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# The Good Practice Model: Community Participation in Luweero District, Uganda

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*June 2005*

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Prepared by:

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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, in conjunction with the Uganda Community-based Health Financing Association, conducted an analysis of the community-based health financing (CBHF) schemes in Luweero district, Uganda, to document the CBHF ‘Good Practice Model in Community Participation’ of Save for Health Uganda (SHU). Information was gathered through review of how credit and mixed insurance/credit scheme models work, and through key informant interviews and focus group discussions. The analysis found a significant level of community participation and stakeholder partnership (financial and technical assistance to schemes), and practical operating and governance structures that encourage participation and coordination among scheme members, elected leaders, and partners. Although SHU has reduced its financial support to schemes, schemes still depend on SHU technical assistance, which may affect long-term sustainability. The paper closes with recommendations to expand use of the Good Practice Model and to otherwise strengthen CBHF schemes in Uganda.

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# Acronyms

|                           |  |
|---------------------------|--|
| <b>ANC</b>                | Antenatal care   |
| <b>CBHF</b>               | Community-Based Health Financing   |
| <b>CIDR</b>               | <i>Centre International Développement et Recherche</i> (International Centre for Development and Research)       |
| <b>EED</b>                | Evangelcher Entwicklungstients – Church Development Services of an Association of Protestant Churches in Germany |
| <b>FGD</b>                | Focus Group Discussion   |
| <b>HC</b>                 | Health Center  |
| <b>ITN</b>                | Insecticide Treated Net  |
| <b>LC</b>                 | Local Council / Local Councillor   |
| <b>M&amp;E</b>            | Monitoring & Evaluation  |
| <b>NGO</b>                | Non-government Organization  |
| <b>PHR<sub>plus</sub></b> | Partners for Health Reform <sub>plus</sub>   |
| <b>SHU</b>                | Save for Health Uganda   |
| <b>UCBHFA</b>             | Uganda Community-based Health Financing Association  |
| <b>USAID</b>              | United States Agency for International Development   |



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Participating scheme group leaders included Edith Nabukeera (Kyeyindula), Kuyaba Kirumira (Mijjumwa), Rosette Katende (Nsabweteka), Sanyu Musoke (Wannonda), Kasolo Mukasa (Kamuli), Jane Nangendo (Yandwe), Florence Mulindwa (Kirowooza), Beatrice Nampungu (Seeta), Fred Ssenabulya (Kayonza), Reginah Nassolo (Kakabala). Other non-scheme participants included staff of the office of the District Director Health Services, Luweero District.

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Mr. Livingstone Namarah (coordinator, UCBHFA) and Susan Scribner (Partners for Health Reform*plus*) have provided constant and valuable technical and editorial support throughout this process.

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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, conducted an analysis of the community-based health financing (CBHF) schemes in Luweero district. The analysis was implemented to document the CBHF ‘Good Practice Model in Community Participation’ of Save for Health Uganda (SHU), and included the level and type of community participation. Findings will provide stakeholders with an insight into the workings of a community-based, rather than a facility-based, scheme model.

Information was gathered through field visits which included the review and documentation of how the different scheme models (credit and mixed insurance/credit hybrid) work. The PHR*plus* team conducted key informant interviews as well as focus group discussions.

The key findings were:

**Community Participation:** This was emphasized from the outset in all schemes in Luweero district, with the active support of the Local Council representatives in the respective communities. Members developed and implemented mechanisms ensuring that all decisions affecting their schemes were made by them, including the setting of premiums and co-payments; choice of providers; choice of ‘banker’; and changing of the type of schemes (from insurance to credit-based).

**Stakeholder Partnership:** Working in close partnership with SHU and Kiwoko Hospital, the schemes received vital technical assistance support from their partners. Emphasis was placed on capacity building and supervision and, in so doing, decision making by scheme members has been encouraged and greatly enhanced.

**Operating and Governance Systems:** Each scheme has developed the practical guidelines that determine their governance structures and the way in which they operate (day-to-day). Regular meetings (general assemblies for all members and monthly meetings for management) are held and attended by representatives of their partner organizations. The schemes also developed an active village-level representation system (through committees), which maintains open feedback channels and thus good coordination between scheme members, their elected leaders, and partners.



# 1. Introduction

In late 2004, the Partners for Health Reform*plus* project (PHR*plus*) conducted an assessment of community-based health financing (CBHF) schemes in Uganda.<sup>1</sup> The assessment confirmed that the CBHF schemes in Luweero district (Annex A) are fundamentally different from other schemes in Uganda. The Luweero schemes are community based, whereas others are facility based. As external resources for CBHF schemes in Uganda – from development partners and the Ministry of Health – become more limited, schemes need to increase their financial and technical self-sufficiency. PHR*plus*, the Uganda Community-based Health Financing Association (UCBHFA), and many of the schemes themselves recognize that increasing community participation and ownership is a means to improve self-sufficiency. This analysis and documentation of the good practice of community participation in Luweero is intended to provide examples and lessons to all stakeholders for CBHF.

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<sup>1</sup> Derriennic, Yann, Katherine Wolf, and Paul Kiwanuka-Mukiibi. February 2005. *An Assessment of Community-based Health Financing in Uganda*. Bethesda, MD: Partners for Health Reform*plus*, Abt Associates Inc.





## 2. Methodology

The PHR*plus* Field Research Team for the analysis of the ‘Good Practice Model: Community Participation in Luweero District’ included Dr. Paul Kiwanuka-Mukiibi (PS Consulting) and Dr. Gloria Karungi (PHR*plus*), with technical support from Yann Derriennic (PHR*plus*). Livingstone Namarah, national coordinator of the Uganda Community-based Health Financing Association, joined the field team for site visits.

