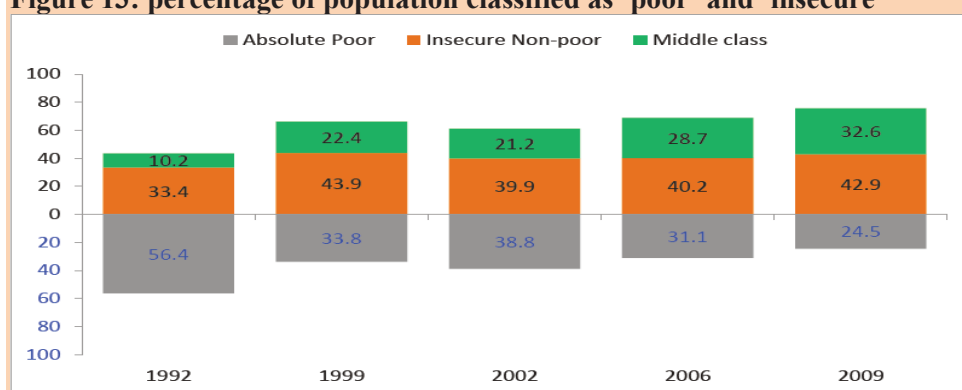
Risks in the informal sector include:

- Ill health, work-related hazards, exploitation and abuse, lack of access to finance and education/training, death and burial expenses, natural disasters and food insecurity.
- Children - especially orphans -, women - especially widows -, the elderly and people with disabilities are among the most vulnerable groups in Uganda.

Challenges of the informal sector:

- Limited financial capacity /fluctuation of incomes
- Low awareness and knowledge of Social Insurance
- Scattered nature and the difficulties faced in their identification;
- High mobility and dynamic/fluid nature;
- Precarious working conditions and the temporality of employment;
- General lack of skills and education;
- Distrust of formal institutions.

Figure 13: percentage of population classified as ‘poor’ and ‘insecure’



Source: MFPED 2012; Poverty Status Report Poverty Reduction and the National Development Process

What are the policy options?

The National Social Protection Policy proposes the following:

- Review existing formal social security schemes- gradually extending to informal sector.
- Design products for informal sector bearing in mind their most felt needs- e.g. medical, fluctuation of incomes.
- Integrate the senior citizens grant (SCG) with National Health Insurance Scheme.
- Provide Health insurance subsidies for categories of vulnerable groups e.g. the elderly, children, pregnant and lactating mothers- NOT indigents or poor.
- Pilot ‘health drives’ at SCG pay points to deliver NHIS package of services.
- Review Legislation to allow employers of informal sector to contribute to social security schemes.
- Advocacy and awareness raising, and community mobilisation .

Key issues Indigents and informal sector participation in UHI coverage

- Community structures can easily identify indigents for enrolment in programs.
- Government should subsidize the cost of managing CHI schemes in order to take care of the costs incurred by indigents in utilizing health care.
- Large family sizes especially those of indigents, high disease burden, poverty are compounding factors to enrolment of indigents.
- Enrolment and payment process must be made very easy e.g. using mobile phones, on-line registration, pay way, etc.
- Public education and demonstration of initiatives fosters compliance

3.2.4.1 Critical role of CHF/I in addressing enrolment of indigents and informal sector in UHI

Panel Discussion

Chair: Dr. Byamukama Agaba, District Health Officer, Nakasongola District

Panelists:

- * Ms. Cynthia Macharia, GIZ, Kenya;
- * Prof. Robert Basaza, Associate Dean, Institute of Public Health and Management, International Health Sciences University, Kampala



Left-right: Ms Cynthia Macharia, Prof. Robert Basaza and Dr. Byamukama Agaba

This panel crowned all deliberations during the conference. Discussants summed up the key issues for enrollment of indigents and informal sector who are the main target of CHF programs. The issues raised were:

- In order to address capacity needs of communities, it is essential to conduct a needs assessment to identify gaps in relation to management and capacity to run the CHI schemes. Consequently, Government and development partners should provide technical assistance through training and mentoring using dedicated technical staff.
- There is need for Government to provide additional finances to run the schemes and take care of the costs incurred by indigents in utilizing health care.
- Government should embrace simple technologies to effectively manage scheme resources as well as profiling its population with the view of creating socioeconomic strata and levying premiums and following up communities to assess the trends of service use. The data should also be used to profile indigents within the population.
- Identification of indigents should be a concerted effort between Government and local communities. Criteria should be set where local communities participate in identifying indigents.
- Collection of premiums using mobile phones on an incremental basis i.e. send whatever they have whenever it is available rather than walking to the scheme offices to remit their installments is a more cost effective management of the schemes and minimizes administrative overheads.
- There should be a pool of trained workers country wide who are dedicated to implement CHI schemes.
- There is need for administrative recognition of CHI and the law comes later.

