



THIRD NATIONAL CHF CONFERENCE REPORT

8th-9th
NOVEMBER
2018

IMPERIAL ROYALE HOTEL, KAMPALA



THEME

Enabling effective participation of the informal sector in community health financing and other social protection initiatives.



CONFERENCE HOST AND PARTNERS



Ministry of Health



**UGANDA VOUCHER
PLUS ACTIVITY**



Ministry of Gender, Labour
and Social Development



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LIST OF ACRONYMS

CBHI	Community Based Health Insurance
CHF	Community Health Financing
DHOs	District Health Officers
DHIS	District Health Information System
HC	Health Center
HSDP	Health Sector Development Plan
IGAs	Income Generating Activities
IPD	In-patient Department
ISER	Initiative for Social and Economic Rights
M&E	Monitoring and Evaluation
LDCHIS	Luwero District Community Health Insurance Scheme
MFIs	Micro Finance Institutions
MOH	Ministry of Health
MOGLSD	Ministry of Gender, Labour and Social Development
NGO	Non-Government Organization
NDP	National Development Plan
NHIS	National Health Insurance Scheme
OPD	Out-patient Department
SACCOs	Savings and Credit Cooperative Societies
SAGE	Social Assistance Grant for Empowerment
SHU	Save for Health Uganda
UDHS	Uganda Demographic Health Survey
UHC	Universal Healthcare Coverage
WHO	World Health Organization
WTP	Willingness to Pay

Executive Summary

This is a report of the 3rd National Community Health Financing Conference held at Imperial Royale Hotel, Kampala, on 8th and 9th November, 2018. The conference was organized by Save for Health Uganda (SHU), with funding from Bread for the World and in collaboration with the Ministry of Health, and Ministry of Gender, Labour and Social Development. Other partners included Smart Applications International Uganda Limited, USAID/Uganda Voucher Plus Activity, Uganda Insurers Association, Federation of Uganda Employers, Initiative for Social and Economic Rights, and Uganda Community Based Health Financing Association. The conference theme was *“Enabling effective participation of the informal sector in community health financing and other social protection initiatives”*. The Conference objectives were:

1. To review progress made in implementing community health financing and introducing the National Health Insurance Scheme (NHIS) in the past 12 months.
2. To demonstrate innovations in managing community health financing (CHF) and other social protection initiatives for enrolment and retention of households of informal sector workers.
3. To identify feasible strategies how the informal sector can access community health insurance, the NHIS and other social protection initiatives.

This conference built on two previous CHF conferences to share evidence on feasible interventions and advocate for inclusion of the informal sector in the NHIS and other social protection initiatives.

The conference was opened by Dr Charles Olaro, Director Clinical Services in the Ministry of Health, who represented Hon Sarah Opendi, the Minister of State for Health in Charge of General Duties. It was closed by Mr. Bernard Mujuni the Commissioner for Equity and Rights in the Ministry of Gender, Labour and Social Development who represented Hon Peace Mutuuzo, the State Minister for Gender and Culture. The ministers pledged, on behalf of their respective ministries, to support community health financing initiatives and other social protection mechanisms that target the informal sector. Dr. Babyo Fatunmbi delivered the keynote address on behalf of the World Health Organisation (WHO) Country Representative in Uganda, Dr. Yonas Tagegn Woldemaria.

There were three sessions which comprised 14 oral and two poster presentations, and plenary. The first session focused on progress made and lessons learned in implementing community health financing initiatives targeting the informal sector including community health insurance (CHI), maternal voucher schemes, and mandatory health insurance products in savings and credit organisations (SACCOs), and other microfinance institutions. The key highlights of the session were:

1. CHI had reached 20 districts mainly in western and some parts of central Uganda, covering about 152,000 people.

2. A total of 53 healthcare providers were providing services to members of CHI schemes. Out of these, 23 were contracted by Save for Health Uganda (SHU) to serve 33,340 CHI scheme members in nine districts.
3. Luwero district passed an ordinance to create one district CHI scheme; the ordinance was awaiting approval by the Attorney General.
4. USAID/ Uganda Voucher Plus Activity was running in 35 districts in eastern and northern Uganda with 232,158 vouchers sold. The vouchers enabled 96,000 mothers to deliver under professional care. A total of 156 private health facilities were participating in the voucher program.

The second session comprised practical demonstrations of innovations used in managing community health financing (CHF) and other social protection initiatives for enrolment and retention of households of informal sector workers and discussions on how these can be replicated. Presenters demonstrated that:

1. Mobile applications (Apps) accessible via telephone handsets greatly improved convenience, simplicity, affordability and efficiency in promoting and managing social protection initiatives. Clients were able to register, enroll, save, check balances and access benefits via telephone handsets. Online registration contributed to growth in the number of people saving voluntarily with Mazima Retirement plan from 2,399 in 2016 to 10,000 in 2018.
2. Online interactive platforms offered members of social protection schemes the option to use email and the website to make enquiries and learn more about services.
3. Constant engagement of members through online, telephone and other platforms raised awareness about benefits of schemes and increased uptake.
4. Biometric systems greatly minimized risks such as fraud, inaccuracies in recording member data, and delays in accessing benefits.
5. Established databases such as that held by the National Information and Registration Authority (NIRA) about citizens simplified selection of program beneficiaries.

The final session entailed sharing and discussing strategies which could enable the informal sector benefit from CHF, the NHIS and other social protection initiatives. A guest from Rwanda showed how Rwanda managed to enrol poor households into viable community-based health financing initiatives while a researcher shared about a study on willingness to pay for health insurance among commercial motorcyclists. The outcomes of the session were:

1. Stratification/ categorizing the population using a community-led approach enhanced equity in healthcare access and health insurance premium contribution.

2. A national population database eased claims processing, access to services, measuring program progress.
3. Massive sensitization campaigns led by the government and other actors were important to raise awareness about health insurance for purposes of increasing uptake.

The conference was attended by 186 participants from 28 districts across the country.

Following the presentations and discussions, five key resolutions were agreed upon as the conference declarations.

1. Luwero District local government will follow through the approval of the Luwero District Community Health Insurance Ordinance 2017 and commence its implementation.
2. Once Luwero District Community Health Insurance Ordinance is approved by the Attorney General, it will be made available to other districts which can use it to guide development of similar initiatives in those districts.
3. Leaders and civil society organisations in other districts will work with Save for Health Uganda to start community health financing initiatives in regions where they do not exist particularly in the north and east.
4. SHU will work with partners to set up a task team to review the progress of the current NHIS Bill and make recommendations on the most appropriate steps to take which may include continued pursuit of the current Bill until it is tabled in Parliament or preparation of a private member's bill.
5. Adapt CHI schemes to modern technology to reduce operational costs, improve efficiency and move away from expensive manual systems of running CHI.

Acknowledgements

Uganda has a very high level of out of pocket payments contributing 41% of the total health expenditure; high poverty levels standing at 21.4% and a low coverage of health insurance at only 5% with 90% of the labour force, most of whom are employed in the informal sector, not having access to formal security. These facts make access to timely, quality and affordable healthcare services very difficult for many citizens. Save for Health Uganda promotes community health financing to enable low-income families pool resources for healthcare under a prepayment arrangement to avoid delaying to seek care or falling into poverty due to medical bills.

The purpose of the National Community Health Financing conferences is to highlight initiatives that ease financial access to health care for low-income families and advocate for recognition and scaling up of such efforts to reach more people across the country.

I, therefore, extend our sincere gratitude, as Save for Health Uganda, to all institutions and individuals that made generous contributions towards the success of this conference. I, in a special way, thank the following organisations and institutions for their various contributions:

- Bread for the World
- Ministry of Health
- Ministry of Gender, Labour and Social Development
- Uganda Insurers Association
- Smart Applications International (Uganda) Limited
- Federation of Uganda Employers
- USAID/Uganda Voucher Plus Activity
- Initiative for Social and Economic Rights
- Uganda Community Based Health Financing Association
- Bishop Caesar Asili Hospital, Luwero
- St. Luke Namaliga HCIII, Luwero
- Apostolic Ministries for the Gospel (AMG) International
- St. Gabriel Mirembe Maria, Mubende
- Mushanga HCIII, Sheema
- Ishaka Adventist Hospital, Bushenyi
- Holy Cross Kikyusa HCIII, Luwero

I wish to recognize the tremendous efforts of presenters and session chairs who sacrificed time and other resources to prepare content for the various sessions. In addition, I am very grateful to all participants for sitting in and participating in all discussions during the two days of the conference. We cannot count any success without you, dear participants.

Last but not least, I applaud members of the organizing committee for the great commitment exhibited throughout the period of conference preparations. Thank you for your time, ideas and strategies shared from time to time.

As we embark on implementing the resolutions we agreed upon together at the conference, I look forward to sharing bigger achievements when we meet again.

Thank you all.



Makaie Fredrick
Executive Director
Save for Health Uganda

About conference organizers and partners



Save for Health Uganda was formed in 2002 and registered as a non-governmental organization (NGO) in 2003. SHU was formed to: improve people's financial access to quality and affordable healthcare services; and rationalize healthcare seeking behaviours. It implements programs in community health financing, livelihood improvement, quality healthcare delivery, and women empowerment. SHU currently works in 10 districts where over 35,000 individuals are enrolled in community health insurance (CHI) schemes. SHU advocates for a universal national insurance law for Uganda.



Bread for the World (BftW) is the globally active development and relief agency of the Protestant Churches in Germany. In more than 90 countries across the globe, BftW empowers the poor and marginalised to improve their living conditions. Key issues of its work are food security, the promotion of health and education, the access to water, the strengthening of democracy, respecting human rights, keeping peace and the integrity of creation.



The Ministry of Health is a government body with the mandate of stewardship and leadership of the health sector. It is responsible for policy review and development, supervision of health sector activities, formulation and dialogue with health development partners, strategic planning, setting standards and quality assurance, resource mobilization, advising other ministries, departments and agencies on health-related matters, and ensuring quality, health equity, and fairness in contribution towards the cost of health care.



Smart Applications International Limited is a leading secure Information Communication Technology (ICT) solutions provider delivering a wide variety of world-class technological business solutions. Smart has established itself as the leader in biometric technology satisfying the need for a secure identification system for the burgeoning private health sector.

Smart pioneered the use of biometric fingerprint identification used in the medical insurance industry for member identification at health facilities before a service is offered. Smart is committed to fast, easy access to healthcare services and endeavors to continuously offer solutions that exceed customers' expectations.



The Ministry of Gender, Labour and Social Development (MGLSD) is a government entity mandated to empower citizens to maximize their individual and collective potential by developing skills, increasing labour productivity, and cultural enrichment to achieve sustainable and gender-sensitive development.



UGANDA VOUCHER PLUS ACTIVITY



The Uganda Voucher Plus Activity is a five-year (2016–2021) USAID-funded project implemented by Abt Associates, a mission-driven global leader in research and program implementation in the fields of health, social and environmental policy, and

international development. The project aims to increase utilization of maternal health services for poor pregnant women by promoting safe, facility-based deliveries through the private sector. The goal is to reduce maternal and neonatal morbidity and mortality in 35 districts of eastern and northern Uganda. To achieve this goal, the Activity builds demand for vouchers through Voucher Community-Based Distributors (VCBDs) who offer vouchers at UGX4,000 to eligible women. The VCBDs provide safe motherhood information to pregnant women, youth, and male partners. The highly subsidized voucher package offers four antenatal care visits, elimination of mother-to-child transmission of HIV services, delivery with a skilled attendant, including referral if needed, postnatal care, and postpartum family planning.



Uganda Insurers Association (UIA) was founded in 1965 by insurance companies to promote the development and expansion of sound insurance and reinsurance activities in Uganda. It brings together all licensed insurance and reinsurance companies in Uganda. Its mission is to promote best practices and the highest standards within the Ugandan insurance sector safeguarding the consumers' best interests. UIA works to advance the interests of insurance and reinsurance companies by adopting a common strategy that encourages and promotes close cooperation, the exchange of business among members,

builds on knowledge through research, influences the enactment of favourable legislation and presents the views of the membership to government, quasi-government and private bodies. UIA boasts of a membership of over 30 insurance companies.



INITIATIVE FOR SOCIAL AND ECONOMIC RIGHTS

The Initiative for Social and Economic Rights (ISER) is a registered, not-for-profit human rights NGO in Uganda founded in February 2012 to address the gaps that exist in respecting, protecting and fulfilling economic and social rights in Uganda and to improve government accountability for this category of rights. The strategic approach for the organization is based on the core

principles of equality and non-discrimination in access to social and economic services, accountability, citizen/community participation, adequacy and quality. Fulfillment of ISER's objectives is implemented along thematic programmes namely: (a) The Right to Education; (b) The Right to Health; (c) Business and Human Rights; (d) Social Accountability and Citizen Participation; and (e) Economic Policy.