The assessment employed mostly qualitative techniques to gather data and document the Luweero district schemes’ good practices. Data collection instruments were developed in conjunction with relevant stakeholders including the UCBHFA. All 10 currently functioning schemes in Luweero district were catalogued and contacted with SHU’s assistance. Group leaders of the schemes contacted readily agreed to participate, as did the management of both SHU and Kiwoko Hospital.

Data were collected through focus group discussions (FGDs) with the Luweero CBHF scheme group leaders (see Annex B for the FGD topic guide) and key informant interviews with the management of Save for Health Uganda (SHU) (see Annex C), and the management of Kiwoko Hospital (see Annex D).

The group leaders interviewed were from the following schemes:

1. Mijjumwa
2. Kirowooza
3. Kakabala
4. Kyeyindula
5. Wannonda
6. Kayonza
7. Seeta
8. Yandwe
9. Kamuli
10. Nsabweteka

FGDs consisted of a group of 10 participants and lasted about 90 minutes. Participants were questioned about community participation in scheme initiation, decision making, and day-to-day operations. Dr. Kiwanuka-Mukiibi and Dr. Karungi facilitated the FGDs, with the assistance of Mr. Namarah. The FGDs were conducted in Luganda.



## 3. The Model

‘Good Practice,’ as evidenced by the schemes in Luweero district, refers to the level of active community participation. It can be described in three parts, as indicated below:

1. Community participation
2. Stakeholder partnership
3. Operating and governance systems

### **Community Participation**

Community participation was emphasized in all schemes that evolved in Luweero district. The ‘Luweero Triangle’ was the major battleground during the civil war of 1981–86, resulting in ‘societal-breakdown’ and the dissolution of community structures. The decision was thus made to form village groups, the specific imperative being to establish health schemes as one way of encouraging group solidarity and re-establishing community cohesion.

From the outset, the support of the Local Council (LC) representatives in the respective communities was sought. The LCs are now fully involved in sensitizing members of their communities about CBHF schemes, and in encouraging membership and participation.

Once an understanding of how CBHF schemes worked was gained, the prospective members developed and implemented mechanisms ensuring that they made all decisions affecting their schemes. This included the setting of premiums and co-payments; choice of providers; choice of ‘banker’; and ultimately changing of the type of schemes (from insurance to credit-based).

### **Stakeholder Partnership**

The schemes work in very close partnership with Save for Health Uganda and Kiwoko Hospital. These organizations have played a vital role giving much-needed technical assistance. From the start, emphasis was on capacity building and supervision. In so doing, decision making by scheme members has been encouraged and greatly enhanced over the years.

### **Operating and Governance Systems**

The schemes have evolved such that each one develops the practical guidelines that determine their governance structures and the way in which they operate (day-to-day, as directed by the scheme management teams).

Three general assemblies are held annually for all members, and there are also regular (monthly) meetings for schemes’ group leaders. Both the general assembly meetings and the group leader meetings are attended by representatives from SHU and Kiwoko Hospital, which greatly enhances stakeholder monitoring and evaluation (M&E).

Active committees ensure village-level representation, which maintains open feedback channels and thus good coordination between scheme members their elected leaders and partners (see Box 1).

### Box 1. Scheme Partners

- ▲ **Kiwoko Hospital** – Founded as a clinic in 1988 by Dr. Ian Clarke, Kiwoko opened as a faith-based hospital in 1990. Now one of the two hospitals in Nakaseke County Health Sub-District, it serves an official 'catchment population' of 34,243\* people in Kikamulo and Wakyato sub-counties. However, the hospital has over the years become the provider of choice (especially for referral) for many of the community members of the 21 sub-counties of Luweero district.
- ▲ **Uganda Community-based Health Financing Association (UCBHFA)** took over the role of the Community Health Financing Project, which was funded by the British Department for International Development and established in 1995. Registered as an NGO in 2000, UCBHFA is committed to promoting community-based health financing and increasing access to affordable health services in Uganda. UCBHFA provides technical assistance to member schemes and compiles financial and membership statistics from schemes each quarter.
- ▲ **Centre International Développement et Recherche (CIDR, International Centre for Development and Research)** is a French NGO created in 1961. It aims at promoting social and economic systems that fulfill the fundamental needs of individual human beings while at the same time remaining mindful of the common welfare.
- ▲ **Evangelischer Entwicklungsdienst (EED, Church Development Services of an Association of Protestant Churches in Germany)** supports the development work of churches, Christian organizations, and private agencies through funding, seconding qualified personnel, and offering consultancy services. Within the framework of a global partnership network, EED plays its role in creating a just society.

2002 Uganda Population and Housing Census (2005)

## 4. Evolution of the Good Practice Model

### 4.1 Introduction of the Facility-Based Insurance Schemes

In 1999, the International Centre for Development and Research (*Centre International Développement et Recherche*, CIDR) was approached by Kiwoko Hospital to help solve its ‘bills-settlement’ problem. This was done with the assistance of Dr. Gerry Noble, then the coordinator of the Association of Member Schemes.<sup>2</sup>

Members of the community, often unable to pay for their medical care, were being ‘detained’ by the hospital. This resulted in the situation where both hospital and community found it increasingly difficult to achieve reasonable levels of health care access. As a faith-based hospital that saw ‘community involvement’ as part of their mission, Kiwoko Hospital felt that they had a responsibility to the community for finding a solution.

CIDR proposed and developed a prepayment scheme for the hospital and its clients. In order to do so, a hospital survey (see Box 2) was first carried out to determine (primarily) what kinds of services the community sought, and their ability to pay.