4.0 Conference Declarations

4.1 Introduction

One of the conference objectives was to make declarations on how the current CHF initiatives can be strengthened to contribute to the achievement of UHI and eventually UHC. As such, participants made declarations that will be the milestones for assessing progress made by government in fast-tracking the proposed NHIS in view of the conference proceedings and based on the experiences of Tanzania, Kenya, Rwanda and other countries.

4.2 Declarations

We the participants of the **first National Community Health Financing Conference 2016 at Silver Springs Hotel Bugolobi, Kampala organized by** Save for Health Uganda in partnership with Bread for the World Germany; Ministry of Health, UCBHFA; Makerere University School of Public Health; Uganda Insurers Association; and Uganda Health Care Federation between **1st - 2nd December 2016**, hereby declare as follows:

1) Realizing that funding for health care has stagnated at about 8% of the national budget;

- a) We call upon Government to strengthen CHI as an integral part of the health care financing mechanism and provide financial support to the scheme;
- b) We urge the private sector, development partners and households to support funding of CHF scheme;

2) Cognizant of the fact that the current health system is more skewed towards curative health care services;

- a) We urge government to clearly earmark a budget line for delivery of cost effective preventive health care services;

3) Recognizing that the current free health care service delivery fostered by Government has serious limitations in addressing the health care needs of the population;

- a) We implore Government to introduce social marketing as one of the health care delivery models that serve different population segments with appropriate health care services;
- b) We further urge Government to make clear provisions for identification and enrolment of indigents into CHI schemes in order to have equitable health care services for the population;

4) Cognizant of the lack of explicit legislation to regulate Community Health Financing and the inherent contextual sociocultural and economic disparities in the diverse communities in Uganda;

- a) We implore Government to show its commitment by expediting the process of passing the NHI Bill into law in order to regulate CHI in the country while ensuring integration of other forms of health insurance;
- b) We further call upon Government to phase implementation of the NHI scheme within the premises of its financial implications;

5. Recognizing that there is low awareness of communities and decision makers about the merits of Community Health Financing in reducing out-of-pocket expenditures thus mitigating catastrophic health expenditures among the poor communities;

- a) We call upon Government and CSOs to design and operationalize a health insurance education strategy to raise awareness of all stakeholders on CHF as a way of increasing buy in, participation and enrolment
- b) We do call for combined efforts of the Government, bilateral and multilateral partners, civil society and the private sector to invest in action research on community health financing in order for the country, region and even beyond to understand what works, in what way and in what context.



A section of some of the conference participants



A participant makes a submission during plenary

5. Closing Ceremony

Representatives of key stakeholders including SHU, the Ministry of Health, the Parliamentary Committee on Health, and the Ministry of Gender, Labour and Social Development made remarks during the closing ceremony.

Dr. Sam Kamba who represented the Ministry of Health said the Ministry was championing the introduction of the national health insurance scheme as a way to address the inequities in service delivery and raise additional finances to support the health system. He reiterated the Ministry's commitment to ensure that CHI sector is vibrant and promised to work hand in hand with its promoters to strengthen it.



Dr. Sam Kamba

The SHU Executive Director, Mr Fredrick Makaire, thanked all participants for attending the conference, the first of its kind in Uganda. He highlighted the objectives which the conference was intended to achieve and noted that it was a great success considering the numerous categories of stakeholders who participated in it and congratulated all participants. He added that another aspect of success was the fact that participants were able to demonstrate why CHF should be an important component of the proposed NHIS. He promised to disseminate the conference report to all participants and key stakeholders in policy making as well as use the declarations to advocate for a legal framework for existing CHF initiatives. He pledged SHU's commitment to continue promoting CHF and promised to hold the second conference in 2017. He thanked partners and sponsors who made financial and other contributions towards the conference.



Mr. Fredrick Makaire

The Chairperson of the Parliamentary Committee on Health, Hon. Dr. Michael Iga Bukenya, observed that CHI caters for the average Ugandan in the village adding that many existing CHI schemes should be supported to expand so that policy makers who are still scared to start the national health insurance scheme can learn from them. He revealed that national health insurance was one of the top issues on their agenda as members of Parliament but they were being frustrated because they had not been given an opportunity to debate it. Dr. Bukenya observed that a contributory health insurance scheme will increase accountability and equity in health service delivery. He hinted on the possibility of introducing a health insurance bill in parliament as a private member's bill in case the Ministry of Health failed to do so.