The Federation was initially registered in 1960 as a corporate body under the names of Society of Employers which was changed to Federation of Uganda Employers (FUE) in 1961 under the Trustees Incorporation Act, 1939. Today, FUE is the voice of employers on social and economic issues. It is recognized both locally and internationally as a top notch employers'

organization. FUE is affiliated to the International Organization of Employers, Business Africa and East African Employers Organization. It officially represents Ugandan Employers at the International Labour Organization's Annual Labour Conference. Our vision is to be the leading organization in serving employers' interests and needs and our vision is to enhance employers' competitiveness through policy advocacy, fostering best employment relations and provision of business development services.



Uganda Community Based Health Financing Association (UCBHFA) is a network of Community Health Financing (CHF) initiatives in Uganda formed in 1998. The association coordinates and supports the establishment and management of sustainable CHF initiatives in Uganda. It does this through building competencies and skills in managing community based health financing initiatives; advocating for people centered policies and practices that promote sustainable CHF initiatives; facilitating, supporting and coordinating development of CHF schemes across the country. UCBHFA has 23 members that include health care facilities and CHF (CHI) promoting organizations with over 150,000 beneficiaries. The activities of UCBHFA members are in 20 districts mainly in western and central Uganda.

Bishop Caesar Asili Hospital

It is a private-not-for-profit (PNFP) hospital owned by the Catholic Church. It is a 100-bed facility located at Kasana, Luwero Town Council along Kampala-Gulu highway. The hospital has served CHI schemes in Luwero, Nakaseke and Nakasongola districts since 2007.

St. Luke Namaliga HCIV

It is a PNFP facility owned by the Catholic Church. It is located at Bombo in Luwero district. The 37-bed facility has served CHI schemes in Luwero area since 2017.

St. Gabriel Mirembe Maria HCIII

It is a PNFP facility owned by the Catholic Church. It is located at Namiringa in the newly created district of Kassanda which was part of Mubende district. The 28-bed facility has served CHI schemes in Kassanda and Bukuya sub-counties since 2013.

Apostolic Ministries for the Gospel International (AMG)

AMG owns Hope Medical Centre, a PNFP facility located in Bugongi Town council, Sheema district. It has served CHI schemes in Bushenyi and Sheema districts since 2009.

Mushanga HCIII

It is a PNFP facility owned by the Catholic Church. It is located in Sheema Municipality, Sheema district. The 28-bed facility has served CHI schemes in Bushenyi, Sheema and Mitooma districts since 2015.

Ishaka Adventist Hospital

It is a PNFP hospital owned by the Seventh day Adventist Church. It is a 110-bed capacity facility located in Ishaka Municipality, Bushenyi district. The hospital has served CHI schemes in Bushenyi, Sheema and Mitooma districts since 2007.

Holy Cross Kikyusa HCIII

It is a PNFP facility owned by the Catholic Church. It is Located in Kikyusa sub-county, Luwero district. The 25-bed facility has served CHI schemes since 2017.

1.0 Introduction

Save for Health Uganda (SHU) with funding from Bread for the World and in collaboration with the Ministry of Health, Ministry of Gender, Labour and Social Development, and other partners, hosted the 3rd National Community Health Financing (CHF) conference in Uganda on 8th and 9th November, 2018 at Imperial Royale Hotel, Kampala. The conference objectives were:

1. To review progress made in implementing community health financing and introducing the National Health Insurance Scheme in the past 12 months.
2. To demonstrate innovations in managing community health financing and other social protection initiatives for enrolment and retention of households of informal sector workers.
3. To identify feasible strategies how the informal sector can access community health insurance, the National Health Insurance Scheme and other social protection initiatives.

The conference theme was ***Enabling effective participation of the informal sector in community health financing and other social protection initiatives.***

1.1 Background

Many Ugandans face financial challenges in accessing healthcare services due to poverty and high out-of-pocket payments. The Uganda Household Survey Report of 2016/17 indicated that 21.4% of the population (8.1 million people) lived below the poverty line. According to the National Health Accounts, 2017, out-of-pocket expenditure is 41% of total health care expenditure, way above the 15% recommended by the World Health Organization (WHO). A significant proportion of Ugandans are thus adversely affected by ill-health. Households often resort to distress sale of productive assets to pay for health services, driving the members deeper into poverty.

The first and second national CHF conferences successfully raised awareness and brought to the limelight the CHF initiatives in the country, and demonstrated their potential to contribute to the realization of a fair National Health Insurance Scheme (NHIS). Consequently, CHI gained recognition among some policy makers as a viable social protection intervention in Uganda. In addition, health insurance for the informal sector gained more prominence in national level dialogues. Further, communities and leaders were mobilized to support CHF schemes and consequently, Luwero district started the process of establishing a district-wide CHI scheme. During the 3rd CHF conference, there was thus a call to all stakeholders to play their part to increase coverage of CHF to all districts in Uganda.

At national level, the government plans to introduce a universal national health insurance system. This commitment is anchored in the Uganda Vision 2040, the National Development Plan II, the Health Sector Development Plan 2015/2016 – 2019/2020, and the National Social Protection Policy, 2015, among others. At the moment, the draft National Health Insurance Scheme (NHIS) bill, 2014, is pending presentation to Parliament.

However, there are concerns over delays in the process of enacting the bill into law and absence of adequate provisions on how the informal sector will be enrolled into the NHIS.

1.3 Brief overview of community health insurance in Uganda

1.3.1 Community Health Financing

It is an arrangement for simplifying access to health care where a group of people voluntarily agree to pool resources and share the health risks. Community health Insurance (CHI) is one of the CHF instruments for mitigating shocks caused by ill-health and improving access to healthcare for low-income families. Benefits of CHF include protecting families from catastrophic expenses which would result from high medical bills; making financial access to health services easy; increasing cost recovery for healthcare providers because of reduced runaway cases and defaulters; mobilising additional resources for healthcare, among others. The other CHF instruments include voucher schemes, community health funds, health revolving funds, and drug revolving funds.

1.3.2 History of CHI in Uganda

The first CHI scheme in Uganda was established in 1996 at Kisiizi Hospital in Rukungiri District with support from the government of Uganda and United Kingdom Department for International Development (DFID). Following the successful piloting of the scheme, other schemes started coming up. These were promoted by non-governmental organizations (NGOs), civil society organizations, community self-help groups, religious institutions, and healthcare providers.

The CHI schemes registered under Uganda Community Based Health Financing Association (UCBHFA) are distributed in 20 districts in Uganda (12 western, 7 central and 1 eastern) covering about 152,000 people. The members of these schemes receive healthcare services from 53 health care facilities at various levels. The healthcare facilities include government, private-for-profit and private-not-for-profit.

2.0 Opening ceremony

This session entailed welcome remarks by SHU Executive Director and Board Chairperson plus opening remarks by the Minister of Health.

2.1 Welcome remarks by the Executive Director of SHU



Mr. Fredrick Makaire

Mr Frederick Makaire was happy that the conference attracted participants from all regions of the country, which reinforced the fact that it was a national conference. He recognized participants from each of the 28 districts represented including Kyenjojo, Kabarole, Kanungu, Kileleshwa, Lira, Oyam, Alebtong, Bukedea, Apac, Mbale, Pallisa, Butaleja, Sironko, Amuru, Iganga, Mubende, Kassanda, Mityana, Masaka, Butambala, Luwero, Nakaseke, Nakasongola, Bushenyi, Mitooma, Sheema, Wakiso and Kampala. He also welcomed the participant from Rwanda who was invited to share his country's experience in reaching the informal sector with health insurance.

He thanked partners who supported the conference as well as individuals who sponsored themselves to attend. He pointed out that the conference was bigger in scope than previous ones because it focused on both CHF and other social protection initiatives for the informal sector.

Mr. Makaire observed that SHU had continued to organise CHF conferences for participants to generate strategies, solutions and policy proposals for addressing challenges such as the high out-of-pocket expenditure which stood at 41% of the total health expenditure, impoverishing healthcare expenditures, low budget allocation to the health sector in the national budget, and delayed enactment of the NHIS bill into law.

He reiterated that this conference was aimed at reviewing progress in CHF and the NHIS, demonstrating innovations for implementing CHF and other social protection initiatives, and identifying feasible strategies of engaging the informal sector to ensure they access CHF and NHIS.

He ended his remarks with brief audio-visual highlights of the second CHF conference held in 2017.

2.2 Welcome remarks by the Chairman of the Board of Directors of SHU

Mr. Zakaria Kasirye Muwanga thanked participants for honouring the invitation to the conference. He was glad that the purpose of holding annual CHF conferences was being realised with achievements such as increased awareness about CHI since the first conference. He pointed out Luwero District which had passed the district community health insurance ordinance as one of the positive achievements since the second conference held in 2017.

Mr. Kasirye appreciated the Ministry of Gender, Labour and Social Development for recognizing CHI as a key social protection instrument and for fostering discussions and encouraging interventions targeting the informal sector.

He congratulated the Ministry of Health on infrastructural investments undertaken at health facilities and emphasized the urgent need to introduce health insurance for all to enable low-income earners access services at the modernised facilities where user fees were being reintroduced. He requested the Ministry of Health to consider CHI schemes for direct budget support to enable them continue preparing the informal sector for the NHIS.

Mr. Kasirye said the theme of this year's conference which is *'enabling effective participation of the informal sector in community health financing and other social protection initiatives'* was selected in recognition of the fact that CHI is a component of a larger social protection agenda. He said the aim of conference organisers was to exchange knowledge and experiences on how various social protection initiatives were successfully reaching individuals and households in the informal sector.



Mr. Zakaria Kasirye

2.3 Opening remarks by the Minister of State for Health - General Duties

Dr. Charles Olaro, the Director for Clinical Services at Ministry of Health, represented Hon. Sarah Opendi, the Minister of State for Health in Charge of General Duties who was out of the country on national duties. Dr Olaro read out the Minister's speech where she commended SHU together with partners for organizing the conference and acknowledged the involvement of government (Ministries of Health and Gender, Labour and Social Development) in the conference preparations. She underscored the investments made by the government in the health sector with up to 86% of the population now living within a 5km radius from a health facility and was quick to point out that they were working towards reducing this even further to 4km in line with the Astana Declaration.



Dr. Charles Olaro

The Minister noted that the Ministry of Health was working to move to Universal Health Coverage (UHC) which would increase financial risk protection and reduce impoverishment due to health expenditure. The Minister acknowledged that households' out-of-pocket expenditure at 41% was way above the Health Sector Development Plan target of 30% by the year 2019/20.

The minister commended civil society organizations and development partners promoting prepayment schemes such as CHI that instill a culture of taking responsibility for unforeseeable and catastrophic health care eventualities among Ugandans. She, however, noted that

the population covered by health prepayment mechanisms was still very low standing at about 300,000, which is 0.8% of Uganda's population.

The Minister congratulated Luwero district leaders for taking the bold step of passing an ordinance on CHI and used this as an example of how everyone could do what is within their capacity to create impact at their various levels. She pledged on behalf of the Ministry of Health to support Luwero district in implementing the CHI ordinance, which could serve as a pilot for rolling out CHI schemes under the planned NHIS.

The Minister reiterated government commitment to the process of establishing the NHIS as a means of protecting households and individuals as well as mobilizing additional resources for health in an equitable manner. She gave an update that the Cabinet Memo on the draft NHIS bill was discussed by Cabinet which gave comments to the Ministry of Health to be addressed. The Ministry had made the adjustments recommended and was ready to return the bill to Cabinet. She reported that government had allocated UGX 2 billion in the budget for 2018/19 financial year to support preparatory activities such as awareness creation, review of the benefit package, development of regulations and institutional building for establishment of the NHIS. The Minister pledged, on behalf of government, to fast track NHIS and present it to Parliament before the end of the financial year.



A section of participants on the first day of the conference

3.0 Conference proceedings

3.1 Key note address by World Health Organization Country Representative

Dr. Babyo Fatunmbi delivered the keynote address on behalf of the WHO Country Representative, Dr. Yonas Tegegn Woldemaria. He noted that the conference had come at a critical point when Uganda is pursuing the path of ensuring that all people have equitable access to quality and effective healthcare without facing financial hardships.

He noted that two weeks prior to the conference, the government of Uganda had joined the rest of the world to reaffirm its commitment to Universal Health Coverage (UHC) at a global conference held in Astana, Kazakhstan. They had made a declaration committing to making bold choices in promoting and protecting the right to the highest attainable standard of health.

While he recognized Uganda's continued commitment to the important global agenda of Sustainable Development Goals (SDGs) and UHC, he pointed out that a lot more still needed to be done to ensure that no one is left behind on the path to UHC, particularly the informal sector who form the majority of the population.



Dr. Babyo Fatunmbi

Dr. Fatunmbi pointed out some of Uganda's grim statistics that showed how far the country fell short of the desired situation regarding catastrophic expenditure and social protection. For instance, he quoted the National Health Accounts 2015/16 which showed dependence on direct out-of-pocket payments from households at 41% of total health expenditure. He added that the Uganda National Household survey 2016/17 indicated that only 5% of the population was covered by health insurance. The majority of this population is the urban rich (health insurance is 7.8 percent coverage in the urban areas compared to 3.3 percent in the rural areas). He decried the heavy financial burden borne by households as a result of high household out-of-pocket payments for health care.

