



PHRplus Project

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USAID
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*Catalogue of Community Based
Health Financing Schemes*

UGANDA

June 2006

CHeFA-EA

Community Health Financing for Eastern Africa

Foreword

USAID REDSO/ESA has provided ongoing support to information and technical guidance for policy makers and communities in the East and Southern Africa region in the area of health care financing, with specific focus on community based health financing (CBHF). In an effort to strengthen regional and national community based health financing associations, Partners for Health Reform *plus* (PHR*plus*) in collaboration with the Community Health Financing Association for Eastern Africa (CHeFA-EA) has produced a catalogue of CBHF schemes in four countries in the region: Kenya, Tanzania, Uganda and Rwanda. This activity was financed by USAID REDSO/ESA and carried out in 2006.

The aim of the catalogue is (i) to establish a database of existing CBHF schemes and initiatives for the use by the national and regional associations (ii) to share information with stakeholders on the CBHF movement in the region, and (iii) to demonstrate an approach to document the characteristics, and monitor the progress, of individual schemes and the national level movement, including donor involvement. Potential users of the catalogue include national and regional CBHF associations, Ministries of Health, donors, NGOs and researchers.

Data collection was carried out by regional consultants, using a structured questionnaire in Uganda, Kenya and Tanzania. In Rwanda, an existing database was made available by the Ministry of Health. The Catalogue consists of three parts: 1) a description of the national CBHF association (and the regional association contained in the Uganda volume), 2) a matrix presenting the main characteristics of the CBHF schemes, and 3) the completed questionnaires, providing detailed information on each individual scheme. It is envisaged that national associations can utilize and update essential data such as membership, service coverage, and donor assistance, on an annual basis.

An additional element of this project included providing in depth management assistance to selected schemes in two countries, Uganda and Kenya. Technical assistance included training, community mobilization, management information system development, and, in Uganda, an incentive scheme providing subsidized insecticide treated mosquito nets (ITNs).

Acknowledgement

PHR*plus* acknowledges with appreciation the contributions of regional consultants Jean Damascene Butera, who carried out the data collection and technical assistance in Kenya, Tanzania, and Rwanda, and Dr. Gloria Karungi, who carried out the work in Uganda. PHR*plus* staff Stephen Musau, Melinda Ojermark, Lillian Kidane and Ellie Brown contributed to the design, review and management of the project. The contributions of the following leaders and stakeholders in the regional CBHF movement were highly appreciated:

East and Southern Africa Region:

Joseph Kiggundu, Regional Coordinator of the Community Health Financing Association for Eastern Africa (CHeFA-EA)

Uganda:

Livingston Namara, Chairman, and Joy Batusa, Association Secretary of the Uganda Community Based Health Financing Association (UCBHFA)

Kenya:

Lucas Wadenya, Chairman of the Kenya Community Based Health Financing Association (KCBHFA) and Executive Chairman of the CHeFA-EA, all STIPA staff, Dr Samuel Mwenda Rukunga of CHAK and Ven. Zacchaeus I. Masake

Tanzania:

Sr. Rita Toutant: Vice Chairperson, Prof. Manoris V.Meshak: Secretary; Dr. S.A. Sheuya, Member of the TNCHF Executive Committee, Mushi Angsar, Member of the TNCHF Executive Committee

Rwanda:

Mr. Inyarubuga Hertilan, Coordinator of the Cellule Technique.

Finally we wish to thank our USAID/REDSO/ESA partners Moses Mukuna and Maria

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Community Based Health Insurance in Uganda: Background

SUMMARY

Overview

The establishment of CBHI schemes provided a means for families to ensure that they could pay for health services at local facilities, government or private. After the presidential election of 2001, the government abolished user fees in public facilities making public sector schemes unnecessary. However, free-of-charge health care schemes at private not-for-profit facilities continued to be utilized by some populations for reasons of quality of care or convenience. Thus, currently there are 13 schemes, the majority of which are facility-based i.e. owned by the facility itself and are usually managed by facility staff. The schemes primarily target community groups as clients.

The Department of Planning in the Ministry of Health Uganda (MoH) remains responsible for the schemes under the umbrella non-government organization Uganda Community Based Health Financing Association (UCBHFA), whose predecessor was Community Health Financing (CHF).

Ministry of Health Involvement

Over time, the Ugandan government and the Ministry of Health in particular, have demonstrated willingness to explore alternative health-financing strategies that would ensure equity for the poor. In 1995, the MoH planning department reviewed the options for health financing and recognized that community financing i.e. health insurance through prepayment schemes would be among the options that could be considered. The MoH then moved to pilot the first scheme in Uganda, the Kisiizi Hospital Society Health Plan, which was founded and modeled on a similar facility-based scheme in Kenya. At the time, government health care financing policy included cost sharing, where individuals paid user fees to access government-provided health care when seeking health services. Following this, a number of Community Based Health Insurance schemes (CBHIs) have been established including the only community-based scheme; Save for Health Uganda (Munno mu Bulwade), in Luwero.

Support System

1. UCBHFA

UCBHFA supports all schemes registered as members; the nature of support is financial as well as technical assistance. Amount of financial assistance is 400,000 UGS per quarter for data collection. MoH Uganda: Provides financial support to UCBHFA to support the member schemes.

Contact: Dr Robert K.Basaza,

Senior Health Planner,
Department of Health Planning, Ministry of Health.
Plot 6 Lourdel Road
P.O. Box 7272
Kampala, Uganda
Tel: 041-340383
Fax: 041-340877/235478

Health Partners: Started in 1997; 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, Health Partners 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 Health Partners.

Contact Head Office:

Joy Batusa,
Director of Health Partners/Uganda Health Cooperative,
c/o PSI Box 33781
Kampala, Uganda
Tel: +256-41-342353 or + 256-77-433109
Fax: +256-41-258678
E-mail: ribatusa@psiu.co.ug

2. Microcare Health Limited

Microcare Health Ltd is a private company that developed out of the not-for-profit organization, Microcare. Currently, it is a health maintenance organization with an insurance component added to it. 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 still exists in name as a shareholder of Microcare, Ltd. Microcare manages Kisiizi Hospital Society Health Plan.

Contact Head Office:

Dr Gerry Noble,
Director of Microcare Health Ltd.
Plot 23 Prince Charles Drive, Kololo
P.O Box 29252
Kampala, Uganda
Tel: +256-41-235120/123, 236463/4, +256-31-264450/1/2
Fax: +256-41-236465
Cell: +256-71 698888
E-mail: gerry@microcare.co.ug
Website: www.microcare.co.ug

3. Save for Health Uganda (SHU), Luwero

SHU is a local non-government organization (NGO) established in 1999 and acts as an umbrella group for community-based health schemes in the area (currently 10).

The schemes that constitute SHU are both insurance, credit and credit/insurance schemes. These schemes 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 center, an out-patient 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 in that 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 their treatment.

Contact Head Office:

Mr Fredrick Makaire,
Save for Health-Uganda (SHU)
Project Manager
P.O.Box 123 Luwero- Uganda
Tel: +256-41610187
Fax: +256-41610132
E-mail: shu@utlonline.co.ug

UGANDA Community Based Health Financing Association (UCBHFA)

BACKGROUND

UCBHFA formed in 1998 and registered with the NGO board in 1999. Currently, the Association is operational in 7 districts of Uganda, with a catchment population area of over 4.5 million. There are 8 schemes enrolled with total beneficiaries of 28,032 as of 30th June 2004. The Association has a constitution, a five-year strategic plan, and an independent secretariat and full time staff

Services provided:

- Promotion of CBH care
- Improves accessibility of affordable, quality health care in order to achieve better health for the people of Uganda
- Coordination of all CBHF schemes
- Liaises with Ministry of Health and all development partners in the field of health on behalf of the participating health schemes
- Coordinates appropriate research
- Provides financial and managerial support to enhance the skills of individual scheme staff so as to improve the implementation of CBF

Location:

Plot 39 Bukoto Street, Kamokya
P.O.Box 830
Kampala, Uganda

Contact info:

Mr. Livingstone Namarah
National Coordinator,UCBHF

Donor assistance:

- The association has received support from:
- MOH-----annually
- EED through CBHF-ECSA-----annually
- USAID through PHRplus-----occasionally
- CIDR provides support to SHU
- Health Partners through Uganda Health Cooperatives supports selected schemes
- Microcare supports selected schemes

Schemes known and registered*

- Bushenyi Medical Centre,BMC*

- Comboni Hospital*
- Kaloli Lwanga Hospital, Nyakibale*
- Church of Uganda Kisiizi Hospital, Kisiizi*
- Kitanga
- Mother Child Rescue-Project*
- RUBAHEF
- Rugarama Health Centre
- St. Francis Hospital ,Mutolere*
- St. Joseph Hospital, Kitovu*
- Save for Health Uganda, Luwero*/ CIDR
- Ishaka Adventist Hospital Health Plan*
- Nyamwegabira Bataaka Health Insurance

Catalogue of CBHF Schemes - UGANDA

	Scheme Name	Contact Information <i>including</i> contact name, physical address, telephone and email (if applicable)	Urban Rural	No. of Members	Year Est.	Benefit package includes the following services
1	BMC	Mr William Rwabukare (Scheme Manager), Bushenyi Medical Centre P.O.Box 347 Bushenyi Tel: +256-77626555 Email: rwabukare@yahoo.co.uk	Rural		1998	General medical, dental, eye, x-ray, laboratory tests, blood transfusion, family planning and MCH, IEC, VCT and PMTCT. Excluding eye glasses, cosmetic dental care cosmetic surgery, self inflicted conditions, transport, abortion/post abortion care, delivery without antenatal care.
2	Comboni Hospital	Ms Amelia Namanya (Scheme Administrator/Manager), P.O. Box 112 Bushenyi Tel: +256-77609881 Email: kyamu@ucmb.co.ug	Rural	1852	2002	In-patient and out-patient services with co-payment, subsidised Smart Net when available, health education Mamma kits when available.
3	Ishaka Hospital Health Plan	Mr Kakunta Daniel (Scheme Manager) Ishaka Adventist Hospital P.O.Box Ishaka Tel: 077625733 E-mail; kakuntadaniel@yahoo.co.uk	Rural	924	1999	All In-patients access to doctors/clinical officers consultations, x-ray and laboratory tests, semi-private room . Out-patient care services as provided at the hospital. An ambulance is available to specified geographic areas. Provision of health care programmes. Exclusions include chronic conditions, dental and optical care.
4	Kitanga Health Centre III	Tumuhaira Provia (Scheme Manager) Kitanga Health Centre III P.O.Box 03 Mparo-Kabale Tel; 078685078	Rural		2001	Out-patient services include (Drug prescription, Laboratory tests and drugs) In-patient services (admission in the Health centre and those the Health centre who cannot manage are referred to Hospital for further management). Maternity services (include antenatal care and deliveries). VCT services (new programme in the Health centre. Provided to the whole sub-county of Kashambya)