Dr. Michael Bukenya

The Commissioner for Equity and Rights in the Ministry of Gender, Labour and Social Development, Mr Benard Mujuni, who officially closed the conference on behalf of the Permanent Secretary, said his Ministry was pushing for an enabling law which can make health insurance either contributory or compulsory and the attendant policy. He observed that CHI provides alternatives and increases financial inclusion and commended efforts to bring the informal sector into the formal arena. He said health insurance increases labour productivity and competitiveness and pledged to work with CHI promoters to push it forward.



Mr. Benard Mujuni



Mr. Ivan Busulwa from USAID Uganda Private Health Support Program makes a submission during a plenary session



The President of Munno mu Bulwade (CHI) Union of Schemes Organisation (MBUSO) speaks during plenary

Appendices

Conference organizing committee

#	Name	Organization	Position	Position on the committee
1	Mr. Makaire Fredrick	Save for Health Uganda	Executive Director	Conference Chair
2	Prof. Robert Basaza	Institute of Public Health and Management, IHSU	Prof/Associate Dean	Committee Chairman
3	Mr. Aliyi Walimbwa	Ministry of Health	Senior Health Planner	Ministry of Health representative
4	Ms Grace Ssali Kiwanuka	Uganda Healthcare Federation	Executive Director	Member
5	Mrs Juliet Nazibanja Kibirige	Save for Health Uganda	Programs Officer	Member in charge of programme
6	Ms. Asio Veronica	Save for Health Uganda	Finance and Administration Officer	Member in charge of budget
7	Mr. Eria Mugisa Kumaraki	Save for Health Uganda	Monitoring and Evaluation Officer	Member in charge of documentation
8	Mr. Kabaale Robert	Uganda Community Based Health Financing Association	Coordinator	UCBHFA representative
9	Ms. Nnamulondo Proscovia	Save for Health Uganda	Communication and Advocacy Officer	Secretary



The Germany Ambassador to Uganda Dr. Peter Blomeyer with representatives of conference hosts, partners and members of the organising committee.

Conference program

SAVE FOR HEALTH UGANDA

National Community Health Financing Conference 2016

Date: 1st - 2nd December 2016

Venue: Silver Springs Hotel Bugolobi, Kampala

THEME: Advancing Community Health Financing in achieving Universal Health Coverage

PROGRAMME

Agenda	Presenters	Time	Session Chair/ facilitator
Opening ceremony 8:30 – 10:00 AM	Opening 1) Uganda Anthem 2) East African Anthem 3) Prayer	10 Minutes	Prof. Robert Basaza, Associate Dean, Institute of Public Health and Management International Health Sciences University, Kampala (IHSU)
	Welcome remarks 1. Mr. Zakaria Muwanga Kasirye Chairperson of the Board, Save for Health Uganda (SHU) 2. Ms. Hellen Turyahabwa Chairperson, Uganda Community Based Health Financing Association (UCBHFA) 3. Ms. Yvonne Papendorf Program Officer for Uganda, Bread for the World - Protestant Development Services, Germany	15 Minutes	
	Official opening Guest of Honor H.E Peter Blomeyer Ambassador of Germany in Uganda	15 Minutes	
	Vote of thanks Prof. Robert Basaza, Chairman of the conference organizing committee	5 Minutes	
	Key note address <i>Advancing Community Health Financing in achieving Universal Health Coverage</i> Dr. Francis Runumi Independent Health Financing Specialist.	45 Minutes	
Tea break and visiting exhibition stalls (10:00 – 10:45 AM)			
Theme 1: Showcasing Uganda’s achievements and initiatives in community health financing			
Topics	Presentations	Time	Session Chair/ facilitator
Achievements of various initiatives in Uganda (10:45 – 11:55 AM) (Power Point Presentations)	Ms Juliet Nazibanja Kibirige Head of Programs, Save for Health Uganda. <i>SHU is an NGO promoting member managed and third party managed CHF schemes since 2002.</i>	10 Minutes	Mr. Fredrick Makaire Executive Director, Save for Health Uganda (SHU)
	Dr. Edwin Birungi Mutahunga Executive Director, Bwindi Community Hospital- Kanungu District <i>The hospital has been running a facility managed CHI scheme (e-quality) since 2011</i>	10 Minutes	

