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An Assessment of Community- Based Health Financing Activities in Uganda

February 2005

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Mission

Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:

- ▲ *Implementation of appropriate health system reform.*
- ▲ *Generation of new financing for health care, as well as more effective use of existing funds.*
- ▲ *Design and implementation of health information systems for disease surveillance.*
- ▲ *Delivery of quality services by health workers.*
- ▲ *Availability and appropriate use of health commodities.*

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Abstract

The Partners for Health Reform*plus* Project (PHR*plus*), in conjunction with the Uganda Community Based Health Financing Association (UCBHFA), conducted an assessment of community-based health financing (CBHF) schemes in Uganda. The purpose of the assessment was to identify good practices/models and key obstacles to sustainability in terms of governance and management, financial management and viability, risk management, marketing and membership incentives, community buy-in, and impact on quality of life of members. The PHR*plus* team conducted key informant interviews and focus group discussions with CBHF scheme managers, current scheme members, and former members. These data were supplemented by records from the UCBHFA and a desk review of relevant literature. The assessment revealed that scheme membership improved overall quality of life for scheme members; however, community participation and management practices should be strengthened to improve scheme viability and sustainability. The findings will be shared among scheme managers and support organizations to improve CBHF schemes' long-term sustainability.

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Acronyms

BMC	Bushenyi Medical Centre
CBHF	Community-Based Health Financing
CMS	Commercial Market Strategies
DfID	British Department for International Development
FINCA	Foundation of International Community Assistance
FT	Full-time
IEC	Information, Education and Communication
IP	Inpatient
ITN	Insecticide-Treated Bednets
MCH	Mother-Child Health
MIS	Management Information Systems
MoH	Ministry of Health
NGO	Nongovernmental Organization
OP	Outpatient
PHR<i>plus</i>	Partners for Health Reform <i>plus</i>
PTMTC	Prevention of Mother-to-Child Transmission
SHU	Save for Health-Uganda
UCBHFA	Uganda Community Based Health Financing Association
UMU	Uganda Microfinance Union
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing

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Meetings with scheme members and former members at Comboni, Mutolere, Bweyogerere, and Luwero offered a keen perspective on the inner workings of CBHF schemes in Uganda from the consumer side.

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Executive Summary

The Partners for Health Reform *plus* Project (PHR *plus*) in conjunction with the Uganda Community Based Health Financing Association (UCBHFA) conducted an assessment of community-based health financing (CBHF) schemes in Uganda in September–October 2004. The assessment was implemented to provide PHR *plus* with the appropriate background to successfully implement CBHF strengthening activities. This assessment will provide stakeholders with a portrait of CBHF activities throughout the country and provide the PHR *plus* team with a framework for continuing CBHF activities.

The purpose of the assessment is to examine good practices/models and key obstacles to sustainability in terms of governance and management, financial management and viability, risk management, marketing and membership incentives, community buy-in, and impact on quality of life of members.

The PHR *plus* team conducted key informant interviews in conjunction with focus group discussions. These data were supplemented by records from the UCBHFA and a desk review of relevant literature.

The key findings are:

- ▲ **Quality of life.** Scheme members report a significant improvement in quality of life as a result of membership. This pertains directly to members' health and to their ability to cope with health care costs.
- ▲ **Management and Governance.** There is a wide diversity of management structures and members' role in the decision-making process, with varying degrees of community involvement.
- ▲ **Financial Management and Viability.** Scheme membership base is a better predictor of cost recovery than premium payments are. Schemes need to improve accounting mechanisms and financial management for informed decision making.
- ▲ **Risk Management.** There is a range of understanding of risk management and insurance concepts among scheme members. It appears that membership policies may be significantly inhibiting scheme growth. Risk management techniques, such as the use of ceilings and review of the 60-percent group membership rule should be investigated further.
- ▲ **Marketing and Membership Incentives.** Marketing research will improve the identification and sensitization of potential new scheme members. Insecticide-treated net subsidies have been identified as an effective marketing strategy for recruiting new scheme members.

- ▲ **Community Buy-in.** There is a need for increased sensitization among scheme members regarding insurance concepts. Member groups are interested in pursuing income-generating activities to supplement premium payments.
- ▲ **Sustainability.** There is a need to re-examine concepts of scheme sustainability and scheme health, in terms of membership criteria, financial health, community involvement, and effective management techniques.

1. Introduction

Community-based health financing (CBHF) aims to empower communities to meet their health financing needs through pooling of resources to pay for health care as a group. “CBHF schemes share the goal of finding ways for communities to meet their health financing needs through pooled revenue collection and resource allocation decisions made by the community... However, unlike many insurance schemes, CBHF schemes are typically based on the concepts of mutual aid and social solidarity” (Bennett, Gamble Kelley, and Silvers 2004). Schemes employ a variety of financial structures, including insurance, prepayment, and credit schemes, with premiums ranging from a once-per-annum payment during harvest season to a monthly or quarterly fee. CBHF schemes can act as a resource to pay for services through a community fund or can be facility-based. Unlike community-based health insurance schemes or mutual health organizations in West Africa, the majority of community-based health insurance schemes in Uganda are in fact facility-based schemes that target community groups as clients. Facility-based schemes are owned by the facility itself and are usually managed by facility staff, thus resembling health maintenance organizations.

Community-based health financing was introduced in Uganda in 1995, as part of the Ministry of Health’s (MoH’s) move to pilot community health financing approaches in the country. The Kisiizi Hospital Society Health Plan was the first scheme¹ founded and was modeled on a similar facility-based scheme in Kenya. At that time, government health care financing policy included cost sharing, meaning that individuals paid user fees to access government-provided health care when care was sought. Community-based health insurance provided a means for families to ensure that they could pay for health services at local facilities, government or private. After the presidential election in 2001, the government of Uganda abolished user fees in public facilities, making public sector schemes unnecessary. Despite the availability of free-of-charge health care, schemes at private not-for-profit facilities continued to be utilized by some populations. Apparently they believed that they received a better quality of care outside of the public sector, they found the privately provided services more convenient, or they chose to use private services for some other reason.

The Community Health Financing Project, the predecessor of the Uganda Community Health Financing Association, was established in 1995 by the MoH’s Health Planning Department and was managed by Department for International Development (DfID)-funded planners within the ministry. The project established several schemes within private not-for-profit hospitals. The provider-managed model was chosen, as the “onus was on the hospitals to keep costs low” (Uganda Community Based Health Financing Association [UCBHFA] n.d.) In 2000, the UCBHFA registered as a nongovernmental organization (NGO) and took over the role of the Community Health Financing Project. DfID continued to fund the deficits of CBHF schemes belonging to the UCBHFA until 2002, when it withdrew its financial support. The MoH continues to provide the UCBHFA with financial

¹ In the context of facility-based CBHF schemes, the term "scheme" is used to refer to the overall insurance mechanisms owned by the facility. The term "group" is used to refer to pre-existing social groups that have opted to join a given insurance scheme.

and technical support. Currently, the hosting health facilities absorb any deficits incurred by the facility-based CBHF schemes.²

The Partners for Health Reform *plus* Project (PHR *plus*) was requested by the United States Agency for International Development (USAID)/Uganda to provide assistance to the Ministry of Health and the Uganda Community Based Health Financing Association to strengthen CBHF schemes nationally. In order to provide appropriate technical assistance in this area, PHR *plus*, in collaboration with UCBHFA, implemented an assessment to collect basic information about currently functioning CBHF schemes and support organizations (Boxes 1 and 2). Most of the schemes examined are UCBHFA members. (A full list of schemes in Uganda is in Annex A).