Ownership and Management	Donor involvement		
	Donor name	Nature of support	Contact info
<p>Private Health Care Facility</p> <p>Obj: To ease students' access to good quality and affordable curative health care and encourage health promotion.</p> <p>Membership: Schools, burial societies, coffee and dairy association.</p> <p>Mgt Structure: Facility director, scheme manager, scheme assist. manager work with hospital administration.</p>	<p>1. Bushenyi Medical Centre (BMC)</p> <p>2. Uganda Community Based Health Financing Association (UCBHFA)</p>	<p>1. BMC; gives operational assistance, support supervision and technical assistance as well as financial.</p> <p>2. UCBHFA; contributes on yearly losses, pays salary of the data clerk and gives support supervision.</p>	<p>1. Contact the scheme Manager .</p> <p>2. Contact the UCBHFA National coordinator. Mr Livingstone Namarah Plot 39 Bukoto Street, Kamokya, P.o.Box 830 Kampala Tel: 077663071/031262013 Fax: 031262013 E-mail: ucbhfa@africaonline.co.ug</p>
<p>Comboni Hospital</p> <p>Obj: improve access and affordability of health care services in community; improve utilization of health services by sharing the burden; change health seeking behavior in community; to reduce health costs for the community</p> <p>Membership: Factory employees, school and community groups.</p> <p>Mgt structure: Medical superintendent, scheme manager, community group leader, employees group management and school administration.</p>	<p>1. Health Partners/Uganda Health Cooperative and</p> <p>2. Comboni Hospital</p> <p>3. Uganda Community Based Health Financing Association (UCBHFA)</p>	<p>1. Health Partners; pays scheme manager's salary, gives support supervision and technical assistance.</p> <p>2. Comboni Hospital; gives operational assistance, support supervision and technical assistance.</p> <p>3. UCBHFA; contributes on yearly losses, pays salary of the data clerk and gives support supervision.</p>	<p>1. Head Office-Health Partners/Uganda Health Cooperative c/o PSI Box 33781 Kampala, Uganda Tel; +256-41-342353 Fax; +256-41-258678</p> <p>2. Contact Amelia, Health Plan Administrator-Comboni c/o Comboni Hospital Health Plan, Comboni Hospital, P.O. Box 112 Kyamuhunga Tel: 077 609 881 .</p> <p>3. Contact the UCBHFA National coordinator. Mr Livingstone Namarah Plot 39 Bukoto Street, Kamokya, P.o.Box 830 Kampala Tel: 077663071/031262013 Fax: 031262013 E-mail: ucbhfa@africaonline.co.ug</p>
<p>Ishaka Adventist Hospital.</p> <p>Obj: Affordable and accessible health care services and health promotion.</p> <p>Membership: dairy cooperative, engozi groups, school (staff), credit and savings schemes, hospital staff.</p> <p>Mgt structure: Medical director, health plan manager, hospital treasurer, scheme out-research officer, scheme secretary.</p>	<p>1. Ishaka Adventist Hospital</p> <p>2. UCBHFA</p>	<p>1. Ishaka Adventist Hospital gives operational assistance, support supervision and technical assistance.</p> <p>2. UCBHFA; contributes on yearly losses, pays salary of the data clerk and gives support supervision.</p>	<p>1. Contact the scheme Manager, Mr Daniel Kakunta.</p> <p>2. Contact the UCBHFA National coordinator. Mr Livingstone Namarah Plot 39 Bukoto Street, Kamokya, P.o.Box 830 Kampala Tel: 077663071/031262013 Fax: 031262013</p>
<p>Kitanga Health Centre III</p> <p>Obj: to make avail affordable health services to the Kitanga community.</p> <p>Membership: Peasant farmers</p> <p>Mgt Structure: Scheme Manager , Health Provider (Sr In-charge of H/C)</p>	<p>1. Kitanga Health Centre III</p> <p>2. UCBHFA</p> <p>3. Health Office Kabale diocese</p>	<p>1. Kitanga Health Centre III, gives operational assistance, support supervision and technical assistance as well as financial.</p> <p>2. UCBHFA provides technical assistance and creates a network for donors when available.</p> <p>3. Health Office Kabale diocese occasionally provides financial assistance.</p>	<p>1. Contact the scheme manager of Kitanga Health Centre III for details of the scheme and the Health Office Kabale diocese.</p> <p>2. Contact the UCBHFA National coordinator .</p>

Catalogue of CBHF Schemes - UGANDA

Scheme Name	Contact Information including contact name, physical address, telephone and email (if applicable)	Urban Rural	No. of Members	Year Est.	Benefit package includes the following services
5	Kitovu Patient Pre-payment Ms Namugenyi Josephine, P.O.Box Kitovu Hospital, Tel: 0481 20097/077842316 E-mail; kitovu@ucmb.co.ug	Rural	842	1998	In-patients (deliveries, surgical, medical and pediatrics) and out-patient services (as long as they are provided in Kitovu hospital). Health education includes Malaria prevention, antenatal care, immunization and HIV/AIDS. Note: the scheme provides symptomatic treatment for HIV related conditions but no ARVS. Exclusions include: Dental, Optical, Open-heart Surgery and private services.
6	Luwero(SHU) Mr Fredrick Makaire Save for Health-Uganda (SHU) Project Manager P.O.Box 123 Luwero- Uganda Tel; +256-41610187 Fax; +256-41610132 E-mail; shu@utlonline.co.ug	Rural	2,156	1999	In-Patients access to services at Kiwoko Hospital and Kasaala Health centre, subsidized ambulance services, access to premium-financing activities, some schemes only cover in-patient care. Out-patient services as long as they are provided in Kiwoko and Kasaala. Exclusions: Opportunistic infections, chronic conditions.
7	Mother Child Rescue Project (MCRP) Mr Mugisha Allan (Scheme Manager) , P.O Box 347, Bushenyi Tel: +256-77888855 Email: mugishaalan20@yahoo.co.uk	Rural	488	1999	In-patient and out-patient services available at the Health centre including medical treatment, maternal services, antenatal care services, laboratory services, education on health care, referral services to BMC at scheme cost and PMTCT. Exclusions include chronic conditions and opportunistic infections, cosmetic dental and optical care.
8	Microcare-Kisiizi Dr Gerry Noble Director of Microcare. Plot 23 Prince Charles Drive, Kololo P.O Box 29252 Kampala, Uganda Tel: +256-41-235120/123, 236463/4, +256-31-264450/1/2 Fax: +256-41-236465 Cell: +256-71 698888 e-mail: gerry@microcare.co.ug Website: www.microcare.co.ug	Rural		1995 (Operational in 1996)	In-patients and Out-patients are entitled to all services available at Kisiizi Hospital. Exclusions include normal deliveries, cosmetic dental care, major surgery, self-inflicted conditions.

Ownership and Management	Donor involvement		
	Donor name	Nature of support	Contact info
<p>Kitovu Hospital ,</p> <p>Obj: enable the poor to access health care without paying large sums of money.</p> <p>Membership: Peasant farmers, the clergy and students. Mgt</p> <p>Structure: Scheme manager, health provider, data manager and field assistant.</p>	<p>1.UCBHFA and</p> <p>2.Kitovu Hospital</p>	<p>1. UCBHFA contributes yearly losses and</p> <p>2. Kitovu hospital pays the scheme manager.</p>	<p>1. Contact the Scheme Manger for details of KPPS</p> <p>2. Contact the UCBHFA National coordinator. Mr Livingstone Namarah Plot 39 Bukoto Street,Kamokya, P.o.Box 830 Kampala Tel: 077663071/031262013 Fax; 031262013 E-mail; ucbhfa@africaonline.co.ug</p>
<p>Kiwoko Hospital and Kasaala Health Centre.</p> <p>Obj: Improve access to health care; create the solidarity that had been lost in the community; help improve facility income.</p> <p>Membership: villages in the area .</p> <p>Mgt structure: scheme board, social group leader,scheme executive committee.</p>	<p>1. Kiwoko Hospital</p> <p>2. Save for Health Uganda (SHU)</p> <p>3. Centre Internatonal Development et Research (International Centre for Development and Research)</p> <p>4. UCBHFA</p>	<p>1. Kiwoko Hospital provides the scheme with their own special cashier and benefit discounts</p> <p>2. SHU builds the capacity with in the community members to create and sustain the community owned prepayment schemes as well as improving the financial resource of the health cae providers especially when the health providers accumulate run away cases.</p> <p>3. CIDR supports SHU financially and through research. 4.UCBHFA provides technical support.</p>	<p>1. Kiwoko Hospital Contact Mr Ssekidde Moses, Planning Officer. Cell no: +256-77- 462482 e-mail: ssekimo@yahoo.com</p> <p>2. SHU contact the project Manager, Mr Fred Makaire</p> <p>3. CIDR Contact SHU</p> <p>4. UCBHFA contact Mr Livingstone Namarah.</p>
<p>Mother Child Resue Project and BMC</p> <p>Obj: to decease mortality and morbidity in the under 5s and pregnant mothers during and after labour. Membership:</p> <p>Tea growers of Buhweju County</p> <p>Mgt Structure: Scheme manager and the Scheme management committee of 11 people (chairperson, vice chairperson, secretary and treasurer and 7 committee members)</p>	<p>1. Health Partners-Uganda</p> <p>2. UCBHFA</p> <p>3. BMC</p>	<p>1. MCRP since its inception in 1999 was funded by Health Partners - Uganda. Although of late Health Partners has stopped its funding.</p> <p>2. UCBHFA technical and financial support and also pays the data clerk.</p> <p>3. BMC is the service provider</p>	<p>1. Contact the scheme manager of MCRP and BMC.</p> <p>2. Contact the UCBHFA National coordinator.</p>
<p>Microcare -Kisiizi</p> <p>Obj: Provide affordable and accessible health services to the population.</p> <p>Membership: Engozi groups teachers' associations and women's groups.</p> <p>Mgt structure: Micro head office, scheme branch manager, field worker and nurse.</p>	<p>1.Kisiizi Hospital</p> <p>2. Microcare Health Ltd.</p>	<p>1. Kisiizi Hospital provides the health care services and office space.</p> <p>2. Microcare head office provides financial and technical support to the scheme.It also provides human resource for the specified duties i.e field work and nursing.</p>	<p>1. Contact the Scheme manager Kisiizi Hospital</p> <p>2. Contact the Microcare Head Offices. Dr Gerry Noble, Director of Microcare.Plot 23 Prince Charles Drive, Kololo P.O Box 29252 Kampala, Uganda</p> <p>Tel: +256-41-235120/123, 236463/4, +256-31-264450/1/2</p> <p>Fax: +256-41-236465</p> <p>Cell: +256-71 698888 e-</p> <p>mail: gerry@microcare.co.ug</p> <p>Website: www.microcare.co.ug</p>