He further highlighted additional statistics as follows;

- According to the Uganda National Household Survey 2016/17, 4.2% of Ugandan households incur catastrophic health expenditures due to direct household out-of-pocket payments which compromise household welfare and affect their ability to afford other basic needs such as food, education and shelter.
- Even worse, 2.5% more people are driven into absolute poverty as a result of direct out-of-pocket payments for health care. This includes some households falling from being among the richest to the poorest welfare quintile.
- The Uganda National Social Protection Policy 2015 notes that over 90 percent of the labour force, most of whom are employed in the informal sector, do not have access to formal security.

- The traditional social protection structures such as family and communities have been strained due poverty, inequality, diseases such as HIV, and migration patterns.

Dr. Fatunmbi stressed that the absence of social protection has resulted into a very high level of vulnerability to shocks including those related to life cycle such as pregnancy and delivery. He reported that WHO has been able to partner with Uganda's Ministry of Health in the area of health financing through supporting:

- Generation, translation and dissemination of valuable evidence for health financing such as national health accounts;
- Developing policies, strategies and guidelines and their monitoring and implementation; and
- Building institutional capacity for sustainable health financing.

He indicated that WHO would continue to support development of the multi-sectoral roadmap towards UHC for Uganda.

He made the following calls for action:

- i. The Ministry of Health and Ministry of Gender, Labour and Social Development should explore all innovative ways to ensure that the informal sector is considered in all plans for achieving UHC in Uganda.
- ii. Noting with appreciation the progress made thus far in the preparation for introduction of the NHIS, he called upon all the key stakeholders including cabinet and parliament to fast-track efforts for passing the NHIS bill into law.
- iii. Ministry of Health and all implementing partners should build all the necessary capacity and structures in preparation for implementing the NHIS in Uganda.
- iv. He called for deliberate efforts to involve the informal sector in implementing social protection interventions so that no one is left behind.



Mr. Fredrick Makaire (left) with Dr. Babyo Fatunmbi (centre) and Dr. Charles Olaro after the opening ceremony.

Thematic Presentations and discussions

3.2 Session I: Current Status of Community Health Financing Schemes in Uganda

This session focused on objective one which was to review progress made in implementing community health financing and introducing the National Health Insurance Scheme in the past 12 months. A total of seven presentations were made to give conference participants an account of the status of the country in implementing community health financing. It was an opportunity to review the milestones attained and best practices that were being implemented; and identify any gaps and barriers to effective participation of the informal sector in social protection.

The session was chaired by Mr. William Kidega, the Deputy Chief of Party, USAID - Advocacy for Better Health Program implemented by PATH. Presenters included Ms Proscovia Nnamulondo, the Communication and Advocacy Officer of SHU, Ms Christine Namayanja, the Chief of Party, USAID/Uganda Voucher Plus Activity, Dr. Sylvester Ndiroramukama, Executive Director of Uganda Cooperative Savings and Credit Union (UCSCU) Limited, and Mr. Michael Mugisha, the Credit Administration Manager, BRAC Uganda Microfinance.



Left – right: Dr. Sylvester Ndiroramukama, Mr. Michael Mugisha, Ms Christine Namayanja and the session chair, Mr William Kidega.

3.2.1 Voluntary Community Health Insurance Schemes, a case of Save for Health Uganda.

Ms Proscovia Nnamulondo gave a brief history of CHI in Uganda which started at Kisiizi hospital in 1996. The CHI schemes were started to ease financial access to quality healthcare services, protect households from impoverishing healthcare expenditures, and increase cost recovery for healthcare providers. She showed that the schemes were owned either by communities or healthcare providers and enrolment was voluntary. CHI schemes

were characteristically not-for-profit, espoused solidarity, risk pooling, active participation of members in decision making, and democratic governance.

Ms Nnamulondo shared that SHU, which was established in 2002, had so far created 113 CHI schemes in nine districts (Nakaseke, Nakasongola, Luwero, Mityana, Mubende, Bushenyi, Sheema, Mitooma and Masaka). The strategies used to enroll community members into CHI schemes included health education, health insurance education, diversification of benefits and modes of premium payment, transparency and accountability, and involvement of members in decision making and scheme management. Scheme members paid premiums ranging from UGX12,000 – UGX50,000 per head per year. CHI schemes within regions were federated into a single network



Ms Proscovia Nnamulondo

that brings together several schemes in different parishes, sub-counties and districts. The networks are managed by members through their leadership structures.

Ms Nnamulondo informed participants that over the past 12 months, SHU had expanded coverage to more parishes in Luwero district, contracted three more healthcare providers and started operations in Mityana Municipality.

She outlined several challenges facing schemes which included high costs of mobilising people to enroll; low incomes of target beneficiaries; long distances to health facilities; adverse selection; and fluctuation of numbers of people enrolled. She concluded that there was need for long term investment to achieve high levels of insurance literacy and reach a critical mass in CHI schemes since the people who enrol are usually those who have gained a higher level of understanding and appreciation of health insurance.

Key highlights of progress in CHI implementation

1. CHI had reached 20 districts mainly in western and parts of central Uganda
2. There were about 152,000 people enrolled in CHI schemes.
3. A total of 53 healthcare providers were providing services to members of CHI schemes.
4. SHU alone was covering 33,340 individuals from 5,660 households. These were accessing healthcare services at 23 health care providers (4 hospitals, 3 HCIV, 13 HCIII, 3 HCII).
5. SHU supported Luwero district to develop an ordinance for establishing a district CHI scheme. The ordinance was approved by the district council in October, 2018.

3.3.2 Voluntary voucher schemes for maternal and neonatal health, a case of USAID/Uganda Voucher Plus Activity

This presentation was made by Ms Christine Namayanja, the Chief of Party for the USAID funded Voucher Plus Project implemented by Abt associates. She indicated the key function of the project as creating demand for maternal services. The project targeted private facilities as well as private wings of the public health facilities to provide services to mothers that present vouchers to them. The vouchers were being bought by mothers at UGX4,000 each and presented to service providers for a defined package of services that included antenatal care (ANC), delivery, emergency transport, elimination of mother-to-child transmission (eMTCT) of HIV, complications during pregnancy, and post-natal care. The same voucher was enabling the health providers to claim payment for the services provided to the voucher holding client. Providers were expected to invest in the provision of services that are commensurate to the payments. The programme used national tools to report their activities and district biostatisticians helped to compliment the reporting.

Ms Namayanja emphasized that vouchers were contributing directly to the three UHC principles of equity, financial protection and quality. Vouchers were enabling vulnerable populations to access priority health services without having to pay at the point of care, thereby protecting them from catastrophic health expenditure. At the same time, providers were being incentivized to improve the quality of care.



A sample of the maternal voucher

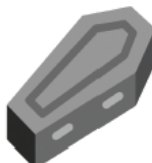
Ms Namayanja indicated that vouchers were providing an innovative solution for smooth transition to Results Based Financing (RBF) and the NHIS. Providers participating in the voucher project could understand how to work with results based financing mechanism. The project was also empowering private providers to start CHI schemes.

Key highlights of progress in the USAID/Uganda Voucher Plus Activity

1. The voucher plus program was running in 35 districts in eastern and northern Uganda.
2. A total of 232,158 vouchers had been sold.
3. The vouchers enabled 96,000 mothers to deliver under professional care.
4. A total of 156 private health facilities were participating in the program.
5. More than 300,000 people were reached with community level awareness events.

3.2.3 Mandatory micro health insurance, a case of Micro Financing Institutions (MFIs)

Mr. Michael Mugisha presented about the credit life insurance benefit BRAC Uganda Finance Limited introduced in 2016 for its clients in partnership with Liberty Life Assurance Uganda Limited. The objectives of the product were to provide a reliable safety net for clients and mitigate credit risks for the organisation. The credit life insurance cover was designed to pay off debts of clients in the unfortunate event of scenarios indicated below:

Catastrophic Loss	Temporary and Total Disability	Permanent and Total Disability	Critical Illness	Death of Pre-named Child or Spouse	Death of Client
					

Risks covered under the BRAC microfinance credit life insurance

Mr. Mugisha further explained that the credit life insurance benefit was mandatory to all borrowers and covered the period of the loan or until death of the client. Every loan applicant was required to sign up for the benefit and make a premium payment.

However, the early stages of implementation were characterised by challenges such as large scale of roll out, long and manual claim processing, low percentage of settled claims, failure of clients to obtain critical claim documents, and low public acceptance. These were addressed through analysing the claims data, tools improvement, staff training and sensitization. The interventions resulted into a 15% premium reduction, reduction of the number of days for claims settlement, increase in the settlement ratio by 19% and increase in the percentage of paid claims by 30% out of total claims.

Mr. Mugisha showed that the scheme was helping improve death and marriage registration, healthcare seeking behaviours and accident reporting, among other outcomes. The organisation's future plan was to attach insurance services to all other products and automate operational processes.

Key outcomes of the presentation on BRAC Uganda's intervention

1. BRAC managed to successfully blend health insurance with loan products.
2. Automation of the credit life insurance claims process increased the settlement ratio by 19%, the percentage of paid claims by 30%, and the claims paid out of total claims increased from 53% to 83% between July 2017 and April 2018.

3.2.4 Mandatory micro health insurance, a case of Savings and Credit Cooperative Societies (SACCOs)

Dr. Sylvester Ndiroramukama who made the presentation explained that SACCOs are started and owned by people with common interests and challenges. They are not less than 30 members who join by saving and buying shares. Savings are made regularly at an agreed interval and borrowing is done at an interest to the borrower. At the end of the year, the savings generate interest which is shared among the members. SACCOs are member owned and managed for their own benefit.

He gave the four common types of insurance in SACCOs which are: Internal loan protection fund, re-insurance, direct insurance for members, and cooperative insurance.

- a. Internal loan protection fund: SACCOs charge 2% on every loan as insurance premium to protect borrowers in case of death, grave illness, or permanent disability of the borrower. The SACCO pays off the outstanding loan in case of occurrence of the risk.
- b. Re-insurance: a SACCO charges a premium and buys a group insurance policy for all members. A SACCO contracts a registered insurance firm to re-insure the loans. The premium collected through loan protection fund is shared between the SACCO and the insurance firm. The policy normally covers death, critical illness and permanent disability.
- c. Direct insurance policies for members with a partner insurance company: A SACCO selects and contracts a firm to provide insurance services to members. The SACCO works as an insurance agent on behalf of the insurance company and earns a commission. Members buy insurance policies direct from the insurance firm.
- d. Cooperative Insurance model: SACCOs pull resources and establish an insurance company which is professionally run as an independent entity but belongs to the shareholding SACCOs. SACCOs channel all insurable risks to the firm. SACCOs benefit through indemnity in case of risk occurrence and dividends as shareholders on profits made.

Dr. Ndiroramukama cited an example of Butuuro SACCO located in western Uganda where each member contributes UGX1,000 per month and is provided with a medical card. Any member who falls sick, no matter the magnitude of sickness, contributes Ugx.5,000 as co-payment at the point of receiving healthcare. Each member's children and relatives can access medical services as long as they enroll in the SACCO.

Type of coverage: Voluntary

Type of policy: Group policy

Eligibility: All citizens can enroll

Benefits/services covered:

Out-patient care, consultations, immunizations and preventive care, medications, basic package of curative and preventative services at pharmacies and health care centers.

Premium amount: Each household pays the same amount (household premium rates may vary between regions)

Subsidy: Partial subsidy for all members

Cost-sharing: Co-payment



Some health insurance benefits provided under SACCOs

Plenary discussion

The key issues raised during the plenary discussion following the presentations include:

- ◆ The need to be conscious of dwindling donor funds and hence a necessity to take the lessons and raise local funding.
- ◆ There is hope for the Ministry of Health results-based financing being implemented although it is still donor funded.
- ◆ It is important for leaders like members of parliament, district health officers and chief administrative officers to do strong advocacy to ensure CHI programmes are implemented and sustained.
- ◆ Political will is vital and cannot be substituted.
- ◆ The voucher program should consider covering children and spouses as well so that they cater for the whole family.
- ◆ Enrolment in community health financing needs time, members need to be helped to understand that health insurance is not like savings which they will access any time. They need to be sensitized that the savings are for health care, not only for themselves but also other members in the scheme.
- ◆ Voluntarism is one of the principles that hold SACCOs together as they leverage on the members' expertise like medical personnel for medical advice, lawyers, etc which the SACCO would otherwise not afford.