Box 1. Facility-Based CBHF Schemes Interviewed*

- ▲ **Bushenyi Medical Centre (BMC) Health Society:** The scheme at BMC was established in 1998. The scheme is predominantly aimed at local schools (School Health Made Easy Scheme) but also includes community groups (Group Health Plan). BMC offers health care services at its hospital, as well as at satellite clinics in the area. BMC is one of the few CBHF schemes to have an active management information system. This allows it to separately analyze and report on data from its school and community groups.
- ▲ **Comboni Hospital Health Plan:** The health scheme at Comboni Hospital began in July of 2002 and has a combination of member groups, including engozi societies and other community groups, employees and local schools.
- ▲ **Ishaka Hospital Health Plan:** Ishaka Hospital founded the health scheme in early 1999 and currently consists of 15 groups, including hospital staff.
- ▲ **Nyakibale Hospital Community Health Plan:** The scheme at Nyakibale Hospital was started in June of 1998 and currently has 11 member groups.
- ▲ **Kirinya Farmers Cooperative, Bweyogerere:** The Kirinya Farmers Cooperative was founded as a women's self-help group through the YWCA in 1959. The group began a health plan in the early 2000s and was dissolved in 2002. Scheme membership fell off as a result of the end of cost sharing at government facilities and more convenient local facilities.
- ▲ **Kisiizi Hospital Society Health Plan/Microcare Health, Ltd.:** Kisiizi Hospital is home to the oldest health scheme in Uganda, which began providing services in 1996. Initially the hospital managed the scheme, however in 1999 Microcare, previously a not-for-profit organization, now for-profit company focused on health management, became involved in the scheme.
- ▲ **Kitovu Patients Pre-Payment Scheme:** Kitovu Hospital began its health scheme in 1998. Kitovu is comprised of self-help groups, students and teachers groups, totalling 30 groups.
- ▲ **Mutolere Pre-Payment Scheme:** The scheme at Mutolere Hospital was formed in June of 1998. This scheme encompasses community self-help groups and employees. When Microcare opened a branch in Kisoro, it offered to take over the Mutolere Prepayment Scheme, as had been done at Kisiizi, however the hospital refused.
- ▲ **Rugarama Health Centre Health Plan:** The health plan at Rugarama Health Centre is one of the newest schemes, initiated in June of 2003. The scheme is currently comprised of the Rugarama Dairy Cooperative and is in negotiations with the Kigezi Diocese and Kabale University to increase membership.
- ▲ **Microcare Health, Kisoro Branch:** The Kisoro Branch of Microcare Health, Ltd is a for-profit commercial insurance provider. The office in Kisoro opened in 2003 and focuses solely on higher income groups, such as private employers and school groups. Microcare-Kisoro offers a variety of benefit packages that include outpatient care at private clinics and inpatient care at Mutolere Hospital.

* Also interviewed were community-based schemes grouped under Save for Health-Uganda (SHU), Luwero. See Box 2 for more information about SHU.

² The exception to this is at Kisiizi, where Microcare underwrites the scheme's losses.

Box 2. CBHF Support Organizations

- ▲ **Uganda Community Based Health Financing Association:** The UCBHFA is a non-profit organization committed to promote community-based health financing and increase access to affordable quality health services throughout Uganda. The UCBHFA provides technical assistance to member schemes and compiles financial and membership statistics from schemes each quarter.
- ▲ **HealthPartners** (Head Office): In 1997, HealthPartners began to develop a pre-paid health care delivery system through the Uganda Health Cooperative. The project partnered with already existing microfinance groups, tea and coffee cooperatives, schools, and *engozi* societies to create a pool through which comprehensive health services would be “pre-paid.” Until June 2004, HealthPartners worked with 59 groups nationally; the organization has recently scaled back operations, limiting assistance to schemes in the western part of Uganda. The remaining schemes have continued to function, however, they are no longer receiving support from HealthPartners.
- ▲ **Microcare Health Limited** (Head Office): Microcare Health, Ltd, is a private company that developed out of the not-for-profit organization, Microcare. According to the medical director, the stated objective of Microcare Ltd. is to offer access to quality health services through reduction of fraud and managed care. The not-for-profit component of the organization exists in name as a shareholder of Microcare, Ltd.
- ▲ **Save for Health-Uganda** (SHU), Luwero: SHU was established in 1999 and acts as an umbrella group for community-based health schemes in the area (currently 11). The schemes that constitute SHU are both credit and combination insurance/credit schemes. They are the only de facto community-based (i.e., not tied to a single facility) schemes currently known in Uganda. Because the schemes are community-based, some have been able to include services at Kasaala Health Centre, an outpatient clinic, in addition to care at Kiwoko Hospital. The structure of these credit and credit/insurance schemes differs from that of the facility-based schemes: members pay an annual premium (set by SHU) and an annual management fee (set by the individual scheme). When members access health services, their medical bills are paid by the scheme account, to which members are then beholden. Scheme members then have three months to reimburse the scheme for the cost of their treatment.

The purpose of the assessment is to identify best practices and examine key obstacles to sustainability in the areas of scheme governance and management, financial management and viability, community buy-in, and impact on quality of life of members. Findings will provide stakeholders with a portrait of CBHF activities throughout the country and provide the PHR*plus* team with a framework for continuing support for CBHF activities.

2. Methodology

The *PHRplus* field research team for the CBHF scheme assessment in Uganda included Dr. Paul Kiwanuka-Mukiibi (PS Consulting) and Katherine Wolf (*PHRplus*), with technical support from Yann Derriennic (*PHRplus*) and Stephen Musau (*PHRplus*). The field team was joined for site visits by Livingstone Namarah, the national coordinator of the Uganda Community Based Health Financing Association.

The assessment employed mostly qualitative techniques to gather data on the sustainability of CBHF schemes in Uganda. Data collection instruments were developed in conjunction with relevant stakeholders including the UCBHFA and counterparts in the Ministry of Health and scheme managers. Data were collected through key informant interviews with scheme managers and CBHF project leaders, focus groups with scheme members and former scheme members, and a desk review of relevant documents.

All 12 currently functioning schemes in Uganda and one recently dissolved scheme (Kirinya Farmers' Cooperative) were catalogued and contacted for phone interviews or site visits. All of the schemes contacted readily agreed to participate. However, the scheme managers at Mbale and Mayanja Memorial Hospital were not available to meet with the team during the study period; because this would have limited data collection, those schemes were excluded from the assessment. The Mother Uplifting Child scheme, based at Lacor Hospital in Gulu, also was excluded.³

Data collection took place from 27 September to 7 October 2004. Of the 12 currently operational schemes, the assessment team visited nine and interviewed three by telephone. (See Annex B for questionnaire used with scheme managers.) All four support organizations were visited.

The schemes and support organizations visited were the following:

- ▲ Bushenyi Medical Centre (BMC)
- ▲ Comboni Hospital (with focus groups)
- ▲ Kirinya Farmers Cooperative, Bweyogerere (with focus group) (scheme recently dissolved)
- ▲ Kisiizi Hospital/Microcare
- ▲ Mutolere St. Francis Hospital (with focus groups)
- ▲ Rugarama Health Centre

³ The health insurance scheme at Lacor Hospital is the only scheme in the war-torn north of Uganda. While it perhaps would make an interesting case study, the scheme serves an extremely poor sector of the population and is unlikely to ever achieve financial sustainability without outside donor funding and improved security. For this reason, it does not fit into the overall scope of this assessment.

- ▲ Save for Health-Uganda, Luwero (with focus groups)
- ▲ Uganda Community Based Health Financing Association
- ▲ Health Partners (Head Office)
- ▲ Microcare Limited (Head Office)
- ▲ Microcare, Kisoro Branch
- ▲ Mayanja Memorial Hospital (later excluded)
- ▲ Mbale Health Centre (later excluded)

The schemes interviewed via telephone were:

- ▲ Ishaka Hospital Health Plan
- ▲ Kitovu Patients Pre-Payment Scheme
- ▲ Nyakibale Hospital Community Health Plan

Focus groups were conducted with current or former scheme members at four sites. (Annexes C and D contain discussion guides for current and former members, respectively). Participants were recruited through scheme managers and community leaders. Each group numbered 8–15 and lasted 60–90 minutes; community leaders and scheme managers attended the discussions. Kiwanuka-Mukiibi and Wolf facilitated the focus groups in English; Kiwanuka-Mukiibi, Namarah, or scheme leaders translated to the local language as needed. Participants were questioned about community participation in scheme initiation and decision making, scheme premiums and benefits, health services utilization, and perceived change in health status.

Data were collected at interviews and focus groups under the following headings: quality of life for members, management and governance, financial management and viability, risk management, marketing and membership incentives, community buy-in, and sustainability. Data then were compiled and analysed. Where available, qualitative data analysis was supplemented with statistics from quarterly reports that schemes make to the UCBHFA.⁴

⁴ It should be noted that several of the establishment dates provided in interviews with scheme managers and CBHF projects do not match the dates noted by the UCBHFA for the same events. In fact, the UCBHFA has membership, utilization and cost recovery data for several schemes from several years before the schemes supposedly were established.

3. Discussion and Findings

With one exception (the umbrella organization Save for Health Uganda Project [SHU], in Luwero), all CBHF schemes presently functioning in Uganda are facility based, i.e., health care facilities both administer the schemes and provide the health care offered through the scheme. Most of the facilities are mission (NGO) or other private not-for-profit hospitals. As this implies, the aim of the facilities is to fulfill the societal need of providing health care and promoting health rather than to seek profits. By hosting CBHF schemes, these facilities encourage increased utilization of health services in the communities they serve, as can be seen by the benefits packages offered. (Annex E describes benefits packages as well as scheme management and premium structures, management information systems [MIS], and mechanisms used to pay providers). This societal role of CBHF schemes is discussed in the *Situational Report on Community Health Insurance Schemes in Uganda* (Basaza and Namarah 2003); the report outlines the three types of objectives for community-based health insurance: (1) financial (stable resources for functioning of health services), (2) operational (improving access to health services), and (3) social (promotion of organization of health service users).

Membership in the schemes themselves is through social groups: community groups, employer groups, and school groups. Many of the community groups are self-help groups such as cooperatives, microcredit groups, or *engozi* societies.⁵

Discussions with CBHF scheme leaders and community groups provided much insight into the current status of health schemes in Uganda. Findings are grouped by the data collection topics discussed in Chapter 2.