Catalogue of CBHF Schemes

Ownership and Management		Donor involvement				
		Donor name	Nature of support	Contact info		
9	Mutolere	Ms Edith Nziza (Scheme Manager) Mutolere - Kisoro , Tel: +256 78 819404 E-mail: nziza_e@yahoo.com	Rural		1998	In-patients and Out-patients are entitled to all services available at Mutolere Hospital. Public education, subsidised ITNS when available, can defer payment of co-payment when necessary. Exclusions include provision of private rooms, cosmetic dental care, plastic surgery.
10	Nyakibale	Mr Atwine Levino, (Scheme Manager) Nyakibale Hospital P.O.Box 31 Rukungiri Tel; 077476530 E-mail; nyakhosp@ucmb.co.ug	Rural	961	1998	In-patients (Malaria, tyhoid treatment and general ward costs,operations and deliveries) Out-patient services including Malaria, tyhoid, lab tests, tooth extractions and eye care. Health education including Malaria prevention. Exclusions include; buying eye glasses, cosmetic dental care and surgery, HIV testing, giving ARVs, referrals to other health providers, transporting bodies home and treating self-inflicted wounds. Still to review are diabetes and hypertension.
11	Nyamwegabira (Bataka Group Health Insurance)	Sr Cathereine, Nyawegabira Health Insurance Scheme P.O.Box 5 Kihiihi - Kanungu,Uganda. Tel; 077995511	Rural	1422	2001	All in-patient and out-patient services available at Nyamwegabira Health Unit III.
12	Rural Based Health Foundation (RUBAHEF)	Mr Tumanyire George Rural Based Health Care Foundation P.O.Box 155 Kabwohe Tel; 078827642 E-mail; tumaxg@yahoo.com	Rural	218	2001	No in-patients services offered, all patients requiring further treatment are referred to neighbouring health providers i.e BMC, Mbarara community Hospital and Ishaka Adventist Hospital. Out-patients receive treatment from a herbalist and Malaria treatment.
13	Rugarama	Mr Hannington Katarahweire Adminstrator Rugarama Hospital P.O.Box 342 Kabale Tel; 078458189 E-mail; rugaramahospital@yahoo.com	Rural		2002	In-patients (deliveries,surgical,medical and pediatrics) and out-Patients services (as long as they are provided in Rugarama hospital). Health education includes Malaria prevention, antenatal care, immunization as well as Health promotion seminars. Exclusions include: opportunistic infections and chronic conditions

Ownership and Management	Donor involvement		
	Donor name	Nature of support	Contact info
<p>St Francis Hospital Mutolere</p> <p>Obj: Improve the local population's access to good health care</p> <p>Membership: Engozi groups, employee groups and village groups.</p> <p>Mgt structure: Scheme coordinator, scheme manager and scheme accountant.</p>	<p>1. St Francis Hospital Mutolere</p> <p>2. UCBHFA</p>	<p>1. St. Francis Hospital Mutolere provides gives operational assistance, support supervision and technical assistance as well as financial.</p> <p>2. UCBHFA gives support supervision and contributes yearly losses .</p>	<p>1. Contact the scheme manager of Mutolere scheme</p> <p>2. Contact UCBHFA National coordinator.</p>
<p>Nyakibale Hospital/Community Group members.</p> <p>Obj: Assist the local people to have access good quality health care and to obtain prompt early treatment.</p> <p>Membership: Peasant farmers, small scale traders, teachers and students</p> <p>Mgt Structure: Scheme Manager, Health provider including Medical Superintendent, Hospital accountant and Cashier, group leaders and scheme members.</p>	<p>1. UCBHFA</p> <p>2. Nyakibale Hospital and</p> <p>3. CORDAID through Health Office Kabale diocese</p>	<p>1. UCBHFA gives support supervision and contributes yearly losses. 2. Nyakibale Hospital gives operational assistance, support supervision and technical assistance as well as financial.</p> <p>3. CORDAID through the Health Office Kabale Diocese occasionally assists financially with funds for mobilisation and sensitisation.</p>	<p>1. Contact the Scheme Manger for detailes of Nyakibale and CORDAID.</p> <p>2. Contact the UCBHFA National coordinator, Mr Livingstone Namarah Plot 39 Bukoto Street, Kamokya, P.o.Box 830 Kampala Tel: 077663071/031262013 Fax: 031262013 E-mail: ucbhfa@africaonline.co.ug</p>
<p>Nyamwegabira Health Unit III.</p> <p>Obj: Fight disease and chage peoples' mentality about prepayment for health.</p> <p>Membership: Peasant farmers.</p> <p>Mgt structure: Scheme coordinator, scheme manager and scheme accountant.</p>	<p>1. Nyamwegabira Health Unit III 2. Health Office of Kabale diocese</p>	<p>1. Nyamwegabira Health Unit III provides operational assistance and support supervision and Technical assistance. 2. Health Office of Kabale diocese</p>	<p>1. Contact the scheme manager of Nyamwegabira Health Unit III for details of Nyamwegabira and Health Office of Kabale diocese.</p>
<p>RUBAHEF is a non-government organisation.</p> <p>Obj: To improve the welfare of the communities through health services provision and income generating activiites.</p> <p>Membership: "Boda boda" associations, credit and savings organisations, mothers union groups, small Christian churches, UTODA, Schools.</p> <p>Mgt structure: Has a director of the NGO, a mobiliser, a coordinator, a community health care coordiantor and an accountant.</p>	<p>1. RUBAHEF</p> <p>2. UCBHFA</p>	<p>1. RUBAHEF gives operational assistance, support supervision and technical assistance as well as financial when available to keep the NGO going. 2. UCBHFA provides technical support.</p>	<p>1. Contact the NGO manager of RUBAHEF.</p> <p>2. Contact UCBHFA National coordinator.</p>
<p>Rugarama Health Centre.</p> <p>Obj: Provide affordable and accessible health services and health promotion</p> <p>Membership: dairy farmers, soon will incorporate university staff and diocese.</p> <p>Mgt structure: Hospital adminstration, health insurance liaison officer.</p>	<p>1. UCBHFA</p> <p>2. Rugarama Health Centre</p>	<p>1. Rugarama Health Centre ; gives operational assistance, support supervision and technical assistance as well as financial support.</p> <p>2. UCBHFA; provides technical support and network for donors when available.</p>	<p>1. Contact the scheme manager of Rugarama Health Centre.</p> <p>2. Contact UCBHFA National coordinator.</p>

Inventory of CBHF Schemes Uganda

5. What is the number of Members and/or Beneficiaries [FY 2003-2005]? Use the table below.

	Year 2003		Year 2004		Year 2005	
	Adults	Children	Adults	Children	Adults	Children
Male	2456		4689		5900	
Female	3567		5678		9876	
Total /age / year	6023		10367		15776	

6. What does the benefit package include?

- a. Health education/Prevention care
Yes
- b. Out patient care (including hospitalization at a health center)
Yes
- c. Inpatient care
Yes
- d. HIV/AIDS care
VCT and PMTCT
- e. Other services
Dental care, eye care, examinations, x-ray, Radiography, maternity, counseling, laboratory, blood transfusion and family planning.

7. Are there specific exclusions?

Eye glasses, cosmetic dental care, cosmetic surgery, major surgery, self-inflicted conditions, transport, abortion/post-abortion care, delivery w/o antenatal care and terminally ill cases

8. What is the premium?

3,500 per student quarterly

9. Is the premium paid monthly, quarterly or yearly?

Quarterly

10. How are premiums collected?

By the scheme accountant through visits to the schools and community groups

11. Are there co-payments? How much and how are they administered?

Yes and these are paid as members visit the centre and apply only to non-student members

12. Reasons for co-payments?

For administrative costs and also to discourage service misuse

13. What is the scheme income trend for the last three years? Refer to the table below.

Income Source	Year 2003	Year 2004	Year 2005
Premiums	62,356,000	65,467,800	72,358,700=
Co-payments	423,000	567,000=	645,000=
Donors	-	-	-
Others	-	-	-
Totals	62,779,000=	66,034,800	73,003,700=

14. What is the scheme expenditure trend for the last three years? See table below

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical claims	48,350,000	50,468,000	52,760,00
Administration	730,000	756,000	773,000
Personnel	18,789,000	21,120,000	22,145,700
Others [specify]			
Totals	67,869,000	72,344,000=	75,678,700=

15. What is the legal and regulatory framework of the CBHF? Is the scheme registered? What are the governing documents (specify)?

There is no national frame work, the scheme was passed by the District council meeting in 1998. And the scheme is registered with Uganda Community Based Financing Agency.

16. Please describe the management structure of the scheme.

The scheme has a manager, co-coordinator, accountant, Medical officer, Data entrant and the Driver.

17. Is the community involved in scheme management? How?

Yes, the community leaders mobilize members and have regular meetings. Premiums fro community groups are collected by the association treasurers

18. How many people work on scheme management? Full time/part time? Paid/volunteer?

6 full time and one volunteer

19. Is there a feedback mechanism for scheme members?

Yes

20. Is there a waiting period? Yes and this is three months

No response

21. Are there controls over moral hazard?

Yes

22. Are there controls over adverse selection?

Yes, because the whole family has to enroll and the whole school (institution), entitling them to identification cards.

23. Are there controls over Fraud?

Yes, members have medical treatment authorization cards.

24. Are there controls over cost escalation?

Yes, standard rates are charges and a list of all this information is available at BMC. In addition to this, chronic illnesses are not covered but discussions are underway.

25. How are providers reimbursed for services?

BMC operates on a provider payment mode.

26. Are statistics on services utilization by members, membership and finances available?

How regularly are they prepared?

Reports are available and these are prepared every quarter (a performance spreadsheet) and sent to UCBHFA.

27. Are there income-generating activities that contribute to the scheme?

None

28. Are there external donor funds or support that contributes to the scheme?

None except occasional funds from UCBHFA through the MOH when available for data collection.

29. Are their mechanisms for enrolling indigents?

No.

30. What are the scheme's major successes to date?

1. Increasing membership
2. And community sensitization on insurance principles

31. What are the major obstacles to sustainability?

1. Seeking donor support,
2. Increasing premiums
3. And initiating income generating projects

32. What strategies or plans are in place to address the issues above?

1. Increased enrollment
2. And increasing the premiums

Identification

Name of scheme	Comboni Hospital Health Plan
Year established	2002
Purpose	Improve health care services Reduce health care costs for families Improve revenue flows for health care
Name of respondent(s)	Amelia Namanya
Contact information	
Address	COMBONI HOSPITAL P.O.BOX 112 BUSHENYI
Telephone	+256-77-609881

Location: Rural

Coverage: Geographical

Initiator: Health Partners/Uganda Health Co-operative.

Ownership: Comboni Hospital

Other Stakeholders: Comboni Hospital, Uganda Health Co-operative, UCBHFA, ECSA, Scheme Members

Brief Background

(CHHP) is provider-based scheme and it covers the community around Comboni Hospital catchments area. This scheme started in July 2002 with help of Health Partners Uganda Health Co-operative its main objective is:

- To create affordable and quality health care to its members and improve revenues for the health care provider.
- Our members are composed of local community people and company employees. In 2003 the scheme was registered with UCBHFA where it supported the scheme with the mobilization fund up to 2004. The scheme is still supported by Health Partners in marketing and technical part. But lacks funds to do administrative and sensitization activities

Management

1. What is the enrollment mode (Individual, Household, Group, Institution)?

Group and Institution

2. What is the size of your target population?

11,893

3. What is the population size of your area of operation?

25%

4. What are the socio-economic characteristics of your current membership?

Peasants growing food and cash crops on small scale, others are involved in small businesses have some credit and saving associations and others are company employees.