	Mr. James Mubangizi Scheme Manager, Happy Community Health Insurance scheme - Ntungamo District <i>The scheme has been running since 2008.</i>	10 Minutes	
	Dr. Elizabeth Ekirapa – Kiracho Lecturer, Department of Health Policy and Management, Makerere University School Of Public Health. <i>Makerere University has been implementing a maternal health financing project in Eastern Uganda.</i>	10 Minutes	
	Dr. Archibald N.S Bahizi Medical Superintendent, Rukunyu Health Centre IV, Kamwenge District. <i>The Health Centre together with diabetic patients established a Diabetes club in 2012 Through which care is financed.</i>	10 Minutes	
	Plenary discussion	20 Minutes	
Experiences of Health Care Providers working with Community Health Financing schemes in Uganda (11:55 – 12:35 PM) (Power Point Presentations)	Dr. Johnson Kabwishwa, District Health Officer, Sheema District and former Medical Superintendent Kitagata Government Hospital <i>The hospital has been serving CHI schemes since 2009.</i>	10 Minutes	Dr. Ronald Kasyaba Deputy Executive Director, Uganda Catholic Medical Bureau (UCMB)
	Mr. Moses Kintu Sekidde, Manager, Community Based Health Programs Kiwoko Hospital (Private not for Profit) <i>The hospital has been contracted and has served CHF schemes since 2000.</i>	10 Minutes	
	Plenary discussion	20 Minutes	
Current policy, legal and regulatory framework for Community Health Financing (12:35 – 1:20 PM) (Panel discussion)	Mr. Protazio Sande Ass. Director (Research and market development) Insurance Regulatory Authority of Uganda	45 Minutes	Ms. Grace Kiwanuka Ssali, Executive Director Uganda Healthcare Federation (UHF)
	Ms. Lydia Nabiryo Senior Program Officer Capacity building & Social Inclusion Expanding Social Protection Programme, Ministry of Gender, labor and social development, Uganda		
	Dr. Sarah Byakika Commissioner of Health Services (Planning), Ministry of Health, Uganda.		
Lunch break and visiting exhibition stalls (1:20 PM – 2:20 PM)			
Theme 2: Global and regional perspectives on the role of CHF in healthcare financing			
Global view points on healthcare financing of the people at the bottom of the pyramid. (2:20 – 3:20 PM) (Panel discussion)	Dr. Peter Okwero World Bank, Uganda	1 hour	Ms. Robinah Kaitiritimba, Executive Director, Uganda National Health Consumers Organization (UNHCO)
	Dr. Owembabazi Wilberforce USAID, Uganda		
	Ms. Cynthia Macharia GIZ, Kenya		
	Ms. Yvonne Papendorf Bread for the World, Germany.		
The East African experience on the role of community healthcare financing in	Pascal Birindabagabo Health Insurances Policies Specialist, Rwanda	10 Minutes	Mr. Opio Douglas, Deputy Executive Director,
	Dr. Amani Anaeli Senior Lecturer Department of Public Health Muhimbili University of Health and Allied Sciences.	10 Minutes	

broader healthcare financing (3:20 – 4:10 PM) (Power Point Presentations)	Tanzania		Federation of Uganda Employers (FUE)
	Mr. Stephen John Africa Director, Health Insurance Management Organization, Mbeya. Tanzania	10 Minutes	
	Plenary discussion	20 Minutes	
Tea break and visiting exhibition stalls (4:10 – 4:40 PM)			
Conclusions - Day one 4:40 – 5:30 PM	CHI Video Documentary	30 Minutes	Ms. Proscovia Nnamulondo, Communication and Advocacy Officer, Save for Health Uganda (SHU)
	Day one key messages	20 Minutes	Dr. Hizaamu Ramadhan Conference Rapporteur
End of day one			
DAY 2			
Theme 3: The proposed national health insurance scheme for Uganda and the envisaged role of community health financing /insurance			
Universal coverage and sustainable development goals (8:30 – 9:00 AM) (Power Point Presentation)	Dr. Juliet Evelyn Bataringaya Country Advisor - Health Systems Development World Health Organization, Uganda	20 Minutes	Dr. Charles Okiria, Senior Lecturer, Institute of Public Health and Management, International University of Health Sciences
	Reactions	10 Minutes	
How to achieve a fair National Health Insurance Scheme (NHIS) in Uganda, (9:00 – 10:00 AM) (Panel discussion)	Mr. Pascal Birindabagabo Health Insurances Policies Specialist, Rwanda	1 hour	Mr. Dennis Odwe, Executive Director, Action Group for Health human rights and HIV/AIDS Uganda (AGHA)
	Mr. Tom Aliti Assistant Commissioner of health Services (Planning) Ministry of Health, Uganda (MOH)		
	Mr. Fredrick Makaire, Executive Director Save for Health Uganda (SHU)		
	Ms. Hannah Baldwin Technical Advisor, Program for Accessible Communication and Education (PACE)		
	Ms. Grace Kiwanuka Ssali, Executive Director Uganda Healthcare Federation (UHF)		
	Ms. Allana Kembabazi Head, Health Rights Program Initiatives for Social and Economic Rights (ISER)		
Tea break and visiting exhibition stalls (10:00 – 10:45 AM)			
How Community	Dr. Amani Anacli	1 hour	Dr. Sebastian