3.1 Quality of Life

Interviews of scheme managers and discussions with focus groups revealed the extensive and positive impact that CBHF schemes have on the overall quality of life of scheme members.⁶ Improvements to quality of life occur in terms of members' health status and their ability to manage the cost of illness. Financial benefits also accrue to the schemes and host facilities.

For example, members no longer postpone seeking health care until they are very ill. Before entering the scheme, to avoid paying onerous user fees at the point of service, they might have put off seeking health care until they were seriously or catastrophically ill. Alternatively, they may have self-medicated, risking drug complications for themselves and even public health problems from, say, misuse of antibiotics that contributed to drug-resistant germs. In addition to health risks, these alternatives to early care carried greater financial burdens, as greater fewer resources were needed to treat the patient.

⁵ Engozi are stretchers. Engozi societies traditionally were formed to help with the burial of members, or to carry sick members to hospitals in mountainous regions.

⁶ "Member" is used to refer to anyone who can access health scheme benefits, for example, a household head and all nuclear family members who live under the same roof.

When asked how the health scheme had changed their health, a focus group participant at Comboni said, “The health plan is like a parent to us.” The scheme “doesn’t allow the disease to remain inside you.” Members of the Mutolere scheme said that people now access care more easily; before, they wasted a lot of time, waiting until they had to be carried to the facility. In addition, women are not worried if a child is sick, especially when the husband is away.⁷ “The scheme cards are insurance for life.” (See Annex C.)

Former scheme members who were interviewed (see Annex D) emphasized that their quality of life had suffered considerably since dropping out. “We are now dying,” said a focus group participant at Comboni, stressing the difficulties faced in accessing health care services. Participants also stressed that government facilities do not provide an adequate level of care and consistently do not have supplies or drugs for treatment.

The non-health improvements in quality of life have also significantly impacted CBHF scheme members. The focus group discussions at Comboni, Mutolere, and Luwero confirmed that, with scheme coverage, members no longer have to hurriedly sell assets – presumably at a loss – in order to pay medical bills.

Until recently, the hospital at Luwero would detain patients until they or their families paid their hospital bills. Now, those enrolled in the credit schemes and insurance/credit schemes can pay their medical bills over time and therefore are not forced to sell assets to pay hospital bills.⁸ This freed up income allows the population to purchase other necessary goods and services.

The dropout group at Mutolere noted that, since their group has left the scheme, former members have had to sell assets. Some have been forced to borrow from money lenders at high interest rates to pay for medical care. In contrast, a woman at Mutolere who is still a scheme member reported that she uses health services “every day,” indicating the high frequency of utilization; if she were not a part of the health plan, she would have had to sell her home by now.

CBHF schemes have also provided broader benefits. In addition to improving access to curative care, the CBHF schemes provide health education and promotion. Most CBHF schemes have sold subsidized SmartNets (insecticide-treated mosquito nets) to scheme participants, which has reportedly reduced the number of malarial episodes experienced by scheme members. In Mutolere, the distribution and utilization of SmartNets significantly reduced the burden of disease during a large malaria epidemic, according to hospital public health staff.

There is anecdotal evidence that schemes have helped to sensitize members to the value of long-term planning and saving. A participant at Comboni reported that the scheme has taught members about saving for the future. A Luwero community member noted that the scheme started at a difficult economic time, when people were particularly sensitive to the value of having savings.

When asked how schemes could be improved, several communities felt that the scheme benefits should expand the pool of affiliated providers so that members can obtain outpatient care at clinics closer to their homes. This would save members both time and transport costs. It also has the potential to lower treatment costs to the scheme, as outpatient clinics generally have lower overhead costs than

⁷ In some traditional Ugandan societies, a woman must wait for funds or permission from her husband before seeking health care for herself or her children.

⁸ Credit schemes require members to pay a premium to join. Schemes pay members’ medical bills at the time of service; members have three months to repay the scheme. In this way, savings in treatment cost is passed on to scheme members.

do hospitals. However, this is likely to be difficult for most schemes as the majority of them are owned by the facilities in which they are based; increasing the number of affiliated facilities would add to the complexities of contracting with providers.

Currently, BMC and Luwero are the only schemes providing outpatient services in more than one health facility, BMC through satellite clinics and Luwero through contracts with local private clinics and or health centers. Despite the focus group at Luwero's access to Kasaala Health Centre, there were requests for closer, more convenient facilities. The Foundation of International Community Assistance (FINCA) group that left the Kitovu scheme cited distance to the facility as one of the main hindrances to benefiting from the scheme. In Bweyogerere, where the now-disbanded Kirinya Farmers' Cooperative scheme was located, the addition of a nearby outpatient clinic was listed one of the major reforms that could make a scheme there viable for the community.

3.2 Management and Governance

CBHF schemes use a wide range of management and governance practices. Compared to the community-based schemes of West Africa, the facility-based schemes in Uganda offer less opportunity for the community to play a substantial role in scheme management and decision making. In fact, the *Final Project Evaluation Report: Community Health Financing Project* notes that communities rarely participated in decision making in Ugandan CBHF schemes (Wilson 2002). Most management decisions are made by hospital administrators or management committees.

Nevertheless, individual cases of community input exist: Meetings of the Executive Committee at Luwero include member group leaders. Many scheme managers, such as the one at Kisiizi, meet periodically with members to inform members of scheme status or provide an avenue for dialogue. There are varying degrees of community involvement in setting premiums and co-payments. In 2000, the Ishaka Hospital Health Plan suffered a significant drop in membership after raising premiums. To staunch this decline, the scheme began to involve community members in decision making. Because the community came to understand why the resources were needed and how they would be used, the scheme did not lose members following a premium increase earlier this year.

While member schemes currently report basic scheme statistics to the UCBHFA on a quarterly basis, most schemes lack a general management information system (MIS) that would allow managers to make sound, evidenced-based decisions. For example, an MIS would enable scheme management and the UCBHFA to examine more complex issues associated with risk management and financial health.

A few schemes do have components of an ideal MIS: BMC uses an Oracle database to track patient history and service utilization. Microcare's MIS is more extensive, including the cost of treatment within the database. These two MISs have the ability to aid schemes in making management decisions, although the extent to which they actually do so is unclear.

3.3 Financial Management and Viability

The long-term sustainability of CBHF schemes depends on a number of factors: financial viability, management capacity; management information systems, and community support. As noted in the Partnerships for Health Reform (PHR) report *Community-Based Health Insurance: Experiences and Lessons Learned from East Africa* (Musau 1999), "(t)he schemes can be sustainable in the long term only if serious attention is paid to their design and management."

In the past, the issue of financial viability has often overshadowed other components of scheme success and sustainability. Previous assessment reports have questioned the financial viability and long-term sustainability of schemes in the absence of external donor funding or underwriting. The majority of these reports were compiled in 2002, when DfID withdrew its financial support for scheme deficit funding from a number of Ugandan schemes. The DfID-funded *Report on Study of Future Financial Viability of Community Health Insurance Schemes in Uganda* concluded that none of the schemes functioning demonstrated financial independence at that time, and that the schemes would need external support in order to remain in existence in the long term (The one exception to this was Bushenyi Medical Centre's health scheme, which showed some potential for viability in the future.) (Magezi, Maseko, and Wheeler 2002).

While the schemes have survived the cessation of DfID assistance, and not discounting the other components of sustainability, the issue of financial viability merits discussing. This section does that, in terms of cost recovery and the need for good accounting mechanisms.

Cost recovery. The majority of past assessments of CBHF in Uganda considered the achievement of full cost recovery to be the most significant predictor of sustainability. As Table 1 shows, most of the schemes have experienced an increase in cost recovery over the last several years. A number of schemes, such as Bushenyi Schools, Mutolere, and Kisiizi, have been able to achieve or exceed full cost recovery at some point. Anecdotal evidence at Luwero suggests that schemes have achieved 100 percent cost recovery. While actual cost recovery data are not available for Rugarama and Luwero, scheme managers report that the health schemes have consistently increased income to the clinic. Microcare-Kisoro, a for-profit venture, has reportedly been able to achieve cost recovery (specific data are not available) through targeting higher income groups with a variety of benefits packages focusing on private outpatient clinics.

Table 1: Cost Recovery Rates (%) Reported by CBHF Schemes, January 2001–January 2004

		Bushenyi Group	Bushenyi Schools	Ishaka	Kisiizi*	Kitovu	Mutolere	Nyakibale	Average
2001	1 st Q	54	59	58	47	53	69	46	55
	2 nd Q	33	172	90	90	75	84	68	87
	3 rd Q	85	160	84	101	60	97	51	91
	4 th Q	30	86	79	90	74	92	52	71
2002	1 st Q	32	119	85	80	95	77	57	77
	2 nd Q	122	119	83	97	95	77	60	93
	3 rd Q	24	77	78	148	75	102	65	81
	4 th Q	36	154	84	131	84	102	65	93
2003	1 st Q	89	162	84	N/A	70	132	63	100
	2 nd Q	85	109	84	N/A	85	128	63	92
	3 rd Q	85	160	84	N/A	60	97	51	90
	4 th Q	54	119	84	77	82	128	96	91
2004	1 st Q	50	105	93	74	75	132	102	90
Average		60%	123%	82%	100%	76%	101%	65%	

Source: UCBHFA

Notes: Percentages are rounded. Rates are calculated against treatment costs; they are not measured against total (administrative, outreach) costs.