5. What is the number of Members and/or Beneficiaries for the FY 2003 - 2005?

	Year 2003		Year 2004		Year 2005	
	Adults	Children	Adults	Children	Adults	Children
Male						
Female						
Total /age / year						

6. What does the benefit package include?

- a) Health education/Prevention care
Malaria, Nutrition Hand washing, Safe water and Hygiene, First Aid
- b) Out patient care (including hospitalization at a health center)
Receiving patients, Directing patients, Health education, treat out patient
- c) Inpatient care
Hospitalization, General nursing care, Delivery services and operations
- d) HIV/AIDS care
Testing and counseling is free and the scheme cares for opportunistic infections only.
- e) Other services
In 2003 the scheme offered its members treated mosquito nets on subsidized prices

7. Are there specific exclusions?

Yes clinical illnesses such as Cancer, Diabetes, and Pressure.

8. What is the premium?

20,000 as a flat pay for a family of four or less and added members 3,000 each.

9. Is the premium paid monthly, quarterly or yearly?

It's paid quarterly.

10. How are premiums collected?

Collected by leaders

11. Are there co-payments? How much and how are they administered?

Yes, 2,000 Out Patient and 3,000 and this is paid directly to the hospital cashiers.

12. Reasons for co-payments

To control over-utilization

13. What is the scheme income trend for the last three years? Refer to the table below.

Income Source	Year 2003	Year 2004	Year 2005
Premiums	12,752,000	17,516,400	17,370,300
Co-payments	1,715,000	2,459,000	3,358,000
Donors	1,773,510	1,080,000	400,000
Others	—	—	—
Totals	16,240,510	21,055,400	21,128,300

14. What is the scheme expenditure trend for the last three years? See table below

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical claims	25,373,800	24,421,170	26,076,460
Administration	1,000,000	1,800,000	4,475,000
Personnel	—	586,100	520,000
Others [specify]	—	—	—
Totals	26,373,800	26,807,270	31,071,460

15. What is the legal and regulatory framework of the CBHF? Is the scheme registered? What are the governing documents (specify)?

No, the scheme is not registered.

16. Please describe the management structure of the scheme

1. Medical Superintendent, Hospital Administrator and Health Partners/Uganda Health Co-operative Director
2. Scheme Manager
3. Group leaders

17. Is the community involved in scheme management? How?

Yes, leaders are involved in premium collection, calling group meetings and members are encouraged to market the scheme.

18. How many people work on scheme management?

Full-time employees: 2, Volunteer: 1

19. Is there a feedback mechanism for scheme members?

Yes, members are given feedback quarterly on utilization costs

20. Is there a waiting period?

No, but members are trained about on time premium payment and its importance so members are encouraged to have finished paying their premium by 15th of each new quarter.

21. Are there controls over moral hazard?

Yes e.g. Co-payment in patient co-payment is 3,000 while outpatient co-payment is 2,000.

22. Are there controls over adverse selection?

Yes, the scheme has flat pay of 20,000 for each family of 4 members

23. Are there controls over Fraud?

Yes, each member has to produce a family I.D and a receipt each time he/she comes to see a doctor and lists are checked.

24. Are there controls over cost escalation?

Yes e.g. the scheme meets operation costs if a member has been in the scheme for a year.

25. How are providers reimbursed for services?

All the premiums and co-payments are deposited with the hospital.

26. Are statistics on services utilization by members, membership and finances available?

How regularly are they prepared?

Yes, Utilization is prepared monthly while membership and finances are prepared quarterly

27. Are there income-generating activities that contribute to the scheme?

No

28. Are there external donor funds or support that contributes to the scheme?

No

29. Are there mechanisms for enrolling indigents?

Yes if they can be assisted to get income generating activities to help the pay premiums.

30. What are the scheme's major successes to date?

Members get treatment on reduced cost and early enough.

31. What are the major obstacles to sustainability?

1. Over utilization
2. Lack of Administrative, mobilization and sensitization funds.
3. Increased dropouts

32. What strategies or plans are in place to address the issues above

1. Increase on premium
2. Seek support from Donors and Government
3. Do more sensitization and mobilization

Management

1. **What is the enrollment mode (Individual, Household, Group, Institution)?**
Groups and institutions
2. **What is the size of your target population?**
314,692
3. **What is the population size of your area of operation?**
314,692
4. **What are the socio-economic characteristics of your current membership?**
Majority of the members are peasants and a few are employed teachers
5. **What is the number of Members and/or Beneficiaries for the FY 2003 - 2005?**
We are unable to provide the above information, because the beneficiaries of FY 2003-2005 are not arranged according to males and females or according to adults and children.
6. **What does the benefit package include?**
 - a. Health education/Prevention care?
Yes
 - b. Out patient care (including hospitalization at a health center)
Includes doctor/clinical officer consultations, drugs, laboratory tests and x-ray procedures.
 - c. Inpatient care
Includes doctor consultations, drugs, laboratory tests, x-ray procedures, surgery and general ward accommodation.
 - d. HIV/AIDS care
A member who has HIV/AIDS or is just HIV sero-positive is covered for only Malaria.
 - e. Other services
All normal and abnormal deliveries are covered. Caesarian operation, vacuum extraction, breech presentation are covered only if the pregnant woman member has attended at least three antenatal visits and has been referred to the hospital because of high birth risks.
7. **Are there specific exclusions?**
 - Routine check ups like for those seeking employment or for students.
 - Eye-glasses and eye examinations
 - Dental services and cosmetic surgery
 - Antenatal visits unless, certain conditions are fulfilled,
 - Ambulant services
 - Semi-private and private rooms
 - Self inflicted wounds/problems
 - Referral to other health providers and transportation of dead bodies home,
 - Pre-existing conditions and if the illness is covered by another finance scheme.
8. **What is the premium?**
A family of 2-4 members pays the minimum premium of 15,000 Ugsh. And any additional family member pays 3,700 Ugsh. The premium covers a period of 3 months.
9. **Is the premium paid monthly, quarterly or yearly?**
Quarterly
10. **How are premiums collected?**
The group leaders collect the premiums from their members but some individuals also bring the premiums at the scheme office.

11. Are there co-payments? How much and how are they administered?

The OPD co-pay is 2,000 Ugsh and IPD co-pay is 6,000 Ugsh per visit. This is with effect from March 2006. The patient pays the hospital cashier at the OPD/IPD and the money is debited in the Health Plan account.

12. Reasons for co-payments:

To protect the Health Plan membership from excessive use of medical services (abuse of services)

13. What is the scheme income trend for the last three years? Refer to the table below.

Income Source	Year 2003	Year 2004	Year 2005
Premiums	13,645,200	11,838,275	
Co-payments	2,358,800	3,204,800	
Donors	-	-	
Others	29,905,232	1,905,820	
Totals	45,909,232	16,948,895	

14. What is the scheme expenditure trend for the last three years? See table below

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical claims	24,374,652	19,960,620	
Administration	13,781,080	6,370,671	
Personnel	8,148,200	7,146,000	
Others [specify]	-	-	
Totals	46,303,932	33,477,291	

The financial statement for the year 2005 is not yet finalized.

15. What is the legal and regulatory framework of the CBHF? Is the scheme registered?

What are the governing documents (specify)? It is registered with UCBHFA and operating under Ishaka Adventist Hospital as the Health Provider.

16. Please describe the management structure of the scheme.

It's one of the departments under the Hospital Management.

17. Is the community involved in scheme management? How?

Yes. After a pre-existing group decides to join the Health Plan, the group forms a small committee called the Health Plan committee to:

1. Coordinate between the groups and hospital scheme,
2. Receive premiums and bring them to the scheme office,
3. Arrange meetings,
4. And to attend the quarterly meetings.

18. How many people work on scheme management?

Two full-time employees.

19. Is there a feedback mechanism for scheme members?

Yes it is done through group leaders quarterly meetings and meetings at group level with the scheme manager.

20. Is there a waiting period?

Yes, there is a waiting period for 15 days.

21. Are there controls over moral hazard?

Yes, at the registration day, the pre-existing group shows its membership register and their proceedings, before the group is registered. Further more the group is allowed to join if it follows the 60% rule.

22. Are there controls over adverse selection?

Yes, by the use of identification cards (IDs)

23. Are there controls over Fraud?

Yes, MTAC controls fraud (Medical treatment Authorization card)

24. Are there controls over cost escalation?

Yes, a ceiling payment was recently introduced, and chronic illnesses are not covered.

25. How are providers reimbursed for services?

Cheque payments are made in Hospital names and at times paid by cash if payment is from premiums directly.

26. Are statistics on services utilization by members, membership and finances available?

How regularly are they prepared? The scheme management prepares quarterly performance spreadsheet, which is sent to UCBHFA.

27. Are there income-generating activities that contribute to the scheme?

Yes, but at the household level.

28. Are there external donor funds or support that contributes to the scheme?

No committed donor.

29. Are there mechanisms for enrolling indigents?

No.

30. What are the scheme's major successes to date?

1. Good will and popularity; several international research organizations interested in CBHF use the scheme.
2. Spirit of Volunteerism; Group leaders organize the meetings, attend quarterly meetings, collect and report premiums to scheme office.
3. New group such as the schools are joining.
4. Government recognition; Officials from the district participate willingly when ever they are asked to attend workshops.
5. Relationships; the relationship between the health provider and the scheme is good, and in addition to this, the scheme manager attends hospital meetings, management committee and hospital board meetings.

31. What are the major obstacles to sustainability?

The CBHI concept is new in the area. Many people have not heard about it and at the same time, the hospital does not have adequate financial resource to market and maintain administration and operational expenses.

32. What strategies or plans are in place to address the issues above?

1. To review and adjust the premiums when ever need arises.
2. To enforce the marketing of the CBHI scheme in schools so as to enroll more students and school staff.
3. Introduction of the ceiling system.

6. What does the benefit package include?

a. Health education / Prevention care

Health education Delivery
Preventive care Curative
Antenatal care
Immunization
Treatment,

b. Out Patient care (including hospitalization at a health centre) specify services covered

Out Patients above 5yrs pay I, 000/=

c. In Patient care

Here a child who is 0-5yrs in Insurance when admitted pays co-payment of shs. 300= and then one thousand is paid by Insurance. Then 5-yrs and above pay 3,000=

d. HIV/AIDS care Not applicable

e. Other services Delivery: one thousand shillings

f. Family planning: Here a mother pays only

7. Are there specific exclusions? Please list.

No

8. What is the premium?

shs 300=

9. Is the premium paid monthly, quarterly or yearly?

Monthly

10. How are premiums collected?

They are collected by chairpersons of the Ngozi groups

11. Are there co-payments? How much and how are they administered?

Yes. 3,000= for inpatients and 1,000= for out patients mainly for Administration purposes and treatment recovery.

12. Reasons for co-payment

To top up premiums

13. What is the scheme income trend for the last three years?

Refer to the table below.