Health Financing /Insurance can operate in synergy with NHIS based on local and international experience: (10:45 – 11:45 AM) (Panel discussion)	Senior Lecturer Department of Public Health Muhimbili University of Health and Allied Sciences, Tanzania Mr. Pascal Birindabagabo Health Insurances Policies Specialist, Rwanda Mr. Robert Kabaale National Coordinator, Uganda Community Based Health Financing Association (UCBHFA) Prof. Robert Basaza, Associate Dean, Institute of Public Health and Management International Health Sciences University, Kampala. Mr. Aliyi Walimbwa, Senior Health Planner, Ministry of Health, Uganda.		Baine, Senior Lecturer Department of Public Health Makerere University
How to scale up Community Health Financing/ insurance to reach the entire population in Uganda? (11:45 – 1:00 PM) (Panel discussion)	Dr. Ronald Kasyaba Deputy Executive Director, Uganda Catholic Medical Bureau, Member of Uganda Community Based Health Financing Association. Mr. Protazio Sande Ass. Director (Research and market development) Insurance Regulatory Authority of Uganda Ms. Martha Aheebwa Life and Pensions, Uganda Insurers’ Association. Dr. Aloysius Ssenyonjo Study coordinator, Supporting Policy Engagement for Evidence-based Decisions (SPEED) project. Makerere University School of Public Health Mr. Patrick Ayota Chief Finance Officer National Social Security Fund Dr. Sarah Byakika Commissioner of health Services (Planning) Ministry of Health, Uganda.	1 hour 15 Minutes	Dr. Elizabeth Ekirapa – Kiracho Lecturer, Department of Health Policy and Management, Makerere University School Of Public Health.
Lunch break and visiting exhibition stalls (1:00 PM – 2:00 PM)			
Theme 4: Indigents and informal sector participation in universal health insurance coverage			
How to identify and enroll Indigents and informal sector participation in universal health insurance (2:00 – 3:10 PM) (Power Point Presentations)	Mr. Pascal Birindabagabo Health Insurances Policies Specialist, Rwanda	10 Minutes	Dr. Owembabazi Wilberforce PMS – Health systems strengthening, Office of health and HIV USAID, Uganda
	Mr. Patrick Opolot A. Supervisor, Service Management Domestic Taxes Uganda Revenue Authorities	10 Minutes	
	Ms. Proscovia Nnamulondo Communication and Advocacy Officer Save for health Uganda.	10 Minutes	
	Ms. Esther Agali Naasihye Policy and campaigns Coordinator, World Vision Uganda	10 Minutes	
	Ms. Beatrice Okillan Coordinator, Policy and Advocacy, Expanding Social Protection Programme Ministry of Gender, Labour, and Social Development	10 Minutes	

	Reactions	20 Minutes	
Critical role of CHF/I in addressing enrollment of indigents and informal sector in UHI (3:10 – 3:50 PM) (Panel discussion)	Ms. Cynthia Macharia GIZ, Kenya	40 Minutes	Dr. Agaba Byamukama DHO Nakasongola
	Mr. Kirigwajjo Moses Program Officer Uganda National Health Consumers’ Organization (UNHCO)		
	Prof. Robert Basaza Associate Dean, Institute of Public Health and Management International Health Sciences University, Kampala.		
Closing ceremony (3:50 – 4:30 PM)	Conference declarations and way forward Dr. Hizaamu Ramadhan Conference Rapporteur	40 Minutes	Prof. Robert Basaza, Associate Dean, Institute of Public Health and Management International Health Sciences University, Kampala.
	Closing remarks - Mr. Fredrick Makaire Executive Director, Save for Health Uganda (SHU) - Ms. Yvonne Papendorf Bread for the World - Protestant ‘ Development Service, Germany - Dr. Sarah Byakika Commissioner of Health Services (Planning), Ministry of Health, Uganda. - Hon. Julius Ochen Shadow Health Minister - Hon. Dr. Michael Yiga Bukenya Chairperson, Parliamentary Committee on Health		
	Official closure Guest Mr. Pius Bigirimana Permanent Secretary, Ministry of Gender, Labour, and Social Development.		
	Evening tea and departure		