* Kisiizi data reflect figures reported to the UCBHFA. While Microcare-Kisiizi noted that this information does not match its internal records for 2003-04, it did not provide revised figures for the time period

Nevertheless, in interviews done for the current assessment, the majority of the facility-based scheme managers cited cost recovery as a central concern. Managers are well aware that facilities subsidize the schemes by absorbing scheme deficits, and they would like make schemes more self-sufficient because they do not expect facilities to be able and willing to continue subsidies indefinitely. Managers at Comboni⁹ and Ishaka in particular expressed concerned with this issue.

One problem with the cost recovery rates claimed is that most facility-based schemes currently look at cost recovery in terms of percentage of treatment costs covered by premiums and co-payments; they fail to take into account administrative and outreach costs. The exceptions to this are the Nyakibale Hospital Community Health Plan, which has taken the first steps toward establishing a separate scheme account, and the Ishaka Hospital Health Plan, where the scheme is set up as a separate cost center of the hospital. This forces the scheme to include its administrative and outreach costs when determining the rate of cost recovery. Ishaka currently spends approximately 48 percent of its expenditure on medical treatment costs, 30 percent on administration, and 21 percent on outreach, prevention, and sensitization activities. Cost recovery for the Ishaka scheme has improved over time, despite financial constraints. According to the scheme manager, the health plan is now at 84-93 percent cost recovery, and it is likely that the scheme will reach the break-even point soon.¹⁰ Cost recovery rates do not positively correlate with the size of the premiums. There is a significant diversity of premium payments, ranging from US\$750/= to US\$4500/= per quarter per person for approximately the same package of services.¹¹ The Mutolere scheme currently has one of the highest rates of cost recovery (132 percent), but one of the lowest premiums at US\$900/= per quarter per person. While the BMC scheme is doing well overall, the community group component of BMC illustrates the converse of Mutolere: premiums are higher (US\$3750/= per person per quarter) and cost recovery is lower (currently 50 percent).

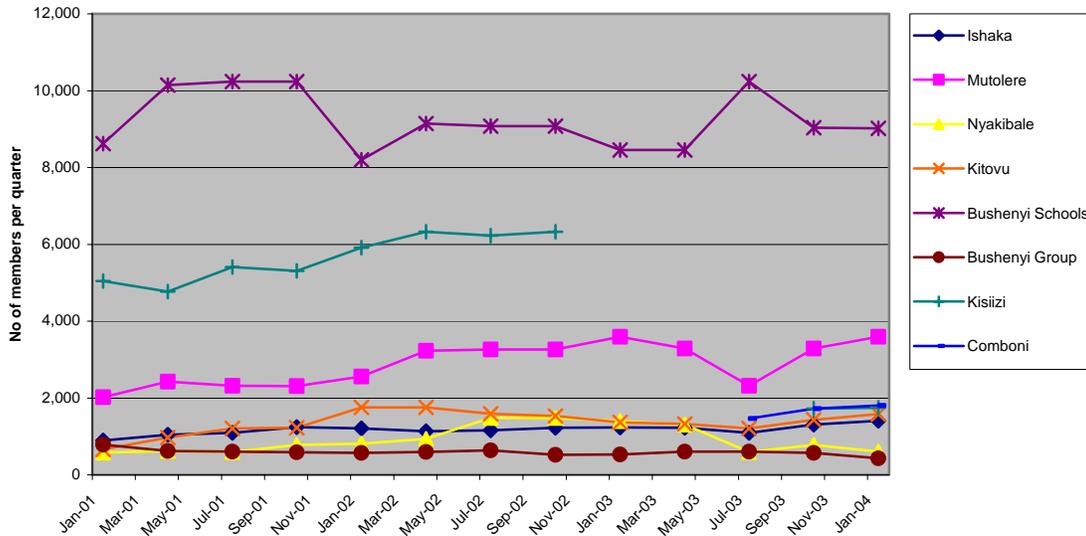
The relationship between premiums and cost recovery can be tied to the issue of scheme size. As seen in Figure 1, there appears to be a positive relationship between larger memberships and higher cost recovery. As membership decreases, the rate of cost recovery also decreases. This can be seen in regard to the Kisiizi scheme. Kisiizi, a community-based scheme with which Microcare became associated in 1999, was once able to achieve full cost recovery; in 2002, cost recovery rates were around 130-148 percent. Soon after, there was a significant increase in the dropout rate, which may have been due to a sharp increase in premiums (specific premium history was not obtained during the interview with the scheme manager), and the cost recovery rate decreased significantly. (Currently, the rate is around 74-77 percent.) Microcare plans to raise premiums at Kisiizi to increase cost recovery. However, such a move could lead to a further drop in membership and full cost recovery may never be achieved because the reduced scheme would have to cover fixed administrative costs.

⁹ As the Comboni Hospital Health Plan does not report basic statistics to the UCBHFA, cost recovery data is not available.

¹⁰ Ishaka Hospital Health Plan has recently raised its premiums in an effort to reach cost recovery.

¹¹ At the time of this assessment, the exchange rate was USD1 = US\$1700.

Figure 1: Total Number of Members in CBHF Schemes, January 2001-January 2004



Accounting Mechanisms. As noted above, scheme managers are aware of their schemes’ shortcomings in regard to cost recovery, and the implications this has on financial sustainability of the schemes. The Comboni scheme manager admitted that the hospital may not be willing to absorb scheme deficits indefinitely. However, it will be difficult for most scheme managers to improve their financial management because they cannot examine scheme finances – most schemes share the hospital’s general accounting system and are not separate cost centers. (Again, Ishaka and Nyakibale are exceptions.)

Scheme managers need tools to separate and analyse their accounts as a cost center within the facility. This will enable them to work with key decision makers to seriously examine scheme finances and financial policies.

3.4 Risk Management

All the CBHF schemes have adopted mechanisms to manage financial risk to the scheme; some have more stringent rules than others. Schemes use co-payments to control moral hazard; have membership policies to avoid adverse selection; and define benefits packages, with benefits ceilings and exclusions, to limit overspending. The effectiveness of these mechanisms depends in part on members’ understanding and acceptance of them, and thus the degree of implementation/compliance with the rules.

Co-payments. Insurance plans adopt co-payments (co-pays) primarily to limit moral hazard, that is, to discourage the overutilization of services that occurs when health care is free at point of service. Among member groups of the schemes in the current study, there is significant diversity in the understanding of insurance concepts, in particular the co-payment.

At Comboni, the Gongo group understood and accepted use of the co-pay for their scheme. Early on in the life of the Comboni scheme, the group recognized that some members were overutilizing health services, which jeopardized the scheme's ability to continue to cover all its members for the contracted services. The scheme manager proposed raising premiums but, in regular meetings and ongoing dialogue between scheme managers and members, the members expressed their preference to raise the co-payment. The increase in the co-pay had the desired effect and utilization was controlled. The Comboni experience also illustrates the community's potential to participate responsibly in informed decision making.

The Mutolere scheme also has a co-payment. In contrast to Comboni, the group that dropped out at Mutolere did not understand the objective of the co-pay. They saw it instead only as a way to help finance the cost of treatment and office supplies for the scheme.

As stated by several community leaders during focus group discussions, there is a need for community sensitization about health insurance and the concepts that accompany it. Lack of understanding of insurance concepts limits the community's ability to participate in an active and educated manner in scheme decision making, and discourages their support of the scheme.

Membership Policies and Solidarity. The schemes assessed have similar membership policies. The primary stipulations are that (1) members must join the scheme as a part of an already-formed group that has been in existence for at least two years; (2) at least 60 percent of the group must be members of the scheme at any given time (the "60-percent rule"); (3) membership should be by household, not individual; and (4) a household is a nuclear family that resides under the same roof. Seven of the schemes interviewed require that premiums must be paid for a minimum of four household members. Five of the schemes have official waiting periods for accessing benefits that range from two weeks to three months after joining the scheme.

These membership policies in general, but the 60-percent rule in particular, have two objectives: to enhance group solidarity and to reduce the likelihood that scheme will only attract sicker members of a given community (adverse selection). The DfID evaluation (Magezi, Masiko, and Wheeler 2002) questioned the effectiveness of the 60-percent rule. However, as there was no empirical evidence to support the rule and several schemes were not enforcing it, DfID team concluded that the effectiveness of the rule could not be assessed at that time.

