



SECOND NATIONAL CHF CONFERENCE REPORT

1st-2nd
NOVEMBER
2017

IMPERIAL ROYALE HOTEL, KAMPALA



THEME

Building informal sector capacity to access the National Health Insurance Scheme for inclusive growth



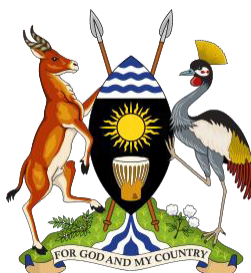
IMPERIAL ROYALE HOTEL, KAMPALA

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Acronyms

ACHEST -	African Centre for Global Health and Social Transformation
CBHI	Community Based Health Insurance
CHF	Community Health Financing
CHI	Community Health Insurance
CSO	Civil Society Organisation
DRDs	Diagnostic Related Diseases
ICOB	Integrated Community Based Initiatives
ISER	Initiative for Social and Economic Rights
MoGLSD	Ministry of Gender, Labour and Social Development
MoH	Ministry of Health
NHIS	National Health Insurance Scheme
NSSF	National Social Security Fund
NPA	National Planning Authority
NSPP	National Social Protection Policy
PHC	Primary Health Care
PWDs	Persons with Disabilities
RAMA	La Rwandaise d'Assurance Maladie
RSSB	Rwanda Social Security Bureau
SHU	Save for Health Uganda
UCBHFA	Uganda Community-Based Health Financing Association
UHF	Uganda Healthcare Federation
USAID	United States Agency for International Development
WHO	World Health organization

Acknowledgement

The second National Community Health Financing conference in Uganda was such a great success that surpassed the expectations of many, including us the organizers. More than 80 percent of participants were seated in the conference hall by 9:00am on the first day. The level of enthusiasm exhibited by participants from all sectors was indeed remarkable.

I, therefore, take this opportunity to thank all our partners for the various forms of contributions made towards the success of the conference. We are very grateful to Bread for the World, Ministry of Health, Ministry of Gender, Labour and Social Development, PATH/Advocacy for Better Health, Smart Applications International (U) Limited, Uganda Community Based Health Financing Association and Uganda Healthcare Federation.



Mr. Makaire Fredrick

My sincere appreciation goes to the Guest of Honour, Hon. Dr. Joyce Moriku Kaducu, the State Minister for Primary Healthcare, who officially opened the conference, and Mr. James Ebitu, the Director for Social Protection in the Ministry of Gender, Labour and Social Development, who presided over the closing ceremony. Their commitment to supporting the introduction of a national health insurance scheme that covers every resident of Uganda without discrimination was a great inspiration to participants.

The rich experiences and great insights shared at the conference were fruits of efforts of special resourceful persons I must appreciate: Mr. Michael J. McCord, the President of the Micro Insurance Centre in the United States of America, Prof. Francis Omaswa, the Executive Director of African Centre for Global Health and Social Transformation, Dr. Wilberforce Kisamba Mugerwa, the Chairman of the National Planning Authority, and Dr. Specioza Wandira Kazibwe, the Senior Presidential Advisor on Health and Population and former Vice President, together with other presenters and panelists.

I am very grateful to the organizations and individuals that volunteered time, resources and knowledge to be a part of the organizing committee. We shall always be proud of you and share with you the fruits of your great contributions at all times.

Thank you so much.

Makaire Fredrick

Executive Director

Save for Health Uganda

1.0 Introduction

The Second National Community Health Financing Conference, hosted by Save for Health Uganda (SHU) and supported by Bread for the World together with other partners, was a follow-up on the first one held in December 2016. The first conference successfully brought to the limelight the Community Health Financing (CHF) schemes which include Community Health Insurance (CHI) schemes that have been operating in Uganda since 1996.

The second conference held on 1st-2nd November 2017 at Imperial Royale Hotel, Kampala, aimed at mobilizing support for CHF initiatives to enhance their capacity and contribute to achieving a fair National Health Insurance scheme (NHIS) for Uganda.

The conference specific objectives were:

1. To assess the nature of the informal sector in Uganda with a specific focus on capacity to contribute for the NHIS;
2. To review access to health insurance by the informal sector and disadvantaged groups in Uganda;
3. To present and discuss the current status of the NHIS and the implementation framework;
4. To assess how inclusiveness can be promoted in the proposed implementation framework of the NHIS.

1.1 Context

The Government of Uganda has been planning to introduce a National Health Insurance Scheme (NHIS) for quite some time. In April 2017, a Certificate of Financial Implications was issued, clearing the way for the Ministry of Health to present the NHIS Bill to Parliament for passing into law. Under the proposed NHIS, CHI is envisaged to cover most of the informal sector which constitutes more than 80% of the country's working population.

However, there are still critical challenges facing Uganda's healthcare system where:

- more than 20% of the population live below the poverty line
- out-of-pocket expenditure is over 40% way above 15% recommended by World Health Organization (WHO)
- informal sector forms a huge section of the population, majority of whom are vulnerable to numerous shocks including those affecting their health
- Low knowledge levels regarding health insurance

These and other critical gaps in policy, financing, management and implementation of the NHIS in Uganda formed the basis for the Theme of the Second National Community Health Financing Conference: **'Building Informal Sector Capacity to Access the National Health Insurance Scheme for Inclusive Growth'**.

2.0 Opening ceremony

2.1 Welcome remarks

The Chairperson of the Board of Directors, Save for Health Uganda (SHU), Mr. Zakaria Muwanga Kasirye, together with the Executive Director, SHU, Mr. Fredrick Makaire with great pleasure welcomed the participants to the 2nd National Community Health Financing Conference in Uganda. Mr. Makaire introduced to participants the theme, sub-themes and objectives of the conference. He informed participants that this year's conference focus was on the informal sector which constitutes a huge section of Uganda's population, majority of which are vulnerable to numerous shocks including those affecting their health.



Mr. Zakaria Muwanga Kasirye

Mr. Kasirye was extremely happy that the promise to make the CHF conference an annual event had been achieved. He said their plan was *not* to make the conference a routine activity for the sake of meeting, but to challenge everybody to think critically about mitigating the plight many people face when illness strikes and whose consequences are common knowledge.

Together, they resonated that participants were invited at the second conference to once again share knowledge, experience and ideas on reducing the financial hardships faced by many Ugandans in accessing healthcare.

Mr. Kasirye reminded participants of results of the Uganda National Household Survey 2016/17 conducted by Uganda Bureau of Statistics which showed that poverty levels were going up again and wondered whether the nature of the country's healthcare system was a contributing factor to this undesirable situation. Participants were challenged to devise ways to ensure that accessing healthcare enhances people's health, without stressing them in other areas of life. Their conviction was that the conference would generate views, comments, evidence and proposals that would benefit both the government and all other stakeholders in checking impoverishing healthcare expenditures.

He re-affirmed SHU's commitment to work with government and all stakeholders to ensure that every resident in Uganda is given an opportunity to participate and benefit from the proposed NHIS.

He was extremely grateful to Bread for the World for sponsoring the conference. He also thanked all other partners who supported the event.

Finally, on behalf of the conference organizers and sponsors, he extended his most heartfelt thanks to everyone for honoring the invitation and wished them most fruitful deliberations.

2.2 Opening remarks

The State Minister for Primary Health Care, Hon. Dr. Joyce Moriku Kaducu, officially opened the Conference on 1st November, 2017. She welcomed all participants and extended special thanks to the organizers whose unwavering commitment made it possible to hold the second national CHF conference.

She expressed her utmost pleasure of being associated with the conference organized to discuss the future of the informal sector and enhance the capacity of community health financing initiatives in order to contribute to achieving an effective national health insurance scheme for Uganda. She viewed the conference as a great opportunity for building meaningful coalitions to support the informal sector to access the national health insurance scheme.

She praised the timeliness and relevance of the conference given the host of challenges facing Uganda's health sector namely:

- low uptake of community health insurance especially among low income population
- out-of-pocket expenditure is over 40% way above 15% recommended by WHO
- over 27% of Uganda's population live below the poverty line
- wide spread lack of knowledge and associated misconceptions about health insurance

She informed the conference that under the second National Development Plan, government continues to propel the country towards middle income status through strengthening competitiveness for sustainable wealth creation, employment and inclusive growth. She relayed good news that the government remains focused on writing good policies and building a strong regulatory environment to lead the nation in a transformation process in order to achieve the shared goals. However, she acknowledged weaknesses in implementing the smart objectives and policies.

The Minister was optimistic that with the NHIS cabinet memo in place, NHIS roadmap and the direction presented in parliament early July, 2017, government was moving in the right direction. She appealed for continued collective responsibility from all sectors, individuals and well-wishers in harnessing resources, ideas and scaling up the NHIS for the good of all people and the country.

She looked forward to concrete decisions and credible recommendations by participants that a country can adopt in advancing community health financing to ensure that the informal sector accesses the NHIS for inclusive growth.

The opening ceremony was graced by the Senior Presidential Advisor on Health and Population and former Vice President, Dr. Specioza Wandira Kazibwe, and Dr. Olaro Charles, Director Clinical Services in the Ministry of Health (MoH). Dr. Kazibwe, who fully attended the conference, emphasized that health should not be regarded as a consumptive sector but rather an investment for national development. She underscored the importance of health insurance in improving



Hon. Dr. Joyce Moriku Kaducu and Dr. Olaro Charles



Dr. Specioza Wandira Kazibwe

the general wellbeing of ordinary people. She added that education and health are the two sectors for equalizing opportunities for all citizens.

On his part, Dr. Olaro appreciated the CHF initiatives in the country which he said the Ministry of Health will learn from in implementing the NHIS. He emphasized the need for a strong accountability framework that will enable people to access the services they need when the NHIS is introduced. He noted that universal healthcare cannot be achieved if the informal sector, which forms the biggest part of the population, is left behind.



Some of the conference participants

3.0 Conference proceedings

3.1 Keynote address

Session Chair: Dr. Ronald Kasyaba, Assistant Executive Secretary, Uganda Catholic Medical Bureau

Key note Speakers: 1. Prof Francis Omaswa, Executive Director, African Centre for Global Health and Social Transformation (ACHEST)

2. Mr. Michael J. McCord, Managing Director, MicroInsurance Centre at Milliman, United States of America



Prof. Francis Omaswa

The keynote speaker, Prof. Omaswa, focused on the relationship between poor health and poverty, and explored the concept and vision of universal health coverage (UHC).

He recounted the health and poverty relationship based on poverty assessments in Uganda where 67% of participants said poor health and disease were the main causes of poverty and an equal percentage said the consequences of their poverty would be poor health and diseases. He further affirmed it using global statistics where Africans who are about 12% of the global population carry 25% of the global disease burden but only spend 1% of global expenditure on health. He emphasized that good health remains the most powerful way of fighting poverty.

Prof. Omaswa stressed that it is critical to develop an opinion at community and country levels which perceives this vision in order to render support to what CHF promoters are trying to solve through initiatives like this conference. He reiterated that investing in health is one of the most powerful ways of getting a productive human resource for development. He assured conference participants that this was the only way to get out of a situation where people blame fate for preventable child and maternal deaths, when actually the people have collectively failed the health system to save lives.

On the way forward, Prof. Omaswa enumerated what is needed to achieve UHC as:

- Political commitment on health as a social goal
- Strong societal values of equity, transparency and accountability
- Political participation and community engagement
- Investing in primary healthcare and community based services

He appealed for strong leadership to strengthen health promotion and provision of the minimum level of healthcare services, strong and well governed institutions at all levels of society informed by evidence from locally driven research. He asserted that the achievement of UHC requires concerted efforts of all stakeholders to address the aspirations of the most vulnerable people and strengthen key institutions in order to cause change of the current health situation in Uganda.