- END -

List of participants

	Name	Organization	Position	Country
1.	H. E Peter Blomeyer	Embassy of Germany in Uganda VI	Ambassador	Uganda
2.	Ms. Yvonne Papendorf	Bread for the World	Program Officer	Germany
3.	Mr. Benard Mujuni	Ministry of Gender, Labour, and Social Development	Commissioner for Equity and Rights	Uganda
4.	Mr. Zakaria Muwanga Kasirye	Save for Health Uganda	Chairperson Board of Directors	Uganda
5.	Mr. Makaire Fredrick	Save for Health Uganda	Executive Director and Conference Chair	Uganda
6.	Dr. Francis Runumi	-	Independent Health Financing Specialist	Ugandan
7.	Ms. Christine Makobole	Uganda community based Health Financing association	Member, Board of Directors	Uganda
8.	Prof. Robert Basaza	International Health Science University	Associate Dean	Uganda
9.	Hon. Dr. Michael Yiga Bukenya	Parliament	Chairperson, Parliamentary Committee on Health	Uganda
10.	Dr. Sam Kamba	Ministry of Health	Senior Health Planner	Uganda
11.	Dr. Juliet Evelyn Bataringaya	World Health Organization	Country Advisor - Health Systems Development	Uganda
12.	Mr. Aliyi Walimbwa,	Ministry of Health	Senior Health Planner	Uganda
13.	Ms. Hannah Baldwin	Program for Accessible Communication and Education (PACE)	Technical Advisor	Uganda
14.	Mr. Pascal Birindabagabo	Ministry of Health	Health Insurances Policies Specialist	Rwanda
15.	Dr. Cynthia Macharia	GIZ Kenya	Healthcare Financing Component	Kenya
16.	Mr. Wilson Wahome	AFYA YETU Initiative		Kenya
17.	Mr. Charles Maina	AFYA YETU Initiative		Kenya
18.	Dr. Owembabazi Wilberforce	U.S. Agency for International Development	PMS – Health systems strengthening	Uganda
19.	Dr. Sebastian Olikira Baine	Makerere University School of Public Health	Head, HPPM Department	Uganda
20.	Dr. Amani Anaali	Muhimbili University of Health and Allied Sciences, Tanzania	Senior Lecturer, Department of Public Health	Tanzania
21.	Mr. Stephen John Africa	Health Insurance Management Organization, Mbeya.	Director	Tanzania
22.	Dr. Ronald Kasyaba	Uganda Catholic Medical Bureau	Deputy Executive Director	Uganda
23.	Dr. Byamukama Agaba	Nakasongola District Local Government	District Health Officer	Uganda
24.	Ms. Robinah Kaitiritimba	Uganda National Health Consumers Organization	Executive Director	Ugandan
25.	Ms. Grace Kiwanuka Ssali,	Uganda Healthcare Federation	Executive Director	Uganda
26.	Dr. Elizabeth Ekirapa – Kiracho	Makerere University School Of Public Health	Lecturer, Department of Health Policy and Management	Uganda

	Name	Organization	Position	Country
27.	Dr. Archibald N.S Bahizi	Rukunyu Health Centre IV, Kamwenge District	Medical Superintendent,	Uganda
28.	Dr. Edwin Birungi Mutahunga	Bwindi Community Hospital- Kanungu District	Executive Director	Uganda
29.	Mr. Dennis Odwe,	Action Group for Health human rights and HIV/AIDS Uganda	Executive Director	Uganda
30.	Mr. Robert Kabaale	Uganda Community Based Health Financing Association	National Coordinator,	Uganda
31.	Dr. Aloysius Ssenyonjo	Makerere school of Public Health	Study coordinator, (SPEED) project	Uganda
32.	Ms. Allana Kembabazi	Initiatives for Social and Economic Rights	Head, Health Rights Program	Uganda
33.	Ms Juliet Nazibanja Kibirige	Save for Health Uganda.	Head of Programs	Uganda
34.	Dr. Hizaamu Ramadhan	HIPO-Africa	Executive director	Uganda
35.	Mr. Patrick Opolot A.	Uganda Revenue Authorities	Supervisor, Service Management, Domestic Taxes	Uganda
36.	Ms. Proscovia Nnamulondo	Save for health Uganda	Communication and Advocacy Officer	Uganda
37.	Ms. Lydia Nabiryo	Expanding Social Protection Programme, Ministry of Gender, Labor and Social Development	Senior Program Officer Capacity building & Social Inclusion	Uganda
38.	Sr. Ernestine Akulu	Bishop Caesar Asili hospital	Administrator	Uganda
39.	Mr. James Mubangizi	Happy Community Health Insurance scheme - Ntungamo District	Scheme Manager	Uganda
40.	Mr. Moses Kintu Sekidde	Kiwoko Hospital	Manager, Community Based Health Programs	Uganda
41.	Mr. Mugisa Eria Kumaraki	Save for Health Uganda	Monitoring and evaluation officer	Uganda
42.	Mr. Bazaarwa David	Franciscan HCIV Kakooge	Accountant	Uganda
43.	Ms. Asio Veronica	Save for Health Uganda	Finance and administrative officer	Uganda
44.	Ms. Nakato Proscovia	Kitovu Hospital	For Administrator	Uganda
45.	Dr. Matene Chris	Mitooma District Local Government	District Health Officer	Uganda
46.	Mr. Nelson Ariiho	Laura H/CIII, Kitabi	In-charge	Uganda
47.	Dr. Wilson Mubiru	Mubende District Local Government	District Health Officer	Uganda
48.	Ms. Winnie Lubega		Independent consultant	Uganda
49.	Dr Fiona Asimwe	Kitagata Hospital	Medical superintendent	Uganda
50.	Mr. Asaph Mwesigye	Ishaka Adventist Hospital		Uganda
51.	Sr Mary Cabrin Nakirijja	Naluggi HCIII	In-charge	Uganda
52.	Sr Blandinah Mbabazi	St Gabriel Mirembe Maria	In-charge	Uganda

