Evaluation of the Effectiveness of CBHIS in Improving Health Care Access in Uganda

A case study of Schemes in Bushenyi Region

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Declaration

I, Nsiimire Doreen Gonahasa, hereby declare that what has been written in this report is my personal work entirely based on research carried out in the field and has never been produced by anyone else before. This work should not be reprinted without permission.

…… Date: …….

Doreen. G. Nsiimire

This special project report has been submitted for examination to International Health Sciences University with my approval as a supervisor

…… Date: …….

John Charles Okiria

University Supervisor

Dedication

I dedicate this book to the entire Gonahasa crowd. The legacy must keep on! Work hard and never, ever give up.

Acknowledgement

Above all, I thank The Lord Almighty for life and health and love!

I extend my gratitude to my wonderful family that has been supportive in every way possible. Thank you very much Mr and Mrs Gonahasa.

My close friends who encouraged and supported me, I thank you! Dora, Assy, Nanky, Ino, Moussa, Faith and all my classmates!

Special thanks to the team at Save for Health Uganda-Bushenyi office. Without your help, this study would have been an immense challenge. To Vicky at UCBHFA and Save for Health Uganda-Kampala office.

I extend my appreciation to my supervisor John Charles Okiria and the entire staff at IHSU.

I also thank all the respondents in this study without whom it would have been futile.

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List of Acronyms

AMG	Allied Medical Group
AHSPR	Annual Health Sector Performance Report
BMC	Bushenyi Medical Centre
CHI	Community Health Insurance
CBHF	Community Based Health Financing
CBHI	Community Based Health Insurance
CHeFA-EA	Community Health Financing Association for Eastern Africa
HC	Health Center
HSSP	Health Sector Strategic Plan
IHP	Ishaka Health Plan
MoH	Ministry of Health
NHIS	National Health Insurance Scheme
SHU	Save for Health Uganda
UCBHFA	Uganda Community Based Health Financing Association
WHO	World Health Organization

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Abstract

Introduction; The study set out to establish how effective community health insurance is in improving health care. The main objective was to evaluate the effectiveness of CBHI schemes in

improving access to health care in Uganda. The specific objectives were to determine the coverage of the scheme in terms of region and services covered, to establish the level of financial leverage to the members and to determine the level of clients' satisfaction. Community health insurance schemes are voluntary arrangements organized at community level to pool resources for health care, particularly amongst the informally employed. It is aimed at improving financial access to health care through prepayment. The HSSP proposes use of CHI as a means of funding and improving health care. There is, however, no evidence that this arrangement has led to the betterment of health care access and the study was conducted to establish this.

Methodology; A cross sectional descriptive study was carried out in Bushenyi region among people who had been enrolled into community based health insurance schemes for at least six months. A total of 250 respondents were involved in a face to face interview. Both primary and secondary data was used.

Findings; From the twelve schemes studied**,** the study revealed that for the majority of the people, the package paid for covers health education, family planning, outpatient and inpatient services, but excludes chronic illnesses, major surgery and self-inflicted injuries. The majority of the respondents were peasant farmers and dependent on small scale sales on their farms for income to make premium payments and cover other costs like the transport and copayment upon service utilization. Many felt that much as the premium fee was fair for the services received, they would prefer to pay a smaller fee than is currently being charged. Respondents felt services were satisfactory and the benefit derived was ranked high. They however noted several challenges such as the fact that health facilities are far away therefore demoralizing at times of need, and hence people being un able to get to the facilities to be served. Members suggested the

Government gives them a hand by offering some money that will cut down on the premium and also to build more facilities so that services are brought closer to the people.

Recommendations; The researcher recommends that more effort be put into sensitizing communities on the role of CHI so that the knowledge gained facilitates them in making informed decisions on joining upon realization of benefits that accrue with the insurance plan. It is also recommended that the government supports sustainability of these schemes through provision of funds that would help reduce premium costs while allowing the rural people participate in their own health financing. This needs to be coupled with increased health facilities that should be well staffed and equipped. Also, timing for premium payment needs to be synchronized with the harvest season to ease payment since the majority of the members are peasant farmers and thus reliant on sales from their produce.

Areas for further research; The researcher suggests, as further areas of study: the timing of premium payment and collection, the reasons for drop out from schemes and role of CHI in rolling out of the proposed NHIS.

Chapter one

Introduction and Background

1.0 Introduction

This chapter gives a brief of the background to the study highlighting the global, regional and the local aspects of health care financing mechanisms, benefits and effectiveness. It also states the objectives of the study and outlines the conceptual framework.