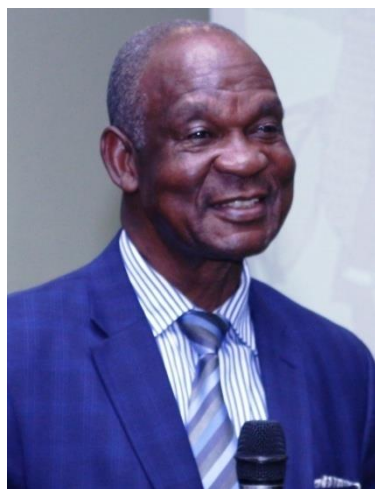
Mr. Michael J. McCord emphasized the importance of health insurance to low income families which often fall back into poverty due to healthcare shocks. He said there cannot be sustainable development without good health insurance. He pointed out that partnerships between the government, the private sector and community health insurance schemes can create a successful and sustainable health insurance system for people to attain good health.



Mr. Michael J. McCord

3.1.1 Discussant of Keynote addresses

Dr. Kisamba Mugerwa, Chairperson, National Planning Authority, Kampala, Uganda



Dr. Wilberforce Kisamba Mugerwa

Dr. Kisamba Mugerwa focused on failure to implement health insurance as an aspect of social transformation in development, challenges of the informal sector and requirements to attain good health in the country. He informed participants that Uganda Vision 2040 is a documentation of the expressed development aspirations of the people of Uganda, in which it was identified that attaining universal health coverage is one of the key drivers in realizing its objectives.

However, he noted that because of budgetary constraints, it is not always possible to cover health services as it would have been required. He said the practice should have been to ensure that the funds released are spent on what they are meant for. He asserted that, in most cases, there has been a mismatch between the way funds are allocated and utilized in regard to set priorities in the National Development Plan (NDP).

He viewed health insurance as an element of social transformation in development which government alone is unable to undertake. This is why public and private sectors as well as civil society organizations (CSOs) have to work together with government.

Turning to the informal sector, Dr. Kisamba-Mugerwa enlisted some of the key challenges: the sector is not structured, not properly organized and is not well known. Efforts have not been made by regulatory bodies to ascertain what constitutes the informal sector. Ironically, though most people in the informal sector are not in the tax bracket, quite a number earn more than those in the formal sector.

He pointed out that when the informal sector starts organizing itself in different schemes of insurance, they get into problems such as costly mobilization, low solidarity and rigidity in the design of insurance schemes, as well as lack of trust as some promoters embezzle premiums.

Dr. Kisamba Mugerwa submitted that to attain good health in Uganda, the country needs to:

- build strong institutions, not merely organizations, as well as norms, values, laws and people;
- work on peoples' knowledge and mindset to promote professional behavior in these undertakings;
- empower people to access factors of production (land and capital) and access credit to increase production and productivity, as well as have disposable income in order to look after their health and contribute to insurance schemes;
- structure the informal sector to be able to collaborate in a meaningful manner.

3.2 Thematic Presentations and discussions

3.2.1 Sub-theme: Status and Implementation Framework for NHIS

Session Chair: Mr. Benard Mujuni, Commissioner Equity and Rights, Directorate of Social Protection, Ministry of Gender, Labour and Social Development (MGLSD)

Presenter: Mr. Aliyi Walimbwa, Senior Health Planner, MoH

This session was intended to update participants on the status of the NHIS Bill, which is anticipated to provide a legal framework for the operations of CHF schemes, and show the linkage between the NHIS and other forms of health insurance.

Mr. Walimbwa recounted the purpose and objectives of the NHIS. He said the purpose of the NHIS is: *To ensure financial access to affordable, equitable and quality healthcare services progressively to all residents in an efficient manner.*

He then listed and clarified each specific objective of NHIS:

- a) *facilitate the provision of efficient, equitable, accessible, affordable and quality health care to the beneficiaries of the Scheme.* The focus here is on governance, regulatory frameworks, institutional arrangements as well as financial and service delivery systems.
- b) *develop health insurance as a complementary mechanism of health care financing in Uganda;* This mainly concerns pooling ample resources that ensure adequate financing of health service packages.
- c) *ensure the quality and equity of health care, the appropriate utilization of services and patient satisfaction in the provision of health care;* This objective is directed at access and quality of health service. While currently one can come from any part of the country and go to Mulago Referral hospital and get services, under Health Insurance it is the card that will guide patients where to get health services through the referral system.
- d) *encourage private sector participation in the provision of health care services.* Under NHIS, the public and private sectors are expected to be the key service providers.
- e) *provide health care services to the indigents.* This is in pursuance of equity considerations by targeting the disadvantaged to ensure that everyone has access to health services.

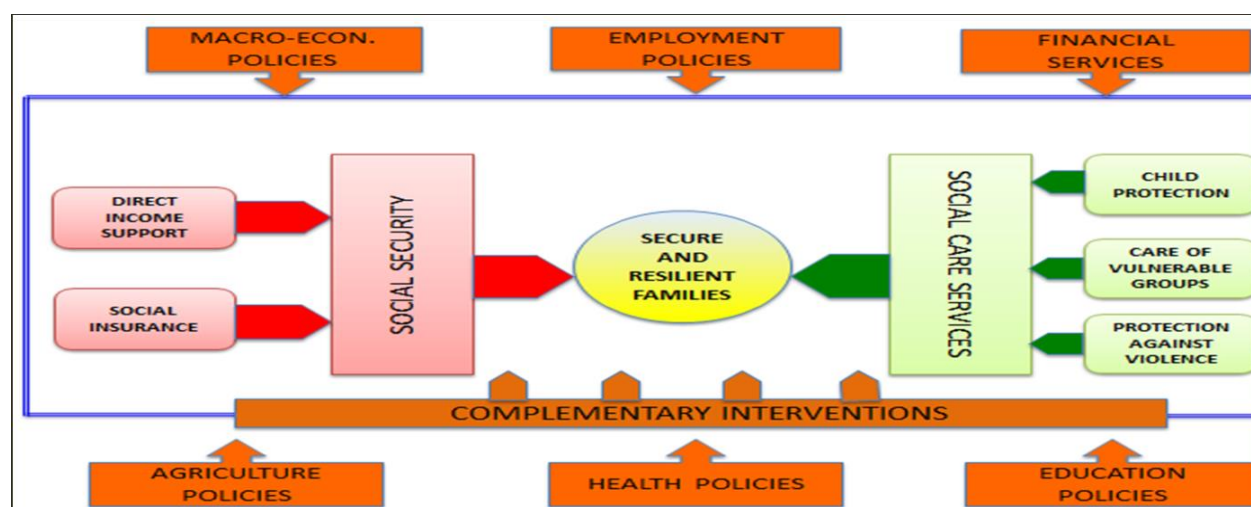
He informed participants that the NHIS will operate under the National Social Protection Policy (NSPP) which has a component of social security. In this initiative, he said, NHIS is looking at income support which will form part of social security and, therefore, have social protection as shown in the framework below.

Reporting on the progress of the NHIS Bill, Mr. Walimbwa said the Ministry of Health obtained a certificate of financial implication and was planning to take the Bill to cabinet. The capacity building for service providers to encourage them run health insurance as a business model was underway in western Uganda and West Nile. In addition, other studies were ongoing in the following areas: costing of services, diagnostic



Mr. Walimbwa Aliyi

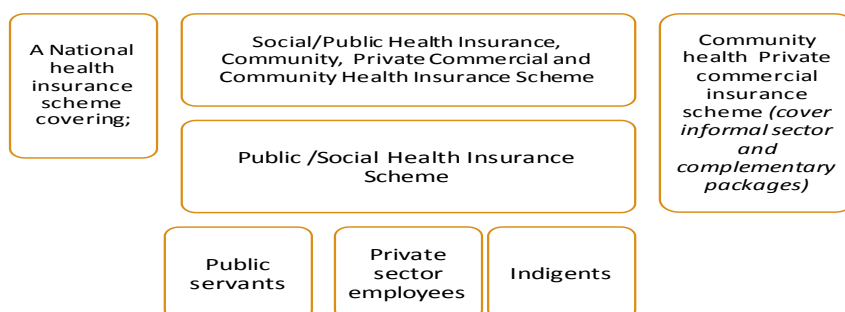
related groups, medicines, benefit package, private sector costing of the benefit package, and capacity building for providers.



Source: Mr. Aliyi Walimbwa, presentation

Mr. Walimbwa explained that Community Health Insurance is a component of the NHIS through which some people will be contributing and others contributed for in terms of subsidies. He then presented what he called the NHIS design here below to further clarify on the position of CHI.

NHIS design



Source: Mr. Aliyi Walimbwa, presentation

In response to issues raised by stakeholders as to whether Uganda should have health insurance under one or different schemes, he reminded participants that insurance is about cross subsidies usually from the low risk to high risk. He reiterate that NHIS will be compulsory for every Ugandan and residents in the country, will have several scheme components and monthly membership contribution of 4% for employees in formal sector and 4% from employers as well as 100,000/= per year for those in informal sector. The dependents covered are four for the formal sector and two for the informal sector.

He called for continuous capacity building at all levels, strengthening of regulatory framework and continued dialogue on NHIS among all stakeholders, particularly in regard to identification and targeting of beneficiaries, and securing political support.

3.2.1.1 Panel discussion: Readiness to introduce, Implement and Participate in the proposed NHIS

Chair:	Mr. Benard Mujuni, Commissioner Equity and Rights, Directorate of Social Protection, MoGLSD
Panelists:	Mr. Robert Kabaale, Coordinator, Uganda Community Based Health Financing Association (UCBHFA)
	Ms Grace Ssali Kiwanuka, Executive Director, Uganda Healthcare Federation (UHF)
	Mr. Ben Asimwe, National Chairman, Informal Sector Workers Association (ISWA)
	Dr. Ekwaro A. Obuku, President, Uganda Medical Association (UMA)



Mr. Benard Mujuni



Dr. Ekwaro A. Obuku



Mr. Robert Kabaale



Ms. Grace Kiwanuka
Ssali



Mr. Ben Asimwe

The session brought together panelists representing key stakeholders in the NHIS to share about the readiness and willingness of their constituencies to participate as the law may require. They voiced their views on how their constituencies were prepared to participate in the NHIS and the preconditions for its successful implementation.

Mr. Robert Kabaale expressed readiness of the CHF promoters to implement the provisions of the NHIS. The readiness is demonstrated by the fact that CHF schemes have existed for a long time and accumulated knowledge and experiences. In addition they have been promoting a number of models that include but not limited to: Community managed schemes – where communities finance, own and manage operations; provider managed – the facility sets up a scheme and communities finance operations, but the management of operations and ownership is taken up by the facility and; third party managed model - where the promoting organization takes up operations, but the financing and actual ownership is by the community.

On the other hand facilities that are providing healthcare to those schemes such as Kiwoko and Kisiizi hospitals do have much understanding about scheme operations and provide a fertile ground for service provision under NHIS accreditation.

However, he noted that since most people in CHF schemes cannot afford actual premiums and membership is voluntary, NHIS needs to squarely address the issues of equity and sustainability. Notable are issues of discrimination based on age, gender and inability to pay due to disability and/or being destitute. He advised that in whichever way NHIS starts, CHI should be brought on board at the onset given that CHF schemes are strategically located to enroll informal sector if provided with technical and financial support for community education/health promotion to mitigate the current high overhead costs. In addition, in the event where NHIS cannot start with the entire population, it can start in regions where CHF schemes are operating to bring everybody on board including indigents with government support.

Ms Grace Kiwanuka Ssali noted that the public private partnership policy provides an opportunity for dialogue through which momentum has been established to create space where government and non-state actors can talk together. Using that window, a taskforce composed of CSOs, faith based organizations and

private sector players was focusing on promotion of human rights in NHIS. Through that forum issues of vulnerability and age were considered to ensure inclusiveness in the formulation of the NHIS.

In pushing for NHIS that is affordable, accessible and provides quality services, UHF was working with MoH on costing studies of health insurance to support smooth negotiations between providers and government. The federation also engaged in a study on private health insurance to understand how to price the structure of the products to ensure value for money. The idea was to make sure private health insurance is robust and offers a minimum health care package, and standard pricing mechanisms.

The federation was also working with MoH and Uganda Medical and Dental Practitioners Council (UMDPC) to support self-supervision of facilities to improve the quality of healthcare in preparation for the NHIS.