	Name	Organization	Position	Country
		HCIH		
53.	Mr Aryatunga Brian Kanyonyozi	Bwindi Community Hospital		Uganda
54.	Ms. Annet Nassaka	St Francis HCIV-Mityana		Uganda
55.	Ms. Aminah Naiga	-	Assistant Rapporteur	Uganda
56.	Mr. Opio Douglas	Federation of Uganda Employers	Deputy Executive Director	Uganda
57.	Mr. Claudius Rutaraka	Luwero NGO Forum	Coordinator	Uganda
58.	Mr. Kenneth Waiswa	Save for Health Uganda	Project Coordinator	Uganda
59.	Mr Atamba Eddie	Western Ankole Civil Society Organizations Forum	Program Assistant	Uganda
60.	Mr. Ntumwa Matovu	Nakaseke Hospital	Hospital Administrator	Uganda
61.	Mr. Bernard Mwijukye	Western Ankore Tweragurize Schemes Association	President	Uganda
62.	Mr. Andrew Lubega	Kiwoko Hospital	Financial accountant	Uganda
63.	Mr. Kiddu Ernest	Save for Health Uganda	Board Treasurer	Uganda
64.	Dr. Edward Mwesigye	Bushenyi District Local Government	District Health Officer	Uganda
65.	Ms. Eve Jagusiewicz	-	Independent Consultant	Britain
66.	Mr. Friday Moses	Western Ankore Tweragurize Schemes Association	Team leader	Uganda
67.	Mr. Peter Kintu	Munno Mu Bulwade Union of Schemes Organisation	President	Uganda
68.	Mr. Kitenda Samuel	Munno Mu Bulwade Union of Schemes Organisation	Union Technical Manager	Uganda
69.	Mr. Masembe Esau	Mubende Schemes Cooperation Mechanism	Chairperson	Uganda
70.	Mr. Ssemiyingo Fred	Mubende Schemes Cooperation Mechanism	Coordinator	Uganda
71.	Mr. Twijukye Augustine	Bitooma HCIH	In-charge	Uganda
72.	Mr. Ivan Busulwa	USAID/Uganda Private Health Support Program	Private Sector Advisor and Team Lead	Uganda
73.	Ms. Joy Batusa	USAID/Uganda Private Health Support Program	Deputy Chief of Party	Uganda
74.	Mr. Paul Mukungu Ssenyonga	Luwero Town Council	Mayor	Uganda
75.	Ms. Esther Nasikye	World Vision Uganda	Communication and Campaigns Coordinator	Uganda
76.	Ms. Nansubuga Dorothy	Save for Health Uganda	Senior field officer,	Uganda
77.	Mr. Wilfred Mujuni	Save for Health Uganda	Field officer	Uganda
78.	Ms. Josephine Namugenyi	Save for Health Uganda	Office Administrator,	Uganda
79.	Ms. Aminah Nababi	Save for Health Uganda	Officer Administrator	Uganda
80.	Mr. Badru Ssekyanzi	Save for Health Uganda	Driver	Uganda
81.	Mr. Samuel Oromchan	Save for Health Uganda	Driver	Uganda
82.	Ms Purity Njagi	Smart applications Uganda	Customer Marketing Manager	Uganda
83.	Mr. Mugoya Judy	Smart Applications Uganda	Country Manager	Uganda
84.	Dr. Edward Kalyesubula	Access Dental Care	Director	Uganda
85.	Mr. Danson Mivule	Kampala Development	Director	Uganda