1.1 Background

According to The UN Declaration, everyone has a right to health (UN, 2008). As such, health needs to be seen not only as an end in itself, but also as a crucial input for development and sustainability. Moreover, sickness is unpredictable and often very expensive when it strikes. Health insurance, the promise for treatment in case of illness given by a health care provider in return for regular payments, has been embraced by only a few Ugandans. Health financing, a concept concerned with how financial resources are generated, allocated and used in health systems, in many low and medium income countries is characterized by elevated levels of out-of-pocket expenditure for serious illnesses resulting in potentially catastrophic payment for health care among its citizens (WHO 2007). Furthermore, very few studies have been done on the feasibility of using health insurance in the delivery of health care in Uganda. By the end of 2006, there were only 19 licensed insurance companies in the country. Only one insurance company, Micro Care Insurance Ltd, offered health insurance and accident cover (Acharya *et al*, 2010). Micro Care is however now out of business.

Community Health Insurance (CHI) schemes are voluntary arrangements, organized at the community level, that target people employed in the informal sector (Creil, 1998; Carrin *et al*,

2005; Tabor, 2005; Basaza *et al*, 2007). They aim to improve people's financial access to health care. They run on a non-profit basis and apply the basic principle of risk sharing with community participation in design and management. The establishment of CBHI schemes provided a means for families to ensure that they could pay for health services at local facilities. In 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. Currently there are 13 schemes, the majority of which are facility-based, that is, they are owned by the facility itself and are usually managed by facility staff. In Senegal, it is reported that most of the CBHI schemes have either been initiated by the health providers, that is, missionary hospitals, or tend to be set around the providers themselves (Jutting, 2003). The schemes primarily target community groups as clients. (PHR Plus, 2006)

Uganda's health care system has continuously been faced with serious financial constraints. Many people are unable to acquire health care due to insufficient funds; as a result much of the country's human resource remains unhealthy. According to the National Health Policy (2009), in recent years, health expenditure as a proportion of Uganda government's discretionary expenditure has been relatively stable around 9.6%, remaining below the Abuja Declaration target of 15%. Also, annual health expenditure stands at US $27, well below the US $44 recommended by WHO. Although user fees were abolished in public hospitals in 2001, the private wings continue to charge fees. As a result, many people still have trouble paying medical bills. Micro insurance schemes which have become a common factor in poverty alleviation are still outside the ambit of public financing. Access and availability of upscale health services is a

challenging so the schemes may limit themselves to the basic health needs and services that they render affordable. Many of the poor people thus still resort to ineffective treatment options including failing to follow the full prescription course, self-medication with purchase of drugs from local pharmacies, using inappropriate traditional medicines, or ignoring the illness in the hope that it will go away on its own (Microcare and SHU, 2007). These coping mechanisms regularly allow the disease to progress. This causes additional complications that increase medical bills in the long run.

1.2 Problem Statement

Shrinking budgetary support for health care services, inefficiency in public health provision, an unacceptable low quality of public health services, and the resultant imposition of user charges are all reflective of a state's inability to meet health care needs of her people (World Bank, 1993).

The health financing in Uganda ranges from reliance on donor funds to out of pocket expenditure. The current per capita income is only about $5 per head which is rather inadequate for health care. In order to cover this gap, a number of options have been proposed, one of which is community health insurance to raise funds from within communities. The Health Sector Strategic Plan proposes use of Community Health Insurance as a means of improving access to health care. The number of CBHI schemes has steadily grown. However, there is no evidence that people have been better placed to seek health care, or that more people have been able to access health services under these schemes; moreover rate of enrollment has been rather low, mainly due to limited understanding of the schemes, lack of trust in management and individuals ability to pay premiums amongst other reasons (Basaza, 2011). It is not clear if this has been effective in terms of improving financial access to health care.

This study therefore sought to establish the effectiveness of these schemes in providing improved access to health care.

1.3 Purpose of the study

The purpose of the study was to determine the effectiveness of the CBHIS in enhancing access to health care services in Uganda, so as to provide meaningful information in the choice, design and successful implementation of the strategy.

1.4 Objectives

1.4.1 Overall objective

The overall objective of this study was to evaluate the effectiveness of Community Based Health Insurance in improving access to and utilization of health care services within the communities in Uganda.

1.4.2 Specific objectives

1. To determine the coverage of the scheme in terms of region and services covered
2. To establish the level of financial leverage to the members
3. To determine the level of clients' satisfaction

1.5 Research Questions

1. What is the coverage level of the scheme in terms of region and services?
2. What is the level of financial leverage realized by members?
3. What is the level of clients' satisfaction of the scheme?

1.6 Significance of the Study

The major significance of this study is that the information that was obtained can be useful for policy makers to make informed decisions on key issues in the formulation and implementation of policies, specifically those pertaining to rural health care access.

Secondly, the study will contribute towards improvement of health service delivery and in the long run lead to improved health status of the populace.