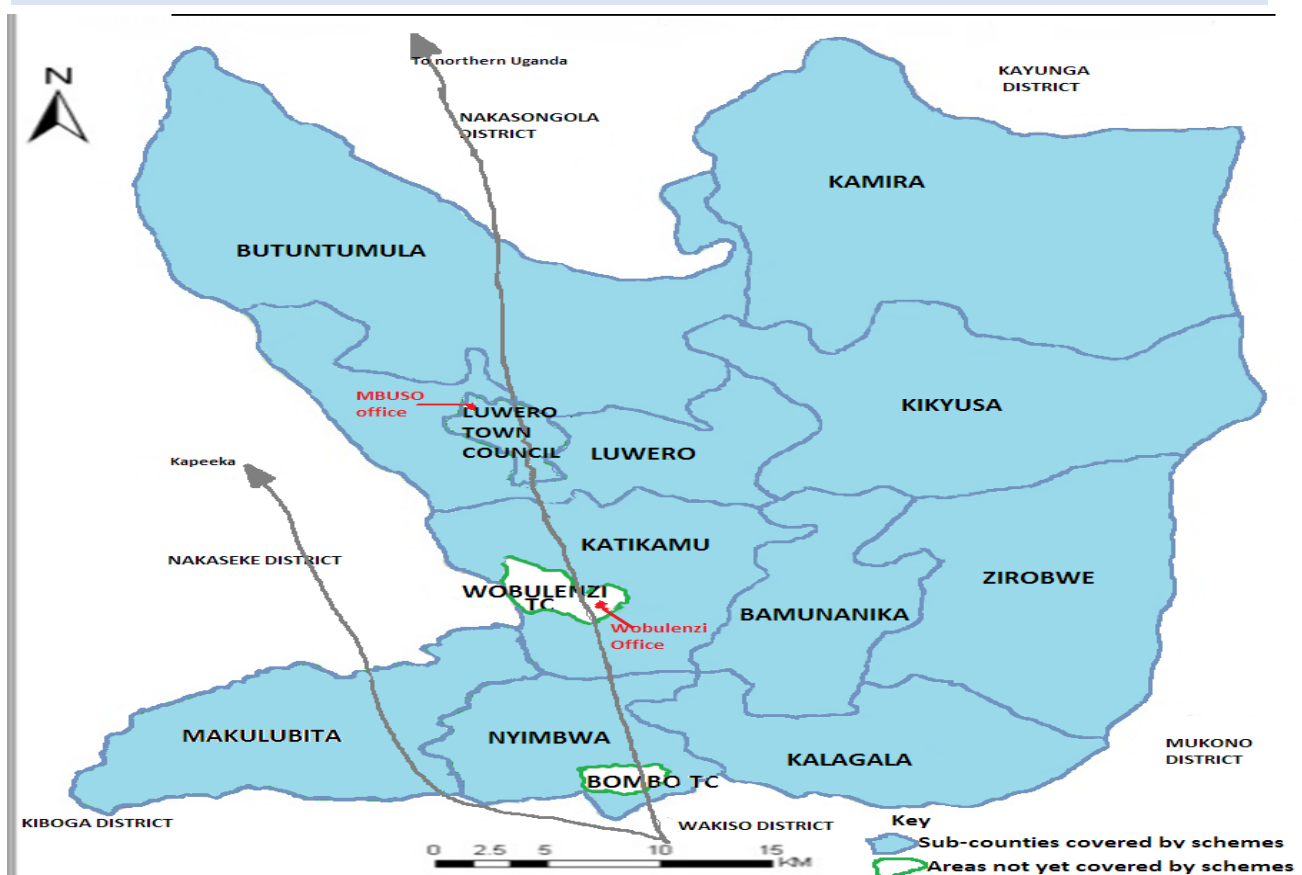
SHU Board members (front row) and other participants

3.2.5 Luwero District Community Health Insurance Scheme Ordinance 2017

Robinah Kaitiritimba, Executive Director, Uganda National Health Consumers' Organization chaired the discussion which mainly focused on the proposed Luwero District Community Health Insurance Scheme (LDCHIS) and the proposed National Health Insurance Scheme (NHIS). Two presentations and one testimony were delivered about LDCHIS while one presentation was made on the NHIS.

Mr. Joseph Serugo, the Vice Chairperson and Secretary for Health, Luwero District Local Government, presented highlights of the ordinance entitled *'The Local Governments (Luwero District) Community Health Insurance Ordinance 2017'* which was passed by the district council on 5th October, 2018 after a process of consultations that lasted 10 months. He started by sharing a brief background about Luwero district which has a population of about 450,000 people with major sources of income being subsistence farming (66%), employment (16%), business enterprises (7%). Poverty levels stand at 18.3%. He showed that CHI was introduced in the district in 1999 by Centre International de De'veloppement et de Recherche) (CIDR) and later by SHU. There were CHI schemes running in 11 out of 13 sub-counties and town councils, covering 18,000 people.

A map of Luwero district showing coverage of CHI schemes by sub-county





Mr. Joseph Serugo

Mr. Serugo shared key provisions of the ordinance whose purpose is to enhance access to equitable, affordable and quality healthcare services to beneficiaries of the scheme; to improve provision of quality health care services in the District; to increase health insurance coverage in the District; and for other related matters for all people in Luwero District. He said the ordinance will come into effect on the day of its publication in the Uganda gazette.

The key provisions in the ordinance concerned sources of funds (premiums, grants, solidarity transfers, donations, income on investments, and fines and penalties); governance structure (general assembly, board, and secretariat); tenure of office of leaders; and role of the district local government in the running of the scheme. The ordinance provided for payment of annual premium contribution by every household, which would be determined in accordance with the financial earnings and standing of a household. The ordinance specifies five different categories of households: poor, low income, average income, high income and rich. Each of these has specific characteristics that distinguish it from others.

Mr. Serugo said the scheme would complement the health services provided by the central government, the district and other lower level administrative units in the district.

The remaining steps towards implementation of the ordinance included obtaining approval from the Attorney General, signing the approved ordinance by the District chairman and its publication in the official gazette.

He thanked SHU for supporting the district to go through the process of developing the ordinance and carrying out consultations with stakeholders.

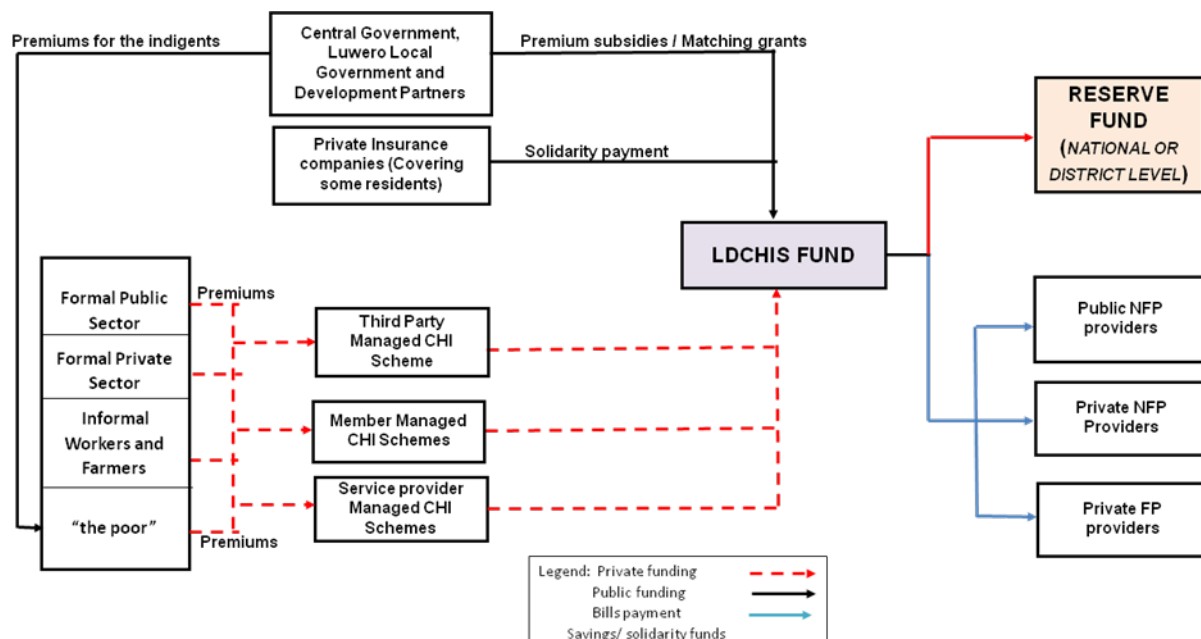
3.2.6 The design and proposed implementation framework of the Luwero District Community Health Insurance Scheme

This was presented by Mr. Fredrick Makaie. He gave a detailed overview of how the proposed Luwero District Community Health Insurance Scheme (LDCHIS) was designed and how it would be implemented. He started off by elucidating the principles which guided the design of the proposed scheme which included: being not-for-profit; contributions according to capacity to pay plus subsidies for low income earners; active participation of members in decision making; separation of technical and non-technical roles; use of existing district structures, provider-purchaser split; and linkage to national health financing and social protection systems.

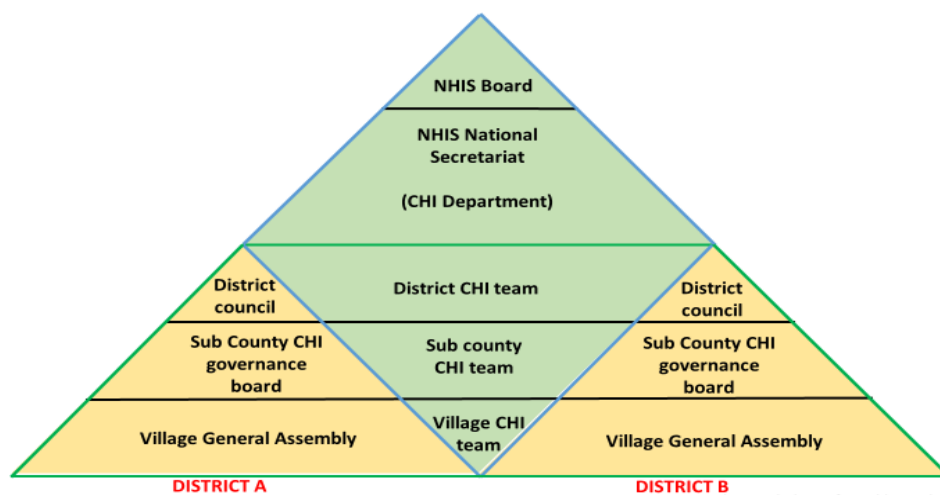
He explained the scheme model which shows the different stakeholders involved including formal and informal sectors, the poor, district local government, the central government plus healthcare providers. The model also accommodates different types of schemes such as third party and provider managed.

Mr. Makaie further elaborated that premiums would be contributed through different means including: direct out-of-pocket payments; microfinance institution deductions on loan repayments; salary deductions (monthly); savings deductions (SACCOs); direct transfers to the scheme (premiums subsidies, grants) among others. Contributions shall be paid by a family not an individual and shall be annual. Families shall pay different premium

contributions depending on the social economic categorization of their households: poor, low income, average income, high income or rich household. A five-member village team of eminent residents shall categorize households in the village and submit the list to the scheme secretariat.



The proposed Luwero District Community Health Insurance Scheme design



The proposed linkage between LDCHIS and NHIS



Testimony

“My name is Hasifa Nakawe, a resident of Yandwe village, Kakabala parish, Butuntumula Sub-county, Luwero District. I am a farmer. I belong to Kakabala Munno Mu Bulwadde (Community Health Insurance) scheme.

In 2002, I went through a very sad experience which took the life of my son. My 6-year-old son fell sick at a time when I did not have money. I rushed him to the nearest government Health Centre IV, which is about 6km from my village. When I reached there, the health workers informed me that my son needed blood transfusion immediately but the service was not available at that facility. My son was referred to the nearest government hospital, which is about 20km away. The health workers warned me that any delay to get the blood could be fatal. Although there is a private hospital just a few metres from the health centre where I was, I could not go there because I had no money.

I managed to get a motorcycle taxi (*boda boda*) which took us to the government hospital. We reached there at around 3pm and I informed the nurses about the situation of my child and the warning of health workers at the health centre. None of the nurses seemed to care. I looked on helplessly as my son laid on the hospital bed, getting weaker and weaker.

At around 8pm, a doctor walked in and assessed my son. He realised the seriousness of the problem and arranged to start the blood transfusion immediately. Unfortunately, my son did not survive. I blamed myself for choosing to go to a facility where my son did not receive the urgent care he needed to save his life, but I had no option due to lack of cash.

During the same year, CHI was introduced in my parish. I attended the sensitization meetings and picked interest to join. I shared with my husband about it but he refused to pay premium because he found it too good to believe. I slowly looked for the money and paid the premium. I continued to subscribe every year but my husband and some of the children thought I was wasting money.

One day at around midnight, I received a phone call from a hostel where my daughter in senior four was residing in Luwero town. I was informed that she was critically ill. I went to a fellow resident who owns a car but he was not at home because he was out celebrating Eid, being a Muslim. Another resident who owns a motorcycle accepted to take me to Luwero, picked my daughter and proceeded to Kiwoko hospital, about 15km away. I had only shs20,000 but I was not worried because I had the Munno mu Bulwadde (CHI) healthcare access card.

When we reached hospital, I handed the shs20,000 note to the motorcyclist expecting him to give me back some balance. He instead disappeared with the money and there I was at the hospital without a single coin.

I presented my card at the hospital and my daughter, who had mock exams to do the following day, was given all the treatment she needed. By morning, she was feeling better and was allowed to go and sit her exam. That's when I started calling home for my husband to bring the money we needed for copayment at the hospital, when my child was already out of danger. That was the first time my family members appreciated the CHI program. My daughter who used to ridicule me saying I should give her her share of the premium and she uses it to meet other needs was short of words.