Income Source	Year 2003	Year 2004	Year 2005
Premiums	7,062,700/=	9,517,800/=	15,118,900/=
Co- Payments	1,170,800/=	1,762,200/=	4,664,600/=
Donors	1,100,000/=	2,200,000/=	2,200,000/=
Others	560,600/=	879,500/=	1,344,800/=
Totals	9,894,100/=	10,183,750/=	23,328,300/=

14. What is the scheme expenditure trend for the last three years?

Expenditure lines	Year 2003	Year 2004	Year 2005
Medical claims	10,535,300/=	8,712,650/=	21,341,400/=
Personnel Costs	1,200,000/=	1,200,000/=	700,000/=
Other Costs	483,450/=	271,100/=	1,206,650/=
Totals	12,218,750/=	10,183,750/=	23,248,050/=

15. What is the legal and regulatory/ framework of the CBIW? Is the scheme registered? What are the governing documents (specify)?

Not applicable

16. Please describe the management structure of the scheme.

Chairperson, Vice Chairperson, Treasurer, Secretary, Vice secretary, 2 mobilizers, 2 Committee members, 3 Advisers.

17. Is the community involved in scheme management? How?

Yes, contributions of local materials (e.g trees). How: Make decisions for the scheme and elect scheme planners.

18. How many people work on scheme management? a. Full time/Part time? Paid /Volunteer?

2 People. One full-time and another one part-time

19. Is there a feedback mechanism for scheme members?

Yes

20. Is there a waiting period?

No

21. Are there controls over moral hazard? (i.e. to make sure there is no over-utilization of the scheme by members)

Yes.

22. Are there controls over adverse selection? (i.e. to make sure that it is not just the sick who are joining the scheme you need both sick and healthy people to join)

Yes.

23. Are there controls over Fraud? (e.g to prevent non-members from accessing services through the scheme)

Yes.

24. Are there controls over cost escalation?

Yes, to ensure that the care provider hospital does not increase costs to the scheme by over-charging or providing unnecessary care

25. How are providers reimbursed for services for services?

At the end of each month, service providers calculate how much has been consumed by the members of the scheme and the bill is sent to the treasurer for reimbursement.

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?

Yes. Monthly partnership

27. Are there income-generation activities that contribute to the scheme? Please describe.

Yes. Brick making has just started for all scheme members. Then with the help of Revolving Fund from Diocesan Health Office, Ngozi groups have income generating activities on small scale (e.g Irish potato growing).

28. Are there external donor funds or support that contributes to the scheme?

Yes

If yes, please give name of donor and contact information. Health Office of Kabale
Telephone: 077-91-04-16 or 077-98-91-77

What kind of support does the donor provide? Donor paid for the insurance of two workers to cover the deficit on treatment. The donor has given our scheme revolving Fund.

29. Are they mechanism for enrolling the poor? Please describe i.e meaning to subsidize for the poor?

No.

30. What are the scheme's major successes to date?

To increase members and easy access to medical care

31. What are the major obstacles to sustainability?

Abject poverty, large families, lack of support from within and without to carry out income generating activities and subsidize the premium, increased sickness consumes all the premiums especially Malaria, low premiums, low level of understanding/appreciating the scheme.

32. What strategies or plans are in place to address the issues above?

- To encourage income generating activities
- To Health educate people on health related matters
- To increase premiums to 400=
- To visit "Ngozi" groups in their localities for the purpose of making them understand the usefulness of the scheme
- To leverage funding for income-generating activities and subsidizes for premiums

Identification

Name of scheme	Kitovu
Year established:	1998
Purpose	Enabling the poor to access quality medical care without paying large sum of money
Name of respondent(s)	Josephine Namugenyi
Contact information	
Address:	KITOVU HOSPITAL
Telephone:	0481 20097/ 077 842316
Email:	kitovu@ucmb.co.ug

Location: Rural

Coverage: Geographic/Professional

Initiator: Kitovu Hospital

Ownership: Provider

Other Stakeholders: none

Brief Background

Opened in October 1998 with the objective of enabling the poor to access quality medical care without paying large sum of money. The scheme is provider-based and was started with funds from DFID, which was used for capacity building, mobilization, sensitization and staff trainings. The scheme operates in a radius of 20km from the provider.

Management

1. What is the enrollment mode (Individual, Household, Group, Institution)?

Groups and institutions.

2. What is the size of your target population?

2000 members by the end of the financial year 2005/2006

3. What is the population size of your area of operation?

Not known.

4. What are the socio-economic characteristics of your current membership?

Peasant farmers with an average of 5 people in a family whose per capital income is less than one donor per day.

5. What is the number of Members and/or Beneficiaries for the FY 2003 - 2005?

	Year 2003		Year 2004		Year 2005	
	Adults 5 yrs plus	Children 0-4yrs	Adults 5 yrs plus	Children 0-4yrs	Adults	Children
Male	637	77	618	74	all Adults	All children
Female	736	89	816	56	738	104
Total /age / year	1373	166	1434	130	738	104

6. What does the benefit package include?

a. Health education/Prevention care (specify types of preventive care, e.g. family planning, antenatal care, immunization, well child visits, etc.)

- Malaria prevention – sale of mosquito nets.
- Antenatal care
- Immunization
- HIV/AIDS education especially to the youth (in schools)

b. Out patient care (including hospitalization at a health center) specify services covered

- All outpatient services - provided it is received at Kitovu Hospital (except dental, optical, open heart surgery and laboratory).

c. Inpatient care

- Deliveries, Surgical, Medical and pediatric

d. HIV/AIDS care

- The scheme covers symptoms but does not give ARVs

e. Other services

- Nil
- Family planning
- Natural family planning encouraged

7. Are there specific exclusions? Please list

- Dental
- Optic
- Open-heart surgery
- Private services

8. How much is the premium?

800/= per head per month

9. Is the premium paid monthly, quarterly or yearly?

Some groups pay monthly and others pay quarterly.

10. How are premiums collected?

Some groups bring the premiums directly to the office and in others it's the scheme manager who collects it.

11. Are there co-payments? How much and how are they administered?

OPD - 500/= (Co-payments are made on every visit).
IP - 1500/=

12. Reasons for co-payments

Measure to control moral hazards.

Contribution toward stationary

13. What is the scheme income trend for the last three years? Refer to the table below.

Income Source	Year 2003	Year 2004	Year 2005
Premiums	12,188,000	12,797,201	
Co-payments	836,000	898,500	
Donors (UCBHFA)	0	3,000,000	
Others mosquito nets	1,967,450	457,900	
Totals	14,991,450	17,153,601	

14. What is the scheme expenditure trend for the last three years? See table below

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical claims	17,453,392	18,033,779	Data not available
Personnel costs	5,453,487	4,644,416	4,803,746
Other costs	4,410,496	1,181,600	2,141,300
Totals	27,317,375	23,859,795	

15. What is the legal and regulatory framework of the CBHF? Is the scheme registered? What are the governing documents (specify)?

The scheme is registered under UCBHFA.

16. Please describe the management structure of the scheme.

1. Provider,
2. Scheme Manager
3. Data Manager
4. Filled Assistant (*but currently it is managed by one person – the scheme Manager*)

17. Is the community involved in scheme management? How?

Premiums collection. Sensitization

18. How many people work on scheme management?

One full time person – paid by the provider.

19. Is there a feedback mechanism for scheme members?

Yes – through meetings with group leaders.

20. Is there a waiting period?

Yes – 2 weeks

21. Are there controls over moral hazard?

Yes. Exclusions, pre-selected provider, claim limit, Co-payment, membership is confirmed prior to registration.

22. Are there controls over adverse selection?

Yes. Enroll groups not individuals. At least 60% of the groups must enroll. At least 4 people in the family must join

23. Are there controls over Fraud?

Identification cards. Computerized ID system in place to ensure verification that patient cover is current.

24. Are there controls over cost escalation?

There is use of the hospitals standard measures. The scheme is provided with the hospital's price list and treatment procedures whenever they are updated. Ceilings (Claims limits).

25. How are providers reimbursed for services?

Internal transfers because the scheme funds are managed by the provider

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?

Statistics are available. Records are made on daily basis but reports are prepared on a quarterly basis.

27. Are there income-generating activities that contribute to the scheme?

Not yet.

28. Are there external donor funds or support that contributes to the scheme?

No

If yes, please give name of donor and contact information

What kind of support does the donor provide? Nil

29. Are there mechanisms for enrolling the poor? Please describe.

No

30. What are the scheme's major successes to date?

Provide medical care to the poor in the community. Increased membership. Partnership with a friend in USA who promised to give us funds to start income generating projects.

31. What are the major obstacles to sustainability?

Over utilization of services, low cost recovery, poverty in the community

32. What strategies or plans are in place to address the issues above?

1. To start IGA
2. Revise premiums and co-payments.

Identification

Name of scheme	Munno Mu Bulwadde
Name of promoter	Save for Health - Uganda
Year established	Programme established in 1999
Purpose	To improve the target population's financial access to quality healthcare
Name of respondent(s)	Makaire Fredrick
Contact information	
Address:	P.O.Box 123 Luweero
Telephone:	041 610187
Email:	shu@utlonline.co.ug
Location: Rural	Coverage: 3 districts (Luweero, Nakasongola and Nakaseke)
Initiator: CIDR	
Ownership: Schemes members'	
Other Stakeholders: SHU, Kiwoko hospital, Local authorities, the community members	

Brief Background

None provided

Management

- 1. What is the enrollment mode (Individual, Household, Group, and Institution)?**
Household
- 2. What is the size of your target population?**
35,000 people
- 3. What is the population size of your area of operation?**
About 900,000 people
- 4. What are the socio-economic characteristics of your current membership?**
Mainly peasants who are dependent of agriculture for income. The communities are multi ethnic
- 5. What is the number of Members and/or Beneficiaries for the FY 2003 - 2005?**

	Year 2003		Year 2004		Year 2005	
	Adults	Children	Adults	Children	Adults	Children
Male						
Female						
Total /age / year	2,156		2,840		3,013	

- 6. What does the benefit package include?**
 - a) Health education/Prevention care
Not included
 - b) Out patient care (including hospitalization at a health center)
Included
 - c) Inpatient care
Included
 - d) HIV/AIDS care
Opportunistic diseases and infections covered but not ARV drugs
 - e) Other services

Subsidized ambulance services

7. Are there specific exclusions?

- Elective surgery

8. What is the premium?

- 3600 UGS

9. Is the premium paid monthly, quarterly or yearly?

- Once in credit schemes and annually in mixed schemes

10. How are premiums collected?

- Visit to members' homes by a scheme leader and payment to the leader by the member

11. Are there co-payments? How much and how are they administered?

- This is not applied universally. Some pay 2000, others 5000, for hospitalization while some pay 500 and others 2000 for OPD. It is administered at the provider

12. Reasons for co-payments

- Control risks

13. What is the scheme income trend for the last three years? Refer to the table below.

No response

14. What is the scheme expenditure trend for the last three years? See table below

No response

15. What is the legal and regulatory framework of the CBHF? Is the scheme registered?

What are the governing documents (specify)?