#### Box 2. Goals of the CIDR/Kiwoko Hospital Survey, 1999

1. The types of medical services typically sought by members of the community.
2. The fees paid for services, by the community.
3. The fees that community members felt they were willing to pay for such services.
4. The ability of the community to pay for services, through a prepayment scheme.

The findings of the hospital survey, as well as a community needs assessment<sup>3</sup> that was carried out at the same time, indicated that the community recognized the need for a solution and showed a willingness to participate in developing that solution. In the subsequent sensitization exercise (first carried out amongst the LCs, which gave their full support), community members were advised on how to set up community-based health insurance schemes.

The first schemes were introduced in 1999/2000, in the sub-counties of Kikamulo and Wakyato,<sup>4</sup> where Kiwoko Hospital already had community-based health outreach programs. These schemes, which were facility-based, developed along the lines of the ‘insurance model,’ with an annual premium paid by members for specific benefits packages. Scheme membership was based on village communities, with a minimum number of 100 people per scheme.

<sup>2</sup> This was later launched as the UCBHFA, in March 2000.

<sup>3</sup> Also called feasibility study in the literature.

<sup>4</sup> Kikamulo and Wakyato constitute Kiwoko Hospital's catchment area within Nakaseke health sub-district.

Although the schemes were essentially developed by CIDR and Kiwoko Hospital, this was done in consultation with community members. The hospital survey and needs assessment findings were used to guide the communities in making decisions about:

1. Premiums
2. Co-payments
3. Ceilings
4. Benefits
5. Handling of members' financial contributions (premiums)

CIDR also helped the schemes negotiate a 5 percent discount on members' medical bills, as well as establish a banking relationship with the hospital (this done at the schemes' request). At the time, due to the collapse of a number of commercial banks (resulting in the loss of savings), community members felt that the only 'financial institution' they could trust with their contributions was the hospital.

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## 4.2 Introduction of Community-based Credit/Mixed Schemes

By the end of the second year (2001/02), the facility-based schemes found themselves facing a number of challenges. The most difficult challenges were:

1. The high degree of dissatisfaction amongst members who had not fallen ill during the year, and thus felt that *'they were carrying the burden for others.'*
2. Heavy claims (in some cases) due to the prolonged hospitalization of a few members, led to the depletion of the community insurance-basket, resulting in schemes finding it difficult to cover further claims throughout the rest of the year.
3. In 2001/02, the district experienced a disastrous season, with much of the coffee crop wilting, resulting in a very poor harvest. This further compounded members' inability (and unwillingness) to pay annual 'insurance' premiums, especially amongst those who had received no (personal) direct benefit<sup>5</sup> during the year.

The result was an increased demand for a change of scheme type, to one that was credit-based. Following various threats to leave and the eventual withdrawal of some members from their schemes, as well as the subsequent collapse of some of the schemes (as illustrated by the Kiruli scheme in Table 1), SHU, at the request of community members, initiated dialogue with CIDR and Kiwoko Hospital. This led to the development of credit and, later, mixed (credit-insurance hybrid) schemes, which were then introduced. The new schemes were developed with the participation of the communities, represented by their leaders.

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<sup>5</sup> Direct benefit meant *'making use of my money by falling ill'* - interviews and FGDs.

**Table 1. Kiruli CBHF Scheme 2000–02**

| <b>Year</b> | <b>Membership</b> | <b>Patients Treated</b> | <b>Comment</b>                         |
|-------------|-------------------|-------------------------|--|
| 2000/1      | 132               | 29                      | Those who did not fall sick complained |
| 2001/2      | 140               | 20                      | The scheme collapsed in July 2002      |

Source: As documented and presented by Kiwoko Hospital management.





## 5. Implementation

In 2001, Save for Health Uganda (see Box 3) became actively involved with the CBHF schemes in the district.

### Box 3. Scheme Partner: Save for Health Uganda

**Save for Health Uganda** (SHU) is a local non-governmental organization (NGO) that registered with the NGO Board in 2001. Acting as a technical assistance and support organization to 10 schemes in Luweero/Nakasongola districts, SHU implements schemes on a 'research-action basis.' By this they emphasize that all partners are still in the process of learning and understanding how best to improve rural health access.

The organization, which is wholly dependent on donor funding, works to:

- ▲ Support rural communities improve their financial access to quality health care.
- ▲ Build capacity within the community to create and sustain community-owned health prepayment schemes.
- ▲ Support health care providers in improving their financial resources, especially by reducing the number of 'run away' cases.

SHU's project implementation methodology emphasizes community ownership of the development activities that promote:

- ▲ Self-financing of the activities
- ▲ Self-management of the organizations through which the activities are carried out
- ▲ Sustainability of the activities

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### 5.1 Selection Criteria for Areas of Intervention

The selection criteria used has been the same throughout: 'the non-existence' of a scheme in a particular area. SHU's method is to first approach the area's local council and then, based on the level of support received from the LC, decide on whether or not to implement a 'scheme project' in that area.

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### 5.2 Formation of New Schemes and Member Recruitment

Once an area has been selected, members of existing schemes carry out a needs assessment, with the technical assistance of SHU. After the needs assessment, a schedule to visit the target area/groups for the new scheme(s) is worked out. 'Advance teams,' composed of group leaders from already/well-established schemes, embark on a sensitization campaign. Working with the LCs (and assisted by SHU), sensitization exercises are carried out throughout the target community, first by community meetings, later by a door-to-door recruitment drive. The door-to-door campaign is carried out with the 'sign-up forms' on hand, to encourage new member recruitment and reach the 100 person minimum membership per (new) scheme.