During the current interviews, it became clear that managers and community members alike saw the 60-percent group membership requirement as a serious barrier to increasing membership and overall scheme sustainability. The rule has prohibited some community groups without the necessary percentage from joining health schemes. Furthermore, with the exception of the Foundation of International Community Assistance (FINCA) microcredit groups that dropped out of the Kitovu scheme,¹² the groups that have dropped out of the health schemes did so because they could not maintain 60 percent scheme membership within the group. This joins an earlier finding by PHR (Musau 1999) on the loss of engozi groups at Kisiizi due to the enforcement of the 60-percent rule.

If the rule were to be relaxed or suspended and schemes were able to open membership more widely (e.g., to individuals or groups with less than 60 percent joining), anecdotal evidence suggests

¹² There appear to be conflicting reasons why six FINCA groups chose to leave the Kitovu scheme. According to the scheme manager, a change in FINCA management resulted in the groups dropping out. According to the manager of FINCA, the groups decided to leave the scheme due to lack of value-for-money; this sentiment derived from the long distance between FINCA groups and the service provider, which made travel to seek care a burden.

that membership could grow significantly. Like the DfID assessment, the current study found that schemes exercise the 60-percent rule to varying degrees. Some of the schemes impose the rule loosely. The Rugarama scheme does not enforce the rule and over the first year of its life has exceeded full cost recovery and made a profit for the facility. This indicates that moving away from a rigid scheme structure spreads risk over a substantially larger pool of members and has the potential to increase the financial viability of schemes.

The other objective of the membership policies, group solidarity, is not a concern at most sites because the groups predate the schemes. The exception to this is the community groups at Luwero. During the civil war (1981–1986) Luwero suffered greatly, being a major battleground for much of the war. Consequently, there was what can only be described as “societal breakdown,” where community structures dissolved. Because of this, village groups were formed with the specific imperative to establish health schemes (insurance or credit), thus re-establishing group cohesion and solidarity. While the Luwero groups do not adhere to the 60-percent rule, at least 100 people are required to join the health scheme in order for a group to be established.

Community participants from the focus group at Luwero view the health scheme differently than they do other community self-help groups, which are not particularly successful. The health scheme is viewed as “a group for life.” The other community groups do not offer proactive self-help measures, only assisting after a member is dead. This suggests that the Luwero schemes have the added advantage to the community of promoting group solidarity.

Exclusions. Most schemes exclude chronic conditions, self-inflicted injury, optical care, and dental care from the benefits package. Most schemes also exclude delivery services, because their inclusion has the potential to consume significant scheme financial resources, particularly in settings such as Uganda where fertility remains high.¹³ The DfID evaluation confirmed that normal delivery is usually excluded, and *Improving Community Access to Health Care through Health Financing*, a report by the USAID-funded Commercial Market Strategies project (CMS) noted that the scheme at Kitovu Hospital is the only scheme that covers normal delivery (Okello and Balal 2004). However, in the interviews, every scheme except Kisiizi reported that normal deliveries that take place in the hospital are covered as inpatient care.¹⁴ Even in schemes such as Mutolere, where women report high utilization of delivery services, cost recovery remains at over 100 percent, at least in part because Mutolere has designated a specific co-pay for delivery services.

Ceilings. A ceiling on benefits can help to control utilization costs to schemes. Currently, only two schemes, Mutolere and Kitovu, employ a per-visit ceiling on benefits the scheme will pay out, although the scheme manager at Ishaka is considering establishing a ceiling. Scheme members at Mutolere commented that the ceiling should be increased from USh60,000 to USh70,000. Lack of data on ceiling monitoring from either scheme makes it difficult to ascertain whether the ceiling has a significant effect on cost containment.

¹³ The 2000 Total Fertility Rate for Uganda was reported at 6.9 (Government of Uganda, MoH 2004).

¹⁴ BMC only covers normal delivery if the mother has attended antenatal services at least three times.

3.5 Marketing and Membership Incentives

As noted above, a scheme's financial viability and therefore its sustainability depend greatly on the size of its membership. A strong membership base requires scheme promotion and marketing to attract new members and membership policies to retain current members.

Most schemes employ marketing techniques to attract new members. The scheme manager at Ishaka frequently makes community field visits to reach out to new members. Nyakibale employs radio spots when funding is available. At Luwero, scheme members promote the scheme to neighbors. To date, these techniques of recruitment have had varying success. It is also unclear whether marketing efforts directed to non-members within a group have proved more or less successful than marketing to entirely new groups.

One technique that has been successful in attracting scheme members is the SmartNet,¹⁵ a long-life insecticide-treated mosquito net (ITN). Malaria currently accounts for 54.6 percent of disease incidence in Uganda (Uganda Bureau of Statistics 2003). Reducing malarial illness by integrating ITNs into scheme prevention activities should reduce treatment costs for health schemes. Because the net effect on the facility's finances is expected to be positive, the hospital is willing to absorb the cost of the subsidy. Members receive malaria prevention messages with the ITNs.

Most schemes have sold SmartNets at a reduced rate to members while their stock of nets lasts. According to the IN-NET Project Evaluation Report, 7,484 SmartNets were sold and the malaria episode per member reduced by 11 percent (outpatients) and 6 percent (inpatients) for Bushenyi Medical Centre, 10 percent (outpatients) for Ishaka Hospital Health Plan, 33 percent (outpatients) and 29 percent (inpatients) for Nyakibale Hospital Health Plan, and 25 percent (outpatients) and 21 percent (inpatients) for the Mutolere Pre-Payment Scheme.

The area around Mutolere St. Francis Hospital, Kisoro, had historically had a low burden of malaria disease, but in the last five years, there has been a surge in malaria episodes. As the population previously had unusually low levels of immunity, the disease has had a serious impact on the health and created a significant financial burden for the hospital. As a result, the hospital expressed its willingness to purchase ITNs at market price and sell them at a subsidized rate. This is not yet occurring since the hospital has not been able to locate an ITN supplier. Currently the only scheme with ITNs in stock is the one based at the Rugarama Health Centre. These ITNs continue to be sold to scheme members at an InNet-subsidized price.

While a formal cost-benefit analysis has not been performed, anecdotal evidence from focus groups suggests that those who have accessed ITNs experienced a decrease in the number of episodes of malaria since ITN use began. This decrease in disease both improves the health of the community and lowers the cost of malaria treatment for the scheme.

¹⁵ The SmartNet has been funded and subsidised through USAID's Commercial Marketing Strategies (CMS) Project. However, in the interest of promoting the commercial market for ITNs, USAID has withdrawn ITN subsidies in all areas of the country outside of the North, where the commercial sector's scope remains limited.

3.6 Community Buy-In

Community buy-in, which refers to the value the community places on the health scheme, is another integral component of the current viability and future sustainability of community-based health insurance (Franco, Mbengue, and Atim 2004). Judging from the comments of scheme managers and members, community buy-in is significant in all schemes as communities recognize the benefits of better access to health services. This buy-in is evidenced by people's willingness to pay for scheme membership when they have the funds. This was the case at Bweyogerere, where cooperative members were willing to pay US\$15,000/= per person per quarter, if they could find a way to make the scheme work in their particular setting. Several community members, however, commented on the need for further sensitization on the concept of health insurance within their group.

Although community buy-in is high, community involvement in scheme management and decision making is not accordingly significant. As discussed above, unlike the truly community-based schemes in West Africa, the majority of schemes in Uganda are facility-based, drawing management focus away from scheme members. The exception to this is found at Luwero, where the health scheme is based in the village community structure.

3.7 Premium Financing

While buy-in by individuals within a member group provides some degree of security for the scheme, it does not guarantee that those members will always be able to pay the premium. The financing of premium payments through group-level mechanisms contributes to schemes' longevity and sustainability.

The community members at Comboni have established a community fund that will begin income-generating activities in the future. The funds from these activities will be used to subsidize health insurance premiums. BMC also has premium financing activities. The community group at Luwero demonstrated an interest in premium financing and asked for technical support to help begin activities.

Mutolere is planning a handicraft project to generate income to support the health scheme. In addition, the community group interviewed at Mutolere indicated that it has an emergency community fund to be borrowed from when a particular individual or family cannot make a premium payment. Unfortunately, the group reported mixed success in payback rates.

Premium financing at Rugarama is more formalized. In that a dairy cooperative provides the base of the scheme, group income generation predates the health scheme. A member of the dairy cooperative who opts to join the health scheme will have premiums paid on their behalf from the proceeds of their dairy sales that are deposited into their account with the cooperative. The scheme at Rugarama is an example of an economically diverse member group. In this case, some of the more affluent members, who often seek private health care outside of the scheme, still pay for membership so as to increase the pool and thus "cover for others." The net result of this is an improvement in the scheme's chances of financial success and financial gain for the facility.

Ishaka also has a formalized system of premium financing. Instead of income generation taking place at the household or community level, it occurs at the scheme office – the scheme office owns a photocopier which other hospital departments are charged for using. While this revenue does not

directly pay member premiums, this type of income generation contributes to the scheme's financial viability and sustainability.