Yes, the schemes are registered with the local authorities of the districts as community based organizations (CBO) – they have certificates of registration.

16. Please describe the management structure of the scheme.

1. Social group leaders (villages divided in smaller manageable groups)

These are two representatives elected by the people during village meetings; one is a mobilizer in charge of dissemination of information and sensitization, while the social group treasurer is in charge of collection of contributions from the members.

2. Executive committee (scheme level).

The executive committee is comprised of three elected persons from the scheme during general meetings of the schemes, namely chairman, secretary and the main treasurer.

17. Is the community involved in scheme management? How?

Yes, according to the design of these schemes members from the community are the sole owners and this is manifested in the powers to vote in and out any leader and sanctions scheme decisions.

18. How many people work on scheme management?

All members of the management board of the schemes are volunteers, and a management board is comprised of all the social group representatives and the EC members. On average each scheme has seven social groups.

19. Is there a feedback mechanism for scheme members?

Yes, the management boards of every scheme are charged with the responsibilities of sensitization, contribution collection, information, credit reimbursement management and planning for the scheme eg membership of the scheme.

20. Is there a waiting period?

All schemes are granted a waiting period of two weeks from the official inauguration (for new schemes) and launching (for the existing schemes).

21. Are there controls over moral hazard?

Yes, schemes have ceilings, co-payments and every family is entitled to one episode of illness covered and to secure the second one has to first reimburse the first credit given to avoid accumulation of debts.

22. Are there controls over adverse selection?

Yes, during the design of the schemes members agreed on family hold membership principle, meaning that every person living under the roof of your homestead is supposed to be scheme members once your family joins the scheme.

23. Are there controls over Fraud?

Yes, every family is given a card bearing all the members of his/her family and another card is kept at the provider by the pre-payment cashier to check fraud.

24. Are there controls over cost escalation?

Currently schemes sign collaboration contracts/agreements with the provider and the follow up to review these collaborations is done annually and sensitization of the medical staff is done by the support agency-SHU.

25. How are providers reimbursed for services?

Providers are paid for the services provider by the schemes at the end of every month when the prepayment cashier take monthly bank statements and claims invoices to the members during the monthly management board meetings.

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?

Yes, these data are available and updates are done during the monthly management board meetings where one of team member of the support agency has to attend (monthly).

27. Are there income-generating activities that contribute to the scheme?

Yes, scheme members have initiated income generating activities to improve on their contributing capacity and the funds used are the accrued amount from the donations, membership fees and 10% discount offered by the provider to each episode of illness that occur.

28. Are there external donor funds or support that contributes to the scheme?

No, nothing.

29. Are they mechanisms for enrolling indigents?

No.

30. What are the scheme's major successes to date?

- Leaders' capacity to negotiate with the identified providers and others partners (bargaining power).
- Creation of income generating activities/projects to strengthen their contributive capacity.
- Member's willingness to re-contribute hence building their financial viability for future sustainability.
- Increased trend of membership.
- Increased claims ratio.

31. What are the major obstacles to sustainability?

- Change in economic context of the area of operation due to the wilting away of coffee plantations and bananas causing low house hold incomes.
- Illiteracy level.
- Low reimbursement rates.

32. What strategies or plans are in place to address the issues above?

- Income generating activities/projects.
- Creation of a union of schemes to manage the schemes.
- Creation of network of schemes.
- Creation of parish schemes from village ones and make villages social groups.

Identification

Name of scheme	Mother Child Rescue Health Plan
Year established	1999
Purpose	The overall objective is to decrease/reduce mortality and morbidity rates in under 5 year olds, and that of pregnant mothers during and after labour, in the remote rural area of Buhweju.
Name of respondent(s)	Mr Nicolas Mugisha (Clinical Officer) and Mr. David Mutesasira (Scheme coordinator)
Contact information	
Address	P.O Box 347 Bushenyi
Telephone	+256-75-2407431
Email:	ucbhfa@africaonline.co.ug
Location:	Rural
Coverage:	Community of Burere Sub-County Buhweju in Bushenyi District 30km from Kabwohe-Itendero Town Council
Initiator:	Community with the assistance from Health Partners Uganda
Ownership:	Community
Other Stakeholders:	Mother Child Rescue Clinic, Nyakashaka Tea growers

Brief Background

The Health Plan is located in the most disadvantaged area not only in Bushenyi district, but Uganda as a whole. The place is characterized by hilly and mountainous terrain that has made health care services available to its inhabitants, inaccessible. Hence, the vulnerable groups, which are the women and children, suffer.

The main source of income for the people is tea, and it appears that during the runny season, these tea plantations are good breeding sites for the mosquito that transmits the malaria parasite. Consequently, this area has the highest under 5 mortality and morbidity as recorded by the DDH's office 2005.

Because of its terrain, Buhweju is hard to reach and consequently, its population lacks health information and the scare involvement of men in the provision of fees for health care to their families makes the already deteriorating situation worse. The plan was started in 1999, mainly being funded by Health Partners-Uganda, Dfid and MOH-Uganda through the Association (UCBHFA).

Currently, the health plan is operational in seven (7) parishes with fifty(50) villages. Membership is per households and as per December 31st 2005, Membership stood at 121 families with 527 beneficiaries.

Management

1. What is the enrollment mode (Individual, Household, Group, Institution)?

Households, groups and institutions

2. What is the size of your target population?

25,4256

3. What is the population size of your area of operation?

25,4256

4. What are the socio-economic characteristics of your current membership?

Tea growers who are subsistence farmers

5. What is the number of Members and/or Beneficiaries for the FY 2003 - 2005?

	Year 2003		Year 2004		Year 2005	
	Adults	Children	Adults	Children	Adults	Children
Male	67	105	51	125	43	139
Female	124	162	149	137	169	176
Total /age / year	191	267	200	262	212	315

6. What does the benefit package include?

- a. Health education/Prevention care
Yes
- b. Out patient care (including hospitalization at a health center)
Yes, medical treatment and referral services at scheme cost to BMC.
- c. Inpatient care
Yes
- d. HIV/AIDS care
Only opportunistic services are catered for.
- e. Other services
Referral costs are shared between the patient and the health provider.
- f. Are there specific exclusions?
All chronic diseases are excluded.

7. What is the premium?

5000 UGS per month for the first 4 members in a family. Any additional member pays 2500 UGS per month.

8. Is the premium paid monthly, quarterly or yearly?

Monthly

9. How are premiums collected?

It is the responsibility of the Chairman of the Health Plan and Scheme coordinator

10. Are there co-payments? How much and how are they administered?

The co-payment is paid every visit done. It is shs.500 only per visit payable to health provider cashier.

11. Reasons for co-payments

To deter misuse of services and as well as provision of additional income to the health plan.

12. What is the scheme income trend for the last three years? Refer to the table below.

Income Source	Year 2003	Year 2004	Year 2005
Premiums	118x 5000 x 12= 7,080,000/=	136 x 5000 x 12= 8,160,000/=	153 x 5000 x 12 = 9,180,000/=
Co-payments	862 x 500 = 431,000/=	1047 x 500 = 523,500/=	1691 x 500 = 845,500/=
Donors	-	-	-
Others	3,000,000/=	4,800,000/=	720,000/=
Totals	10,511,000/=	13,483,500/=	10,745,500/=

13. What is the scheme expenditure trend for the last three years? See table below

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical claims	5,790,245/=	6,093,705/=	6,460,850/=
Administration	2,469,000/=	3,634,500/=	2,890,400/=
Personnel	7,200,000/=	9,400,000/=	9,620,000/=
Others [specify]	8145/=	5,644,705/=	8,225,750/=
Totals	10,511,000/=	19,128,205/=	18,971,250/=

14. What is the legal and regulatory framework of the CBHF? Is the scheme registered?

In the process of being registered as a non-government organization (NGO). It is currently affiliated to UCBHFA.

15. What are the governing documents (specify)?

The by-Laws formulated by members.

16. Please describe the management structure of the scheme.

This is comprised of the steering committee, made up of the Chairman of the tea growers Society, Officer in-charge of the Health Provider, Chairman of the Health Plan, and two technical advisors.

At the Health Plan management level, the Officer in-charge of the Health Provider is the overall, and he is assisted by the Health Plan Chairman and Scheme's coordinator who is selected by the Society and Health Plan executives.

The executives are composed of the Scheme manager and the scheme members of the committee (including chairperson, vice c/person, secretary, treasurer and 7 committee members) all together these are 11 members.

17. Is the community involved in scheme management? How?

Yes. The committee members are composed of members from the villages. In addition to this, it mobilizes fellow members ,pays premiums ,arranges meetings and brings feedback to the health provider.

18. How many people work on scheme management? Full time/part time? Paid/volunteer?

There are 4 full-time employees

19. Is there a feedback mechanism for scheme members?

Yes, usually after the stakeholders quarterly meetings. There are also written quarterly circulars.

20. Is there a waiting period?

Yes, only one month.

21. Are there controls over moral hazard?

This is re-enforced through charging co-payments and sensitization of the people about misuse.

22. Are there controls over adverse selection?

This is enforced through group, household and institution enrollment

23. Are there controls over Fraud?

Yes, internal checks have been put in place .No single person is allowed to handle/see a client/patient alone till the end (reception of treatment to discharge).And the monthly lists are pinned on the notice board.

24. Are there controls over cost escalation?

Yes, standard rates are charged and a list of these rates is pinned on the notice board for all to see.

25. How are providers reimbursed for services?

The society writes cheques at the end of the month.

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?

A Quarterly performance spreadsheet is prepared and sent to the association.

27. Are there income-generating activities that contribute to the scheme?

No

28. Are there external donor funds or support that contributes to the scheme?

No, only some little money from the government through the association.

29. Are there mechanisms for enrolling indigents?

No.

30. What are the scheme's major successes to date?

- Increase sensitization and mobilization,
- provision of medical treatment,
- provision of maternal services including antenatal care services,
- provision of laboratory services,
- health education,
- referral services, and
- outreach home-based care program for CDC project through ICOBI.

31. What are the major obstacles to sustainability?

- Low levels of income among the community hence low premiums
- Low level of participation from men
- High disease burden
- Inefficient skills in CBHI

32. What strategies or plans are in place to address the issues above

- Introduction of income-generating activities,
- Advocacy
- Promotion of community participation
- Addressing gender issues in the community
- Promotion of health education
- Mobilization and sensitization
- To register the Health Plan as an NGO and start writing proposals for funding
- To plan under way so as to make the Health Plan a community Based Health scheme.