Group leaders interviewed stated that they found the needs assessment exercises to be of added practical benefit, essentially working as a ‘pre-sensitization exercise.’ They said that their own communities had benefited, not only by recognising a need ‘*they had never seen before,*’ but also by beginning to appreciate the fact that CBHF schemes present a workable solution.

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### 5.3 Types of Schemes and Their Mechanisms

There are now only two types of schemes, the credit schemes and the mixed (hybrid credit-insurance) schemes. Of the 10 schemes in Luweero district, seven are pure credit schemes and three are mixed.

Credit schemes (see Box 4) evolved first (at the request of scheme members) due to the level of dissatisfaction expressed about the insurance-based schemes. The mixed schemes evolved because some groups felt that their members would be unable to sustain their credit payments, especially in the case of long illness. In the mixed schemes, it was decided that a portion of their contributions would be placed in an ‘insurance-basket’ and a portion in the ‘credit basket.’

#### **Box 4. How the Credit Schemes Work**

1. The scheme member visits the hospital, is treated and billed.
2. The scheme member is given a ‘chit’ by the hospital scheme cashier, with details of the visit (treatment and cost).
3. The hospital bills the schemes once a month.
4. The scheme member’s chit (claim) is cross-checked against the details on the hospital’s bill, to verify the member’s claim.
5. The scheme advances credit to the member by authorizing the hospital to debit the scheme account, for all verified claims bills; authorization is given by the scheme’s management through the treasurer.
6. The hospital debits the scheme-account.
7. The scheme collects payment from the member over a specified time.
8. The hospital provides the scheme with regular statements (of their account).

With assistance from SHU, the various schemes set their premiums and decided on the benefits packages, as well as the payment limits and methods of reimbursement. Each scheme set its own premiums, etc. (which vary from scheme to scheme), based on what they saw as the needs and capacity of their respective communities.

When the schemes first started, SHU also facilitated dialogue between Kiwoko Hospital (the selected provider) and the schemes, in order to determine and ensure:

1. The agreed mechanism of access
2. The method of reimbursement
3. Kiwoko Hospital’s continuation as the schemes’ bank
4. Further discounts (now set at 12 percent), on payment of medical bills

The members manage all schemes' records and finances; the premiums and payment-limits for the three mixed schemes are as shown in Table 2.

**Table 2. Mixed Scheme Premiums and Payment Limits**

|  | <b>Scheme 1</b>                      | <b>Scheme 2</b>                      | <b>Scheme 3</b>                      |
|--|--------------------------------------|--------------------------------------|--------------------------------------|
| Annual insurance premium for first four people | 4,300/=                              | 3,800/=                              | 3,800/=                              |
| Annual insurance premium for additional people | 4,100/=                              | 3,400/=<br>(for 3 people)            | 3,600/=<br>(2 people)                |
| Annual insurance premium for additional people | 3,900/=                              | 3,200/=                              | 3,400/=<br>(2 people)                |
| Annual management fee per person               | 2,500/=                              | 2,500/=<br>(800/= insurance)         | 2,500/=<br>(800/= insurance)         |
| Client contribution to medical costs           | 15,000/=                             | 30,000/=                             | 30,000/=                             |
| Schemes contribution to medical costs          | The rest of the cost up to the limit | The rest of the cost up to the limit | The rest of the cost up to the limit |
| Scheme contribution limit                      | 100,000/=                            | 80,000/=                             | 80,000/=                             |

Note: The 2,500/= and 800/= (credit and insurance scheme management fees) are independent of each other.

## 5.4 Scheme Resources and Financing

SHU provides technical assistance in the form of education and training of group leaders; in the setting up of governance and operating systems; in financial management; and in 'sensitization methods.'

During the initial stages of formation of any scheme (the sensitization exercise), SHU always emphasizes that their role is to provide technical assistance, rather than fund the schemes. Schemes are thus encouraged to become self-financing, depending on their premium collections.

In addition to premiums collected, at the end of each year the schemes place any surplus funds into an Emergency Fund. This is used to provide loans to members who find themselves unable to 'service' their credits. When such a loan is given, new terms of payment between the scheme and the member are agreed upon.

Although SHU does not finance the schemes per se, it established a 'Guarantee Fund.' Although Fund procedures are still being developed (and were thus not made available), the Fund now operates under certain principles:

The money for the Guarantee Fund is banked in SHU's account and monitored by a SHU representative, as well as a number of scheme group leaders. The Fund is used in cases where a particular scheme finds itself (temporarily) insolvent and unable to pay the hospital. It also functions as a lender, the scheme borrowing the money to cover their hospital liabilities and paying SHU later within an agreed time frame. The Fund reportedly had 1,400,000/=, having recently lent some money to one of the schemes.

Kiwoko Hospital also contributes to the financing of the schemes by:

- ▲ Offering a 12 percent discount on treatment costs
- ▲ Acting as a non-charging banking institution for the schemes
- ▲ Offering health education
- ▲ Paying the salaries of the scheme cashiers in the hospital (there are now dedicated scheme cashiers)

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## 5.5 Scheme Governance and Operating Systems

On formation of a new scheme, members develop their vision and mission statements as well as the governing documents/guidelines under which they operate.

The schemes leadership consists of an elected chairperson, treasurer, secretary, and committee members who conduct the day-to-day business of their schemes. The committees are set up on a village-representation basis (*obubondo*), with each community enjoying representation from a member of their own village (*akabondo*).

Members of the various schemes are fully involved in all major decisions, including the type of scheme (determined by a majority vote), premium-setting, benefits, as well as mode and terms of payment.