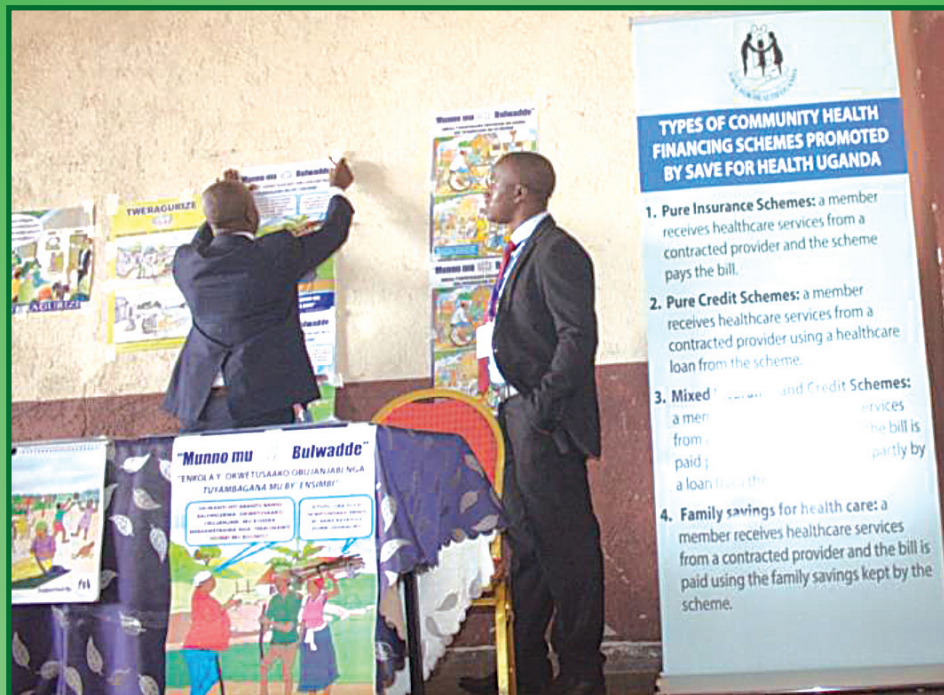
	Name	Organization	Position	Country
		Cooperative Society (KADCOS)		
86.	Mr. David Ogubi	International Health Science University	Student	Uganda
87.	Dr. John Charles Okiria	International Health Science University	Lecturer	Uganda
88.	Mr. Mawejje William		AEA	Uganda
89.	Mr. Isiah Bagyenzi	Ishaka Adventist Hospital	Accountant	Uganda
90.	Ms Justine Muwanga	Kitokolo HC II		Uganda
91.	Mr. Amon Najjuka	Hope Medical Centre	In-charge	Uganda
92.	Dr. Nandugwa Rehemah	Parliament	Personal Assistant to Hon Najuma Sarah Nakaseke District Woman MP	Uganda
93.	Ms. Beatrice Okillan	Expanding Social Protection Programme, Ministry of Gender, Labor and Social Development	Coordinator Policy and Advocacy	Uganda
94.	Ms. Arinaitwe Charity	Uganda Revenue authority	Officer Service Management	Uganda
95.	Mr. Epiaka Charlotte	Uganda Revenue authority	Officer Service Management	Uganda
96.	Dr. Tonny Twesigye	Uganda protestant Medical Bureau	Executive Director	Uganda
97.	Mr. Wagaba S	Health Partners	Partnership coordinator	Uganda
98.	Mr. Ben. Bataringaya	Covoid	Executive Director	Uganda
99.	Mr. Nicholas Lutakome	Sanlam Life Insurance (U) Limited	Head of Corporate Relationships	
100.	Ms. Maria Kyomugisha	WBS TV	Photographer	Uganda
101.	Mr. Steven Mwiri	WBS TV	Videographer	Uganda
102.	Ms Dinnah Kakande	Masaka District Local Government	Health Educator	Uganda
103.	Dr. Atwijuka Balaam Nkunda	Kitagata Hospital	Medical Officer	Uganda
104.	Mr. Stephen Omojong	National Social Security Fund	Product Development Manager	Uganda
105.	Ms Nakuti Adian	UBC TV	Reporter	Uganda
106.	Ms. Kimono Dorcas	UBC TV	Reporter	Uganda
107.	Mr. Mike Sebalu	Radio One	Reporter	Uganda
108.	Mr. Kisige Abou	New Vision	Reporter/ News Anchor	Uganda
109.	Ms. Nakirigya	Daily Monitor	Reporter	Uganda



Plenary session



Plenary session



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