Dr. Ekwaro A. Obuku castigated public authorities for failure to roll out the NHIS. He pointed out that a lot of resources had been wasted on endless studies and consultations for the NHIS while public funds continued to be used to subscribe to private pre-payment schemes for government officials such as parliamentarians and cabinet ministers.

He called upon CSOs, professional associations and prominent individuals to provide leadership to be able to start the implementation of the NHIS and fix challenges later, as and when they unfold. He was optimistic that issues such as salary increase for public health workers could be partly resolved by the health insurance scheme. He was happy that some proposals made by UMA for the NHIS were adopted in the Bill but disappointed by failure to start its implementation.

Mr Ben Asiimwe appealed to stakeholders to use unitary instead of derogatory language when referring to the informal sector given that it is:

- indispensable and heterogeneous;
- the biggest part of Uganda's economy and certainly of the labor force thus playing a key role in employment, production and income generation;
- generates much of the money used by government;
- the host of all other sectors in our economy.

He then proposed ways in which the informal sector can be enrolled in the NHIS:

- employ better value methodology through locally driven research to understand it;
- promoters of NHIS need to step out to reach members of the informal sector;
- informal sector can be better organized in clusters similar to groups and associations;
- frequent mobilization on health insurance and its benefits focusing on women, children and youth
- need for credible, sufficient and effective information dissemination on NHIS using integrated approaches
- engage in friendly and healthy collaboration with clusters to easily embrace the objectives of NHIS

3.2.2 Sub-Theme: Nature of Informal Sector in Uganda

Session Chair: Mr. William Kidega, Deputy Chief of Party, PATH /Advocacy for Better Health

Presenter: Dr. John Ssekamatte Ssebuliba, Head Social Sector Planning, National Planning Authority

This session was intended to assess the nature of the informal sector in Uganda with specific focus on people's capacity to contribute for the NHIS in line with the theme of the conference. Understanding the characteristics of the informal sector is anticipated to greatly influence how the people who belong there will be targeted, the amount of premium they will contribute, the mode of payment and their participation in governance and management of the NHIS.



Dr. John Ssekamatte Ssebuliba

Dr. Ssekamate affirmed that the informal sector is a resource and a constituency to reckon with in order to harness UHC. The major bottleneck is that little is known about this sector. Consequently, it continues to be treated as a homogenous and monolithic block. He cited the International Labor Organisation (ILO) definition that alludes to this kind of thinking. The definition, he said, depicted the informal sector as characterized by: ease of entry, reliance on indigenous resources, family ownership, activities that are labor intensive and is de-attached from technology. In addition the skills used are acquired outside the formal training; is unregulated and does not have a unified market.

The definition suggests that the phenomenon is largely unknown, mostly transient and treated with disregard but affecting economic activity. He noted that as the informal sector abound, misconceptions and connotations equally grew. In 1999, an international symposium focusing on the informal sector described it as follows:

- employers of micro enterprises who employ a few paid workers with or without enterprises
- own account workers, who own and operate one person business, who work alone or with the help of unpaid workers who are generally family members, but sometimes apprentices.
- dependent workers paid or unpaid, including wage workers in micro enterprises, unpaid family workers, apprentices, contract labor, and so on, all those who work in these informal enterprises.

He noted that the symposium recognized that the informal sector was more complex than they had actually thought, and it is not homogenous.

Another definition he cited describes the sector as encompassing all jobs which were never recognized as normal income sources and on which taxes are not paid. This definition usually referenced by International Monetary Fund (IMF) and World Bank indicates that if something cannot be measured, it cannot be taxed. This shows yet another misconception about the informal sector but also recognition of grey areas that are not understood about the sector.

He further pointed out the economic, social and cultural variations across countries which add to various misconceptions and connotations. In the East African region alone, the informal sector has connotations depending on its genesis in a given country such as '*Juwakali*' in Kenya; '*Nguvukazi*' in Tanzania and; '*Nkola Byange*' in Uganda. The various connotations across countries clearly indicate that today, like way back, the informal sector phenomenon is clearly unknown and diverse over space and time.

Features associated with of Informal Sector

The sector is known to be unstructured sending fears to people because it is an uncharted territory which nobody wants to risk in dealing with. The sector is also associated with illegal activities creating suspicion everywhere since it is not known what exactly people are doing. This is coupled with the belief that they deal with inferior quality of services or goods, simply because they are unregulated. Then it is taken as undesirable where nobody in his right mind would want to go and do something. It is also taken as a fallback position for those who have failed and a cruel situation where people are forced work.

The issue here, Dr. Ssekamatte resonated, is that all features listed above degrade the socio-economic activities and people thriving in the informal sector. Consequently, the sector attracts little or no attention from the authorities. For example, the National Social Security Fund (NSSF) Act only permits the institution to take contributions from formal sector employees of enterprises that employ at least 5 or more paid employees.

He reiterated that informal sector is a complex phenomenon more especially that currently, unemployed university graduates join the sector and start their innovations that make them lie between the formal and informal. This makes it a critical shock absorber for youth unemployment such that those who are lucky are absorbed and the unlucky ones sit waiting. However, he lamented that the sector has not been given due attention by agencies responsible for generating information and statistics in the country. He called for thorough research that employs a holistic approach of economic and sociological dimensions to be undertaken to understand and engage this phenomenon.

3.2.2.1 Panel: Capacity and Readiness to pay for NHIS

Chair: Mr. William Kidega, Deputy Chief of Party, PATH/Advocacy for Better Health

Panelists: Mr. Zephaniah Ogen, Senior Programme Officer Social Protection, Expanding Social Protection Programme, Ministry of Gender, Labor and Social Development
Mr. Fredrick Makaire, Executive Director, SHU
Ms Christine Namayanja, Chief of Party, USAID/ Uganda Voucher Plus Activity
Dr. Aloysius Ssenyonjo, Project Manager, SPEED project, Makerere University School of Public Health



Mr. William Kidega



Mr. Zephaniah Ogen



Ms. Christine Namayanja



Dr. Aloysius Ssenyonjo



Mr. Makaire Fredrick

Members of the panel came from various community based financing initiatives implemented in various parts of the country to improve people's access to essential social services particularly healthcare. They shared experiences about ways of mobilizing ordinary people to contribute money for services under pre-payment arrangements, the achievements registered and challenges faced in regard to sustaining such initiatives. They brought out lessons which NHIS implementers could benchmark for better results.

Mr. Zephaniah Ogen informed participants that social protection in the Ugandan context is defined more broadly as “*interventions to address instant vulnerability*”. This is stated in the National Social Protection policy which was

approved by cabinet in November, 2015. The policy recognizes health insurance as one of the priority social protection interventions.

Consequently, health insurance is no longer viewed from the financing angle but as a social protection instrument with a lot of potential for linkage with other instruments within the Social Protection Policy. Given that poverty is dynamic, people may be well off today but if ill-health strikes, they immediately fall into poverty. Though there are guidelines on who the indigents are, communities still need to participate in that process of clearly identifying and supporting them.

Mr. Fredrick Makaire admitted that as promoters of CHF schemes, they charged a uniform premium without taking into account differences which were actually real and present in the communities. The result was that few people joined the schemes but majority stayed away because they could not afford. Even when people paid premiums, they were not paying for health insurance but health services. In the event that they are not satisfied with the services, they usually pull out at the beginning of the next cycle which affects retention. To avoid this, he said, the NHIS should adequately ensure that the service providers offer timely and quality services.

He also reported that a huge price had been paid when it came to mobilizing and educating people expecting them to voluntarily pay in order to join the scheme. Experience showed that it takes about six months to educate people to understand, appreciate, get the trust and then willingly join the scheme. He put NHIS on notice to avoid the big cost right away by making the scheme mandatory.

On the positive side, he reported that community participation has been key to the success of the schemes. He proposed that the NHIS should uphold this virtue by ensuring representation and active involvement of stakeholders at all levels. This coupled with an investment in health education on insurance, the NHIS will reap the benefits of informed minds and community.

Mr. Makaire shared his experience with resource pooling where CHF schemes were initially designed to operate at a parish level (6-7 villages). However, it turned out that the amount of money in each scheme pool was little and unable to support the scheme to run for a full year. When this changed to regional pools with about three districts putting their funds in single bigger pools, schemes were able to pay all hospital bills in time. He suggested that the NHIS should borrow a leaf and start with one big pool for all Ugandans to avoid fragmented and weaker pools.

Ms. Christine Namayanja shared her experience on performance, challenges and lessons learnt in implementing the voucher scheme. The project which operates in the northern and eastern regions targets women who cannot afford the full package of health services. The poor women who are identified through a poverty grading system are targeted to increase access to maternal health services.

The eligible women then buy a voucher at UGX4,000, permitting a woman to access a package of services that would normally cost over UGX100,000/=. The health services package includes 4 antenatal visits, safe delivery which is inclusive of comprehensive management and emergency transport in case of referral from a lower to a higher level facility, usually a hospital or health center IV, for better management. It also entitles a woman to 3 post natal care visits and a family planning method of her choice.

She said, the project works with both faith-based and private healthcare providers who meet minimum standards as stipulated by the Government of Uganda. These are usually given basic training and then approved to start providing services to eligible women in the regions. The presence of services is tagged to providers, but must be within the national recommended 5kms radius of that facility. This is intended to ensure that women deliver in health facilities since it is difficult for a woman to walk 20kms as pregnancy advances.

Ms. Namayanja noted that the greatest challenge has been inadequate staffing levels and skills in accredited health facilities. For maternal and child health (MCH), she noted that there must be midwives for a facility to be accredited, adding that the experience clients get at a facility determines whether they will ever go back or not.

The key lessons she drew from the Voucher Plus activity for NHIS were that the system must be functional in terms of diagnostic processes, adequate drugs and referral mechanisms. She emphasized that the trust of clients can only be built when their expectations are met as promised. Secondly, to sustain a performance based financing system, providers need a constant cash flow to make services readily available.

Dr. Aloysius Ssenyonjo reasoned that while it is really a challenge to determine who should be exempted, it is also not possible to have a national health insurance which is equitable without covering those who cannot afford. He pointed out that as the case is in Rwanda where they have poverty grading that categorizes everybody on a number of parameters, the NHIS will need to design a national system that can be used to determine the poor to be supported.

In reference to SPEED project, he said that though there was need for communities to contribute their own resources, a few characteristics of the saving groups or SACCOs undermined them as a vehicle for promoting health insurance. First, people mostly saved to increase their family income but also have a credit facility that they could get money from to do short term investments but rarely for health. Second, the membership to most of those groups was really small between 15-30 people which is in contrast with the principle of bigger resource pools. Third, in the saving groups, there were power dynamics, male dominance and the gender dynamics around finance flow at household level.

In this regard, he proposed that there is need to have a national framework such that even in areas which do not have existing saving groups and/or CHF schemes, they are able to have a model which will be replicated. Focus on clear goal is needed to help them navigate these tough challenges to accessing health care as people struggle to divide their resources to get food and school fees for their children. He reminded participants of political risks associated with health insurance and the need to ensure that the debate goes beyond reducing catastrophic expenditure to include views of interest groups and overall development of the economy.

3.2.2.2 Plenary discussions - Informal sector

The plenary on informal sector raised a number of questions and comments:

- Luwero district is in the process of coming up with an ordinance to enable CHF schemes to operate in the whole district. However, in the absence of a national framework under which they can operate, the biggest worry was about sustainability of the scheme.
- There was a passionate call not to formalize informality but make sure that all transactions in all areas, wherever people live are captured like it is done in health to avoid calling people elements of informal sector.
- The purpose, reasons and objectives of the NHIS Bill need to be clearly stated and addressed by the provisions of the Bill. This means that problem identification needs to be undertaken short of which the country will roll out a copied system that does not address pertinent issues in Uganda
- What is the basic pay that can attract someone to go to hard to reach areas to practice medicine very well knowing that he will be remunerated not necessarily the salary but even the packages designed under NHIS?
- Well knowing that the informal sector is not homogenous, it then requires setting standards that will guide how the informal sector will join NHIS through the CHI schemes.
- Could it be possible for the Voucher Plus to be extended in central region where there are villages with women who are really badly off as well as cover children below five years due to malaria prevalence which is a major cause of mortality?
- Given the monthly package of UGX25,000/= for the elderly from central government, part of the money should be committed to pay their premiums to CHF schemes where they exist and later into the NHIS.
- The strategy to reach the informal sector is to go down and talk to the people to ascertain their needs, feelings, ability and demands and then advise accordingly rather than dismissing them as not knowing where they are.
- Government on its part should support behavior change of the population through public health programs to improve peoples' health and livelihoods.