The scheme at Kisiizi does not currently have any known premium-financing activities; however, the Uganda Microfinance Union (UMU) will soon be opening next door to the Microcare Office. In a move toward a more stable membership pool, Microcare, Ltd. is in the process of transferring its schemes to an annual membership with an annual premium. In a low-income community setting such as Kisiizi, it will be difficult for households to raise a year's premium at one time. To address this issue, Microcare has formed a partnership with the UMU, which acts as a bank. The UMU intends to extend health scheme-specific loans to community members in addition to its microfinance loans. Through health scheme loans, community members will be able to access funds at a nominal interest rate to pay their scheme premiums in one annual sum.

3.8 The Uganda Community Based Health Financing Association

The UCBHFA was founded in 1998 and registered as an NGO in 1999. It serves as an umbrella support organization to improve the accessibility of affordable good quality health care to achieve better health for the people of Uganda. The UCBHFA coordinates the activities of all the member schemes. It liaises with the Ministry of Health and development partners. It conducts research and provides financial and managerial support to enhance the skills of individual scheme staff. Currently nine of the 12 schemes belong to the association. The UCBHFA operates in seven districts with a catchments population of 4.5 million. In June 2004, there were 28,032 beneficiaries.

The UCBHFA receives a grant from the Ministry of Health (US\$ 120 million in FY 2003–04). Additional funding is received from *Evangelischer Entwicklungsdienst* through the East African Regional CBHF Network Office. It also receives support from USAID through the Partners for Health Reform *plus* Project.

According to its 2003–2004 annual report, the UCBHFA faces a number of challenges: insufficient financial support, inadequate technical skills in CBHF, and poorly performing information management system.

3.9 Sustainability

When scheme managers were asked about their biggest success to date, no fewer than four scheme managers pointed out that their scheme was still functioning and people still had access to affordable care, despite DfID's withdrawal of underwriting support in 2002. The issue of financial viability has created a great deal of pressure on scheme managers over the past two years.

As noted above, a large component of DfID's final CBHF evaluation explored the question of scheme sustainability in terms of financial viability. The assessment defines financial sustainability as "the generation of income from premiums and co-payments greater than the costs of the schemes" (Magezi, Masiko, and Wheeler 2002). The DfID report concludes that BMC is the only scheme with potential for future viability. However, since 2002, some schemes have achieved 100 percent or greater cost recovery without external assistance. Where less than full cost recovery has occurred, the host facilities have absorbed the deficit.

The contrast in notions of sustainability emphasizes a different perspective in current thinking about community-based health financing. Although it is important for schemes to be financially

sound, that is not the sole component of the overall health and sustainability of schemes. The scheme at Kitovu has barely approached full cost recovery, yet it has remained in operation, as the host facility continues to subsidize scheme expenses. In fact, the scheme manager at Kitovu listed a strong membership base and increased access to care as the major achievements of the scheme. “The scheme has managed to continue serving the public even after the loss of DfID financing.”

Sustainability is also reliant on the community’s buy-in to the concept of health insurance. For example, members of the dissolved scheme at Byogerere had difficulty grasping the concept of contributing to a common resource pool. When members had not accessed health services in a quarter, many expected to have their premiums returned. This misunderstanding lessened community buy-in, and contributed to the eventual collapse of the scheme.

As has been pointed out repeatedly, sustainability is about financial health, but it is also about management capacity, community buy-in, comprehension of insurance concepts, membership base, and solidarity. The improved quality of life due to schemes is noted in every interaction with managers and members. It is this acknowledgement that leads community members at Comboni to raise co-pays in order to ensure sustainability of the scheme and the hospital administration at Mutolere to continue the subsidization of ITNs for scheme members. Community leaders in Luwero hope to document the best practices and lessons learned that they have witnessed in their villages through the health scheme.

4. Conclusions

The aim of this assessment has been to explore the potential for the sustainability of CBHF schemes in Uganda through examining best practices and key obstacles. As this has been the first major scheme assessment since the withdrawal of DfID funding in 2002, this assessment has had the opportunity to examine the sustainability of schemes in the absence of significant external funding. In addition to the withdrawal of DfID funding, some schemes have more recently lost assistance from Health Partners. Within the schemes, some community groups have been forced to withdraw membership due to strict member requirements. The scheme in Bweyogerere dissolved after changes in the health sector (abolishment of fees at public facilities) diminished the scheme's viability. Yet commitment to the CBHF schemes remains strong, both among scheme members and former scheme members. There is a high level of recognition of the benefits the schemes have provided to members, to their communities, and, in some cases, to the hosting facilities.

These health schemes are not without financial concerns. In fact, scheme managers across the country mentioned finances as their major concern in scheme management and sustainability. While some schemes are positively contributing to facilities that own them, others have become a financial burden on the hospital. CBHF schemes have been touted as a means to ease the burden of bad debts on hospitals. In the facilities where the health scheme is running at a deficit, it is not clear from this assessment whether the burden of bad debts on these facilities has increased or decreased as a result of the health scheme.

This assessment of current CBHF activities in Uganda has elucidated the good practices and key obstacles to the success and sustainability of schemes. The concept of good practices and key obstacles can be employed as lessons learned, highlighting usefulness of certain practices and proposing adaptations of current practices to increase scheme performance. These lessons should be shared among scheme managers and support organizations. Through information dissemination between schemes and capacity building among scheme managers and community leaders alike, CBHF schemes have the potential to increase their long-term sustainability and continue to finance affordable health services to their communities.

Good Practices/Models

- ▲ The credit scheme at Luwero and insurance schemes at Mutolere and BMC provide a model demonstrating that cost recovery can be achieved. These schemes have successfully identified a target population and set appropriate premiums and co-payments to attract members. The result of this is a strong membership pool, contributing to cost recovery and overall financial viability.
- ▲ The Comboni community group's decision to raise the co-pay to combat overutilization of health services is a positive example of how a sensitized member base can make educated decisions to protect the financial viability of the CBHF scheme.
- ▲ At Ishaka, the CBHF scheme is treated as a cost center within the hospital. This allows the scheme to effectively examine its financial situation, including accounting for administrative

costs in cost recovery calculations. This financial management system provides data for informed and effective decision making by all involved parties.

- ▲ Mutolere Hospital has taken a proactive step in promoting health and reducing curative care costs through its willingness to absorb subsidies for insecticide-treated mosquito nets. This subsidy can both positively impact the health of CBHF members and reduce the costs of curative care to the facility. A full assessment of the costs and benefits would help to demonstrate whether this is a good investment.
- ▲ BMC and Kisiizi both employ the use of MIS, which provides valuable statistics and increases the scope of information available for decision making.

Key Obstacles

- ▲ The facilities hosting poorly performing CBHF schemes currently in debt bear the burden of absorbing scheme deficits. While facilities are currently willing to absorb losses when schemes do not achieve cost recovery, it could be a potential barrier to future scheme expansion.
- ▲ While community buy-in is generally high, the perceived value of the health schemes can be shaken when there is low community participation in decision making. As is seen in the past at Ishaka and at Kisiizi, a change such as an increase in premiums can result in a large dropout rate when scheme members do not actively support the change. The result is a decrease in the value placed on the scheme by the community and a consequent decrease in scheme membership and cost recovery.
- ▲ Many scheme members are not effectively sensitized to insurance concepts. Members of the dropout group at Mutolere did not understand the purpose of the co-pay. Members of the now-dissolved scheme at Bweyogerere expected to have their premiums returned if they did not access health services in a given quarter.
- ▲ The lack of adequate financial accounting systems to provide proper separation of scheme accounts from the hospital's accounts prevents effective decision making by scheme managers.
- ▲ There has been no marketing research to show which marketing strategies (outside of ITNs) can be successfully employed to increase interest in CBHF schemes and promote membership.
- ▲ Not all CBHF schemes belong to UCBHFA; however some member schemes are dependent on the association. UCBHFA has limited resources and needs capacity development.

5. Recommendations

Several general recommendations can be made to strengthen currently functioning and recently dropped community-based health insurance schemes in Uganda. These recommendations have evolved from the general context of health schemes nationally and need to be applied cautiously to schemes.

Quality of Life. The addition of local outpatient clinics to benefit packages may benefit both members, by lessening travel time and cost, and schemes, by lowering treatment costs.

Governance. The management or governing structure for all schemes should include a community or member group representative. The governing body should maintain a public forum for scheme members to remain informed and involvement in scheme governance.

Management. There should be a regular feedback mechanism to enable dialogue between management and scheme members. Decision making about management issues can be improved by the collection of useful and accurate data through management information systems and the informed application of this information.

Financial Management and Viability. All schemes should maintain accounts separate from those of the hospital and schemes should function as a cost center within the facility. This includes a move towards incorporating administrative costs in estimates of cost recovery. These changes should be implemented in conjunction with capacity building of scheme managers' financial management skills.