1.7 Conceptual Framework

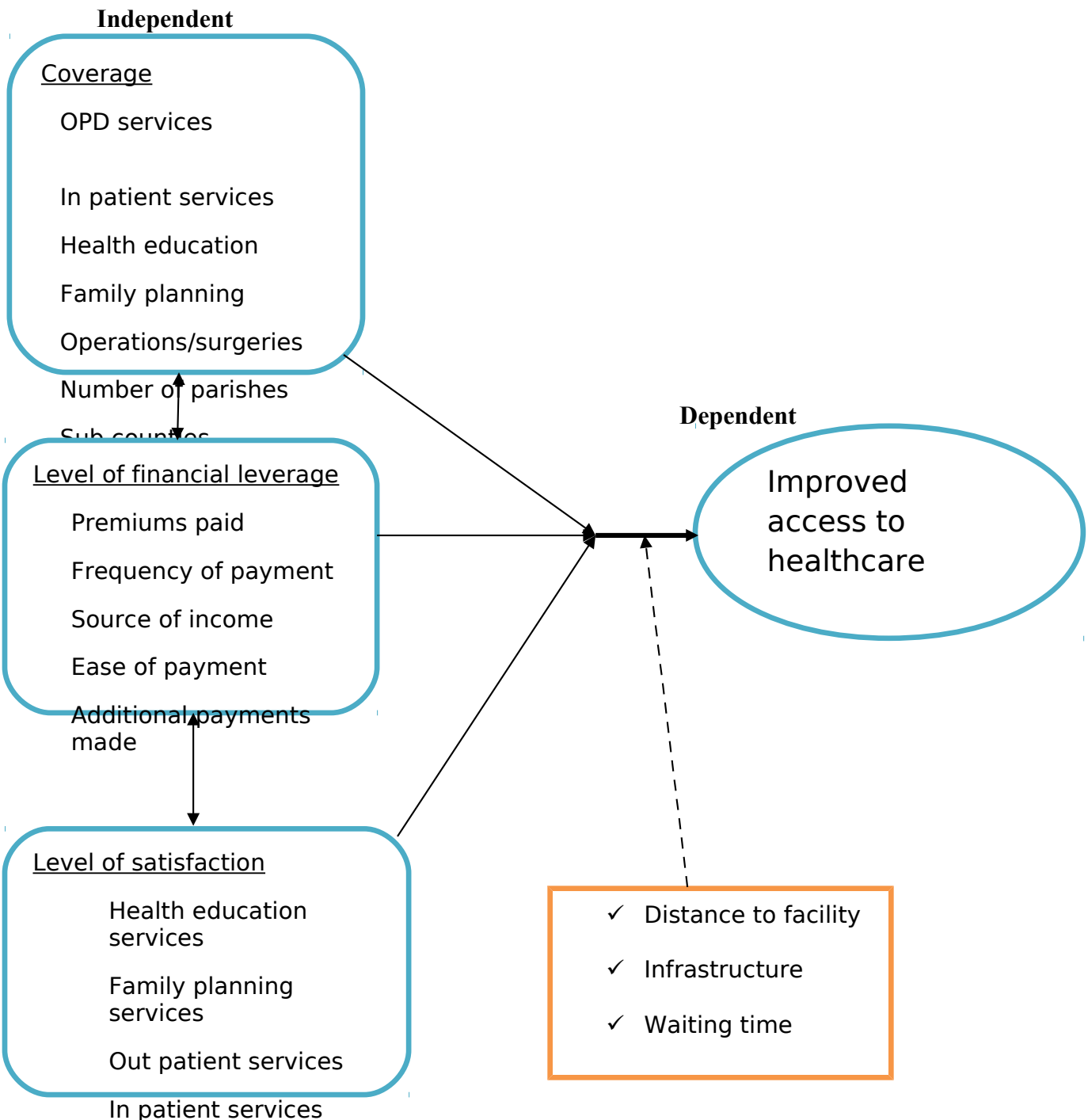

Figure 1: Conceptual framework for the study

The conceptual framework shows the variables that were of interest in the study. As indicated, improved access to health care through community health insurance was the dependent variable. The independent variables are coverage, financial leverage and clients' satisfaction. And the moderating variables are medicines availability, transport and distance.

Chapter Two

Literature Review

2.0 Introduction

This chapter is a collection of information pertaining to the study area as well as related literature from similar studies carried out. It gives a perspective of the study area, also from which secondary data may be drawn.

2.1 Health financing

Health financing refers to the means by which resources are collected and allocated in the health sector. It is meant to provide the resources and economic incentives for operating health systems and is a key determinant of health system performance. Currently, financing and providing health care for over 1.3 billion poor people living in low- and middle-income countries ranks highly among the world's most urgent problems. This is because the majority of these people lack access to effective and affordable drugs and other interventions relating to health care such as surgery as a result of weaknesses in the financing and delivery of health care amongst these communities (Preker, 2001).