It should be noted that, unlike other (facility-based) schemes in the country, should a member wish to belong to another scheme they are free to do so, and are not limited by their location or residence.<sup>6</sup>

Each scheme holds three general assemblies per year (attended by all members), where major decisions are made and elections take place. The scheme group leaders also have monthly meetings, which are attended by a representative of SHU and Kiwoko Hospital and serve as a venue for discussion of current issues.

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## 5.6 Monitoring and Evaluation, and Coordination

An effective M&E system, based on the governance and operating systems, is in place. The fact that both SHU and Kiwoko Hospital attend the group leaders' meetings ensures constant and effective M&E. Their *akabondo* representative keeps scheme members informed of any discussions and/or decisions, and relay members' concerns to the scheme group leaders at meetings.

SHU takes the opportunity to address technical issues, both informally (as ongoing technical assistance education) during both monthly meetings and general assemblies, and formally, at workshops, where and when necessary

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<sup>6</sup> Controls (not specified) related to membership and movement, from one scheme to the other, were reported as being regulated by scheme group leaders.

## 6. Results and Impact of the Luweero Scheme Model

The results and impact of CBHF schemes are clearly visible, according to the scheme group leaders as well as SHU and Kiwoko Hospital management. The major benefits, as described by the scheme group leaders are:

- ▲ Good medical care that is immediately accessible
- ▲ The schemes and their members are treated as ‘preferred clients’
- ▲ The (12 percent) discount has had a significant impact on the schemes, their sustainability, and their attractiveness

The statements taken from interviews and focus group discussions (listed in Boxes 5 and 6), underscore what the group leaders and Kiwoko Hospital management felt was a significant impact.

### Box 5. Scheme Leaders’ Description of Results and Impact

- ▲ The schemes have done a great deal in helping our communities’ access to health services.
- ▲ The fact that we do not have to pay immediately is a very big advantage. Members of our communities no longer have to sell their assets in order to pay their medical bills. In those few cases where sale of assets does occur, it is planned, affording the member the time to get the best deal possible, which was never the case in the past.
- ▲ There has been a visible change in health-seeking behavior in the communities. People no longer wait (hoping to raise ‘hospital money’ beforehand), a practice which resulted in their becoming more ill, and sometimes dying.
- ▲ The comradeship between community members has improved remarkably. People now see themselves as being responsible for their neighbor, visiting those who are ill and sometimes urging a member to go to the hospital, if they have not already done so.
- ▲ Scheme members are more willing to help those who are less well-to-do, as they know that the likelihood of loaned money being paid back is much higher.

### Box 6. Kiwoko Hospital Management's Description of Results and Impact

- ▲ The hospital used to spend a great deal of money 'chasing' debtors. Chasing a person as far as Nakasongola involved a driver, a vehicle, an 80 km trip, an *askari* (Security Guard) and talking to the LCs – all for 5,000/= sometimes; it just wasn't worth it! This situation has greatly improved since the schemes started, with minimal run-a-ways.
- ▲ The hospitals' image within the community has greatly improved because of the above.
- ▲ There has been a marked change in health seeking behavior – very much for the better.
- ▲ The hospital, through the feedback mechanism, now knows what the community thinks and wants. Recently a new Paediatric Nutrition Ward was constructed, based on feedback from scheme group leaders, and their expression of what their community needs.
- ▲ It has made it much easier to bring people together for sensitization. The schemes made it a lot easier for the hospital to launch their PMTCT program.

## 7. Sustainability of the System

Group leaders of the various schemes now believe that their schemes will achieve sustainability and independence from SHU in the near future. This is in great part due to SHU, and how they introduced and assisted the schemes. From the start, emphasis was on ownership by scheme members, with limited direct financial support from SHU; the capacity-building technical assistance was a vital component in their moving towards future sustainability.

During the last few years, the level of financial support from SHU has decreased steadily and is now limited to contributions towards transport, for various scheme outreach activities.

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### 7.1 Marketing

Long-term sustainability, as voiced by scheme leaders during the focus group discussion, will be achieved with improved marketing and increased scheme membership.

- ▲ The group leaders refer to *'those who are non-members'* as their biggest market (niche).
- ▲ The visible improvement in the health of scheme members, and the fact that it is now common knowledge that members do not have to pay medical bills immediately, works as a major incentive for potential/new members.

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### 7.2 The Gaps

Certain success notwithstanding, scheme members and SHU/Kiwoko management alike recognize that there are still gaps which need to be addressed.

Of the three mixed schemes, only one considers the mixed-scheme method to be sustainable into the future. The other two feel that they need to switch to pure credit schemes, in order to ensure that they can generate enough funds, and lose less through (premium-backed) insurance payments. It was not clear, however, whether this is because the schemes first 'pay out on an insurance basis' and then resort to using the 'credit-basket,' or vice-versa. Information on scheme costs and reimbursement methods was not clear (vis-à-vis which is paid first, insurance-basis or credit-basis), but this would certainly play a role/affect scheme finances.

Other gaps mentioned by scheme group leaders, as well as the management of both Kiwoko Hospital and SHU include:

- ▲ The fact that there is still a lack of proper understanding of insurance and its long-term benefits
- ▲ The relatively low education and literacy levels
- ▲ The 'permanency' of poverty, coupled with poor income generation





## 8. Constraints

Schemes have faced a number of constraints, which can be grouped into three categories.