Risk Management. Efforts should be made to spread risk over a larger pool of scheme members. This may be achieved by suspending or lowering the threshold for the 60-percent rule. Removal of the 60-percent rule should be done with caution, as this may detract from other aspects of scheme health, such as a community's ability to participate in decision making and community leaders' role as a liaison between members and management, as well as increasing the risk of adverse selection. Alternative measures to combat adverse selection could include a discount to groups that enroll 60 percent or more and by implementing a longer waiting period or higher premium for those not part of an established group. In addition, the use of benefit ceilings and monitoring of co-payments should be further investigated as a possible mechanism for maximising scheme resources.

Marketing and Membership Incentives. Marketing research would help schemes to better identify how to target and sensitize non-members to join the CBHF schemes. Insecticide-treated net subsidies have been identified as an effective marketing strategy for recruiting new scheme members. ITNs benefit both member health and can act as a cost-cutting technique for facilities.

Community Buy-in. Community understanding of insurance concepts should be increased through sensitization campaigns involving group leaders. Community ability to pay may be supplemented by initiating income-generating activities where they do not already exist.

Sustainability. A shift must take place in the general understanding of the term sustainability as applied to community-based health insurance schemes. Scheme health comprises appropriate membership criteria, financial health, and community involvement, along with effective management techniques. Moving towards a more holistic understanding of sustainability will better enable scheme management to take advantage of individual scheme strengths and tackle obstacles.

UCBHFA. The association should strive to enroll more schemes. Its capacity should be strengthened and developed to improve association support of members.

Government Support. The government, through the Ministry of Health, should continue to support CBHFs through advocacy and investment in the sector, and the UCBHFA.

By incorporating these recommendations into the technical assistance provided to health schemes, both through *PHRplus* and through the Uganda Community Based Health Financing Association, the general health and long-term viability of CBHF schemes in Uganda can be greatly increased.

Annex A: Functioning Community-based Health Insurance Schemes in Uganda

The following schemes are the only CBHF schemes known to be functioning presently in Uganda.

- ▲ Bushenyi Medical Centre (including Mother Child Rescue Project)*
- ▲ Comboni Hospital*
- ▲ Kisiizi Hospital/Microcare*
- ▲ Mayanja Memorial Hospital
- ▲ Mbale Health Scheme
- ▲ Mutolere St. Francis Hospital *
- ▲ Rugarama Health Centre
- ▲ Save for Health-Uganda, Luwero*
- ▲ Ishaka Hospital Health Plan*
- ▲ Kitovu Patients Pre-Payment Scheme*
- ▲ Nyakibale Hospital Community Health Plan*
- ▲ Mother Uplifting Child Project, Lacor Hospital

*Member of Uganda Community Based Health Financing Association

Annex B. Questionnaire – CBHF Scheme Manager

Date _____

CBHF Scheme _____

Scheme manager (respondent) _____

Year established _____

Objectives

1. Please describe the objectives of this health insurance/prepayment scheme.

Management

2. What is the social basis of the scheme (engozi, cooperative, burial society, etc.)
3. Please describe the management structure of the scheme.
4. **If community-based:** Is the scheme registered as an NGO?
5. Is the scheme managed by any governing documents? (specify)
6. What is the decision-making process for scheme management issues?

Membership

7. What are the criteria for membership?
8. What is the unit of membership (institution, community, household, individual)?

Premiums

9. How much are premium payments? Is there a fee scale?
10. How often are premiums paid?
11. How are premiums determined?
12. How often is the premium payment reviewed?
13. Have there been changes in the premium since the scheme began?
14. How are premiums collected?
15. How are late/absent payments handled?
16. What is the co-pay for a facility visit?

Benefit package

17. What does the benefit package include?
 - a. Are there specific exclusions?
 - b. Health education/prevention?
18. Have there been changes to the benefit package since the scheme began?

Risk Management

19. Is there a waiting period after joining the scheme before accessing services?
20. Is there a ceiling on benefits? How much? Is this per individual/household?
21. Are there controls over moral hazard?
22. Are there controls over adverse selection?

Provider Payments

23. How are providers reimbursed for services?

Management Information System

24. Are reports on the scheme prepared regularly?
25. What information do reports include?
26. What are reports used for?

Staff

27. How many people work on scheme management?
 - a. Full time/part time?
 - b. Paid/volunteer?

Socio-Economic data

28. Are there income-generating activities that contribute to the scheme?
29. Are there external donor funds or support that contribute to the scheme?

Community Involvement

30. Was the community involved in the initial design of the scheme?
31. Is the community involved in scheme management? How?
32. Is there a feedback mechanism for scheme members?

Marketing

33. Is the scheme currently being marketed?
34. Who is being targeted by the marketing efforts? (groups, individuals w/in existing groups)
35. Have marketing efforts been successful?

Future/Lifespan

36. What are the scheme's major successes to date?
37. What are the major obstacles to sustainability, other than funding?
38. What do you see as the future of the scheme?
39. Is there anything else you would like to share about the scheme?

Thank you for your time. Please feel free to contact us with any questions regarding this survey.

Annex C. CBHF Focus Group Topic Guide – Scheme Members

Today we would like to discuss the health insurance/prepayment scheme located at _____ (facility)/in _____ (community). This discussion group is part of a research project on community-based health insurance schemes in Uganda and is conducted by the USAID project *PHRplus* in conjunction with _____ (list partners). We are interested in your thoughts and ideas about community-health insurance and the scheme(s) located in your area. You do not have to answer every question, but please feel free to share your ideas when relevant. You may also ask for clarification if a question is not clear. Your names will not be recorded or associated with any remarks that you make. While we may share some of your ideas, your identity will remain anonymous.

This discussion group will last approximately one hour. You are free to leave at any time if you decide you no longer want to participate or if you have other things to attend to.

Before we begin, does anyone have any questions?

Please introduce yourself to the group.

How long have you known about the CBHF scheme in your area?

Are you a member of a scheme?

Which group?

If not, why not?

What do you see as the objective of the scheme?

Why did you decide to join the scheme?

How long have you been a member?

How many people are in your household?

Is everyone in your household covered by the scheme?

What are the major benefits of belonging to a scheme?

Who organized the scheme in your area?

In your opinion, what is the community's role in the scheme?

Is the community involved in making decisions about the scheme?

In what ways?

Have you been involved in the scheme's decision-making process?

Please describe.

Does the community participate in income-generating activities in your area?

Please describe.

Do these activities contribute to the scheme?

How have premiums and co-pays been set for the scheme?
Has the community had input into this discussion?
Were you happy with the process?

How did you find out about the scheme?
Is the scheme being promoted in your area?
Who is the target of the promotion?
Has the community been involved in promotion efforts?
To what extent have promotion efforts been successful?

Has your health care changed since joining the scheme?
How so?
How many times have you accessed health services in the last three months?
Outside of the co-pay, were these services covered or did you pay something additional?
Does the scheme cover the health services you need most?

Does the scheme participate in health education or prevention activities?
What kind? Please describe.

What would you change about the way the scheme works?

Would you recommend this scheme to others?

Thank you for your time. Please feel free to contact us with any questions regarding this research.

Annex D. CBHF Focus Group Topic Guide – Scheme Dropouts

Today we would like to discuss the health insurance/prepayment scheme located at _____ (facility)/in _____ (community). This discussion group is part of a research project on community-based health insurance schemes in Uganda and is conducted by the USAID project *PHRplus* in conjunction with _____ (list partners). We are interested in your thoughts and ideas about community-health insurance and the scheme(s) located in your area. You do not have to answer every question, but please feel free to share your ideas when relevant. You may also ask for clarification if a question is not clear. Your names will not be recorded or associated with any remarks that you make. While we may share some of your ideas, your identity will remain anonymous.

This discussion group will last approximately one hour. You are free to leave at any time if you decide you no longer want to participate or if you have other things to attend to.

Before we begin, does anyone have any questions?

Please introduce yourself to the group.

I understand that you have previously been part of a scheme but no longer participate. Is this true for all of you?

How long have you known about the CBHF scheme in your area?

How did you find out about the scheme?

What do you see as the objective of the scheme?

Why did you decide to join the scheme?

How long were you a member?

What were the major benefits of belonging to a scheme?

What were the major drawbacks?

Who organized the scheme in your area?

In your opinion, what is the community's role in the scheme?

Is the community involved in making decisions about the scheme?

In what ways?

Have you been involved in the scheme's decision-making process?

Please describe.

How have premiums and co-pays been set for the scheme?

Has the community had input into this discussion?

Were you happy with the process?

Did your health care changed while a member the scheme?

How so?

How many times did you access health services in the last three months that you were a scheme member?

Outside of the co-pay, were these services covered or did you pay something additional?

How many times have you accessed health services since leaving the scheme?

While you were a member of the scheme, what was the health service you utilized most?

Has this changed now that you are no longer a member?

What would you change about the way the scheme works?

Would you consider rejoining the scheme?

Under which circumstances?