In many low and medium income countries, health financing is characterized by high levels of out-of-pocket expenditure for serious illnesses often leading to potentially catastrophic payment for health care among its citizens (WHO 2007). This puts many people at a great disadvantage because ill health means they are unable to engage in productive work. The core functions of health financing should therefore be aimed at mobilizing resources for the health system, setting the right financial incentives for providers, as well as ensuring that all individuals have access to effective health care (Oxfam, 2008).

In 2009, the Taskforce on Innovative International Financing for Health Systems (TIIFHS), declared commitments and new financing strategies to generate more money for health financing, with expectation of up to US$5.3 billion. Some developing countries also announced policy reforms to increase access to health services. This, they hoped, would include the elimination of user fees, provision of free care, and new insurance mechanisms (TIIFHS 2009).

In Uganda, several sources of funds for healthcare do exist. These include government budgetary allocation from tax revenues, out of pocket expenditure, private health insurance, community health insurance and donations amongst others (Zikusoka *et al*, 2009). In March 2001, user fees were scrapped from all public hospitals (Tashobya *et al*, 2006) meaning that people could access free health care. This seemed to benefit people for a while but came with a number of challenges like the fact that financing for the health sector was cut short. Although meant to curb catastrophic expenditure, the system did not work because many times drugs were missing from the public facilities leaving no option but to purchase the drugs from private clinics and pharmacies (WHO, 2005).

According to the Annual Health Sector Performance Report, 2010-2011, there was a decrease in the total public health expenditure per capita from UGX 24,423 (US$11.1) in 2009/10 to UGX 20,765 (US$ 9.4) in 2010/11. This was attributed mainly to decrease in external contributions which only constituted 14% of total public health expenditure in 2010/11, compared with 39% in the three preceding years (AHSPR, 2010/11). The Health Sector Strategic Plan's vision is attainment of a healthy and productive population that contributes to socio-economic growth and national development, with a mission to provide the highest possible level of health services to

all people in Uganda through delivery of promotive, preventive, curative, palliative and rehabilitative health services at all levels. One of the strategic objectives is to improve equity in access to defined services needed for health of all individuals

2.2 Health Insurance

Health needs to be recognized as an integral part of any poverty reduction strategy. Existence of a strong link between health and income at low income levels, usually a health shock affects the poor the most. Health insurance can be defined as the promise for healthcare service at time of need for a prepayment made, usually annually. Insurance coverage gives peace of mind, giving assurance that bills will not be a primary worry in a time when you should be focusing on your health. One is more likely to seek a doctor's care if one knows that he/she has insurance coverage to help make it more affordable. It has been generally discovered that poverty amongst many people especially in the Least Developed Countries is as a result of indebtedness due to hospital expenditures (Bhattamishra & Barret, 2008; Aarogyasri, 2009).

Community Health Insurance (CHI), in Uganda, started in 1995 (Kyomugisha *et al*, 2008). However, over the time it has faced low enrolment despite interest by the Ugandan health sector to have CHI as an elaborate health sector financing mechanism (Basaza *et al*, 2007). Insurance schemes offer an alternative channel to mobilize financial resources and increase access to health care (Basaza *et al*, 2010).

User fees were abolished in all government facilities and CHI in Uganda is limited to the private not for profit sub-sector, mainly church-related rural hospitals. 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 (CHeFA-EA, 2006). The Department of Planning in the Ministry of Health Uganda (MoH) is responsible for the schemes under the umbrella non-government organization Uganda Community Based Health Financing Association (UCBHFA) (CHeFA-EA, 2006). Before that they were managed by Community Health Financing (CHF).

The oldest community health insurance scheme in Uganda is the Kisizi Health Insurance Scheme. It was the first micro–health insurance scheme started by Kisiizi Hospital in 1996 with support from DFID in cooperation with the Ugandan Ministry Of Health (UCBHFA, 2010). The scheme was started with the aim of providing the local community with easy financial access to healthcare at the Hospital

In 1995, the Uganda Ministry of Health planning department reviewed the options for health financing and recognized that community financing would be among the options that could be considered. In India, the government recognizing that health was poor, decided to promote community health insurance (CHI) schemes, so that patients could access quality services (Devadasan *et al,* 2008). In the same article the author writes that although insured patients should hypothetically receive better quality of care from providers, there is very little evidence that this relationship between CHI schemes and improved quality of care actually exists.
Furthermore, it is argued that the risk pool with CHI is often too small. As such, adverse selection problems arise, the schemes are heavily dependent on subsidies, financial and managerial difficulties arise and the overall sustainability seems not to be assured (Jutting, 2003).

Community-based health insurance schemes allow many people's resources to be pooled to cover the costs of unpredictable health-related events. They protect individuals and households from the risk of catastrophic medical expenses in exchange for regular payments of premiums (Ranson, 2002).