A section of conference participants



Members of community health insurance schemes from Bushenyi introducing themselves at the conference

3.2.3 Sub-theme: Access to health Insurance in Uganda

Session Chair: Dr. Sam Orach, Executive Secretary, Uganda Catholic Medical Bureau
Presenter: Dr. Elizabeth Ekirapa -Kiracho, Senior Lecturer, Department of Policy and Management, School of Public Health, Makerere University

The session was intended to educate conference participants about the various options for risk and resource pooling in health insurance. The presenter, **Dr. Elizabeth Ekirapa**, explored how risks and resources can be pooled and managed to ensure maximum benefits for contributors.

Dr. Ekirapa defined risk pooling as the accumulation and management of financial resources where large unpredictable individual financial risks are distributed among all members of the pool. It entails transfer of risk between those who are at high risk and those who are at low risk. In health insurance, it aims at reducing the uncertainty that is associated with illness by ensuring that they will be covered when it strikes.

She noted that risk pooling depicts equity and efficiency considerations where the burden of meeting health care costs does not have to fall on individuals, and ensures that the population is healthy, able to work in order to realize their aspirations. However, she said issues to do with efficiency and equity are viewed differently by various communities. While these are things that should merely be taken as technical issues, they need considerable dialogue.



Dr. Elizabeth Ekirapa

She discussed three types of risk pools: The unitary risk pool as usually one funded through general taxation and social health insurance. This kind of risk pool permits equal opportunity of access according to clinical need irrespective of whether an individual has the money to pay for the services or not. Second is the fragmented risk pool, which is usually a series of independent risk pools some of which are the community based. They can be small or large but always with considerable variations across the schemes. She pointed out that in fragmented pools, there is often less than optimal pooling of funds to be able deliver expected service benefit package, among other things. The third is the integrated one where there's compensation for variations of risk. She advised that under NHIS, large risk pools should be considered and made mandatory so as to provide the minimum health care package to everyone without discrimination.

She further discussed factors to be considered under risk pooling: One was to develop appropriate and reliable systems of governance to ensure the collection and stewardship of finances. Consideration here is given to who is taking care of resources, how transparent and accountable to interest stakeholders to put in their money and impact on the eventual size of the pools.

Second is to review existing organizational structures and the regulatory environment taking into account variations such as those between rural and urban areas.

Third, membership criteria and arrangements of pools need to be made very clear. Given the various scheme categories proposed by NHIS, there must be a safety net arrangement to ensure that those who are not covered by the scheme will still be able to access services and that the poor will gradually be covered in the proposed schemes. However, several multiple pools have challenges to do with information flow, monitoring and transferring payments compared to larger non-competitive risk pools, which are usually easier to manage.

Fourth, to ensure that everyone is covered, pools need to be designed in such a way that they have a satisfactory benefit package such that regardless of which pool, beneficiaries receive a comprehensive service package.

Fifth, the policy, health financing strategy, in-coming NHIS Act and implementing strategies need to be regularly reviewed to make the necessary changes. This would inform re-negotiating the budget initially agreed upon and planning to have some reserve funds that can be used to meet the costs of pools that might incur a lot of expenses.

She implored NHIS framers to consider overlapping risk pools where individuals are able to belong to more than one pool. This is useful when you have high risk conditions that can be insured in a higher level pool to ensure that care is provided but also to reduce the risk to the lower pool. Alternatively, the lower level pool also shares costs for high level risk patients with a high level pool. This sharing can be in terms of financial resources, capital cost required, drugs and personnel to help them meet their costs.

She proposed key considerations for NHIS on the way forward as follows:

- significant numbers of the poor need to be included within the insurance risk pool or a safety net needs to be created for them to ensure that they are able to receive the services that they require. This is to avoid a situation where those who already have receive even more and then those who do not have suffer even more.
- stakeholder and community involvement will encourage participation in the schemes and hence create larger risk pools. The extent to which a community shares values and is prepared to support communal structures and pool resources will build solidarity and influence their willingness to pay for health insurance
- political buy-in is very important to support the scheme particularly in Uganda where most politicians promise free care instead of mobilizing people to contribute, or join community based health insurance.
- have integrated risk pools that can be able to provide similar benefit packages that will ensure that the majority of our population can actually receive the services that they require to be a productive population



Hon. Lillian Nakate, Luwero District Woman Member of Parliament at the conference

3.2.3.1 Panel: Pooling risks and resources

Session Chair: Dr. Sam Orach, Executive Secretary, Uganda Catholic Medical Bureau
Panelists: Ms Proscovia Nnamulondo, Communication and Advocacy officer, Save for Health Uganda
 Mr. Nicholas Lutakome, Head of Corporate Relations, SANLAM Insurance
 Mr. Aliyi Walimbwa, Senior Health Planner, Ministry of Health, Kampala



Dr. Sam Orach



Mr. Walimbwa Aliyi



Ms. Nnamulondo Proscovia



Mr. Nicholas Lutakome

Members of the panel discussed the presentation by Dr. Elizabeth Ekirapa basing their arguments on the experiences in the health insurance schemes implemented in their organizations and the proposals in the NHIS Bill.

Mr. Nicholas Lutaakome appreciated the spirit of cross-subsidization of resources between the rich and the poor. However, he maintained that in principle, this departs from insurance. He said he would rather take the cross-subsidization of those exposed and those not exposed because there is something in economics called the tragedy of commons. He advised that NHIS should ensure that everyone has the basics that they can start with without necessarily tying everyone in there.

There should be a leeway for those who can pay, or want to buy private insurance. Given that the biggest proportion is in the informal sector in Uganda, making anything mandatory, collecting the premium, getting everyone to subscribe is always likely to be a big challenge. In his opinion, pooling works more from the perspective of getting the healthy subsidize the unhealthy such that there are minimal exclusions and private health insurance remains to supplement what NHIS provides.

Ms Proscovia Nnamulondo narrated the experience of larger pooling for CHF schemes promoted by SHU. She said that initially, SHU started with individual schemes pooling at parish level with few people contributing for only 12 months. This turned out to be a key challenge since money would run out before the end of the year. This was solved by larger pools where about 50 parishes came together to create one pool for health care. This larger risk pooling also helps to keep the premiums affordable because with smaller pools, premiums need to be higher to ensure that they pay what is enough to cover them for the whole year.

She enumerated two key disadvantages associated with fragmented pools:

- they create a lot of work for service providers whereby if there are more than 70 schemes in an area, a provider has to sign a memorandum of understanding and a service contract with each of them. This tends to overwhelm the facilities and raises issues of inefficiency whereby each scheme has a different pool and a different healthcare package.
- the issue of exclusion is a challenge when it comes to pooling risks that are not mandatory. This means that those who cannot pay will continue not to pay and will be left out and those who are able and are considered to be the well-off will then opt for other alternatives.

Mr. Aliyi Walimbwa re-emphasized that Uganda needs NHIS mainly to solve the problem of out-of-pocket payments for the otherwise free services. He said Uganda Vision 2040 itself focuses on irrational health coverage and the best way to solve the problem is to make sure that people are protected. He noted that all of us have a responsibility in addressing the problem and NHIS should be merely providing a legal framework under which everybody should operate.

He then enumerated how the health sector has positioned itself to ensure universal access to health services under NHIS:

- under the NHIS Bill, health insurance is mandatory for whoever is a resident in Uganda
- it is implementing social health insurance which is social protection not income generating par se
- the Bill recognizes private commercial health insurance, where an individual needs additional services, or opts for private insurance but must still contribute.
- planned to use Diagnostic Related Diseases (DRDs) where classified categories of diseases have a specified amount or an average cost as opposed to a free-for service.
- cost of managing the scheme is proposed at less than 5%, the rest of the money goes to the service provision to ensure value for money
- issues of adequate health facilities and human resources will be addressed based on demand when the NHIS has been rolled out and gaps have become evident.
- mapping and portability is being worked on to enable access to services in any part of Uganda using a card within the framework of the information system through regional offices of NHIS and local governments.

3.2.3.2 Plenary discussions - Pooling Risks and Resources

Participants raised numerous questions and made comments based on the presentation and panel discussion on pooling risks and resources:

If the government is to use revenue generated through taxation to only subsidize people in public service by 4%, why should poor people who are being indirectly and/or directly taxed by government continue to subsidize the salaried public servants through premium under the mandatory system?

Employees in formal sector are expected to make a contribution of 4% of their monthly salary. Will this have a limit based on salary scale given that employees are of different cadres? Will there be a guarantee in terms of what the employee is paying and what they will get in terms of actual services. Will pensioners who receive monthly emoluments from local governments be required to contribute 4% monthly to the NHIS?

Health service delivery continues to be a nightmare, say in case of pregnant mothers, there are no gloves and other requirements calling for everyone, every community to participate in the health services. The technical team is called upon to deliver the NHIS Bill as fast as possible to avert the high out-of-pocket expenditure in facilities including where CHF schemes are operating.

The local politicians present acknowledged the high expenditure on health service by the poor and conveyed their impatience with NHIS to which they pledged not to interfere but to intervene by mobilizing people on the benefits and the significance of joining this scheme.

Will the ailments one had before the NHIS be covered? And when should one be ill after joining the NHIS in order to access the services?



A participant makes a contribution during plenary

The key presenter and panelists responded thus:

Under the NHIS, the issues of when you became sick should not arise. The principle is to keep one alive by providing the basic services to ensure that everyone gets the care that they need. While the beneficiaries can judge the pool performance when they go for services at the facility, government, promoters and providers need distinct monitoring and evaluation indicators to measure performance and assess impact.

Risk equalization and cross subsidization would be a remedy if some people exit and join another scheme so as not to hurt those who benefited from their presence since it is not their fault to have left.

Government should strategize on how it can pool additional resources and add to what it had before under public free services system to provide a percentage contribution for the poor to access basic health packages under NHIS.

There is no guarantee that one will benefit from at least 2% of the 4% contributed. However, there are tangible and intangible benefits such as availability and quality of services when needed.

People in different salary scales are not going to pay the same amount of money and the basis is the percentage rather than a cap on the amount to be paid. This is considered a fair deal where an individual who earns millions pays millions and those who earn nothing definitely contribute nothing.

One of the things that enhance service delivery is more of having a competitive environment even at a time where the funds are pooled to provide for choice and quality care environments. In such as situation, insurance providers tend to ensure that they have packages that address the clients' concern to mitigate competition and meet accreditation requirements annually. Evaluations by customers as well as public private partnerships normally take these things to the next level of sustainability.

With transparency people, are shown how things are done, why they are being done including why a specific service provider was selected, but also permit beneficiaries to select where they prefer to receive services.

The problem comes about when money gets into a pool and those who have contributed are forgotten. It is pertinent that members get to know what happened to the contributed resources. The issues of accountability through their leaders in meetings where they receive feedback greatly inspire them to continue contributing. Evidence shows that community members have enrolled most where local leaders helped to build the trust and support scheme activities.



A section of conference participants

3.2.4 Sub-theme: Scaling up Community Health Insurance

Session Chair:	Dr. Gerald Karegyeya, Claims Manager, Voucher Management Agent, USAID/Uganda Voucher Plus Activity
Presenter:	Prof. Robert Basaza, Associate Dean, Institute of Public Health and Management, International Health Sciences University (IHSU), Kampala



Prof Robert Basaza

This session was intended to explore reasons why existing CHF schemes have had slow growth over the years and propose strategies for scaling them up.

Prof. Robert Basaza, a well-known researcher in the area of CHF started by appreciating CHF schemes because they are not-for-profit and practice in the informal sector where the majority of members are people in the local communities. Their key principle is mutual aid which is clearly embedded in Uganda's self-help culture as exemplified in weddings and times of bereavement.