1. Constraints during introduction
2. Constraints during implementation
3. Constraints related to supervision and monitoring

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### 8.1 Constraints during Introduction

1. The high levels of poverty in the communities
2. The very wide community capacity gap, which initially hindered scheme rollout. This, according to the management of Kiwoko Hospital included:
  - a. A lack of understanding of the principles of insurance
  - b. Lack of (scheme) management skills
  - c. An initial lack in 'self-organization' skills/ability
  - d. Low levels of 'group-cohesion'

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### 8.2 Constraints during Implementation

1. Scheme members initially thought that the schemes 'belonged' to the hospital (facility-based), and thus expected special treatment/concessions from the hospital.
2. The number of provider facilities, a challenge that was voiced by both scheme group leaders and Kiwoko Hospital management. The fact that there are only two facilities means that some members have to travel long distances in order to access health services, and thereby benefit from their schemes. This often results in transport bills that constitute the larger part of members health care budget, especially for the Nakasongola-based schemes.
3. When the supply of insecticide-treated nets (ITNs) dwindled, schemes/members lost a major marketing tool, as well as access to a commodity that significantly improved members' health.
4. The current lack of income-generating activities. This places the burden of financial sustainability solely on premium revenue collection.

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### 8.3 Constraints related to Supervision and Monitoring

- ▲ Kiwoko Hospital still has a capacity problem, with the two scheme specific cashiers not being sufficient. It is necessary to employ and train another cashier, but there is the question of who will cover the cost.
- ▲ The schemes are presently unable to cover their transport costs and are thus dependent on SHU for their outreach and expansion programs

## 9. Conclusions

The Luweero schemes have demonstrated a ‘Good Practice Model in Community Participation,’ with emphasis on the role played by community participation, stakeholder partnership, and operating and governance systems. This is evidenced by the relative degree of success that the schemes have achieved over the last few years.

From the start, the schemes’ partners (SHU, Kiwoko Hospital and initially, CIDR) emphasized full participation of the schemes and their entire membership. All major decisions regarding the schemes are made in full consultation with scheme leadership, and implemented only after the approval of the general membership of the schemes. This is in accordance with their operating and governance systems, in the form of manuals, to which each scheme refers and adheres.

Technical assistance from SHU and other scheme partners (in the form of training in management, organizational, and sensitization skills) has played a significant role in the development of the schemes and their capacity/ability to manage the day-to-day operations. SHU continues with the vital technical assistance necessary for continued scheme capacity building.

Nevertheless, schemes still have a relatively high dependence on SHU, which may affect long-term sustainability. Although SHU has reduced their level of (direct) financial support, it is still apparent (given as transport, sensitization, and training costs covered). This effectively means that outreach (and thus growth in scheme membership) is dependent on an external partner.



## 10. Recommendations

1. The Uganda Community-based Health Financing Association – along with *PHRplus* – should distribute the documented Luweero Good Practice Model to all CBHF schemes and other stakeholders. Schemes need not adopt all aspects of the model, but they and their stakeholders should consider the different roles and responsibilities of facilities and their communities, and collectively determine how to incorporate elements of community participation into existing schemes. For schemes being created, this Good Practice Model can be a guide on how to establish a CBHF scheme with strong community participation and ownership.
2. UCBHFA and scheme managers should continue to sensitize CBHF schemes and their stakeholders in line with the Good Practice Model as documented in Luweero district, emphasizing the following:
  - a. The role of community-participation and involvement in decision making
  - b. The need for schemes to adopt increased levels of ‘ownership’ of their schemes
  - c. The need for schemes to adopt increased levels of ‘in-house responsibility’ for the day-to-day management of their own schemes
  - d. The need for schemes to look for and create opportunities for alternative sources of income, through income-generating activities
  - e. The need for schemes to become increasingly self-financing
  - f. The need for increasing technical assistance as opposed to direct operations funding, as evidenced by SHU's partner model.
3. The Ministry of Health should advocate for CBHF schemes because the schemes increase access to health services, prevent families becoming impoverished due to illness, and assist health facilities financially by reducing the number of patients who run away without paying their bills. Ministry leadership would encourage mobilization and sensitization at the local level. The ministry could provide technical assistance and limited financial support.
4. UCBHFA should work closely with the MOH to publicize CBHF schemes. UCBHFA should provide technical assistance to new and existing schemes, encouraging greater community participation.
5. Local political and opinion leaders can play a critical role in sensitizing communities and mobilizing families to join CBHF schemes. These leaders may include local chairmen from the districts down to the village level, district directors of health services, religious leaders, the media, or others who influence public opinion.
6. Health facilities can work with communities to establish CBHF schemes. Kiwoko Hospital provides an excellent example of how the facility and community work in partnership. The 12 percent discount on treatment costs granted to scheme members is a tangible incentive for community members to join the scheme.

7. Scheme managers facilitate communication between group leaders and health facilities and provide information and technical assistance to the groups. Scheme managers must support community participation and be open to receiving and respecting input from the communities.
8. Group leaders can mobilize other members to join CBHF schemes. They play a pivotal role in facilitating communication between groups and schemes. They can encourage greater community participation in decision making and dialogue and community ownership of the schemes.
9. Community members need to do more than just pay premiums. They need to feel ownership of their schemes, participate in decision making, and invest time and effort to make the schemes better, stronger, and more responsive to community needs.



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## Background

The Luweero Triangle, where the civil war was mainly fought, is one of the regions of Uganda that suffered greatly during the early/mid-1980s. Much of the population was displaced, resulting in a breakdown of community as well as the local and traditional economy.

Since then, despite measures that have been taken to encourage re-settlement of the region and improve the economic situation, investment has been low. The mostly rural population has a high rate of poverty, which has over the years resulted in poor health indices.

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## Geographical Setting

Luweero District, bordered by Wakiso district in the South, Kiboga, and Nakasongola districts in the North, and Mukono district in the East, has a total area of 5773.33 sq. km, of which 5625 sq. km is dry land.