Thank you for your time. Please feel free to contact us with any questions regarding this research.

Annex E. CBHF Scheme Information Matrix

Scheme		BMC	Bweyogerere	Comboni	Ishaka	Kitovu	Luwero	Microcare-Kisizi	Mutolere	Nyakibale	Rugarama
Year established		1998	2000/1	2002	2003	1998	1999	1995 (operational in 1996)	1998	1998	2003
MANAGEMENT	Objectives	Ease students' accessibility to good quality and affordable health-promotive, disease preventative and curative health care	Provide access to affordable health services	Improve access and affordability of health care services in community; improve utilization of health services by sharing the financial burden; change health seeking behavior in community; to reduce health costs for the community	Affordable and accessible health services and health promotion	Help people access quality medical care at a low cost	Improve access to health care; create the solidarity that had been lost in the community; help improve facility income	Provide affordable and accessible health services to the population	Improve the local population's access to good health care	Help community access good quality health care, seek early treatment through risk pooling	Provide affordable and accessible health services and health promotion
	Social composition	Schools, burial societies, coffee association, dairy association	Kirinya Farmers Cooperative	Employee, school, and community groups	Dairy cooperative, engozi groups, schools (staff), credit and savings schemes, hospital staff	13 groups (teachers, students, self-help, engozi)	Villages in the area	Engozi groups, teacher associations, women's groups	Engozi groups, employee groups, village groups	11 groups	Dairy Farmers, will soon add university staff and diocese
	Management structure	Facility director, scheme manager and scheme asst manager work with hospital administration	Management decisions were negotiated by Health-Partners and the facility	Medical superintendent, scheme manager, community group leader, employees group management and school administration	Medical director, health plan manager, hospital matron, hospital treasurer, scheme outreach officer, scheme secretary	Hospital manager and scheme manager	Scheme board, social group leader, scheme executive committee, social group leader	Microcare head office, scheme branch manager, field worker, nurse	Scheme coordinator, scheme manager, scheme accountant	Office manager, accountant, assistant manager, data manager, hospital membership committee	Hospital administration, health insurance liaison officer

		BMC	Bweyogerere	Comboni	Ishaka	Kitovu	Luwero	Microcare-Kisizi	Mutulere	Nyakibale	Rugarama
MANAGEMENT	Governing documents	NO	NO	CBHF Manual	Rules and regulations manual	Membership agreement	None	Documents based at Microcare head office – unavailable at branch	No, but adheres to UCBHFA governing documents	Operation and benefits leaflet	No
	BENEFITS	Benefits	General medical, dental, eye, x-ray, lab, blood transfusion, family planning and MCH, IEC, VCT, PMTCT	Unknown	Inpatient and outpatient services with co-pay, subsidized SmartNet when available, health education, Mama Kits when available	Access to hospital services, ambulance in defined geographic areas, health education program	Access to Kitovu Hospital services, hygiene and HIV/AIDS education	Access to services at Kiwoko Hospital and Kasaala Health Center, subsidized ambulance services, access to premium-financing activities, some schemes only cover inpatient care.	Health services at Kisiizi Hospital	Access to services at facility, public education, subsidized ITNs when available, can defer payment of co-pay when necessary	Health services at facility, PMTCT, ITNs, radio spots
		Exclusions	Eye glasses, cosmetic dental care, cosmetic surgery, major surgery, self-inflicted conditions, transport, abortion/post-abortion care, delivery w/o antenatal care	Chronic illness	N/A	Chronic disease, dental care, optical care	Dental and optical care	Opportunistic infections, chronic conditions	Normal delivery, cosmetic dental care, major surgery, self-inflicted conditions	Private rooms, plastic surgery, dental surgery	Eye glasses, referrals

		BMC	Bweyogerere	Comboni	Ishaka	Kitovu	Luwero	Microcare-Kisizi	Mutolere	Nyakibale	Rugarama
PREMIUMS	Premium structure/fee scale (in Ush)	Schools: 3500/= per term; Community: 15,000/= per family	1-4 family members: 20,000/= then 15,000/= per individual	Employees: 2100/= per person per quarter; Schools: 4000/= per term; Community: 3000/= per person per quarter	1-4 family members: 15,000/=; 3700/= per individual	1-4 family members: 3200/=; 800/= per individual	3600/= per individual per annum	1-4 family members: 6000/=; 5-9: 8000/=; 9-12: 10,000/=; >12: 2000/= per person	1-4 family members: 1200/= per month; 300/= per individual per month	1-4 family members: 11,000/=; 3000/= per individual	1-4 family members: 18,000/=; 4500/= per individual
	Period of payment	Term for schools, quarter for community groups	Quarterly	Quarterly	Quarterly	Quarterly	Annual	Quarterly, in the process of switching to annual	Quarterly	Quarterly	Quarterly
	Changes over time (in Ush)	None	20,000/= per quarter per family of 4 to 15,000 per quarter per individual	Increase in co-pay from 1000/= to 2000/=	1999: 6000/= per family per quarter, 2000: 10,000/= per family per quarter; 2004: 15,000/= per family per quarter	None	Yes	Yes, more changes are being considered	Yes, the scheme began with a premium of 500/= per person per month but no one joined. IT was reduced to 350/= and then 300/=.	Changed three years ago	None
	Co-pay (in Ush)	None for schools, 500/= for outpatient (OP), 2000/= for inpatient (IP)	Unknown	2000/= for community, 1000/= for employees, none for schools	1000/= for OP; 4000/= for IP	500 for OP; 1500 for IP	Varies by scheme	1000/= for OP, 5000/= for IP	OP: 1000/= adult, 500/= child, IP: 3000/= adult, 2000/= child, Maternity 3500/= adult, 3000/= child	1000/= for OP; 4000/= for IP	OP: 1000/= adult; 700/= child; IP: 10,000/= adult, 7000/= child

		BMC	Bweyogerere	Comboni	Ishaka	Kitovu	Luwero	Microcare-Kisizi	Mutulere	Nyakibale	Rugarama
PREMIUMS	Ceiling on benefits (in Ush)	No	Unknown	No, but the issue is under consideration	No, but the issue is under consideration	15,000 per OP visit; 80,000 for IP visit	Yes, there is a household ceiling that varies from scheme to scheme.	No	Yes, 6000/= for inpatient services	No	No
	Waiting period	Yes	Unknown	2-week processing time acts as waiting period	2 weeks	2 weeks	3 months (may be changed to 12 months)	No	3 months	2 weeks	No
	Controls over moral hazard	Co-pays, students must have permission from nurse, photo ID	Unknown	Co-pay, photo ID, quarterly receipt	ID card, co-pay, registration is carried out with schemes' committees to ensure genuine family members are registered, current receipt	Pre-set provider, co-pay, ceilings, photo ID	Co-pay, photo ID, scheme leader committee performs spot audits on facilities, cashier controls in hospital	Co-pay, photo ID, patients must return for appointments or services are not covered	Co-pay, photo ID, exclusions, social controls by members	Photo ID	Co-pay, photo ID
Controls over adverse selection	Members must pay full family premium. 60% rule	Unknown	Members must pay full family premium, 60% rule	Pre-existing groups, 60% rule, registration of new groups by existing scheme managers	Pre-existing groups, 60% group sign-up, 4 person minimum per family	A group must have a minimum of 100 people	60% rule (this may be removed in the near future), control of adverse selection is predominantly left to group leaders	Whole family registration, 60% rule, surcharge for exceeding ceiling, waiting period for new members, non-use discount on renewal	Pre-existing groups, 60% rule	None specified	

		BMC	Bweyogerere	Comboni	Ishaka	Kitovu	Luwero	Microcare-Kisizi	Mutolere	Nyakibale	Rugarama
PROVIDER PAYMENTS	Provider payments	Premiums and copes are made directly to the hospital, calculations to "balance books" are done later	Premiums paid directly to the facility	Premiums and co-pays are made directly to the hospital; calculations to "balance books" are done later.	Scheme has separate account w/provider reimbursed at end of month	Intra-hospital reimbursement	Scheme reimburses providers for services rendered from funds "banked" with providers	Scheme finances are part of hospital accounts; Microcare reimburses quarterly for losses	Premiums and co-pays are made to hospital, donor funds are also used to reimburse hospital	Scheme has separate account w/provider reimbursed at end of month.	The scheme reimburses the health center for services rendered
MIS	Reports available	UCBHFA reports	N/A	UCBHFA reports	UCBHFA reports, monthly report to medical director, quarterly committee reports	UCBHFA, annual provider report, group member reports	Financial report from treasurer and annual report	Microcare MIS system provides reports on membership, utilization-cost, diagnoses, treatment	UCBHFA reports	UCBHFA reports	Yes
STAFFING	FT/PT staff	TWO	N/A	1 paid by Health Partners	3 FT	1 FT	7 FT at SHU	3 FT at branch, paid by Microcare	3 FT, 1 volunteer	2 FT (paid by hospital)	1 FT (paid by health centre)

Annex F. Reference List

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