He stated that while it is hardly possible to have a national health insurance scheme unless there is a law, it is possible to have CHI without it. He noted that so many countries started schemes without necessarily a national law in place and there are also bylaws to govern and manage societies that have been exploited by schemes world over and Uganda in particular. He indicated that Germany, the father of national insurance, is a good case that did not start with one government scheme and that the formation of a national health insurance scheme by Bismark was merely to

contain the workers who were becoming very powerful. Consequently, he asserted that CHF schemes need to be viewed as a transition towards the national health insurance scheme. Once the NHIS is in place, CHF schemes become operators or sub-contractors since they have very great understanding of the local issues and the context.

Prof. Basaza identified key reasons why the CHF schemes are not growing or growing but not as expected. First, CHI has not been implemented as part of the overall socioeconomic development that addresses income at household level to alleviate poverty, promote education and ensure basic requirements such food, water and shelter. A few, however, have been able to support communities to improve their incomes such as distribution of dairy goats by Bishop Ceasar Asili Hospital in Luwero to members of CHI schemes promoted by SHU.

Second, there has not been risk pooling because, for most schemes, membership has been small. Pooling risks can only be realized with ample resources irrespective of where they are coming from be it individuals, private firms or government. Risk pooling is a good measure to protect an individual from catastrophic expenditure currently experienced by most Ugandans, sometimes resulting in sell of property that increases poverty. This, he said, informs us that a health system needs to have a holistic rather than partial approach to establish a meaningful pool.

Third, the schemes were equally undermined by the absence of information and communication strategy on health insurance. This turned out to be a big challenge and a costly venture for promoters in mobilizing communities. Information remains critical in addressing issues of pooling together health and medical insurance as well as individual and community benefits. Each promoter such as Save for Health Uganda, Health Partners and Voucher Plus deliver their messages with sincerity but in an uncoordinated manner leaving beneficiaries with conflicting views, interpretations and doubts on schemes. Consequently, issues of communication on health insurance become pertinent.

Fourth, in most cases, the design of the schemes did not reflect the local context to respond to the needs of the community. In this respect, communities felt they are guests, thereby undermining trust especially in financial matters. The best way, he said, is to give them the knowledge, empower them and let them make decisions and avoid infusing expert rules. Important also is to ensure that providers do not overcharge unnecessarily, and beneficiaries, while in insurance, should not over utilize healthcare so as to empty the pool. The solution could be to identify the package and then attach a figure so that payment is against a particular illness.

The last one was lack of visionary leadership and clear policy at all levels which has been key in impacting on the growth and expansion of health insurance schemes. Citing Rwanda, Ghana, Tanzania and Ethiopia irrespective of the different approaches and time frames, he said that they provided key examples of the role of visionary leadership in implementing successful health insurance. However, he noted that government remains central to health insurance and the best way is to demand that government responds to the needs of its people.

He highlighted the need for a champion to drive the necessary change or innovation at all levels of society such as central government, local government, SACCOs, solidarity groups, development groups with a focus on success rather than failure.

3.2.4.1 Experiences, growth and sustainability of CHF schemes

Chair: Dr. Gerald Karegyeya, Claims Manager, Voucher Management Agent, USAID/Uganda Voucher Plus Activity

Standup presentations and testimonies

Mr. Pontius Mayunga, Senior Administrator, Mutolere Hospital, Kabale Diocese CHI Scheme, Kisoro District

Prof. Tumuhimbise Manasseh, Senior Scheme Manager, Ishaka Health Plan, Bushenyi District

Ms Harriet Mbaziira, Scheme leader, Kakooze Munno mu Bulwadde Scheme, Nakasongola District

Ms Babirye Rusia Batega, Community Health Mobiliser, Integrated Community Based Initiative (ICOB), Jinja District

Mr. Bob Richard Tibasiima, Board Chairman, Butuuro SACCO, Bushenyi District



Dr. Gerald Karegyeya



Mr. Pontius Mayunga



Mrs. Harriet Mbaziira

During this session, members and managers of community health insurance schemes talked about their operations, the challenges responsible for the slow growth of their schemes and proposed interventions for scaling up community health financing.

Mr. Mayunga Pontius narrated that Mutolere Hospital found in south western Uganda bordering Rwanda and the Democratic Republic of Congo is a faith-based organisation under Kabale Diocese and operates under the Uganda Catholic Medical Bureau. The hospital started the CHF scheme in 1999 after an invitation by the Ministry of Health to learn from Kisiizi hospital's experience. The reasons for starting the scheme were several: the hospital was receiving very few patients not because people in the communities were not sick, but because they were not able to pay the user fees. On the other hand, patients were escaping from the hospital after treatment without paying bills, thus causing big losses to the hospital.

The scheme was started to address the two challenges anchored on the existing community solidarity organized under the *Ngozi* groups where at least 95% of the population in Kisoro belongs. The key principle in these groups is mutual aid where members work together to take a sick person to hospital, pick up the body in case of death and organise a decent burial. The hospital exploited the gap in the community where they never considered supporting treatment of the individual to survive by swapping it with unnecessary burial expenses.

The scheme started as a hospital-based insurance plan from 1999 to 2010 with about 10,000 people. In 2011, a bigger group was formed at the diocese, Kabale Diocese Community Financing Scheme, comprising of very many schemes

under the whole of Kabale Diocese including Nyakibaale hospital and lower level units. This continued until 2017 when they faced some few problems mainly as a result of adverse selection using households instead of solidarity groups which were already organised. More recently, it returned to Mutolere Hospital as a purely community based scheme with the hospital only being a service provider.

He noted that the free healthcare system in public facilities resulted into adverse selection in enrolment since only those who were certain that they would use the services in the faith-based facilities such as pregnant mothers enrolled into the scheme. The other challenge was that the very poor were excluded from the scheme due to inability to pay premium.

Despite the challenges, the scheme has increased cost recovery for the hospital since bills of all members are fully paid. The hospital is happy to promote the scheme even in lower level facilities because of its benefits.

He called for increased marketing and capacity building so that people are educated on how to use the scheme, and external support in terms of managerial, technical and financial aid in order to build a strong scheme.

Mr. Tumuhimbise Manasseh said Ishaka Health Plan was set up in 1999 and remains a community-based scheme. The scheme has gone through three phases of growth although the membership has stagnated. It was initially run in partnership with Ishaka Adventist Hospital until 2007 when the hospital pulled out but allowed the scheme to continue operating in its premises. Between 2007 and 2012, the scheme struggled to continue running thriving on three principles:



Prof Tumuhimbise Manasseh

- Solidarity where locals in the community come together around particular interests.
- Enrolment based on pre-existing groups whose members enroll after discussing with the pre-existing leadership.
- The pre-existing leadership being responsible for the collection and mobilization of funds. The role of the scheme management remained that of education and sensitization which was run on a quarterly basis

From 2012 to-date, the process to strengthen the Board to be the key driver in the running of the scheme has been ongoing. The scheme embarked on streamlining management structures in particular and introduced computerized systems to facilitate the quarterly presentation of financial reports for review and evaluation.

Mr. Tumuhimbise reported that the scheme also embarked on adhering to the principles of fund management and finding alternatives of promoting the insurance product. In this case, the scheme tried innovations like 'lighting for health' whereby members are provided with solar lamps by a creditor which has enabled it to maintain the numbers though still low.

The scheme also runs a micro-credit component where the application fee automatically guarantees the applicant as a scheme member to access the insurance services. The innovation which was picked when the scheme management had a field exchange with Butuuro is beginning to help increase membership. An attempt by the scheme to start its own health facility was a total failure because it had no competence in that area.

He pointed out the challenges facing the scheme:

- members are not willing to contribute premiums on an annual basis but prefer to pay on a quarterly basis which greatly affects planning since it has to be done every three months.
- The drop-out rate is high and happens every three months.

- The problem of governance of the scheme is fundamental because it is at the heart of those who provide funds to these schemes. They need to know how they are benefiting, getting their reward, involved and participating in the future plans of these schemes.

Ms Harriet Mbaziira, detailed the formation, development, benefits and challenges facing Kakooge Tweekembe scheme which started in 2000 and currently has 578 members from 80 households. The scheme is a member of Munno mu Bulwade Union of Schemes Organisation (MBUSO) which brings together all CHI schemes promoted by Save for Health Uganda in Nakasongola, Luwero and Nakaseke districts. She reported that membership registration fee to Munno Mubulwade is 2000/= per household and each individual member pays a premium of UGX12,000/=. She said when members get sick, they pay UGX30,000/= and the scheme pays for them UGX220,000/= which totals up to UGX250,000/= per episode of illness to enable them access health services in contracted health facilities in the area. In case the medical bill is above UGX250,000/= the patient meets the additional cost, since the scheme is unable to raise more money.

The scheme benefits include but are not limited to:

- access to timely, quick, quality health services in the selected facilities
- A member does not have to worry about where to get money when he/she falls sick
- UGX220,000/= contribution from the scheme healthcare pool towards each individual's treatment per episode of illness is a key benefit appreciated by members.

The sustainability of the scheme, she said, is based on members' contributions and management. Initially, schemes were organized at parish level. However, it became apparent that the small and fragmented schemes would not enable members to access the services they needed. The schemes in Luwero, Nakaseke and Nakasongola districts formed a partnership to create a bigger pool of resources. The partnership is supported by Save for Health Uganda that provides technical backup such as negotiating with service providers.

She noted that despite the benefits and stakeholders support, the scheme still faces challenges:

- majority of community members are poor such that some who contribute fail to continue to do so in subsequent years citing lack of money to pay annual premiums.
- the effects of the past prolonged dry spell in the districts of Luwero, Nakaseke and Nakasongola impacted negatively on household food security and income thereby increasing poverty in households.

Ms. Babirye Rusia Batega, a community mobiliser in Magamaga village, Buwenge sub-county, Jinja district, came to know about community health insurance through training under the district community development office and a learning visit to Sheema and Rukungiri districts where ICOBI had already established community health plan. While in Sheema district, Ms Babirye learnt that members of the schemes were saving for their lives in contrast with the eastern region where groups were saving for school fees, food and burial contributions. On her return to Jinja after the tour, she inspired her group to start saving for healthcare. In 2016 alone, she managed to enroll 91 households, with 368 beneficiaries and, in 2017 she enrolled 46 households with 136 beneficiaries. The method she used in Jinja is for a group to avail loans without interest to the members who need healthcare. She detailed the challenges which she said were not unique from those facing other schemes:



Ms. Babirye Rusia Batega

- low retention of members in the scheme where the most common question asked is, *'I paid last time and the year ended without falling sick, do you want me to pay another time?'*
- ignorance in the community about how health insurance works
- poverty in communities where the majority are used to receiving handouts like money and food.
- the nearest private health facility that meets the required standards is around 30kms from Buwenge to Jinja whereby someone has to pay a co-payment and some extra money for transport.
- dependence on growing sugarcane at the expense of other crops has made families poorer.

A few suggested solutions to the challenges are:

- using integrated approaches such as strengthening community health financing schemes together with economic empowerment so as to retain members in the schemes.
- investing adequately in advocacy and sensitization programs using media platforms, posters and as well as involving community structures like local councils, village health teams and community based organizations during implementation of community health insurance.
- supporting some nearby private facilities with resources such as medicine, trained health workers and laboratory equipment so as to reduce the cost of transport for scheme members.
- changing from overreliance on a single crop such as sugarcane growing to improve household incomes.

Mr. Bob Tibasiima said Butuuro SACCO was started in 2007 by 20 community members who collected a total of UGX 200million to create a pool to enable them borrow mainly to pay school fees. The pool was later strengthened with very good governance systems, making it one of the top SACCOs in the country supervised by Bank of Uganda.

He noted that the core value of the scheme is to provide products and services that suit members' needs for sustainable development. Butuuro People's Medical insurance scheme with a membership of 5,410 people is a brainchild of the SACCO. The scheme started with an initial fund of UGX50 million from members' savings and loan products. Each scheme member contributes UGX1,000 per month which translates into UGX12,000 per person per year and a fund of UGX64.9million.