According to Basaza *et al* (2010), there is a growing interest in implementing CHI in the health systems of low and middle income countries. The reasons for this are: many countries lack the capacity to levy sufficient tax revenue to finance a well-functioning health system thus insurance schemes offer an alternative channel to mobilize financial resources and increase access to health care, CHI schemes can promote a client-oriented approach, ultimately empowering the customer, as well as in order to meet the Millennium Development Goals.

Currently in Uganda there are about 47 schemes, and 15% are provider while the 85% are community owned (Basaza, 2011, unpublished). In a study by Kyomugisha *et al* (2008), some key informants felt that the contribution of schemes remained insignificant. Enrolment has remained low, with contributions too small to have any real impact on health financing. In the last decade, the health care crisis has led to the emergence of many community-based health insurance schemes in different regions of developing countries, particularly in sub-Saharan Africa (Jutting, 2003).

Community-based health initiatives are essentially designed to improve access to health care through risk and resource sharing (Jutting, 2003). With this aim, it is largely argued that CBHI schemes are effective in reaching a large number of poor people who would otherwise have no

financial protection against the cost of illness (Dror & Jacquier, 1999). CBHI is the most appropriate insurance policy for rural areas where people's incomes are unstable (Banwat *et al*, 2012). However, there are arguments that the risk pool is often too small. This brings in problems of adverse selection, such that the schemes are heavily dependent on subsidies (Creil, 1998). There is also build up of financial and managerial difficulties, thus the overall sustainability seems not to be assured.

2.3 Benefits of Insurance

Health is one thing we never have guarantee over. People constantly fall sick and must seek healthcare to reinstate it. It follows that healthcare is one thing that a lot of money is spent, often leading to catastrophic expenditure especially among the poor. Without the means to cater for hospital bills, many people often tend to find alternative means such as self medication and quite often delaying treatment, which in many cases makes the situation even worse. Prepayment therefore ensures that upon illness one is able to access healthcare in time. According to Cariin *et al* (2005), insurance mechanisms are intended to respond to the goal of fairness in financing. As such, beneficiaries should ideally be asked to pay according to their means while guaranteeing them the right to health services according to need.

Although health care prepayment (premiums) may be expensive, especially if one has to purchase them on their own, in the long run having health insurance is most often less expensive than remaining uninsured. Moreover, without insurance, one is less likely to get regular screenings, or prompt care for conditions that will become more problematic over time. It is well known that delaying or foregoing needed care can lead to serious health problems. This means

that the uninsured are more likely to be hospitalized for avoidable conditions and also less likely to receive preventive care.

Insurance schemes may be considered beneficial in the sense that they directly contribute towards health financing by providing funds for the procurement of drugs and equipment, especially with abolition of user fees in public facilities (Kyomugisha *et al*, 2008). This allows people to contribute to their own health care. Indirectly, it also eases the pressure on public facilities by diverting patients from the public health sector.

2.4 Determination of Premiums in Insurance Companies

Statisticians, known as actuaries, study the factors that determine what the insurance company should charge for coverage. These factors include the average costs of doctor and hospital visits along with the other costs of doing business, such as advertising. Health insurance premiums represent a contractually agreed upon amount to be paid for a defined set of health benefits during a defined period of time, usually a year (Newsom & Fernandez, 2011).

Where one is to purchase an individual plan directly from an insurance company, the cost is higher than say if it were through an employer. This is usually to avoid adverse selection. When a large number of people are insured, it is predictable that some will never have a hospital visit while some visit occasionally and a few regularly. Premium determination also takes into account the age and health habits of an individual.

Insurance companies make careful calculations to determine how much premiums should be. It's a careful balancing of affordability and profitability. The companies need to charge enough so

that they have money to pay claims, but they can't charge too much or people will not pay for the service. The premiums will go up and down as modifications are made to the balance.

With CHI, premiums are determined based on the cost of services at health centers. Essentially, this information is relayed to the community members who in turn are able to discuss amongst themselves to reach a reasonable or required fee to be paid.

2.5 Management challenges for Insurance

CBHI schemes target households majorly in the informal sector to pool resources and membership is voluntary. All decisions undertaken are supposed to be with input of the entire affected community and as such community participation must be encouraged and respected, promoting participatory decision-making and management (Soors *et al*, 2008). The leaders of the schemes are volunteers who the community will accept based on their trust in him/her. These leaders will have had no or inadequate management training in the critical aspects of an insurance business, such as risk management and marketing. This inevitably hampers the success of the schemes. For them to be sustainable, serious attention must be given to the design and management of these schemes (Musau, 1999). Often, community based schemes operate on very small budgets (Kyomugisha *et al*, 2008) because the resource base can only support it thus far as incomes are small and irregular.