I have seen people in my village sell their plots to pay medical bills. I am hopeful that when the District Scheme starts, many people who have been hesitating to enrol and the very poor who cannot afford the premium will join the scheme.” *Testimony given by Ms. Nakawe at the conference.*



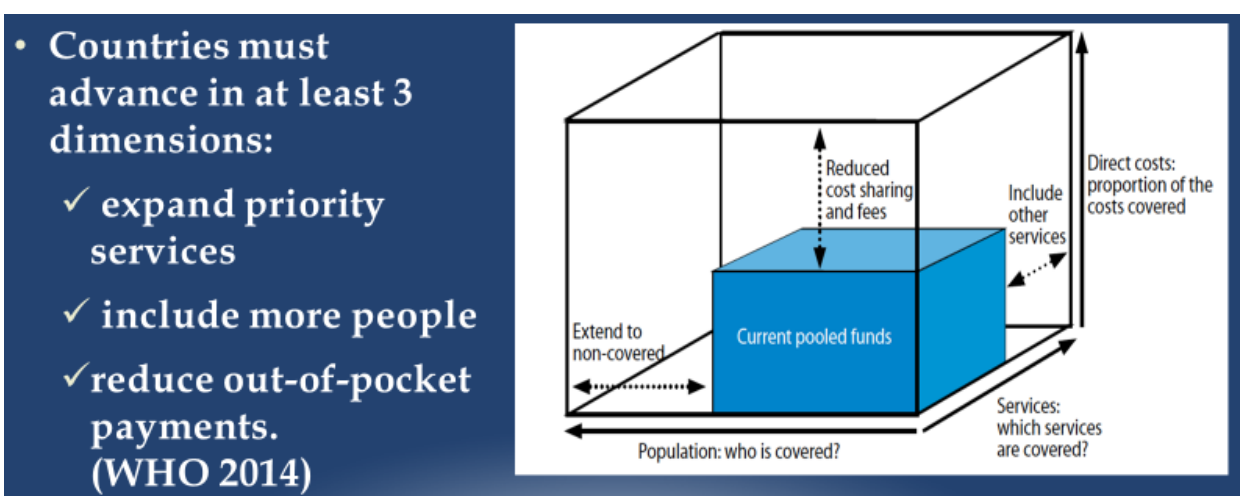
Hon Lillian Nakate, Luwero District Woman Member of Parliament (left), Mr. Brendan Kwesiga from WHO (right) and some leaders from Luwero district at the conference.



Luwero District Chief Administrative Officer, Mr Godfrey Kuruhira, makes a submission during plenary.

3.2.7 Regulation and preparedness for the National Health Insurance Scheme

This presentation was delivered by Ms. Allana Kembabazi, Program Manager, Right to Health at the Initiative for Social and Economic Rights (ISER). She noted that it was vital to understand and recognize that the population has numerous categories of people (informal sector, indigent and other vulnerable groups) and it is incumbent on policy makers and implementers to be cognizant of their existence. Fair representation of the different categories of the population should be a key component of the NHIS as it is premised on a number of major movements to which our country committed including UHC, where all people receive quality health services that meet their needs without being exposed to financial hardship in paying for services. Fair representation also requires ensuring access to services for low-income groups, rural populations and other disadvantaged groups and reaching everyone as quickly as possible. The disadvantaged groups should be given priority in interventions to reduce out-of-pocket payments.



The various dimensions of attaining Universal Health Coverage

She stressed that regulation is vital especially given the significant role the private sector will play during implementation of the NHIS. She pointed out that the private sector posed challenges to the population and it was very crucial to have it regulated and properly monitored because people, mostly the poor and needy, will either have to do without health services or have to endure poor and detrimental services. Some of the challenges that were highlighted include: poor or no reporting of data or sufficiently engaging with health information system; inadequate feedback and sharing of results with government and other stakeholders; poor use of the data generated; limited capacity and resources, among others.

Plenary discussions

Key emerging issues during the discussions were:

- ◆ There was general appreciation of the steps taken by the families and the local government in Luwero to embrace, scale-up and regulate CHI in the district and commendation for SHU for the support provided in this.

- ◆ A call to the central government to take advantage of the proposed Luwero District CHI scheme to start piloting the proposed NHIS and universal insurance coverage, and other districts to take similar steps like Luwero so as to drive the introduction of the NHIS from the bottom, which could likely be shorter than the current top-down approach.
- ◆ Consider the legal frameworks in place like the Public Private Partnership Act, Public Private Partnership in Health Policy, Dental and Medical Practitioners Act, Public Health Act for any community health financing initiatives.
- ◆ There is a need to ensure effective mechanisms of including the poorest of the poor in the NHIS given that they are already vulnerable.
- ◆ Government should strengthen enforcement of regulations so as to protect her people from some of the vices of the private sector.

3.2.7 Remarks by the Chairperson of the Health Committee of Parliament

At the end of the session, the chairperson for the Health Committee of Parliament, Hon Michael Bukenya, addressed participants and advised SHU to consider a private members' bill on health insurance that can be tabled before parliament. Hon Bukenya guided that SHU could work with his office and other MPs so as to prepare the bill in the suitable format for tabling before parliament. Concerning approval of Luwero District CHI ordinance, Hon Bukenya pointed out that the Attorney General's role is to advise on how the ordinance will be operationalised. He, however, noted that one possible challenge was the fact that provision of healthcare was already provided for in the Constitution. He asked participants to emphasize prevention other than waiting to fall sick, citing hand washing which could reduce up to 75% of diseases.



Left-right: Hon. Dr. Michael Bukenya, Ms Robinah Kaitiritimba, Ms Allana Kembabazi and Mr. Fredrick Makaire.

3.3 Session II: Impact of affordable technology and new innovations in managing (collecting contributions, members and benefits) voluntary schemes for the informal sector

This session took place at the beginning of day two and focused on demonstrating innovations in managing community health financing and other social protection initiatives for enrolment and retention of households of informal sector workers. Presentations were aimed at helping participants gain an understanding of the innovations by different actors, learn from each other and scale-up the innovations. The session was chaired by Mr Douglas Opio, Executive Director of Federation of Uganda Employers.

3.3.1 Innovative ways and the role of technology in successfully extending voluntary individual retirement benefits schemes to informal sector families.

Ms Alice Abukito from Mazima Voluntary Individual Retirement Benefits Scheme (MVIRBS) made the presentation. She gave an overview of Uganda's pension sector status which showed that only 2 million out of 17 million people in the workforce had a retirement benefits account, with a pension exclusion rate of 88%. She observed that the pension system was designed for formal employment yet 85% of the people work in the informal sector.

Ms Abukito introduced Mazima scheme which was launched in 2016 and licensed by Uganda Retirement Benefits Regulatory Authority. It had so far registered 1,600 members. She said the scheme is a micro pension savings account which allows people to secure their money for a long term goal like saving for retirement, buying a house or saving for education of children. There is no minimum or maximum deposit amount, no monthly charges levied on account and low charges for mobile money payments. Benefits (interest) to savers are always computed at least 4% above the prevailing inflation rate. A member can only access savings after a period of one year.

She showed that Mazima heavily relied on technology in all its operations. Members could enrol, check balance on account or withdraw savings using a mobile phone and other online platforms. The aim was to build a cashless social enterprise. The benefits of deploying technology included cost effectiveness in operations, convenience to members, quicker identification, correction and verification of mistakes, trust and real time transactions. Members were using private pin codes to secure their accounts. Ms Abukito said such technology could be scaled up and promoted in other contributory initiatives.

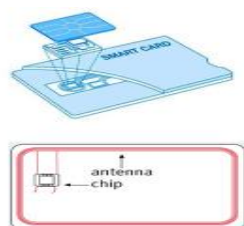
Key issues from the initiative by Mazima scheme

1. Using technology to simplify the product: A mobile phone application (App) was used to enable members register, enrol, save and check balances. All that a client needed to do was to download the App on a mobile phone and start transacting.
2. Online platforms offered members the option to use email and the website to make enquiries and learn more about the services.
3. Mazima engaged telecom companies to provide access to their platform via the unstructured supplementary service data (USSD) code. This enabled members to use their mobile phones for transactions and other inquiries.

3.3.2 Technological advancements and innovations for managing private (macro and micro) health insurance schemes and impact on schemes' performance in Uganda

Ms. Judy Mugoya, Country Manager, Smart Applications International Limited demonstrated how community based health financing schemes and their beneficiaries could be safeguarded from fraudulent service providers and scheme members. She observed that in Africa, 40-60% of all medical bills were fraudulent. Ms Mugoya drew the attention of participants to some of the challenges they needed to be aware of and mitigate in their operations with beneficiaries and service providers using technology. Some of the challenges that were pointed out included: delayed receipt of invoices from service providers; long invoice reconciliation processes; delayed payments for services offered; limitation on technological products to serve changing needs; inability to manage membership and cancellations, among others.

Ms Mugoya said the purpose of Smart Applications International was to create a society of healthy people through easier, simpler and faster access to healthcare and their objective was to provide secure hassle-free access to healthcare services everywhere, anytime. They use technology to achieve this by making processes easy, fast and secure. Their pillars include being ethical, accessible, smart (Cutting Edge, Relevant, Adaptive), and focusing on the client. In Uganda, Smart Applications International Limited had enlisted 430 service providers onto their technology platforms.



Contactless
Microprocessor
Smart Card



Smart card and fingerprint
readers at point of service



Smart data
transmission
equipment
(delivery at best
effort)

Components of a smart system

Three (3) service providers - pilot the project	Real time reports on member expenditure and balances.
Fund set up - seven (7) schemes. Benefit limits defined	Financial obligation to service providers, better projections. Cost control
Unique member identification. Improved controls from manila cards	Call center – 24/7 support

Key information about the service access family card service designed for SHU by Smart

Ms Mugoya explained how Smart was working with SHU to introduce the biometric system to low-income informal sector families. One biometric card was designed for each family and registration was being done at household level to capture fingerprints of all family members. She shared the benefits of the system: a self-service customer web portal for day-to-day scheme administration tasks; price billing and co-pay control; automated email statements; alerts on utilization/visits/ admission including suspicious actions; and electronic processing of claims. The system provides real time client identification and updates.

Key messages from the Smart biometric technology

1. Smart biometric cards minimized risks such as fraud, inaccuracies in recording members, and delays in processing healthcare bills, hence facilitating efficiency in managing members of health insurance schemes.
2. Smart hatched an innovation for SHU promoted CHI schemes to make biometric cards affordable to low-income families. This technology was suitable and efficient for the CHI schemes.



Left-right: Mr. Douglas Opio, Ms Judy Mugoya, Ms Alice Abukito and Mr. Henry Travis Mugerwa during plenary.

3.3.3 Performance of National Social Security Fund's voluntary membership scheme, and lessons for extending other social protection initiatives to informal sector families both in rural and urban settings

Mr. Henry Travis Mugerwa, the Voluntary Business Manager at National Social Security Fund (NSSF) made the presentation and explained the Voluntary Membership Scheme at NSSF which is open to those who were once in formal employment but restricts those who are in the informal sector and have never been in formal employment. He shared the performance of the voluntary scheme since 2016 when it was introduced. He showed that NSSF's strategy focused on product simplicity and good relationship management. He

attributed their success to: giving competitive value on member savings, making it easy for people to enrol and pay online, continuous engagement and offering value adding benefits.



Performance of the NSSF Voluntary Scheme since 2016

He cited some challenges that usually impede proper management of informal sector saving schemes which NSSF should brace itself for if it is to penetrate the sector: the legal framework that is highly restrictive, a poor saving culture among the populace, the mistrust surrounding pension given that there are only a few success stories; and the highly subsistence and un-mobilized informal sector.

Mr. Mugerwa shared that the future for NSSF lay in going a long way in improving the livelihoods of the people including developing new products such as maternity benefit, education benefit, health benefit, housing benefit, funeral benefit, and allowing members the option for pension or draw down.

Key messages from the NSSF voluntary membership scheme

4. Online registration of members was attractive and contributed to the increase in the number of people saving voluntarily from 2,399 in 2016 to 10,000 in 2018.
5. Voluntary savers were using mobile money and other electronic payment systems to pay their savings. Saving with ease also contributed to the increase in the number of savers.
6. Constant engagement of members and financial literacy education through online, telephone and other platforms raised awareness about benefits of the scheme and increased uptake.

Plenary Discussions

A number of emerging issues were highlighted during the discussions particularly on innovations for convenience, simplicity, affordability and efficiency in promoting and managing social protection initiatives. These included:

- ◆ There is need to maximize technological innovations which are vital for saving and prepayment schemes;
- ◆ There is need to continue encouraging and mobilizing communities towards voluntary saving, this will help to improve their livelihoods;
- ◆ Earning interest on savings is a great incentive to savers.
- ◆ Transparency is a vital component in voluntary saving;
- ◆ Constant engagement of the clientele is important for them to trust the service providers;
- ◆ Use of mobile money platforms for payments, withdrawals, etc, gives the clientele more flexibility and should be maximized.
- ◆ There is need to continue efforts around financial literacy which is cardinal for improving the saving culture.
- ◆ Minimizing losses and fraud in healthcare provision gives the full benefit to community health financing.