Mr. Bob Richard Tibasiima

In 2014, the SACCO started its own 12-bed medical facility which serves members of the insurance scheme and other community members. He admitted that a number of challenges abound:

- Some members who do not utilize health services complain about their contributions.
- Members who come from far face challenges in accessing the only healthcare facility.
- High operational costs amounting to about UGX35 million per year.

He mentioned a number of strategies for sustaining Butuuro SACCO including sensitising members on benefits and opening up branches to increase membership and contributions.



The Speaker of Luwero District Council, Mr. Disan Mayanja Kikabi makes a submission during plenary.

3.2.5 Sub-theme: Leaving no one behind in the implementation of NHIS

Session Chair: Mr. Tom Aliti, Assistant Commissioner, Ministry of Health

Presenters: Mr. Arnold Kwesiga, Program manager, Business and Human rights, Initiative for Social and Economic Rights (ISER), Kampala
Mr. Denis Nkunda, Community Health Advisor/Specialist, Ministry of Health, Rwanda



Mr. Denis Nkunda, Mr. Tom Aliti and Mr. Arnold Kwesiga

During the session, presenters focused on how the different population categories can be covered under the NHIS to achieve inclusive growth, and the role of government in ensuring sustainability of the scheme.

Mr. Arnold Kwesiga's presentation focused on groups of people that require to be prioritized for the NHIS. Most of these groups are in the informal sector and include indigents as well as vulnerable groups including children, women, PWDs, and older persons. He emphasized that in planning for a comprehensive NHIS, these are the groups that actually need it most.

Uganda's second National Development Plan clearly states; prioritizing universal health coverage to accelerate movement towards the universal health insurance with essential health and related services is needed for promotion of a healthy and productive life. The 2030 agenda for sustainable development goals, specifically goal number 3 is to ensure healthy lives and promote wellbeing for all at all ages.

Mr. Kwesiga asserted that by accepting to implement UHC, Uganda has to inevitably employ equity and equality strategies to achieve fairness in health services for all. He labored to distinguish the two clauses thus: exercising equality aims to promote fairness but only works where everyone starts from the same landscape which is not true for the mentioned groups. On the other hand, equity is giving everyone what they need to be successful. Therefore, equity requires that further steps are taken to ensure that the vulnerable or most marginalized groups get an extra effort.

He reiterated that out-of-pocket payment is the biggest problem which deters poor people from seeking health services in health facilities. Irrespective of the policy of free public health services, clients are still directly or indirectly charged during diagnosis and procuring of prescriptions. Out-of-pocket expenditures need to be addressed so as to achieve the progressive realization to include everyone as quickly as possible starting with those that need health insurance most.

In conclusion, he enumerated several provisions of the NHIS Bill that render to unfairness:

- people in the informal sector have an option of registering as a member of the private commercial health scheme or Community Health Insurance Scheme (CHIS)

- people in the informal sector, without variation, will contribute UGX100,000/= per year to cover an individual and two dependents but is silent about government contribution for them. However, for the formal sector employees, they will receive 4% from employers and cover four dependents. Given the average size of an African family, this means that many dependants remain uncovered.
- the definition of an indigent person is wanting; a person who has no visible means of income or has nobody to support him or her; worse still it is left at the discretion of the board for one to be identified as such.
- 10% of indigents will be enrolled annually for 10 years: UNHS 2016/2017 reported that 27% of Ugandans are poor, that is nearly 10 million. This means 1million of the indigents will be enrolled annually for 10 years and on assumption that the figure is static.

Mr. Denis Nkunda shared the experience of Rwanda in sustaining health insurance schemes. He said before health insurance was introduced, the government experienced a huge burden to provide healthcare, and there was low access to PHC particularly for poor people in the community. The limited access contributed to high mortality rate, especially for women and children. In addition, financial barriers to healthcare were leading to various forms of exclusion due to irregular household incomes.

This situation compelled the government to introduce the mandatory health insurance for all and enacted the health insurance law that was amended in 2016 whereby article 3 stipulates that any person, whether Rwandese or a foreign national on Rwandan territory, shall be required to have health insurance. Article 4 also mandates all employers, whether public or private to contribute payment for health insurance for their employees. Health insurance coverage stands at about 82% with 76% of them being covered under community based health insurance (CBHI).

Rwanda, he said, anchored the national insurance on the existing institutional arrangements and community groupings coming with several schemes, thus:

- RAMA for all public servants
- Military Medical Insurance (MMI) for all armed forces
- Private health insurance
- Institutional health insurance (University of Rwanda).
- Community Based Health Insurance for the rest of the population
- Current status; about 82% (76% for CBHI and 6% for others).

Mr. Ankunda informed participants that the implementation was not rosy as most people were initially reluctant to enrolment and had to be forced to pay their premiums by local leaders in the rural areas on weekly market days. In so doing crime preventers, that do the policing at the community level would station at the market gates and compel everybody entering with merchandise to show a beneficiary card. In absence of the card, they would follow up people and deduct premium from their sales and issue receipts immediately. However, overtime, compliance improved due to extended mobilization and sensitization regarding health insurance.

As membership increased, financial management of the CBHI program was moved from MoH to Rwanda Social Security Board (RSSB), to improve management of the fund and mitigate conflict of interest of MoH as provider and manager of the fund.

He then detailed a number of strategies being implemented by Rwanda to ensure sustainability of CBHI:

- empowering the population through financial inclusion to enable them pay for health insurance whereby health is being looked at as a cross cutting issue.
- 'Ubudehe' is a socio- economic stratification of the population done by village committees with their village leaders and decides who is eligible under each category.
- *omulengye* is the sector which engages the population in public works to earn a living. Whenever there is something to do such as construction of major and feeder roads and bridges, priority for causal labor is given to the local population in category one to help them earn a living.
- one cow per family targeting poor households where the local population decides which family is eligible for the cow. The cows are productive assets that give milk for consumption and sale, manure for gardens and

health benefit to boost their nutrition. To ensure sustainability, each beneficiary gives back one calf to the community through a revolving arrangement.

Key challenges

- capacity of the population to pay premiums is still low causing financial instability
- reluctance of the youth to enroll in CBHI out of ignorance thinking that they do not need it
- long period between submission of invoices by health facilities and payment by RSSB causing friction between the MOH and RSSB
- limited financial management capacity of the managers and invoice auditors
- About 20% or even more especially of the informal sector remains uninsured
- management of membership is still largely paper based
- though mandatory for the entire family, larger families cannot afford to pay for all their members
- claims of unfair stratification under *Ubudehe*.

Key lessons learned

- National Health Insurance needs strong and consistent political will coupled with very good policies, very good technocrats and a vibrant civil society.
- Successful health insurance schemes require CBHI, increased healthcare utilization and outcomes, and continuous community mobilization through multiple channels including local governments, churches, electronic media and communal gatherings.
- Premiums co-payments must be set carefully.
- Proper financial management systems are critical for sustainability.
- Engagement of development partners is important to achieve a sustainable health insurance system.

4.0 Closing Ceremony

The representatives of SHU, MoH, MGLSD and the Presidential Advisor on Population and Health made remarks at the closing ceremony on 2nd November 2017.



Mr. Tom Aliti, Mr. James Ebitu, Dr. Specioza Kazibwe, Dr. Ronald Kasyaba and Mr. Makaire Fredrick

The Executive Director of SHU, Mr. Fredrick Makaire extended his appreciation to all participants for honoring the invitation. He remarked that for two days, participants were patient and actively participated in discussions, making the second conference even much more successful than the first one. He extended his appreciation to all sponsors more specifically Bread for the World, PATH/Advocacy for Better Health, and SMART Applications International. He thanked the MoH, MoGLSD and UCBHFA for the great partnership that made the conference very relevant.

He was indebted to the conference organizing committee which included representatives from MoH, MoGLSD, Federation of the Uganda Employers, Uganda Catholic Medical Bureau, USAID/ Voucher Plus Activity, UHF, UCBHFA and Save for Health Uganda. He also thanked the various SHU staff for the work done to put the conference together.

Great appreciation was extended to the former Vice President and Presidential Advisor on Population and Health Dr. Specioza Kazibwe for having graced the conference and having promised to be part of the Luwero mission and a champion for CHF schemes.

He observed that this conference, like the first one which brought to the limelight the existence of the CHF schemes, had immediately achieved some of its key objectives. The conference whose focus was to mobilize support for CHF initiatives and build their capacity had yielded support of the former Vice President, district leadership from Luwero who intend to pass an ordinance to roll out a district-wide CHI scheme.

He promised to organise another conference next year whose main objects as discussed throughout this conference will be to evaluate performance in implementing resolutions and come up with solutions pertaining to the challenges that may be faced along the way.

On behalf of MOH, Mr. Tom Aliti thanked SHU and all other partners for giving an insight on what MoH needs to do regarding the NHIS. He was optimistic that the health sector will take the conference recommendations and ensure that they are incorporated in the bill.

He believed that if the financial risk protection and equity considerations were included in the NHIS, it would inspire the country to universal health coverage and achieving related sustainable development goals. He affirmed MoH commitment to work with CHF promoters, development partners and the private sector to take the NHIS to its adoption and implementation in Uganda.

Dr. Specioza Wandira Kazibwe called upon the conference organizers to consider involving ministries that have the mandate to implement government policies. She pointed out the Ministry of Local Government which had already started piloting social community schemes, and the Ministry of Information and Communication Technology, which should advise on the relevant technology to deploy in implementing insurance schemes.

She advised officials from the Ministry of Health to borrow a leaf from experiences of CHF schemes in Uganda and national health insurance programmes within the East African region so as to develop clear plans for implementing the NHIS for the good of all people.

She expressed delight over the commitment of district leaders particularly from Luwero to implement a district scheme and pledged to support the initiative at all stages.

Mr. James Ebitu, the Director for Social Protection in the Ministry of Gender, Labour and Social Development officially closed the conference. In his remarks, he observed that the conference was perfectly in line with the plan for implementation of the social protection policy which government approved in the year 2015. The policy seeks to increase access to social security services in healthcare, protection and support of vulnerable people, and strengthening institutional framework for social protection service delivery.

Among the specific objectives of the policy is to increase coverage and scope of contributory schemes for social security in both formal and informal sector, which was a subject of discussion at the conference. It also seeks to enhance access to health insurance. He was, therefore, glad that the conference brought the issue of community health insurance to prominence.

He reminded participants that they were at the conference to address themselves to establishment of the NHIS that is effective and sustainable. The NHIS needed is one that facilitates pooling of resources for paying for healthcare in advance at predetermined premiums, and respects the principles of social solidarity, among others.

He appealed to all stakeholders to make concerted efforts in the provision of health services and be committed with whatever they are doing as already demonstrated by the local governments of Luwero and Sheema districts, as well as others that are already in the process of implementation of these policies.

He called upon all to work closely with the MoH to ensure that the NHIS Bill becomes law. He assured participants of the commitment of MoGLSD which is responsible for coordination of activities for social protection sub-sector where NHIS is a component.

He enumerated a number of existing livelihood programs such as the youth livelihood program, the women enterprise program, operation wealth creation, labor intensive public works, Northern Uganda Social Action Fund (NUSAF), village savings and loan schemes, and challenged stakeholders to find ways and means of prioritizing health insurance in such programs.

He noted that the locally tested community health financing in selected districts in central and western Uganda provided credible insights and lessons to support the rolling out of NHIS without necessarily waiting for perfection in order to move. He called upon the participants to stop wasting more time but get serious about having things implemented and avoid unnecessary and extended planning processes. He implored stakeholders to keep the discussion going, generating more useful ideas that will enable the development of the most appropriate outfit for the NHIS for the country.