2.6 Packages provided

Usually, CBHI schemes tend to cover high-frequency low-cost services (Mclntyre *et al*, 2008), they are unable to cover all health care services especially in the beginning. This is majorly because the number of members may be too small and as a result pooled resources too little to

cover the services (Soors *et al*, 2008). As a result, most insurers are normally unwilling to take costly risks for small schemes largely because it endangers solvency when the number of claims rise (Onwujekwe *et al,* 2010).

Moreover, increasing the benefit package would lead to an increase in the premium that has to be paid yet in designing these packages, relevance of the benefit packages to beneficiary communities needs to be taken into consideration. Furthermore, making packages all inclusive almost always leads to adverse selection which strains scheme resources. With time, however, as understanding and confidence grow and the number of members increases, members may be willing and schemes able to add services to the initial package.

Community participation in deciding the benefit packages to be covered in advance is a strength of CHI (Onwujekwe *et al,* 2010). Much as initially members and schemes have difficulties in making choices on what to cover and what to leave out, eventually, the package on offer will reflect a balance between social priorities as defined by members within the community and technical priorities as proposed by scheme managers (Soors *et al*, 2008). On the whole, services most included in CBHI scheme packages are those that are most frequently needed and used. These are the curative services at first-line level, generic drugs and uncomplicated deliveries. Referral care and transport are hardly ever met.

2.7 Payment Mechanisms

In a study carried out by Robyn *et al* (2012) to evaluate health worker preferences for community-based health insurance payment mechanisms, it was noted that provider payment mechanisms can crucially determine CBI performance, and should be designed taking into

account health worker preferences. Essentially, premiums are flat rates, thus not modulated according to ability to pay but are independent of individual health status (Soors *et al*, 2008).

Several studies show that people are willing to make prepayments to secure their healthcare needs even if it meant paying in kind (Banwat *et al*, 2012 & Atugaba, 2008). WHO (2000) proposed, as the health system's goals, contribution to good health, responsiveness to expectations of the people and establishment of fairness in the financial contributions to the health system. In that light, therefore, financial contributions for health would be considered as fair, when health expenditure of households is distributed according to their ability to pay rather than to actual costs incurred or associated with ailment as a consequence of illness.

2.8 Community Health Insurance in Uganda

As it is with many other regions of the world, CBHI schemes in Uganda may be diverse. However, certain features remain constant. These include: the voluntary participation of the people, not-for-profit objective in organizing the scheme, scheme management by the community itself, and some degree of risk pooling. Although community-based health insurances are typically very small, they are of increasing interest to government and international donors. These schemes make positive contribution in terms of financial protection, resource mobilization, social exclusion and in health care provision (Ahuja & Jütting, 2003).

In Uganda, CHI schemes were first set up in 1996, the first one being Kisizi Hospital Health Insurance Plan (Basaza, 2011, Wooding *et al*, 2012). These were started jointly by the Ministry of Health and donors, primarily the Department for International Development of UK (DfID) and United States Aid for International Development (USAID). All the existing schemes were based

on or linked to PNFP health facilities. An inventory of the Ugandan CHI schemes done in 2007 by the Uganda Community Based Health Financing Association (UCBHFA) indicates that there are fourteen schemes. Total membership was 100,000 people with varying coverage from 5-10% of the catchment population and contributing 5-10% of the facility budgets. Schemes were implemented in faith-based hospitals because they still charge user fees, are quite widely used and generally perceived as providing good quality of care.

UCBHFA, an NGO established in 1998 is responsible for coordination and promotion of CHI as well as carrying out research and building technical capacity of community based health care financing initiatives in Uganda. It currently has twenty five member organizations.

2.9 Model schemes in Uganda

2.9.1 Save for Health, Uganda

The purpose of the scheme is to improve financial access to quality healthcare services by expanding and extending well managed health micro-prepayment schemes, and strengthening their networks. Its aim is to reduce barriers to accessing quality healthcare services by the rural poor in Uganda. It is aimed at reducing barriers to accessing quality health care services by the rural poor in Uganda (UCBHFA, 2011). It constitutes of two schemes, one in Luwero and another in Bushenyi.

In Luwero, this scheme was started in 1999 by Kiwoko Hospital together with *Centre International de Development et de Recherche* (CIDR), a French organization. When it started out, the hospital acted as a banker for the scheme but it was later transferred to Save for Health

Uganda (SHU) with oversight from CIDR (Wooding *et al*, 2012). The premium was set at Shs3, 000, but with the increasing economic stress currently stands at Shs4, 000.

2.9.2 Ishaka Health Plan

Ishaka Health Plan is a legally registered, non – profit oriented based organization. The Scheme is purely community/member owned, with their offices located on Ishaka Adventist's Hospital in Ishaka town, Bushenyi District, Southwestern Uganda. It was originally a hospital-based scheme from the year 1999 but changed to member ownership in 2007 to date.