It is presently composed of three counties; Nakaseke, Bamunanika, and Katikamu. Each county is further divided into 5-6 sub-counties, making for a total of 18 sub-counties. There are three town councils (Luweero, Wobulenzi, and Bombo) and 134 parishes.

Rainfall is fairly well distributed throughout the year, with the average rainfall being 1,300 mm; peak rain periods are March–May and October–November. The dry season occurs in December–March and June–July.

The mean annual maximum temperature ranges between 15°C and 17.5°C.

The main economic activity of Luweero district is agriculture. Most of the people are peasant farmers, dependent on subsistence farming in the southern region; semi-nomadic pastoralists are found in the northern part of the district.

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## Demographic Statistics<sup>7</sup>

Area: 5773.53 sq. km

| <b>Population</b>      | <b>Luweero</b>  | <b>National</b> |
|------------------------|-----------------|-----------------|
| Male                   | 478,595 – 49.5% | 48.7 %          |
| Female                 | 236,748 – 50.5% | 51.3 %          |
| Rural                  | 419,553 – 87.7% | 87.7 %          |
| Urban                  | 59,042 – 12.3%  | 12.3 %          |
| Population growth rate | 2.7 % per year  | 3.3 % per year  |

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<sup>7</sup> 2002 Uganda Population and Housing Census (March 2005).



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## Population Groups<sup>8</sup>

| Group                  | Luweero District | National |
|------------------------|------------------|----------|
| Under 1 yr             | 3.82 %           | 4.1 %    |
| Under 5 yrs            | 18.64 %          | 18.5 %   |
| Between 6–12 yrs       | 24.03 %          | 21.9 %   |
| Under 15 yrs           | 52.15 %          | 49.3 %   |
| Under 18 yrs           | 58.53 %          | 56.0 %   |
| Between 10–14 yrs      | 15.86 %          | 14.3 %   |
| Between 15–24 yrs      | 17.75 %          | 19.9 %   |
| Above 18 yrs           | 41.46 %          | 43.9 %   |
| Between 18–30 yrs      | 19.96 %          | 22.3 %   |
| Above 60 yrs           | 5.55 %           | 4.5 %    |
| Average Household Size | 4.4              | 4.7      |

Population within 5 km of a health services unit<sup>9</sup>: 43.0 percent

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## The District Health Sector:

There are four health sub-districts in Luweero: Katikamu North, Katikamu South, Nakaseke, and Bamunanika. They operate a total of 58 health facilities (three of which are hospitals), serving a total population of 478,595 people.

### Luweero District Health Units by Health Sub-District

| Health Sub-District | Hospital |          | HC IV    |          | HC III    |          | HC II     |           | Total     |
|---------------------|----------|----------|----------|----------|-----------|----------|-----------|-----------|-----------|
|                     | GOV      | NGO      | GOV      | NGO      | GOV       | NGO      | GOV       | NGO       |           |
| Katikamu North      | 0        | 0        | 1        | 0        | 2         | 3        | 5         | 1         | 12        |
| Katikamu South      | 1        | 0        | 1        | 0        | 7         | 2        | 1         | 6         | 18        |
| Nakaseke            | 1        | 1        | 1        | 0        | 3         | 1        | 5         | 3         | 15        |
| Bamunanika          | 0        | 0        | 1        | 0        | 4         | 2        | 3         | 3         | 13        |
| <b>TOTAL</b>        | <b>2</b> | <b>1</b> | <b>4</b> | <b>0</b> | <b>16</b> | <b>8</b> | <b>14</b> | <b>13</b> | <b>58</b> |

Note: 3 hospitals, 4 HC IVs, 24 HC IIIs, and 27 HC IIs

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<sup>8</sup> 2002 Uganda Population and Housing Census (March 2005).

<sup>9</sup> Luweero District Health & Community Services Sector Report (2002-2003)

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## Luweero District Health Indicators<sup>10</sup>

- ▲ Immunization coverage = 46 percent
- ▲ Infant mortality rate = 112/100,000 live births
- ▲ Under-five mortality rate = 150/1000 live births
- ▲ Stunting rate = 40 percent
- ▲ Underweight = 23 percent
- ▲ Acute malnutrition = 7 percent
- ▲ Maternal mortality = 506/100,000

### Antenatal care (ANC):

- ▲ ANC attendance rate = 60 percent
- ▲ Delivery by trained staff = 36 percent
- ▲ Modern contraceptive prevalence rate = 23 percent (of target population)
- ▲ Access to safe water = 54 percent
- ▲ Latrine coverage = 57 percent

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## Access to Electricity<sup>11</sup>

- ▲ 13 sub-counties have electricity.
- ▲ 8 sub-counties do not have electricity.

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## Road Network with Respect to Access of Health Facilities

- ▲ The district has a total road network of 735.8 km of which 397.9 km is feeder roads.
- ▲ Most of the roads are generally passable throughout the year except for a few parts of the district, like Wakyato and Ngoma sub-counties.

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<sup>10</sup> Luweero District Health & Community Services Sector Report (2002-2003)

<sup>11</sup> Luweero Health & Community Services Sector Report (2002-2003)

# Annex B: Luweero CBHF Focus Group Topic Guide

We would first like to say how happy we are to be able to come and see you again, and we thank you for making the time to talk to us (*introduce ourselves at this point*).

Today we would like to discuss in more detail your health-financing scheme, as part of the USAID-funded PHR*plus* project, in conjunction with the Uganda Community Health Based Finance Association (UCBHFA). We are interested in your thoughts and ideas about community-health insurance and the scheme(s) located in your area, especially with respect to your own participation in making this scheme work. 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?