Identification

Name of scheme **Mutolere**
Year established November 1998
Purpose Help the poor access quality health care even at times of the year when money is not readily available
Name of respondent(s) E. Nziza, Bob Kwibuka
Contact information
Address: St. Francis Hospital Mutolere
P.O. Box 26
Telephone: 078819404
Email: nziza_@yahoo.com

Location: Rural **Coverage:** Geographic
Initiator: Mutolere Hospital Management team spear headed by the hospital admin
Ownership: UCBHFA
Other Stakeholders: MUTOLERE HOSPITAL

Brief Background

No information provided

Management

1. What is the enrollment mode (Individual, Household, Group, Institution)?

Group, Institution

2. What is the size of your target population?

10,862.5

3. What is the population size of your area of operation?

21,725

4. What are the socio-economic characteristics of your current membership?

Peasants

5. What is the number of Members and/or Beneficiaries for the FY 2003 - 2005?

	Year 2003		Year 2004		Year 2005	
	Adults	Children	Adults	Children	Adults	Children
Male	906	102	1011	127	200	452
Female	2502	111	2024	126	781	805
Total /age / year	3408	213	3035	253	981	1257

6. What does the benefit package include?

- Health education/Prevention care
- Out patient care
- Inpatient care
- HIV/AIDS care

There is a general ceiling for OPD and In patients care, besides, HIV drugs are supplied free of charge to every patient who qualifies for the drugs

- Other services

7. Are there specific exclusions?

Yes: Self inflicted problems, cosmetic surgery, Dental cosmetics, optical surgery, sight correction, ambulances, referrals to elsewhere,

8. What is the premium?

500/=/person /month starting with a minimum of 4 i.e. if a house hld has 2 members, they pay 500*4=2000/=

9. Is the premium paid monthly, quarterly or yearly?

Every two months

10. How are premiums collected?

Members have a fixed date for paying in their villages. Premiums are collected by a committee put in place by their members; Chairman, Secretary Treasurer. These are re-elected every year

11. Are there co-payments? How much and how are they administered?

Yes, paid on every episode/visit to the hospital to the pre-payment office.

12. Reasons for co-payments

It serves as a 'Gate Keeper'/Scare those who would want to misuse the scheme services

13. What is the scheme income trend for the last three years? Refer to the table below.

Income Source	Year 2003	Year 2004	Year 2005
Premiums	11,670,200	6,724,700	5,025,000
Co-payments	4,437,100	3,434,500	2,415,900
Donors	—	7,000,000	4,000,000
Others smartnets	772,000	Refunds = 32,000	11,480,900
Totals	16,879,300	17,191,200	11,480,900

14. What is the scheme expenditure trend for the last three years? See table below

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical claims	12,776,800	10,685,850	10,908,400
Administration			
Personnel			
Overtime Allow	676,000	593,000	207,000
Salaries	3,792,521	3,968,725	3,273,610
Photographs/IDs	9,050	—	—
Office supplies	499,400	146,800	20,000
Sensitization	106,000	77,000	10,000
Annual transport allowance	—	25,000	25,000
Staff medical Treatment	—	35,000	35,000
Photocopies	—	43,600	44,900
Communication	175,000	50,000	8,600
NSSF	—	—	278,003
Travel expenses	200,000	496,700	13,000
Workshops	—	102,500	102,500
Others [specify]			
Totals	18,234,771	16,224,175	15,043,013

15. What is the legal and regulatory framework of the CBHF? Is the scheme registered? What are the governing documents (specify)?

Yes, ref. UCBHFA

16. Please describe the management structure of the scheme.

- Scheme Coordinator/Hospital Admin (hospital management team)
- Office manager
- Scheme accountant/ data manager
- Community leaders/members
- Bottom top management

17. Is the community involved in scheme management? How?

Yes, participation in the day to day running of the scheme, setting premiums and co-payments, registration of new members, and collection of premiums

18. How many people work on scheme management?

Full time/ paid salary 2, part time 1, paid volunteer 1 (4)

19. Is there a feedback mechanism for scheme members?

Yes, monthly and quarterly meetings then annual evaluation meetings, and adhoc in case need arises

20. Is there a waiting period?

Yes, 3months

21. Are there controls over moral hazard?

Yes, co-payments, limitation of coverage & no discount on renewal,

22. Are there controls over adverse selection?

Yes, registration of pre –existing groups i.e. 60% of the existing group, Whole family registration, Waiting period; 3months.

23. Are there controls over Fraud?

Yes; IDs and compulsory registration of whole family.

24. Are there controls over cost escalation?

Yes; proper premium calculation, & (see adverse selection_22)

25. How are providers reimbursed for services?

Reconciliation of bills between hospital and scheme bills; premiums, co-payments, and when available, donor funds

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?

Yes; on quarterly basis

27. Are there income-generating activities that contribute to the scheme?

Started of recent by one pilot group & yet to spread to other groups (piggery)

28. Are there external donor funds or support that contributes to the scheme?

Currently, CORDAID

29. Are they mechanisms for enrolling indigents?

No response

30. What are the scheme's major successes to date?

- Community awareness
- Scheme ownership by community members

31. What are the major obstacles to sustainability?

- Lack of management skills by community members as owners of the scheme
- Irregular hospital changes on general treatment charges
- Poor motivation of the scheme staff by the head office

32. What strategies or plans are in place to address the issues above

No response

5. **What is the number of members and/or Beneficiaries for the FY 2003-2005?**

	Year 2003	Year 2004	Year 2005
Male	106	91	126
Female	171	136	202
Children	500	423	633
Total	777	650	961

6. **What does the benefit package include?**

a. Health education/Prevention care

We provide ITNS

b. Out patient care (including hospitalization and a health center)

Malaria, Typhoid, Lab tests, Tooth extraction, eye care.

c. Inpatient care

Malaria, typhoid, general ward costs, operations deliveries.

d. HIV/AIDS care

We don't cover the costs associated with HIV/AIDS such as HIV test, CD4 and ARVs.

e. Other services

7. **Are there specific exclusions?**

Yes, we exclude the following: buying eye glasses, Cosmetic dental care and surgery, Testing HIV/AIDS, Giving ARVS, Referral to other providers, transporting bodies home, self inflicted problems.

8. **What is the premium?**

A family of 1-4 people pays 7000, and each additional person pays 2000= for a period of three months.

9. **Is the premiums paid monthly, quarterly or yearly?** It is paid quarterly.

No response

10. **How are premiums collected?**

They are collected by group leaders from members and bring them in the scheme office for recognition and banking to the scheme account.

11. **Are there co-payments? How are they administered?**

We have Outpatients co-payment of 1000= per visit and Inpatients co-payment of 4000= on discharge. They are paid to the hospital cashiers and they reduce scheme treatment costs

12. **Reasons for co-payments.**

They help to control Moral hazard

13. **What is the scheme income trend for the last three years? Refer to the table below.**

Income source	Year 2003	Year 2004	Year 2005
Premiums	15,251,202	5,549,202	4,288,647
Co-payments	3,071,000	1,833,000	2,253,000
Donors	—	3,000,000	—
Others (Private Room & ITNS)	1,927,600	529,800	642,500
Total	20,249,802	10,912,002	7,184,147

14. **What is the scheme expenditure trend to the last three years? See table below.**

Expenditure lines	Year 2003	Year 2004	Year 2005
Medical claims	30,011,850	10,087,500	13,623,600
Administration	493,350	785,100	974,050
Personnel	—	—	—
Others (specify) ITNS	1,050,000	—	—
Totals	31,555,200	10,872,600	14,597,650

15. What is the legal and regulatory framework of the CBHF? Is the scheme registered? What are the governing documents (Specify)

1. The scheme is registered under UCBHFA and
2. The documents used by the scheme are those of UCBHFA.

16. Please describe the management structure of the scheme.

1. Medical Superintendent is the Over all supervisor of the scheme
2. Head of Community Health Department is the immediate supervisor.
3. Scheme Manager coordinates the scheme activities
4. Group leaders. Collect premiums and do mobilization and sensitization
5. Scheme members, who pay premiums, mobilize and sensitize others.

17. Is the community involved in scheme management? How?

The community is involved in doing the following:

- They are involved in mobilization and sensitization
- They are involved in collection of premiums
- Involved in premium setting
- Involved in decision making through quarterly meetings.
- Involved in raising funds for Income generating projects.

18. How many people work on the scheme management? Full time/part-time? Paid/Volunteer?

- We have 1 full time staff who is a scheme manager, paid by hospital
-We have 12 part-time who are the group Leaders and they are all volunteers.

19. Is there feedback mechanism for scheme members?

Yes. -This is done in quarterly meetings

Quarterly group Utilization rates

20. Is there a waiting period?

We have a waiting period of 14 days

21. Are there controls over moral hazard?

Yes, -We use co-payments of 1000= for OPD and 4000= for Inpatients

We use a waiting period of 14 days.

22. Are there controls over adverse selection?

Yes, We enroll members through existing groups.

23. Are there controls over Fraud?

Yes, We use membership Cards and family photographs

24. Are there controls over cost escalation?

Yes, The hospital uses standard treatment protocols

We provide services according to defined package.

25. How are providers reimbursed for services?

The provider gives the scheme treatment bills, which are reconciled with the scheme records, and then payment is made on monthly basis.

26. Are there statistics on utilization by members, members ship and finances available How regularly are they prepared?

The above statistics are available and are prepared quarterly.

27. Are there income-generating activities that contribute to the scheme?

We started Bee-keeping project in this year 2005.

28. Are there donor funds or support that contributes to the scheme?

We don't have any donor funds but this year we got technical assistance from PHRplus.

29. Are there mechanisms for enrolling indigents?

No response

30. What are the scheme's successes to date?

- Scheme members access early treatment
- Scheme members have understood the benefit of risk pooling

- Members participate in scheme management for example premium collection mobilization and sensitization.
- Members get quality treatment.
- Membership has increased
- The scheme started Be-keeping project, financed by members.

31. What are the major obstacles of sustainability?

- Lack of funds for mobilization and sensitization
- Lack of enough income generating projects.
- Some Scheme members are very poor and therefore can't afford to pay premiums.
- Lack of transport means
- Lack of member retention.
- Lack of incentive to scheme members especially those who don't fall such
- Some Members far away from the provider.
- Malaria epidemic especially in October to January every year.

32. What strategies or plans are in place to address the issues above?

We want to expand our income-generating project.

- To start other income generating projects like tree planting and poultry keeping.
- To include Health education in our benefit package
- To sell ITNS to scheme members to reduce on malaria
- To start satellite schemes in lower health units to reduce on the distance.

e) Other services

Home Visits are done for some patients when need arises.

7. Are there specific exclusions?

Yes

8. What is the premium?

300 Ughs. Per member in a family /household for a month

9. Is the premium paid monthly, quarterly or yearly?

Twice a year (in 6 months)

10. How are premiums collected?

Premiums are paid via registered groups and the scheme managers have to acknowledge a receipt.

11. Are there co-payments? How much and how are they administered?

Co-payments are paid directly to the Health Care i.e

1. Outpatient is 200 Ughs.
2. Inpatient (delivery) is 2000 Ughs.

12. Reasons for co-payments

For medical services rendered to the recipient i.e it is a source of revenue.