The catchment area of Ishaka Adventist Hospital is 501000 people (2000 projection population) found in Ruhinda, Igara and Bunyaruguru counties in Bushenyi District. The scheme has target coverage of 3000 people and currently has a penetration rate of 98%. The goal is to scale up membership from the current of 4017 members to 6000 in 2015. This includes low earners in the informal sector population, pre- existing self help groups, students, school staff and hospital staff (UCBHFA, 2011).

The services offered include outpatient care, inpatient care and health education. In 2011, 444 members received OPD services while 212 received IPD services (IHP annual report, 2011). Premium payments are such that the first four members of the family pay Ugshs 15,000 per quarter and any additional person pays Ug shs 3,700.

The scheme is managed by three members of staff; a scheme manager, a social worker or field officer and the accountant also working as the secretary. Major challenges faced include inadequate funding, low growth rate, low membership participation as well as inadequate

preventive practices like health education and use of mosquito nets that could reduce occurrence of disease.

2.10 Insurance Scheme Challenges

Because the overall enrollment and coverage of CBHI schemes remains rather low, most of these schemes have small risk pools and limited cross-subsidies (Mclntyre & Gilson, 2005). Moreover making local communities understand the concept behind this arrangement tends to be difficult. In a study by Shimeles (2010) carried out in Rwanda, he points out that some strong critiques argue that CBHIS schemes have the potential to further alienate the extreme poor from utilizing health services.

Certain factors hinder the success of CHI including affordability of premiums, the trust in the integrity and competence of the managers, the attractiveness of the benefit package as well as the quality of care that is offered by the providers (Carrin *et al*, 2005). Furthermore, the scheme management is almost always voluntary. Without any serious incentives, these managers tend to be reluctant and as a result problems like lack of oversight and bargaining will are lacking.

Robyn *et al* (2012) point out that some of the challenges faced by CBHI schemes stem from low enrollment rates of community members and high dropout rates which translate into low coverage. As a result, revenue is low and risk pooling is poor hence schemes become financially and organizationally vulnerable to sudden changes in income and unexpected diseases. CBHI schemes usually do not cover all heath care needs. Mainly due to relatively small resource pool, they are unable to cater for those services that weigh heavily on funding. So they cover mostly the frequent minor diseases such as common cold and malaria. This may also discourage

possible members who would have liked other complications like eye and dental care to be addressed as well.

Another key challenge with CHI is the fact that many of the rural people do not quite understand the concept of insurance. One may think that since they are not sickly they do not need to be a part, forgetting that should they fall sick, it will certainly be a lot more costly. Others may feel that say if in a given year they have paid premium and not utilized the services, their money has gone to waste. Moreover, should this happen even for two consecutive years, one may pull out with the view that they are simply spending on someone else.

As a means of counteracting the management challenges of CBHI schemes, Jacobs *et al* (2008) suggest the set up of support organizations that can help in management assistance which can even be subcontracted to an umbrella organization or the schemes merged. It should also be noted that viability and acceptance of a scheme is highly dependent on its design and management (Wiesmann & Jutting, 2003). This means that community preferences and ideas need to be taken into consideration and the scheme organized accordingly.

2.11 Financial protection

The World Health Assembly resolution 58.33 (2005) points out the neeed for everyone to be able to access health services without being subjected to financial hardship in doing so (WHO, 2010). CHI is aimed at providing financial protection from the cost of seeking and/ or utilizing health care (Fairbank, 2003, Mladovsky &Mossialos 2006). Some studies undertaken reveal that community financing improves access to health care among the rural and informal sector people and provides them with some financial protection against the cost of illness (Preker *et al*, 2001).

Similar studies in some regions such as Tanzania reveal that people, even the rural, are willing to make prepayments, whether in kind or otherwise, rather than have to pay up at the time of receiving services, because then it may be quite challenging to collect the required amounts (Mubyazi, 2003). Although the function of health insurance is to provide financial protection against high costs of health care, evidence from many developing countries in line with this has been rather inconsistent (Nguyen *et al*, 2011). According to the International Labor Organization (ILO), absence of financial protection exists when excessive health expenditure reduces households' other household consumption to below the poverty line (Baeza *et al*, 2002)

In 1996 when the government of Tanzania initiated CHI, it was to improve access and protect people against the financial cost of illness in an environment of shrinking budgets for the health sector (Msuya *et al*, 2007). The study they carried out revealed that insured members were more likely to receive health care and thus more financially protected against health shocks. However, the authors report that the poorest of the poor are not catered for because they are unable to afford regular insurance premiums.

Since CBHI schemes are funded by annual or more frequent contributions without requiring payments at the time of using health services, they lower financial barriers to access (McIntyre *et al*, 2005). There is also some degree of cross-subsidy, particularly from the healthy to the ill. As a result, CBHI proves a preferable alternative to out-of-pocket payments.