Dr. Ronald Kasyaba, the Master of Ceremony, interacts with Dr. Specioza Kazibwe and Mr. Tom Aliti

ORGANIZING COMMITTEE MEMBERS



Mr. Makaire Fredrick, Save for Health Uganda



Dr. Gerald Karegyeya, USAID/Uganda Voucher Plus Activity



Ms. Nnamulondo Proscovia, Save for Health Uganda



Dr. Ronald Kasyaba, Uganda Catholic Medical Bureau



Ms. Veronica Asio, Save for Health Uganda



Ms. Juliet Nazibanja Kibirige, Save for Health Uganda



Mr. Walimbwa Aliyi, Ministry of Health



Mr. Zephaniah Ogen, Ministry of Gender, Labour and Social Development



Ms. Grace Kiwanuka Ssali, Uganda Healthcare Federation



Mr. Douglas Opio, Federation of Uganda Employers

Ms. Cynthia Nona Tamale, Initiative for Social and Economic Rights

LIST OF CONFERENCE PARTICIPANTS

No.	Name	Organization	Position
1.	Hon. Dr. Joyce Moriku Kaducu	Ministry of Health	State Minister for Primary Health Care
2.	Dr. Specioza Wandira Kazibwe	Office of the President	Senior Presidential Advisor, Population and Health
3.	Dr. Wilberforce Kisamba Mugerwa	National Planning Authority	Chairman
4.	Prof. Francis Omaswa	African Centre for Global Health and Social Transformation (ACHEST)	Executive Director
5.	Mr. Michael J. McCord	MicroInsurance Centre, USA	President
6.	Hon. Nakatte Lillian	Parliament of Uganda	Luwero District Woman MP
7.	Hon. Koluo Joseph	Parliament of Uganda	MP Toroma County
8.	Dr. Olaro Charles	Ministry of Health	Director Health Services (Clinical & Community)
9.	Mr. James Ebitu	Ministry of Gender, Labour and Social Development	Director Social Protection
10.	Mr. Martin Wandera	Ministry of Gender, Labour and Social Development	Director Labour and Industrial relations
11.	Dr. John Ssekamatte Ssebuliba	National Planning Authority	Head, Population and Social Sector Planning
12.	Mr. Benard Mujuni	Ministry of Gender, Labour and Social Development	Commissioner Equity and Rights
13.	Mr. Tom Aliti	Ministry of Health	Assistant Commissioner
14.	Mr. Denis Nkunda	Ministry of Health - Rwanda	Community Health Advisor/Specialist
15.	Mr. Walimbwa Aliyi	Ministry of Health	Senior Health Planner
16.	Mr. Makaire Fredrick	Save for Health Uganda	Executive Director
17.	Mr. Byamungu Elias	Bushenyi District Local Govt	Chief Administrative Officer
18.	Ms. Nakate Edith	Nakasongola District Local Govt	Assistant Chief Administrative Officer
19.	Mr. Kyeyune Freddie	Luwero District Local Govt	Deputy Chief Administrative Officer
20.	Mr. Serugo Joseph	Luwero District Local Govt	Vice Chairman/ Sec for Health
21.	Mr. William Kidega	USAID/PATH, Advocacy for Better Health Project	Deputy Chief of Party,
22.	Ms. Christine Namayanja	USAID - Uganda Voucher Plus Activity	Chief of Party
23.	Dr. Gerald Karegyeya	USAID - Uganda Voucher Plus Activity	Claims Manager
24.	Dr. Elizabeth Ekirapa – Kiracho	Makerere University School of Public Health	Senior Lecturer, Department of Health Policy and Management
25.	Dr. Aloysius Ssenyonjo	Makerere University School of Public Health	Project Manager, SPEED Project
26.	Prof. Robert Basaza	International Health Sciences University	Associate Dean
27.	Dr. Ekwaro A. Obuku	Uganda Medical Association	President
28.	Dr. Mukuzi Muhereza	Uganda Medical Association	Secretary General
29.	Dr. Patrick Kadama	African Centre for Global Health and Social Transformation (ACHEST)	Director Policy and Strategy
30.	Dr. Sam Orach	Uganda Catholic Medical Bureau	Executive Secretary
31.	Mr. Zakaria Muwanga Kasirye	Save for Health Uganda	Board Chairman

No.	Name	Organization	Position
32.	Ms. Leticia Nakimuli	Kyambogo University	Lecturer
33.	Mr. Paul Waigolo	DFCU Bank	Manager, Bank Support
34.	Dr. Ronald Kasyaba	Uganda Catholic Medical Bureau	Assistant Executive Secretary
35.	Ms. Judy Mugoya	Smart Applications International	Country Manager
36.	Dr. Ssesimba Badru	Nakaseke District Local Govt	District Health Officer
37.	Dr. Byamukama Agaba	Nakasongola District Local Govt	District Health Officer
38.	Dr. Johnson Kabwishwa	Sheema District Local Govt	District Health Officer
39.	Ms. Dinah Kakande	Masaka District Local Govt	Assistant District Health Officer
40.	Dr. Asiimwe Stephen	ICOB	Executive Director
41.	Ms Grace Ssali Kiwanuka	Uganda Healthcare Federation	Executive Director
42.	Dr. Stella Nakiwala	Health Partners Uganda	Chief of Party
43.	Mr. Nicholas Lutakome	Sanlam Insurance	Head of Corporate Relations
44.	Ms. Lydia Nabiryo	Ministry of Gender, Labour and Social Development	Senior Programme Officer Advocacy
45.	Mr. Zephaniah Ogen	Ministry of Gender, Labour and Social Development	Senior Programme Officer Social Protection
46.	Mr. Ssentumbwe John Jones	Parliament of Uganda	Senior Clerk Assistant
47.	Ms Ruth Uwizeye	Parliament of Uganda	Economist
48.	Ms. Kebirungi Sandra	Ministry of Health	Senior Health Planner
49.	Ms. Atuhairwe Fiona	Ministry of Health	Policy Analyst
50.	Ms. Rukia Bari	Smart Applications International	Customer Marketing Manager
51.	Dr. Martin Ruhweza	Healthwise Uganda Ltd	Executive Director
52.	Mr. Ben Asiimwe	Uganda Informal Sector Association	Chairman
53.	Dr. Druwal Alfred	National Medical Stores	Chair- TPDC Board
54.	Mr. Delius Asiimwe	Private consultant	Rappotuer
55.	Mr. Robert Kabaale	Uganda Community Based Health Financing Association	National Coordinator
56.	Mr. Kisakye Joseph	Luwero District Local Govt	Assistant District Health Officer
57.	Mr. Mayanja Dithan Kikabi	Luwero District Local Govt	Speaker
58.	Ms. Katasi Florence	Luwero District Local Govt	District Community Development Officer
59.	Ms. Ndagire Mariam	Mubende District Local Govt	District Community Development Officer
60.	Mr. Muhanguzi Basil	Bushenyi District Local Govt	District Community Development Officer
61.	Mr. Sentongo Badru	Nakaseke District Local Govt	District Community Development Officer
62.	Mr. Buyinza Simon	Nakasongola District Local Govt	District Community Development Officer
63.	Mr. Arnold Kwesiga	Initiative for Social and Economic Rights	Program Manager
64.	Sr. Ernestine Akulu	Bishop Caesar Asili Hospital	Administrator
65.	Sr. Maria Goretti Namuwulya	Kitovu Hospital	Administrator
66.	Sr. Christine Naabirye	Kitovu Hospital	Principle Nursing Officer
67.	Mr. Rugambana Aggrey	Kitagata Hospital	Accountant
68.	Sr Margaret Nangendo	St. Matia Mulumba Mulajje HCIII	In Charge
69.	Sr Priscillar N. Mukiibi	Franciscan HCIV Kakooge	Administrator
70.	Sr Blandina Mbabazi	St. Gabriel Mirembe Maria HCIII	In-charge
71.	Mr. Bob Richard Tibasiima	Butuuro SACCO	Board Chairman
72.	Mr. Turyamureeba Bosco	ICOB	Capacity Building Officer

No.	Name	Organization	Position
73.	Ms. Sharon Munguryek	Smart Applications International	Customer Marketing Executive
74.	Ms. Prossy Namyalo Kiddu	Ndejje University	Lecturer
75.	Mr. John Bosco Mubiru	Fredrich Ebert Stiftung	Senior Program Officer
76.	Ms. Juliet Nazibanja Kibirige	Save for Health Uganda	Program Officer
77.	Ms. Veronica Asio	Save for Health Uganda	Finance and Administration Officer
78.	Ms. Nnamulondo Proscovia	Save for Health Uganda	Communication and Advocacy Officer
79.	Mr. Deogratias Agaba	USAID/PATH, Advocacy for Better Health Project	
80.	Mr. Jude Bigirwenkya	USAID/PATH, Advocacy for Better Health Project	
81.	Mr. Musherure Apolo	ICOB	Training and Advocacy
82.	Mr. Tumuhairwe Johnbosco	ICOB	Project Manager
83.	Mr. Turyahabwe Kenneth	ICOB	Program Officer
84.	Mr. Tukamushaba Moses	Kisiizi Hospital HIS	Field Officer
85.	Sr. Nakirijja Cabrin	Naluggi HCII	Incharge
86.	Ms. Eva Kadimba	St. Francis HCIV, Mityana	Administrator
87.	Mr. Andrew Lubega	Kiwoko Hospital	Prepayment Cashier
88.	Mr. Kaweesi Robert	Kiwoko Hospital	Cashier
89.	Mr. Nayebare Aniset	Bitooma HCIII	In-charge
90.	Mr. Bagyenzi Isaiah	Ishaka Adventist Hospital	Pre-payment Cashier
91.	Ms. Annet Nakalo	Luwero District Local Govt	Holly Cross Kikyusa HCIII
92.	Ms. Judith Kiconco	UPMB	Reproductive Health Officer
93.	Mr. Ernest Magezi Barusya	The Actuarial Bureau of Uganda	Managing Partner Operations
94.	Sr Monica Tuhaise Mukama	Mushanga HCIII	In-charge
95.	Mr. Najjuka Amon	Hope Medical Centre	In-charge
96.	Ms. Atuzarirwe Allen	Mitooma District Local Govt	District Community Development Officer
97.	Mr. Brian Aryatunga Kanyonyozi	Bwindi Community Hospital	Scheme Manager
98.	Mr. Pontius Mayunga	Mutolere Hospital -Kabale Diocese CHI scheme	Senior Administrator
99.	Mr. Mukungu Paul Ssenyonga	Luwero District Local Govt	Mayor - Luwero Town Council
100.	Ms. Kayaga Aisha Shamim	Luwero District Local Govt	Councillor - Butuntumula Subcounty
101.	Mr. Mwesigye Patrick	Luwero District Local Govt	Councillor - Kamira subcounty
102.	Ms. Nakitende Flavia	Luwero District Local Govt	Councillor- Kalagala Subcounty
103.	Ms. Namugambe Harriet	Luwero District Local Govt	Councillor - Ziobwe Subcounty
104.	Mr. Ssemugabi Emmy	Luwero District Local Govt	LCIII Chairman - Luwero Subcounty
105.	Mr. Omarali Kyagulanyi	Luwero District Local Govt	LCIII Chairman - Katikamu Subcounty
106.	Mr. Sematimba Abubakar M	Luwero District Local Govt	LCIII Chairman - Kikyusa Subcounty
107.	Mr. Musoma George W	Luwero District Local Govt	LCIII Chairman - Bamunaanika
108.	Mr. Osman Kassim Ramathan	Luwero District Local Govt	LCIII Chairman - Bombo Town Council
109.	Mr. Ddungu Henry	Luwero District Local Govt	LCIII Chairman - Butuntumula
110.	Ms. Bukirwa Joyce	Luwero District Local Govt	Butuntumula