3.3.4 The role of existing government and other structures, systems and technology in the implementation of Social Assistance Grant for Empowerment Program (SAGE): lessons for implementing the proposed National Health Insurance Scheme.

The presentation was delivered by Mr Zephaniah Ogen from the Program Management Unit of Expanding Social Protection Programme (ESPP), Ministry of Gender, Labour and Social Development (MGLSD) on behalf of Mr. Stephen Kasaija the Head of the Program Management Unit (PMU). The session was chaired by Mr. Emmanuel Tugabiirwe from the Ministry of Local Government.

Mr. Ogen introduced the Social Assistance Grant for Empowerment (SAGE) program implemented by the MGLSD through the ESPP Management Unit. It was intended to generate evidence on feasibility, impact and sustainability of delivering direct income support to vulnerable people. The programme targets 100 oldest persons per sub-county. By the end of financial year 2014/15, the programme had covered 15 pilot districts and would reach 57 by end of 2018/2019. The minimum age of beneficiaries was increased from 60 to 80 years for one to enrol.

Seven Regional Technical Support Units (RTSUs) were set up in Moroto, Gulu, Kaberamaido, Kamuli, Kyenjojo, Kiboga and Nebbi districts to provide technical support to districts in the various sub-regions.

Selection of beneficiaries relied on National Information and Registration Authority (NIRA) data. A list of potential beneficiaries is printed and submitted to selected districts for verification after which accounts are opened up by the Payment Service Provider (PSP). The PSP then goes to the selected districts to enroll the verified beneficiaries electronically

by capturing biometric data, including taking photographs. After enrollment, the beneficiaries are paid in the subsequent payment cycle.

The SAGE programme uses a customised web-based management information system (MIS) to manage information on beneficiaries such as registration, enrolment and payments. It is only accessed by authorised users. NIRA data is automatically uploaded into the MIS. Disbursement of funds to Post Bank Uganda for payment to beneficiaries is based on the payroll generated from the SAGE MIS.

Mr. Ogen shared the lessons learnt from SAGE implementation which could benefit the process of rolling out the NHIS. These are:

- It is imperative to strengthen collaboration with other ministries, departments and agencies, which have fundamental roles to play in the implementation of the NHIS;
- Partnership with the private sector is inevitable, but must be governed by clear contracts;
- Consider establishing regional offices to facilitate effective delivery of services to all categories of the population throughout the country;
- Use existing local government structures to support mobilization, sensitization and verification of individuals and households for NHIS;
- The NIRA data is useful for providing a unique identifier and avoiding duplication in access to health services under NHIS;
- The targeting mechanisms used by SAGE can support in identification of indigents under the NHIS;
- While universal coverage should remain the ultimate goal of the NHIS, it is advisable to implement the Act through a phased approach, targeting all categories;
- Development of an appropriate MIS is indispensable for proper management of NHIS information.



Mr. Emmanuel Tugabiirwe and Mr. Zephaniah Ogen

Key issues in the presentation on SAGE program

1. SAGE relied on the already established database of the National Information and Registration Authority (NIRA) to identify the target group.
2. An electronic internet-based management information system was crucial for control and effective management of the program.
3. A biometric system for identification of beneficiaries eliminated fraud in distribution of benefits.

Plenary discussions

Emerging issues during the discussion included:

- ◆ Recognition of the importance of the SAGE scheme as old persons have been able to construct permanent houses, start up income generating activities, and are able to take care of the orphans that have been left in their care although the proposition to move the age of consideration to 80 years leaves out many of the eligible people.
- ◆ There is need for more transparency in the disbursement of the funds.
- ◆ Medical insurance for the elderly should be considered as they are so vulnerable at that age.
- ◆ The coverage should be increased as some districts have been left out, yet the need is great.
- ◆ Technology is a vital part of SAGE as it helps to keep the database updated with ease and thus should be utilized.

3.4 POSTER PRESENTATIONS/ VIEWING

The poster session was a demonstration of the communities' readiness to embrace CHI/CBHI for those communities where it has not yet taken root. Two posters were presented.

3.4.1 Improving Efficiency of Member Management Processes in Community Health Insurance Schemes using Mobile Technology: Experiences from the Rwibaale Universal Health Project by Sr. Gertrude Kabanyomozi, Director, UHC Project, Rwibaale HC III Kyenjojo district.

Sr Kabanyomozi together with Sr Juliet Asimwe demonstrated how they were using a mobile phone technology application named *meso* to enrol community members into a CHI scheme and manage beneficiary records. The mobile phone app improves enrollment turnaround time, quickens member identification at the health facility and improves claims management processes thereby improving efficiency and scheme member management

costs. It reduces time for compiling reports because the system is automated which makes it easy to retrieve data from the dashboard.

The *meso* app also has potential to reduce fraud in CHIS by either the beneficiary or the health workers because the platform is secure and it is not easy to manipulate: impersonation is not easy because the finger prints and photograph of the beneficiary are already captured in the system, so at every visit, they are verified by scanning QR codes on their ID cards; claims cannot be hiked because they are calculated by the technology; each user of the App has a login password and are monitored by the system administrator.

The system curbs the problem of waiting time at the facilities whereby patients' information and drugs prescribed are obtained from the database by just clicking. This is unlike the situation where each time the patient enrolled in CBI goes for treatment, the file has to be searched from the pile.

Main outcome of the poster presentation on a mobile app for CHI

Using mobile phone App (Meso®) significantly improved community scheme member enrolment turn-around time, quickened member identification at the health facility and improved claims management processes thereby improving efficiency, scheme member management costs and has the potential to reduce fraud in CHIS.



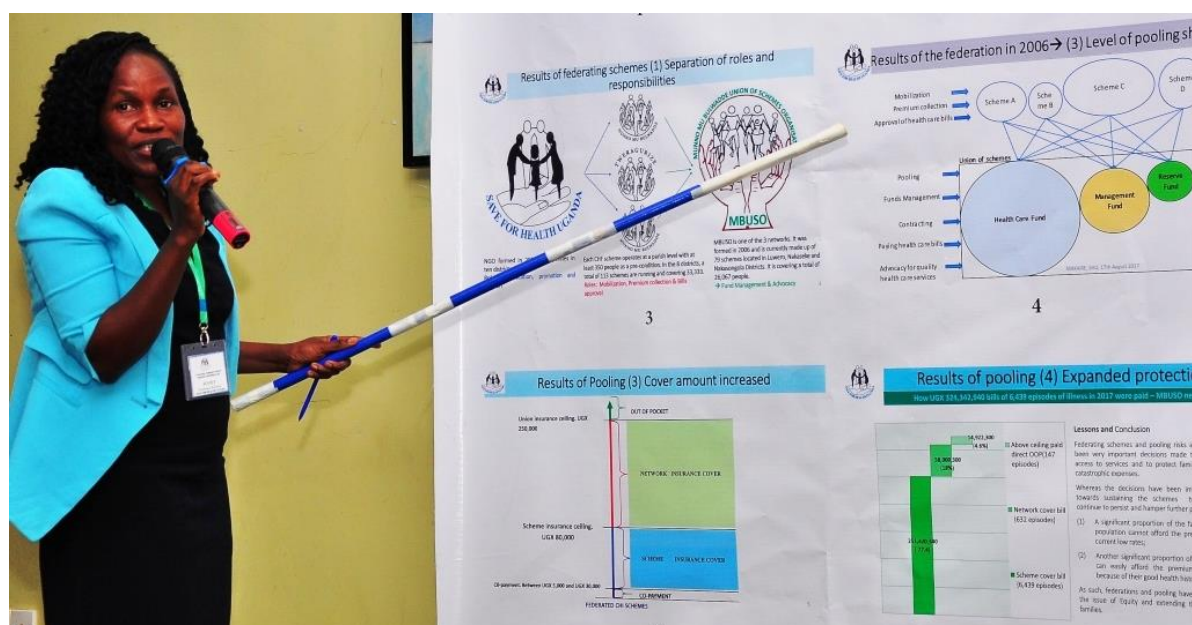
Left-Right: Sr. Gertrude Kabanyomozi and Sr. Juliet Asiimwe demonstrate how the meso technology works.

3.4.2 Federating community health financing schemes to increase risk and resource pooling in eight districts of Uganda, by Ms. Juliet Nazibanja, Programs Officer, SHU.

The second poster presentation focused on how communities could be mobilized to pool resources so as to reduce out-of-pocket payment for health services that has the risk of leading to impoverishment. Ms Nazibanja demonstrated how different communities came together to form CHI schemes and how different CHI schemes successfully came together to form networks or federations without losing their individual autonomy. The network/federation is fully registered and led by a committee elected from the individual schemes with each scheme having a representative. This network pools together and manages the premiums collected by individual schemes after they have fulfilled the required minimum number of members. Through the network, there is risk pooling on a wider scale such that members of the network continue to access healthcare even when the contributions from their individual schemes are exhausted before the end of the scheme year.

Main outcome of the poster presentation on federating CHI schemes

Federating communities into CHI networks with unifying bodies led to having sufficient funds to cover members with an attractive benefit package and low premiums; sharing roles and responsibilities; improved capacity to manage technical roles; sustainability of schemes and continuity of services.



Ms Juliet Nazibanja presenting a poster

Key issues emerging from the poster presentations

- ◆ There was a general sense that communities were generally ready for community CHI and NHIS as seen from the uptake of CHI and the different innovations put in place to minimize fraud and improve monitoring of the medical operations and procedures.
- ◆ The mobile app is pivotal in improving record keeping, a major challenge in many facilities, private or public.
- ◆ Cost effectiveness of the app is a major component for any health scheme to acquire or operate it; the app comes in handy to help mitigate the effects of losses and fraud in healthcare which are rampant.
- ◆ There is a high likelihood of satisfying more beneficiaries when schemes pool resources together and operate in transparency. This is a motivation for sustained membership and an attraction for others to join.

3.5. Identifying feasible strategies on how the informal sector can access community health insurance, the National Health Insurance Scheme and other social protection initiatives.

This session focused on the conference objective three and was chaired by Mr. Tom Aliti, Assistant Commissioner for Planning, Ministry of Health Uganda. Two presentations were made where presenters described feasible ways in which the informal sector could be helped to access community health insurance, the national health insurance and other social protection initiatives.

3.5.1 Assessment of strategies employed by governments to make it easy for informal sector families to access community health insurance, National Health Insurance Scheme and other Social Protection initiatives; Experience from Rwanda.

Mr Pascal B. Birindabagabo Amato presented a paper titled ***Reaching out to the Informal Sector for effective movement towards UHC: the experience of Rwanda***. He explained that community based health insurance (CBHI) in Rwanda uses a program called Ubudehe which is managed by the Ministry of Local Government. Ubudehe concept means “mutual help or mutual assistance among people for solving problems in the community”. It is an ancient traditional practice in Rwanda, which has been used to help people in need and mostly with no assistance (orphans/widows/old and sick people) in different socio-economic activities (agriculture, building, wedding, etc.). The concept is used to determine the nature and levels of poverty through categorization



Mr. Pascal Birindabagabo

and a social mapping system (stratification). Households are categorized as poorest, poor, somewhat poor, resourceful poor, and rich. Communities conduct their own mapping of these different categories. This is illustrated in the figure below:

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

Social stratification of economic status of households in the Ubudehe program

Mr. Birindabagabo stressed that in order to improve the grassroot person, their participation is of paramount importance, right from problem identification, leadership and implementation.

The rationale for the *Ubudehe* undertaking was to make sure that everyone, mainly the poor and poorest people have access to healthcare. The contributions and premiums made by the different categories are provided below:

Category	Premium contribution	Health care package
Cat 1 and 2	2000 RwF (USD2.4) per Individual per Annum. The Government and Donors cater for their contribution	All the benefit package at PHC : Copayment Free PCA and Referral Hospital (Free):
Cat 3 and 4	3000 RwF (USD3.8) per Individual per Annum. Pay for themselves	PHC: (Copayment): 200 PCA and Referral Hospitals (Copayment): 10% of the healthcare bills at each level
Cat 5 and 6	7000 RwF (USD8.6\$) per Individual per Annum	PHC (Copayment): 200 PCA and Referral Hospital (Copayment): 10% of the healthcare bills at each level

Premiums by category for the Ubudehe Program

Key messages on extending CBHI to the informal sector

1. Stratification/ categorization of the population using a community-led approach to enhance equity in healthcare access and CBHI premium contribution.
2. Developing a national database (UBUDEHE Categorization Database) generated from the stratification process eases claims processing, access to services, measuring program progress.

3.5.2 Determinants of willingness to pay for community health insurance among Commercial motorcyclists in Nakawa division - Kampala city.

This was a scientific research paper presented by Ms. Judith Hope Kiconco, Manager Nursing Operations, Makerere University-John Hopkins Research Collaboration. It was intended to give scientific evidence and backing of the extent to which the informal sector was ready, if mobilized, to embrace community health financing.