13. What is the scheme income trend for the last three years?

Income Source	Year 2003	Year 2004	Year 2005
Premiums	852,800	710,000	828,400
Co-payments	107,000	73,200	41,000
Donors	2,200,000	2,200,000	2,200,000
Others	40,000	456,000	372,000
Totals	3,199,800	3,439,200	3,441,400

14. What is the scheme expenditure trend for the last three years?

Expenditure Lines	Year 2003	Year 2004	Year 2005
Medical claims	1,546,300	1,110,600	645,000
Administration	139,700	56,750	404,100
Personnel	1,475,000	1,847,000	1,680,000
Others [specify]	330,000	916,350	732,400
Totals	3,491,000	3,930,700	3,461,500

15. What is the legal and regulatory framework of the CBHF? Is the scheme registered?

The scheme is registered at the Sub-County Level.

16. Please describe the management structure of the scheme.

There is an executive committee made up of five members headed by the chairman and other four community representatives elected by members. Along side these are the Scheme manager and the scheme assistant.

17. Is the community involved in scheme management? How?

Yes, there is an executive committee directly elected by adult members. The members also make resolutions in general meetings.

18. How many people work on scheme management?

Two full-time paid workers; then the executive committee plans and monitors on volunteer basis.

19. Is there a feedback mechanism for scheme members?

Yes

20. Is there a waiting period?

No

21. Are there controls over moral hazard?

Yes

22. Are there controls over adverse selection?

Yes, the group enrolment.

23. Are there controls over Fraud?

Yes

24. Are there controls over cost escalation?

Yes

25. How are providers reimbursed for services?

The providers make the treatment bill and then the scheme management pays it in Cash.

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?

Yes, Statistics on service utilization is done monthly. Membership and finances are prepared quarterly.

27. Are there income-generating activities that contribute to the scheme?

Yes, there is a piggery income-generating activity which is doing well.

28. Are there external donor funds or support that contribute to the scheme?

Yes, there is a diocesan support fund done on an annual quarterly basis.

29. Are there mechanisms for enrolling indigents?

No

30. What are the scheme's major successes to date?

1. Holding meetings on annual and quarterly basis
2. Have been able to secure 100 long-lasting mosquito bednets from PHRplus Uganda Project and subsidized the price for our members .
3. Provision of a timely treatment for members on a reasonable package.
4. Starting up a piggery income-generating activity.

31. What are the major obstacles to sustainability?

1. Low level of Community Participation.
2. High level of poverty among members.

32. What strategies or plans are in place to address the issues above

1. Massive sensitization and workshops.
3. Integrating a variety of Income-generating projects.

Identification

Name of the Scheme RUBAHEF COMMUNITY HEALTH PLAN (RCHP)
Year established 2005
Name of respondent(s) Mr. George Tumanyire
Contacts
Address P.O Box 155
Bushenyi
Telephone +256-71-2-977607 or +256-78-2-353692
Email twijukyees@yahoo.com or tumaxg@yahoo.com

Location: Rural **Coverage:** Geographical
Initiator: Tumanyire George and Stephen Muhumuza
Ownership: Company Limited by guarantee
Other Stakeholders: Community Based Organisations (CBOs)

Brief Background

The scheme is organized at LC1 level with a coordinator at the LC11(parish)known as the community Health Financing Agent who is responsible for collecting premiums and coordinating all RUBAHEF's activities .RUBAHEF ,works hand in hand with sister organizations such as Bushenyi Medical Centre and Ishaka hospital who are basically the health service providers

Management

- 1. What is the enrollment mode (Individual, Household, Group, Institution)?**
Individual, Household and group.
- 2. What is the size of your target population?**
Not known
- 3. What is the population size of your area of operation?**
Not known
- 4. What are the socio-economic characteristics of your current membership?**
Majority are Subsistence farmers
- 5. What is the number of Members and/or Beneficiaries for the FY 2003 - 2005?**

	Year 2003		Year 2004		Year 2005	
	Adults	Children	Adults	Children	Adults	Children
Male	86	44	110	62	78	136
Female	205	56	232	78	184	60
Total /age / year	291	110	342	140	262	196

- 6. What does the benefit package include?**
 - a. Health education/Prevention care** Yes
 - b. Out patient care (including hospitalization at a health center)** Yes
 - c. Inpatient care** Yes
 - d. HIV/AIDS care** No
 - e. Other services** caring for admitted students by providing facilitations such as food (a meal).
- 7. Are there specific exclusions?**

Yes, such as those with hypertension as well as chronic illnesses.

8. What is the premium?

3000 Ugs per four (4) months for a family of 4 people and 2000 Ugs for every additional member.

9. Is the premium paid monthly, quarterly or yearly?

Quarterly

10. How are premiums collected?

By the community health financing agents or the group members and members who are able to bring the premiums to the scheme office can do.

11. Are there co-payments? How much and how are they administered?

No co-payments.

12. Reasons for co-payments

N/A

13. What is the scheme income trend for the last three years?

No response

14. What is the scheme expenditure trend for the last three years? See table below

No response

15. What is the legal and regulatory framework of the CBHF? Is the scheme registered? What are the governing documents (specify)?

Scheme operates using the memorandum of association registered with the registrar of companies, in Kampala.

16. Please describe the management structure of the scheme.

This is made up of the board of directors.

17. Is the community involved in scheme management? How?

Yes, but not directly, community involvement is limited to premium collection by the group member.

18. How many people work on scheme management?

Full time/part time? Paid/volunteer?

3 full-time volunteers, 2 full-time paid employees, 3 part-time paid personnel and other volunteers facilitated with lunch and transport allowances.

19. Is there a feedback mechanism for scheme members?

Yes.

20. Is there a waiting period?

The group determines it as soon as they pay and are registered.

21. Are there controls over moral hazard?

No

22. Are there controls over adverse selection?

No

23. Are there controls over Fraud?

Yes, working hand in hand with experienced partners/staff (health provider) and try to keep all activities as transparent as possible.

24. Are there controls over cost escalation?

Very difficult to put into place.

25. How are providers reimbursed for services?

They are paid upon registration of invoices.

26. Are statistics on services utilization by members, membership and finances available? How regularly are they prepared?

The scheme does not have a data manager; hence most of the statistics is not in place we only manage to prepare end of year financial and activity reports.

27. Are there income-generating activities that contribute to the scheme?

- Micro-finance program

- Reverse slope terrace program with high yield crops are utilized to provide source of income for some members to share.

28. Are there external donor funds or support that contributes to the scheme?

None

29. Are there mechanisms for enrolling indigents?

No.

30. What are the scheme's major successes to date?

Major success is the fact that the scheme was started by us and we have managed to exist on without external donor funds.

31. What are the major obstacles to sustainability?

- Need for mobilization so that more members can join and understand the concept of CHI
- High level of poverty among our members
- Lack of technical staff in data management

32. What strategies or plans are in place to address the issues above

- Lobbying government and donors to increase on loan money at a subsidized interest rate.
- Negotiate with landowners such as the Church to give us land so as to increase on crop production for our reverse slope terrace program.

Identification

Name of scheme	Rugarama Health Centre
Year established	June 2003
Purpose	Provision of affordable and accessible health services and health promotion.
Name of respondent(s)	Mr Katarahweire Hanningtone, the hospital administrator
Contact information	
Address	Rugarama Health Centre. P.O Box 785 Kabale
Telephone	078-458189
Email:	rugarama_hospital@yahoo.com

Location: Rural

Coverage: Geographical

Initiator:

Ownership: Rugarama Health Center together with two Kigezi Dairy Cooperatives.

Other Stakeholders:

Brief Background

The scheme that started in June 2003 had members who were enthusiastic at first and had keen interest in the scheme. The family members contributed a premium of 18,000 Ugs per 3 months. They received health services from Rugarama Health Centre III. However, since July 2005, they have stopped contributing premiums to the scheme. The families have directed the scheme managers to stop deducting their money for treatment at the health centre and consequently the health centre does not offer these families health care services as before.

Management

1. **What is the enrollment mode (Individual, Household, Group, and Institution)?**

Group

What is the size of your target population?

About 200,000

2. **What is the population size of your area of operation?**

About 200,000

3. **What are the socio-economic characteristics of your current membership?**

Dairy farmers

4. **What is the number of Members and/or Beneficiaries for the FY 2003 - 2005?**

SCHEME UNABLE TO PROVIDE ALL STATISTICS

	Year 2003	Year 2004	Year 2005
Members	-	-	350

5. **What does the benefit package include?**

a. Health education/Prevention care

Yes

b. Out patient care (including hospitalization at a health center)

Yes

c. Inpatient care

Yes

d. HIV/AIDS care

Counseling

e. Other services

N/A

6. Are there specific exclusions?

Treatment of opportunistic infections and chronic diseases

7. What is the premium?

18,000 Ugs per family of 1-4 per quarter.

8. Is the premium paid monthly, quarterly or yearly?

Quarterly

9. How are premiums collected?

Farmers premiums are collected by dairy scheme managers who submit the money to Rugarama Health Centre.

10. Are there co-payments? How much and how are they administered?

-payments

11. Reasons for co-payments

N/A

12. What is the scheme income trend for the last three years?

SCHEME UNABLE TO PROVIDE TOTALS

13. What is the scheme expenditure trend for the last three years? See table below

No response

14. What is the legal and regulatory framework of the CBHF? Is the scheme registered?

What are the governing documents (specify)? No, the scheme is not registered with UCBHFA but an agreement was written done between the Rugarama health centre (providers) and the dairy cooperation (the members). These documents are currently with the hospital administration.

15. Please describe the management structure of the scheme.

- Medical Superintendent
- Hospital Administration
- Chairman of the two dairy cooperatives
- Scheme manager of the two dairy cooperation (Kigezi and Kabale dairy cooperatives)

16. Is the community involved in scheme management? How?

Yes. The involvement of the chairman and the two scheme managers of the two dairies.

17. How many people work on scheme management?

They used to be 2 Full-time paid people before the members stopped paying their premiums. Currently, there is only 1 full-time paid person; the administrator, who is also an employee of Rugarama health centre.

18. Is there a feedback mechanism for scheme members?

Yes, the scheme management (the scheme administrator), meets up with the 2 scheme managers to rely all necessary information. The scheme managers carry out the responsibility of sensitization, premium collection and delivering the collected premiums to the scheme administrator.

19. Is there a waiting period?

Yes, for three months

20. Are there controls over moral hazard?

Yes, by use of membership card system

21. Are there controls over adverse selection?

Yes, through group enrolment

22. Are there controls over Fraud?

Definitely yes, card membership photographic identification.

23. Are there controls over cost escalation?

Yes

24. How are providers reimbursed for services?

The scheme reimburses the health center for services rendered.

25. Are statistics on service utilization by members, membership and finances available? How regularly are they prepared?

Yes, quarterly, but no performance spreadsheet is made. The health centre has its own records on member payments.

26. Are there income-generating activities that contribute to the scheme?

No

27. Are there external donor funds or support that contributes to the scheme?

No

28. Are there mechanisms for enrolling indigents?

No

29. What are the scheme's major successes to date?

Scheme was providing access to health care services to the people but now due to inability to pay premium the scheme is not having any tangible success.

30. What are the major obstacles to sustainability?

The farmers have stopped premium payments to the scheme since July 2005 with no apparent reason given.

31. What strategies or plans are in place to address the issues above?

A series of meetings with scheme managers have been held but with no tangible results.