No.	Name	Organization	Position
111.	Mr. Kisitu Fred Magambo	Kamira Sub-county	Chief
112.	Mr Muwayire G. W	Luwero District Local Govt	LCIII Chairman - Nyimbwa Sub-county
113.	Mr. Balyejusa Zakalia	Luwero District Local Govt	for Mayor - Wobulenzi Town Council
114.	Mr. Imarach Pascal	Luwero District Local Govt	LCIII Chairman - Ziobwe
115.	Mr. Kenneth Waiswa	Save for Health Uganda	Project Coordinator
116.	Ms. Dorothy Nansubuga	Save for Health Uganda	Senior Field Officer
117.	Mr. Samuel Kitenda	Save for Health Uganda	Field Officer
118.	Mr. Mujuni Wilfred	Save for Health Uganda	Field Officer
119.	Mr. Friday Moses	Save for Health Uganda	Team Leader
120.	Mr Apenyo Robert	Private consultant	Rappotuer
121.	Ms. Seti Patience	Ministry of Health	PA Minister of State for Primary Healthcare
122.	Mr. Abudhala Haruna	Ministry of Health	Technical Assistant Minister of State for Primary Healthcare
123.	Mr. Kakande Albert	Ministry of Health	
124.	Mr. Bizimana Derick	Ministry of Gender, Labour and Social Development	
125.	Ms. Nakuya Joan	Ministry of Gender, Labour and Social Development	
126.	Dr. Tumuhimbise Manache	Ishaka Health Plan	Senior Scheme Manager
127.	Mr. Sekyanzi David	Kyambogo CHI scheme	CHI Scheme leader
128.	Mayanja Moses	Magoma CHI scheme	CHI Scheme leader
129.	Ms. Mbaziira Harriet	Kakooge CHI scheme	Scheme leader
130.	Mr. Bainomugisha Vincent	Bitooma-Katenga CHI scheme	WATSA-CHI scheme leader
131.	Ms. Katushabe Caroline	Nyarwenshama CHI scheme	WATSA-CHI scheme leader
132.	Mr. Ssemiyingo Fred	Mubende Schemes Cooperation Mechanism	Volunteer
133.	Ms. Masembe Esau	Mubende Schemes Cooperation Mechanism	Chairperson
134.	Ms. Babirye Rusia Batega	ICOB	Community Health Mobilizer
135.	Mr. Kato Adiru Mwanje	Twekembe Busukuma Cooperative Society	Member
136.	Mr. Semakula Fredrick	Twekembe Busukuma Cooperative Society	Member
137.	Ms. Iga Joyce	Twekembe Busukuma Cooperative Society	Member
138.	Ms. Angella Kawooya	IHSTU	Student
139.	Mr. Wapowo John A	Makerere university	Student
140.	Mr. Eranda Derrick	Kyambogo University	Student
141.	Mr. Nkalubo Jonathan	Makerere University	Student
142.	Mr. Kevin Nwanna	Stafford University	Student
143.	Ms. Namakula Threza	Kyambogo University	Student
144.	Ms. Namagembe Beatrice	Kyambogo University	Student
145.	Mr. Kato Yusuf	Kampala University	Student
146.	Ms. Josephine Kemigisha	Save for Health Uganda	Office Administrator
147.	Mr. Ssekyanzi Badru	Save for Health Uganda	Driver / Office Assistant
148.	Mr. Samuel Oromchan	Save for Health Uganda	Driver / Office Assistant
	Journalists		

No.	Name	Organization	Position
149.	Ms. Lillian Namusoke Magezi	Vision Group	Editor
150.	Ms. Rosette Nansamba	Musana FM	News Editor
151.	Ms. Judith Kukunda	Uganda Radio Network	Reporter
152.	Ms. Adiah Nakuti	UBC TV	Reporter
153.	Mr. Mike Sebalu	Radio One / Kaboozi	Reporter
154.	Ms. Zahara Namuli	NBS TV	Reporter
155.	Ms. Nassali Fatiah	NBS TV	Reporter
156.	Ms. Gloria Nakajubi	New Vision	Reporter
157.	Mr. Godfrey Lugaaju	Daily Monitor	Reporter
158.	Mr. Milton Emmy Okwam	Red Pepper Publications Ltd	Reporter
159.	Mr. Stephen Mwiri	Private consultant	Videographer
160.	Mr. Katende Muhammed	Private consultant	Photographer

Conference Programme

1st - 2nd November 2017

Day 1 1 st November 2017				
Agenda		Presenters / panelists	Time	Session chair
Arrival and registration of participants				
Welcome remarks 8:30 – 8:40 AM		Mr. Fredrick Makaire, Executive Director Save for Health Uganda	10 minutes	Dr. Ronald Kasyaba, Assistant Executive Secretary, Uganda Catholic Medical Bureau
Video highlights on last year’s conference 8:40 – 9:00 AM		Ms. Proscovia Nnamulondo Communication and Advocacy Officer Save for Health Uganda	20 minutes	
Key note Address 9:00 – 9:20 AM		Prof. Francis Omaswa Executive Director of the African Centre for Global Health and Social Transformation (ACHEST)	20 minutes	
Key note Address 9:20 – 9:35 AM		Mr. Michael J Mc Cord President of Micro insurance Centre, USA	15 minutes	
Discussing the Key note address 9:35 – 9:50 AM		Dr. Kisamba Mugerwa Chairman National Planning Authority	15 minutes	
Official Opening 9:50 – 10:25 AM		Mr. Zakaria Muwanga Kasirye Chairperson of the Board, Save for Health Uganda (SHU)	5 minutes	
		Hon. Dr. Sarah Opendi State Minister for Health, General duties Guest of honor	30 minutes	
10:20 – 10:55 AM	TEA BREAK		30 minutes	
Theme 1: Status of the NHIS and how it can be implemented				
Sub-theme	Topics	Presenters / panelists	Time	Session Chair
Active participation in the management and governance of the NHIS 10:55 – 11:25 AM	Key note Presentation on; - status of the proposed NHIS for Uganda - how should the sub-schemes of the NHIS work independently and collectively to achieve the NHIS goal? - participation of the informal sector in the management and	Dr. Henry Mwebesa Director planning, Ministry of Health	30 minutes	Mr. Benard Mujuni Commissioner, Ethic and Rights, Ministry of gender, Labor and social development

11:25 – 12:50 PM	governance of the NHIS.			1hour 30 minutes	
	Panel discussion on determining readiness for introduction and running of the NHIS for all and willingness of residents to participate in the proposed NHIS.	Mr. Robert Kabaale National Coordinator, Uganda Community Based Health Financing Association			
		Ms. Grace Ssali Kiwanuka, Executive Director Uganda Health Federation			
		Mr. Ben Asiimwe Chairman of the Informal sector			
		Dr. Ekwaro A. Obuku President, Uganda Medical Association			
		Mr. Peter Christopher Werikhe Secretary General, National Organization for Trade Unions			
S M A R T					
12:50 – 1:55 PM	LUNCH BREAK		1 hour		
Theme 2: Understanding the informal sector in Uganda					
Sub-themes	Topics	Presenters / panelists	Time	Session Chair	
Capacity to pay for the National Health Insurance Scheme (NHIS) 1:55 – 2:25 PM	Key note presentation on diversity of the informal sector in Uganda	Dr. John Ssekamatte Ssebuliba, Head of Social sector planning, National planning Authority.	30 Minutes	Mr. William Kidega; Deputy Chief of Party & partnership specialist, Advocacy for Better Health USAID / PATH	
2:25 – 3:55 PM	Panel discussion on; - premiums and mechanisms for the informal sector to contribute to the NHIS; - The indigents, who pays and how?	Mr. Fredrick Makaire Executive Director Save for Health Uganda	1hour 30 minutes		
		Dr. Aloysius Ssenyonjo Makerere University School Of Public Health.			
		Ms Christine Namayanja Chief of Party, USAID, Uganda Voucher PLUS			
		Mr. Stephen Kasaija, Head expanding social protection program management unit			

		Ministry of Gender, labor and Social Development – SAGE and contributory program		
43:55 – 4:25 PM	Conclusion of day one	Outcome of the discussions on day 1 Mr. Delius Asiimwe, Conference Rapporteur	30 minutes	
4:25 PM	EVENING TEA			
Day 2 2 nd November 2017				
Theme 3: Access to health insurance in Uganda				
Sub-themes	Topics	Presentations	Time	Session Chair
Pooling risks and resources 8:30 – 9:00 AM	Key note presentation on What is pooled under the NHIS	Dr. Elizabeth Ekirapa – Kiracho Lecturer, Department of Health Policy and Management, Makerere University School Of Public Health.	30 minutes	Dr. Sam Orach, Executive Secretary, Uganda Catholic Medical Bureau
9:00 – 10:30 AM	Panel discussion on ideal management of the NHIS funds; single or multiple pools	Dr. Sarah Byakika, commissioner Planning Ministry of Health	1 hour 30 minutes	
		Mr. Moses Bekabye, Technical Advisor, Ministry of finance Planning and Economic Development		
		Ms Proscovia Nnamulondo Communication and Advocacy Officer Save for Health Uganda		
		Mr. Milton Owor Director, HR and Administration National Social Security Fund		
		Mr. Nicholus Lutaakome Uganda Insurers Association (UIA)		
10:30 – 11:00 AM	TEA BREAK		30 minutes	
	Topics	Presentations	Time	Session Chair
Scaling up community health financing 11:00 – 11:30 AM	Key note presentation on why the CHF schemes in Uganda have had slow growth	Prof. Robert Basaza, Associate Dean, Institute of Public Health and Management International Health Sciences University, Kampala (IHSU)	25 Minutes	Dr. Owembabazi Wilberforce PMS – Health systems strengthening, Office of health and HIV USAID, Uganda
11:30 – 11:40 AM	Documentary about benefits of CHF		10 minutes	
	Stand up presentations experiences on growth	Mr. Pontius Mayunga	10 minutes	

11:40 – 12:30 PM 12:30 – 1:00 PM	and sustainability of CHF schemes	Senior Administrator Mutolere Hospital Kabale Diocese		
		Mr. Daniel Kakunta Senior Scheme manager Ishaka Hospital Health plan	10 minutes	
		Ms Harriet Mbaziira, Scheme leader Kakooge Munno mu Bulwadde scheme, Nakasongola	10 minutes	
		Ms. Babirye Rusia Batega Community health mobilizer for ICOB	10 minutes	
		Mr. Bob Richard Tibasiimwa Board chairperson Butuuro Savings and credit cooperative Uganda Health cooperatives	10 minutes	
	Plenary discussion on how CHF can be scaled up for maximal inclusiveness of the population in Uganda?	All participants	30 minutes	

Theme 4: Leaving no one behind in the implementation of the NHIS

Sub-theme	Topic	Presenters/panelists	Time	Session chair
1:00 – 2:00 PM	LUNCH BREAK		1 hour	
Inclusive implementation of the NHIS 2:00 – 2:10 PM 2:10 – 2:30 PM 2:30 – 3:00 PM	Introductory remarks on fair representation of all population categories in the phased implementation of the NHIS.	Hon. Rossette Mutambi Member of the health committee of Parliament	10 minutes	Dr. Sarah Byakika Commissioner planning Ministry of Health
	Power point presentation on Fair representation of all population categories in the phased implementation of the NHIS.	Ms. Namusobya Salima Executive Director Initiative for Social and Economic Rights (ISER)	20 minutes	
	Plenary discussion on fair representation of all population categories in the phased implementation of the NHIS	All participants	30 minutes	
Government support for sustainability of NHIS	Paper presentation on Government's support for	Dr. Nkunda Denis Community Health Advisor/Specialist,	20 minutes	

3:00 – 3:20 PM 3:20 – 3:50 PM	sustainability of the NHIS; <i>experience from Rwanda</i>	Ministry of Health, Rwanda		
	Plenary Discussion about government support for sustainability of NHIS	All participants	30 minutes	
Conclusion 3:50 – 4:10 PM	Conclusions of the conference	Mr. Delius Asiimwe, Conference Rapporteur	20 minutes	Dr. Ronald Kasyaba, Assistant Executive Secretary, Uganda Catholic Medical Bureau
Closing ceremony 4:10 – 4:30 PM	Closing remarks	Mr. Fredrick Makaire, Executive Director, Save for Health Uganda.		
		Mr. James Ebitu Director social protection Ministry of Gender Labour and social Development		
		Dr. Henry Mwebesa Director planning, Ministry of Health		
	Official Closure	Hon. Dr. Michael Iga Bukenya Chairman of the health committee of Parliament	10 minutes	
4:30 PM	EVENING TEA AND DEPARTURE			



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