Her study assessed the Willingness to Pay (WTP) for health insurance among commercial motorcyclists in Nakawa Division, Kampala Capital City, Uganda. She noted that Boda Boda riders were key players in Uganda's economy and were prone to accidents accounting for 40% of trauma cases at Mulago Hospital and 20% of these being from Nakawa Division. Injury treatment costs ranged from UGX300,000 to UGX1,000,000 and monthly income averaged UGX 400,000.



Ms. Judith Hope Kiconco

According to her findings, up to 70% of commercial motorcyclists were willing to pay if the annual premium was UGX70,000 per person per year. Duration in that business, single marital status and motorcycle ownership were significantly associated with willingness to pay for health insurance. There were increasing odds of willingness to pay with increasing work experience in commercial motor cycle riding and awareness.

Key message from the study on willingness to pay for health insurance

Massive sensitization campaigns led by the government and other actors is important to raise awareness about insurance programs and packages available and increase their uptake.

Plenary discussions

Emerging issues during the discussions included:

- ◆ Other key players in the economy of Uganda like market vendors, public transporters should also be organized and mobilized to participate in community health financing and studies targeting their willingness to pay would be helpful.

- ◆ More research is needed to avail evidence-based innovations and interventions to improve CHF.
- ◆ Third party insurance payment should also be used to contribute to health financing for those who pay.
- ◆ Massive sensitization campaigns by government and other actors on the need to save for health is pivotal for increasing awareness about insurance packages available.
- ◆ The government and the private sector can work together to enhance community health financing.
- ◆ Political will is the backbone of CHF and any other development initiative.
- ◆ The poorest of the poor should be first priority for interventions.
- ◆ The criteria for enrolment and premium setting should be tried, tested and transparent.
- ◆ Home grown solutions for development offer more sustainability than foreign ones.
- ◆ Community participation is the best way to achieve utmost success for any intervention.

4.0 Closing Ceremony

The closing ceremony entailed presentation of the conference declaration, closing remarks by the Executive Director, SHU, and a closing speech by the State Minister for Gender and Culture in the Ministry of Gender Labour and Social Development, Hon Peace Mutuuuzo.

4.1 Conference Declaration

Dr Martin Ruhweza who was responsible for capturing the conference proceedings, presented key follow up actions for input and verification by participants. Following the discussions, five key resolutions were agreed upon, constituting the conference declarations. They are outlined below:

1. Luwero District local government will follow through the approval of the Luwero District Community Health Insurance Ordinance 2017 and commence its implementation.
2. Once Luwero District Community Health Insurance Ordinance is approved by the Attorney General, it will be made available to other districts which can use it to guide development of similar initiatives in those districts.
3. Leaders and civil society organisations in other districts will work with Save for Health Uganda to start community health financing initiatives in regions where they do not exist particularly in the north and east.
4. SHU will work with partners to set up a task team to review the progress of the current NHIS Bill and make recommendations on the most appropriate steps to take which may include continued pursuit of the current Bill until it is tabled in Parliament or preparation of a private member's bill.
5. Adapt CHI schemes to modern technology to reduce operational costs, improve efficiency and move away from expensive manual systems of running CHI.

4.2 SHU Executive Director's closing remarks

Mr. Frederick Makaire, thanked all participants for attending the conference and for their active participation. He recognized some key people such as members of parliament from the Health Committee including Hon Baguma Spelanza, Hon Lydia Mirembe, Hon Rose Ayaka, Hon Michael Bukenya, Hon Lilian Nakatte among others who attended the conference. He also recognized the chairpersons of Luwero, Mubende, Nakasongola, Nakaseke and Mitooma district local governments. He appreciated the partners who made contributions towards the conference: Smart Applications International represented by Ms Judy Mugoya, the Country Manager; Uganda Insurers Association represented by Mr Joshua Akena; USAID/Uganda Voucher Plus Activity implemented by Abt Associates represented by Ms Christine Namayanja; the Chief of Party, Initiative for Social and Economic Rights represented by Ms Allana Kembabazi, Federation of Uganda Employers represented by Mr Douglas Opio, the Executive Director; Uganda Community Based Health Financing

Association (UCBHFA) represented by Mr. Robert Kabaale, the National Coordinator, and Bread for the World, among others. He also recognized partner healthcare providers serving CHI schemes who contributed to the conference.

He pointed out that the conference had been hugely successful and went on to explain that the organizing committee had achieved more than they had anticipated. He listed three highlights that led him to this conclusion:

- a. They had planned for 170 participants and 161 participants had turned up by the end of day one constituting a 95% turn up rate.
- b. A number of commitments had been made by key stakeholders. For instance, WHO country office offered to support the next conferences and also participate actively. There were also commitments from other stakeholders to extend community health financing initiatives to unreached regions: Voucher Plus Activity and Health Partners Uganda pledged to reach the North and East, CUAAM to initiate and establish CHI in Oyam, Forum for Development to establish CHI initiatives in greater Nebbi (Zombo, Nebbi and Packwach), Luwero district to implement the ordinance, other district local governments to support processes of implementing the ordinance.
- c. Members of Parliament pledged to support the NHIS bill once presented whether by government or as a private member's bill.

Moving forward, Mr. Makaire stated that SHU was going to disseminate the report and presentations; set up a post conference committee to analyze the actions and follow them up till completion. He also indicated that consultations were ongoing regarding the fourth national conference slated for November 2019 which could be held in Luwero if implementation of the ordinance commenced. This would be a great opportunity for participants to spend a day in the field seeing firsthand how CHI is working in the district. He called upon more partners to come up and support the subsequent national conferences. He reported that MGLSD and MOH as confirmed by Mr Tom Aliti had already promised financial support towards the next conference.

He concluded by thanking the organizing committee for the thorough preparations and congratulated them upon the success registered at the conference.

4.3 Guest of Honors' closing remarks

The Guest of Honour, Hon Peace Mutuuzo, State Minister for Gender and Culture, was represented by Mr. Bernard Mujuni, Commissioner - Equity and Rights, MGLSD who read her speech. She appreciated MOH for supporting the conference and acknowledged the keynote speaker from WHO, the presence of Commissioners for Planning from MOH who always support and participate in organizing the CHF national conferences.

The Minister noted that according to the National Social Protection Policy, 85% of paid workers were in the informal sector with no social protection, thus the need to commit to

expanding socio protection to the informal sector. She was happy to point out that MGLSD had a number of initiatives aimed at improving social protection such as SAGE program. She noted that the aged needed help because they were vulnerable to a number of risks including ill health as well as depletion of savings. She added that government through the MGLSD was supporting Socio protection initiatives for different categories of people; the youth, women, elderly, and other groups. She urged participants to prioritize and devise mechanisms for saving money used for health through CHI and embrace technology to beat bureaucracy. She expressed gladness about the fact that conference participants had come up with resolutions and pledged to support these to the extent that they fall under the MLGSD. The Minister concluded by appreciating SHU for their leadership in organizing the conference and all the participants for their presence and deliberations. She urged them to pick best practices and see how these can be customized within their own settings.

Annexes

Annex 1: Partners that collaborated with SHU to support the conference

1. Ministry of Health
2. Ministry of Gender, Labour and Social Development
3. Bread for the World
4. USAID/Uganda Voucher Plus Activity
5. Smart Applications International
6. Initiative for Social and Economic Rights
7. Uganda Insurers Association
8. Federation of Uganda Employers
9. Uganda Community Based Health Financing Association
10. Bishop Caesar Asili Hospital, Luwero
11. Luke Namaliga HCIII, Luwero
12. Gabriel Mirembe Maria, Mubende
13. AMG International, Sheema
14. Mushanga HCIII, Sheema
15. Ishaka Adventist Hospital, Bushenyi
16. Holy Cross Kikyusa HCIII, Luwero

Annex 2: Organizing committee members



**Mr. Makaire Fredrick,
Save for Health Uganda**



**Dr. Ronald Kasyaba,
Uganda Catholic
Medical Bureau**



**Ms. Nnamulondo Proscovia,
Save for Health Uganda**



**Dr. Gerald Karegyeya,
USAID/Uganda Voucher
Plus Activity**



**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**



Mr Robert Kabaale, UCBHFA

Annex 3: List of participants

	Name	Organisation	Position	District
1	Dr. Olaro Charles	Ministry of Health	Director Clinical Services	Kampala
2	Mr. Mujuni Bernard	Ministry of Gender, Labour and Social Development	Commissioner - Equity and Rights	Kampala
3	Dr. Babyo Fatunmbi	World Health Organization	Ag. Country Representative	Kampala
4	Mr. Pascal Birindabagabo	Ministry of Health - Rwanda	Health Insurance Policies Specialist	Kigali
5	Hon. Bukenya Iga Michael	Parliament	Chairperson - Health Committee	Kampala
6	Hon. Baguma Spellanza	Parliament	Vice Chairperson - Health Committee	Kyenjojo
7	Hon. Nakate Lillian	Parliament	Luwero Woman MP	Luwero
8	Hon. Mirembe Lydia	Parliament	Woman MP Butambala District	Butambala
9	Hon. Ayaka Rose Atima	Parliament	Maracha District MP	Maracha
10	Ms. Amwiine Hope	Parliament	Senior Clerk Assistant / Clerk Health Committee	Kampala
11	Mr. Sekimpi Brian	Parliament	Personal Assistant to MP	Luwero
12	Ms. Bena Naigembe	Parliament	Researcher	Kampala
13	Ms. Ajambo Dorah	Parliament	Researcher	Kampala
14	Dr. Sarah Byakika	Ministry of Health	Commissioner for Planning	Kampala
15	Mr. Tom Aliti	Ministry of Health	Assistant Commissioner	Kampala
16	Mr. Walimbwa Aliyi	Ministry of Health	Senior Health Planner	Kampala
17	Ms. Seti Patience	Ministry of Health	Personal Assistant to State minister for Health	Kampala
18	Ms. Natabi Aisha	Ministry of Health	Office of State Minister for Health	Kampala
19	Ms. Ritah Musuya	Ministry of Health	Office of State Minister for Health	Kampala
20	Dr. Nancy Njeri	Ministry of Health	Consultant on UHC	Kampala
21	Mr. Kenera Patrick	Ministry of Defence		Kampala
22	Mr. Zephaniah Ogen	Ministry of Gender, Labour and Social Development	Senior Programme Officer Social Protection	Kampala

23	Mr. Kaggwa Andrew	Ministry of Local Government	Principal Assistant Secretary	Kampala
24	Mr. Tugabiirwe Emmanuel	Ministry of Local Government		Kampala
25	Mr. Kwesiga Brendan	World Health Organisation	Health Economist	Kampala
26	Mr. Kiira Brian Alex	Initiative for Social and Economic Rights		Kampala
27	Ms. Allana Kembabazi	Initiative for Social and Economic Rights	Program Manager, Right to Health	Kampala
28	Ms. Christine Namayanja	USAID - Uganda Voucher Plus Activity	Chief of Party	Kampala
29	Dr. Gerald Karegyeya	USAID - Uganda Voucher Plus Activity	Claims Manager, Voucher Management Agent	Kampala
30	Ms. Judy Mugoya	Smart Applications International	Country Manager	Kampala
31	MS. Rukia Barii	Smart Applications International	Customer Marketing Manager	Kampala
32	Ms. Peace Uwor	Smart Applications International	Business Development Officer	Kampala
33	Ms. Sharon Munguryek	Smart Applications International	Business Development Officer	Kampala
34	Mr. William Kidega	USAID/PATH, Advocacy for Better Health Project	Deputy Chief of Party,	Kampala
35	Mr. Henry Travis Mugerwa	National Social Security Fund	Voluntary Business Manager	Kampala
36	Dr. Ronald Kasyaba	Uganda Catholic Medical Bureau	Assistant Executive Secretary	Kampala
37	Mr. Fredrick Ouma Bwire	Uganda Social Protection Platform	Chairman	Kampala
38	Mr. Joshua Akena	Uganda Insurers Association	Life and Pensions	Kampala
39	Dr. Kadama Patrick	ACHEST	Director	Kampala
40	Mr. Robert Kabaale	UCBHFA	National Coordinator	Kampala
41	Ms. Sarah Murungi Adyeri	Health Partners	Chief of Party	Kampala
42	Ms. Robinah Kaitiritimba	UNHCO	Executive Director	Kampala
43	MS. Alice Abukito	Mazima Retirement Plan	Administrator	Kampala
44	Mr. Ndiroramukama Sylvester	Uganda Cooperative Savings & Credit Union	Chief Executive Officer	Kampala
45	Mr. Mugusha Michael	Brac Uganda	Manager, Credit Administration	Kampala
46	Mr. Kiseka Denis	Brac Uganda		Kampala