Perhaps we can start off letting you introduce yourselves, and then we will proceed with some questions.

1. When was the scheme started?
2. What was the reason behind the original idea for the scheme?
3. When did your group(s) join the scheme?
4. How many members does the scheme have?
5. How did your scheme come about?
  - a. Who introduced the idea?
  - b. Were there any actors in the community that pre-disposed to the formation of the scheme?
  - c. Were the providers in any way involved in setting up the schemes?
  - d. What role did community members play in setting up the scheme at the start?
  - e. Did the community feel that the scheme was owned by them at the start? If not, when did they gain the feeling of ownership?
  - f. What was the level of trust of/for the scheme during the initial stages?

- g. Who made the decision on the minimum number of members per group?
  - h. How was the decision made?
  - i. Was a Needs Assessment ever done, and who by?
  - j. Before the scheme became operational, was the community educated about such schemes and what form did the sensitization take?
6. Does the scheme have a Vision and a Mission; what are they?
  7. Who were involved in formulating the scheme's Vision and Mission?
  8. Does the scheme have a constitution/governing document?
  9. How often are elections held and for what?
  10. Who is most involved in day-to-day decision making, and what is the process?
    - a. Decision making.
    - b. Monitoring & Evaluation.
  11. How regularly are meetings held with the general membership of the scheme?
  12. What form of communication is used to relay scheme-related information to members?
  13. How are member concerns dealt with?
  14. Are there any committees; if so, what are they (for)?
  15. What is the community's involvement in planning for the scheme's funds?
  16. What do you consider to be the scheme's 'market niche'?
  17. What method of recruitment (of new members) does the scheme use?
  18. Is there a scheme performance evaluation method in place?
  19. Do you hold meetings with key stakeholders (donors, etc); when was the last one?
  20. How many and what are the different types of schemes?
  21. How did the new schemes come about; how did the community express their desires and concerns and who decided on the new schemes?
  22. How did SHU respond to the community's (expressed) concerns?
  23. How were the new scheme models then developed, and by whom?
  24. How do the different schemes work?
  25. Which type of scheme is most popular, and how many members in each scheme?

26. What are the advantages and disadvantages of the different models?
27. Do your groups have consensus on which scheme to belong to?
28. If a member wants to be part of a different type of scheme, how is that handled?
29. What are the biggest constraints faced by the scheme (other than financial)?
30. Are there any future plans for increasing income generation?
31. What do you consider to be the scheme's greatest successes so far?
32. Do you find that the scheme adequately serves the needs of the community, or is the community too large?
33. Do the new schemes (credit and hybrid) better meet the community's needs?
34. How have the needs and concerns of the community evolved? Are these products still responsive?
35. What is the repayment rate on the credit scheme? Why is it high or low? Does it need to be improved?
36. How would you describe to other communities the advantages and disadvantages of the credit scheme, hybrid scheme, and insurance scheme?



## Annex C: Questionnaire – SHU Management

1. What are the main sources of the scheme's funds?
2. Who are the scheme's key development partners/funders?
3. To what extent is the scheme dependent on donor funding?
4. How does the scheme generate income (if at all)?
5. What is the scheme's '*generated income : donor funding*' ratio?
6. Does the scheme have an annual budget?
7. Does the scheme have a financial reporting system in place; what kind of financial reports are prepared and how often?
8. How, on whom and what does the scheme spend its funds?
9. Does the organisation have a bank account?
10. Who is/are signatories to the account?
11. What method of compensation does the scheme use?
12. How many and what are the different types of schemes?
13. Who decided on the need for new schemes models?
14. How were the new scheme models developed, and by whom?
15. How do the different schemes work?
16. How many members for each of the different type of schemes?
17. What are the advantages and disadvantages of the different models?
18. How many members started out with the different type of schemes?
19. How many members have dropped out from the different type of schemes?
20. What is the income-generation (ratio) of the different type of schemes?
21. How did the switch from insurance to credit or hybrid schemes affect resources – number of members, cash on hand, overall pool of resources, etc.?

22. From a management perspective, what are the advantages and disadvantages of credit, hybrid, and insurance schemes?



# Annex D: Questionnaire – Kiwoko Hospital Management

1. When were ITNs first introduced by the scheme and who by?
2. What was the reason for the introduction of the ITNs?
3. What was the community's response to the introduction of the ITNs?
4. Who first expressed the idea of having ITN's as part of the scheme's benefits?
5. Who is eligible to access ITNs through the scheme; do non-members access them?
6. How much does each ITN cost the scheme?
7. What is the scheme's level of subsidy on the ITNs?
8. Does the scheme give Terms of Payment; if so, what are they?
9. How was the decision about the Terms of Payment made, and who by?
10. What if any significant impact have the ITNs made?
11. Are the ITNs readily available?
12. What do you think would happen if ITNs were not available?
13. How much would the scheme be willing to pay for ITNs and how many ITNs would the scheme be willing to purchase at a time?
14. What financial impact have the ITNs had on the scheme and/or hospital?
15. How many ITNs are used per family, and how?
16. What are the main sources of the scheme's funds?
17. Who are the scheme's key development partners/funders?
18. To what extent is the scheme dependent on donor funding?
19. How does the scheme generate income (if at all)?
20. What is the scheme's '*generated income : donor funding*' ratio?

21. Does the scheme have an annual budget?
22. Does the scheme have a financial reporting system in place; what kind of financial reports are prepared and how often?
23. How, on whom and what does the scheme spend its funds?
24. Does the organisation have a bank account?
25. Who is/are signatories to the account?
26. What method of compensation does the scheme use?