47	Mr. Mubiru John Bosco	Friedrich Ebert Stiftung	Program Manager	Kampala
48	Mr. Makaire Fredrick	Save for Health Uganda	Executive Director	Kampala
49	Mr. Zakaria Muwanga Kasirye	Save for Health Uganda	Board Chairman	Kampala
50	Mr. Douglas Opio	Save for Health Uganda	Board Member	Kampala
51	Ms. Leticia Nakimuli	Save for Health Uganda	Board Member	Kampala
52	Mr. Paul Waigolo	Save for Health Uganda	Board Member	Kampala
53	Mr. Tumukurate Espilidon	Jhpiego	NPD Associate	Kampala
54	Mr. Obong John	CUAMM	Social worker	
55	Mr. Opio Anthony	CUAMM	Social worker	
56	Mr. Aryatunga Brian	E-quality health Bwindi	Coordinator	Kanungu
57	Ms. Grace Kiwanuka	Uganda Health care Federation	Executive Director	Kampala
58	Mr. Mugabi Denis	Uganda Health care Federation	Administrator	Kampala
59	Mr. Innocent Kabizu	RHU/ABC Africa	Data Analyst/SO	Kampala
60	Ms. Juliet Nazibanja Kibirige	Save for Health Uganda	Program Officer	Kampala
61	Ms. Veronica Asio	Save for Health Uganda	Finance and Admin Officer	Kampala
62	Ms. Nnamulondo Proscovia	Save for Health Uganda	Communication and Advocacy Officer	Kampala
63	Mr. Kenneth Waiswa	Save for Health Uganda	Assistant Programs Officer	Luwero
64	Mr. Friday Moses	Save for Health Uganda	Team Leader	Bushenyi
65	Mr. Samuel Kitenda	Save for Health Uganda	Team Leader	Luwero
66	Mr. Mujuni Wilfred	Save for Health Uganda	Senior Field Officer	Mityana
67	Mr. Mwesigwa Fred	Save for Health Uganda	Junior Field Officer	Luwero
68	Ms. Namugenyi Josephine	Save for Health Uganda	Office Administrator	Luwero
69	Ms. Josephine Kemigisha	Save for Health Uganda	Office Administrator	Kampala
70	Ms. Akatukwatsa Sonia	Save for Health Uganda	Administrative Assistant	Bushenyi
71	Mr. Ssekyanzi Badru	Save for Health Uganda	Driver / Office Assistant	Kampala
72	Mr. Samuel Oromchan	Save for Health Uganda	Driver / Office Assistant	Kampala
73	Mr. Sekyanzi David	Munno mu Bulwadde Union of Schemes Organization	President	Luwero

74	Mr. Mayanja Moses	Munno mu Bulwadde Union of Schemes Organization	Board Member	Luwero
75	Ms. Masembe Esau	Mubende Schemes Cooperation Mechanism	Chairperson	Kassanda
76	Ms. Rurangira Teopista	Mubende Schemes Cooperation Mechanism	Board member	Kassanda
77	Mr. Muhumuza Stephen	Western Ankole Tweragurise Schemes Association	Board Chair	Sheema
78	Ms. Natukunda Mary	Western Ankole Tweragurise Schemes Association	Board Treasurer	Bushenyi
79	Ms. Teopista Nabwami	Butaba Company Limited	Team Leader	Kassanda
80	Ms. Evelyn Kisubi	SHU Finance	Team leader	Luwero
81	Ms. Nakawe Hasifa	Kakabala CHI Scheme	Scheme member	Luwero
82	Mr. Fred Ssenabulya	Kakinzi CHI Scheme	Scheme member	Luwero
83	Mr. John Paul Kibalama	Bamugolodde CHI Scheme	Scheme member	Luwero
84	Ms. Nakato Ssembajjwe	Luteete CHI Scheme	Scheme Agent	Nakaseke
85	Mr. Godfrey Kuruhiira	Luwero District	Chief Administrative Officer	Luwero
86	Mr. Serugo Joseph	Luwero District	Vice Chairman/ Sec for Health	Luwero
87	Mr. Mayanja Dithan Kikabi	Luwero District	Speaker	Luwero
88	Dr. Innocent Herbert Nkonwa	Luwero District	District Health Officer	Luwero
89	Mr. Namakola Henry	Luwero District	Health Educator	Luwero
90	Ms. Katasi Florence	Luwero District	District Community Development Officer	Luwero
91	Ms. Kayaga Aisha Shamim	Luwero District	Councillor - Butuntumula Sub-county	Luwero
92	Mr. Mwesigye Patrick	Luwero District	Councillor - Kamira sub-county	Luwero
93	Ms. Nakitende Flavia	Luwero District	Councillor- Kalagala Sub-county	Luwero
94	Ms. Namugambe Harriet	Luwero District	Councillor - Ziobwe Sub-county	Luwero
95	Mr. Semugabi Emmy	Luwero District	LCIII Chairman - Luwero Subcounty	Luwero
96	Mr. Mukungu Paul Ssenyonga	Luwero District	Mayor - Luwero Town Council	Luwero

97	Mr. Kalibbala Charles	Luwero District	LCIII Chairman - Makulubita	Luwero
98	Hajji Omar Ali Kyagulanyi	Luwero District	LCIII Chairman - Katikamu	Luwero
99	Mr. Sematimba Abubakar M	Luwero District	LCIII Chairman - Kikyusa	Luwero
100	Mr. Osman Kassim Ramathan	Luwero District	LCIII Chairman - Bombo Town Council	Luwero
101	Mr. Kibalama John Paul	Luwero District	LCIII Chairman - Butuntumula	Luwero
102	Mr. Sserubidde Daniel	Luwero District	LCIII Chairman - Kalagala	Luwero
103	Mr. Senyonjo Edward	Luwero District	LCIII Chairman - Kamira	Luwero
104	Mr Muwayire G. William	Luwero District	LCIII Chairman - Nyimbwa	Luwero
105	Mr. Imarach Pascal	Luwero District	LCIII Chairman - Zirobwe	Luwero
106	Mr. Koomu Ignatius Kiwanuka	Nakaseke District	District Chairman	Nakaseke
107	Ms. Mukagatale Gorretie	Nakaseke District	Secretary for Health	Nakaseke
108	Mr. Sentongo Badru	Nakaseke District	District Community Development Officer	Nakaseke
109	Mr. Kigula Samuel	Nakasongola District	District Chairman	Nakasongola
110	Dr. Byamukama Agaba	Nakasongola District	District Health Officer	Nakasongola
111	Mr. Buyinza Simon	Nakasongola District	District Community Development Officer	Nakasongola
112	Mr. Francis Kibuuka Amooti	Mubende District	District Chairman	Mubende
113	Dr. Mutundi vicent	Kassanda District	for DHO	Kassanda
114	Ms. Namukwaya Winfred	Kassanda District	DCDO	Kassanda
115	Ms. Ssentamu Margaret	Mityana District	Vice Chairperson	Mityana
116	Ms. Katumwa Sarah	Mityana District	Nursing Officer	Mityana
117	Mr. Mayiga Anthony	Mityana District	For District Community Development Officer	Mityana
118	Mr. Dauda Kewaza	Masaka District	District Health Inspector	Masaka
119	Ms. Peace Tibakuna	Bushenyi District	Secretary for Health	Bushenyi
120	Dr. Edward Mwesigye	Bushenyi District	District Health Officer	Bushenyi
121	Dr. Atwongyeire Dickens	Sheema District	District Health Officer	Sheema
122	Mr. Mbeine Robert	Mitooma District		Mitooma
123	Mr. Tumuhaise Sylvester	Mitooma District	Chairman LCV	Mitooma

124	Ms. Atuzarirwe Allen	Mitooma District	Senior Community Development Officer	Mitooma
125	Mr. Naijuka Amon	AMG-Bugongi HCIII	In-charge	Sheema
126	Dr Johnson Kabwishwa	Kitagata Hospital	Medical Superintendant	Sheema
127	Sr Monica Tuhaise Mukama	Mushanga HCIII	In-charge	Sheema
128	Mr. Nayebare Aniset	Bitooma HCIII	In-charge	Bushenyi
129	Ms. Lydia Komugisha	Ishaka Adventist Hospital	Senior Hospital Administrator	Bushenyi
130	Mr. Bagyenzi Isaiah	Ishaka Adventist Hospital	Prepayment Cashier	Bushenyi
131	Mr. Amoru Paul	Bata Medical Centre		Kole
132	Sr. Claris	Holly Cross Kikyusa HCIII	In - Charge	Luwero
133	Sr. Ernestine Akulu	Bishop Caesar Asili Hospital	Administrator	Luwero
134	Mr. Edema Jimmy	Bishop Ceasar Asili Hospital	Public Health Officer	Luwero
135	Mr. Ocen James	Gift Life Medical Centre and Laboratory		Lira
136	Mr. Felix Oyugi	Aero Medical Clinic		Oyam
137	Mr. Geoffrey Ocheng	Alleluyah JMC		Alebtong
138	Mr. Denis Omonya	Heaven of Peace Medical Centre		Lira
139	Dr. Odongo Jimmy Felix	Bala Medical Centre		Kole
140	Mr. Moses Aisia	Holy Innocent HC III		Bukedea
141	Mr. Geoffrey Tsapwe	Hope Medical Centre		Mbale
142	Mr. Kalere Anthony	Galimagi HC III		Pallisa
143	Mr. Boaz Aruho	Mbale Peoples' Clinic		Mbale
144	Dr. Modusu John	Kabasa Memorial Hosp		Butaleja
145	Mr. Musedde Deborah	Destiny Dormiciliary		Sironko
146	Mr. Onek Richard	Keyo Medical Centre		Amuru
147	Mr. Emmanuel Amanyanya	Shared Blessings		Sironko
148	Ms. Nakayenze Emily	Devine Medical Centre		Sironko
149	Mr. Acobi Andrew	Florence Nightngale		Apac
150	Mr. Onek John Omeda	PABBO MEDICAL CLINIC	Proprietor	

151	Mr. Namugera Julius	Bethany Medical Centre AMC	MLT	
152	Mr. Tumwine Ambrose	Kalo Hospital		Kanungu
153	Sr. Gertrude Kabanyomozi	Rwibaale HCIII	Director UHC Project	Kyenjojo
154	Sr. Juliet Asiimwe	Rwibaale HCIII	Coordinator UHC Project	Kyenjojo
155	Mr. Mutsopa William	Hope Medical Centre	In-charge	Sheema
156	Sr Margaret Nangendo	St. Matia Mulumba Mulajje HCIII	In Charge	Luwero
157	Sr. Jeya Chitra	St. Luke Namaliga HCIII	In Charge	Luwero
158	Mr. Ssebaggala Emmanuel	St. Kizito Nattyooole HCIII	In Charge and Administrator	Luwero
159	Mr. Tumusiime Tadeo	St Francis Health Centre Kijaguzo	In- charge	Luwero
160	Mr. Samuel Okwir	St. Mary Health Centre Kasaala	Clinical officer	Luwero
161	Mr. Alfred Resnata	Good Samaritan HC Katikamu	Clinical officer	Luwero
162	Dr. Peter Serwadda	Kiwoko Hospital	Medical Director	Nakaseke
163	Mr. Kaweesi Robert	Kiwoko Hospital	Cashier	Nakaseke
164	Mr. Lubega Andrew	Kiwoko Hospital	HPR	Nakaseke
165	Dr. Lumala Alfred	Kitovu Hospital	Chief Executive Officer	Masaka
166	Sr. Mary Cabrine N	Naluggi HCII	In-charge	Kassanda
167	Mr. Ikoba Godfrey	St. Gabriel Mirembe Maria HCIII	Clinical officer	Kassanda
168	MS. Annette Akankwatsa	Kitokolo HCII		Kassanda
169	Sr. Rosemary Nakiwala	Franciscan HCIV Kakooge	In-Charge	Nakasongola
170	Ms. Judith Hope Kiconco	Makerere University -John Hopkins Research Collaboration	Manager, Nursing Operations.	Kampala
171	Ms. Nakazibwe Brenda	Makerere University School of Public Health	MPH Officer	Kampala
172	Ms. Maria Nannini	University of Florence	PHD Candidate	
173	Dr. Martin Ruhweza	Healthwise Uganda Ltd	Rapporteur	Kampala
174	Ms Brenda Walyawula	Healthwise Uganda Ltd	Rapporteur	Kampala
175	Ms. Stella Naigino	New Vision	Reporter	Kampala
176	Ms. Juliet Kasirye	New Vision	Photographer/Journalist	Kampala

177	Ms. Evelyn Lirri	Social Media	Reporter	Kampala
178	Ms. Charlotte Ninsiima	Social Media	Reporter	Kampala
179	Ms. Vivian Agaba	Social Media	Reporter	Kampala
180	Mr. Umar Weswala	Social Media	Blogger/Managing Editor	Kampala
181	Mr. Mike Sebalu	Radio One / Kaboozi	Reporter	Kampala
182	Ms. Nakuti Adiah	UBC TV	Journalist	Kampala
183	Mr. Akatuhurira Nelson	UBC TV	Camera man	Kampala
184	Mr. Julius Wasajja	HEJNU/Social media	Journalist/Social media	Kampala
185	Mr. Otar James Richard	Consumers guide magazine	Journalist	Kampala
186	Mr. Stephen Mwiri		Videographer	Kampala

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