2.12 Health care access

The concept of access needs to be better understood. According to Gold (1998), it involves looking beyond utilization as a measure of access to a more wholesome consideration including

the effectiveness of services used based on the costs and outcomes of health services. Conventionally, healthcare access was measured in terms to proximity to providers of health care, focusing on whether people were able to get to facilities and into the system to obtain health services (Gold, 1998). This meant that where facilities were far out of reach or even unavailable, access was poor. Quite often the result was that people resorted to self medication, many a time an ineffective measure. There is, however, need to reduce the magnitude of geographical and more importantly financial barriers to health care. This should also translate into timely receipt of healthcare which has been shown to improve health outcomes.

Much of the health care payment is out of pocket and many a time catastrophic especially among the rural poor. Several studies (WHO, 2005; Carrin *et al*, 2005) show that millions of people are driven into poverty due to catastrophic health expenditure every year. As can be undoubtedly imagined, most of these reside in resource poor settings such as Sub Saharan Africa, Uganda inclusive, with very weak modern health care systems and in most cases without any functioning health insurance schemes. As a result of this, these regions are faced with high disease burden that has inevitably led to the propagation of a sickly, unproductive labor force. In Sub-Saharan Africa, formal and well functioning health insurance schemes generally exist for the very few who are employed in the formal sector. For the majority, however, health care is accessed through out-of-pocket expenditure, which in many cases leads to suboptimal use of health care services.

Essentially, CBHI is aimed at increasing access to health care by making it more affordable. (Cripps *et al*, 2000). However, much as health insurance should have a positive effect on access to health services, more or so on reducing catastrophic health expenditure for a certain section of

the population, it also poses a threat to equity and efficiency of health care services and systems (Oxfam, 2008). The concept of community insurance is ideally aimed at risk sharing to ease the financial burden for the individual or household (Soors *et al*, 2008). Furthermore, prepayment ensures quick access at the time of need since the service is as good as already paid for.

2. 13 CHI in improving health care access

Direct out of pocket expenditure on healthcare through user fees was previously reported to improve efficiency and coverage of health services even without denying the poor access. This however, came with controversy (Mubyazi, 2003) as many people were unable to afford this money due to low unsteady incomes. In China a policy of Rural Mutual Health Care, pretty much similar to CHI was set up with improvement of access to healthcare as one of the major aims (Yip *et al*, 2009).

The 1978 Alma Ata Declaration urging maximum community participation in organizing primary health care can be considered to play a role in the workability of CBHI schemes. CHI is a means of pooling resource so that at the time of need, one is able to seek health services without the worry of where or how to find the money to pay as required. Insurance removes financial barriers to access of health care services (Wiesmann & Jutting, 2002). Overall, the premium payment is considerably cheaper than what one would need to pay out of pocket at the time of service consumption.

It is documented that removal of user fees does not necessarily improve access; people still go to private facilities for services and issues like drug stock out, unofficial fees and overworked staff who tend to be too tired to provide quality services still exist (Kyomugisha *et al*, 2008). It is

therefore recommended that government funding to health services increases to ensure quality of services does not deteriorate.

According to some studies from certain countries in sub-Saharan Africa and Asia, CBHI operations have only had limited successes in ensuring affordable, participatory, and sustainable access to health care (Uzochukwu *et al*, 2009). Much as these schemes are aimed at proving affordable access to healthcare, success of these initiatives has not been fully felt by the rural communities (Ataguba, 2008). Moreover, there is strong evidence that neither purely statutory social health insurance nor commercial insurance schemes alone can significantly contribute to increase coverage rates and thereby the access to health care. The feeling is even greater in the environment of rural and remote areas where unit transaction cost of contracts are too high leading often to a state and market failure (Jütting 2000). As a consequence in low-income countries the majority of the population remains uncovered against the risk of illness (World Bank 1994)

Jacobs *et al* (2008) points out the need for government subsidies to schemes to be targeted towards the poor, more specifically those unable to pay a premium, to enable equitable access to health services. This would ideally mean that the rural poor make part payment, with the government making a contribution so that the constraint of having to find so much money to cover health expenses weighs a little lighter on them.

Chapter Three

Methodology

3.0 Introduction

This chapter presents the methods that were adopted in carrying the research.

3.1 Study Design

A cross sectional descriptive research design was used to establish whether more people have sought, benefited and been protected from financial health care risk due to the fact that they are enrolled in a CBHI scheme. Both qualitative and quantitative data was collected.

3.2 Target population

The target population was the community in the Bushenyi region

3.3 Sources of Data

Both primary and secondary data was be used, the greatest percentage being primary.

3.4 Study Population

The target study population for this research was the members enrolled into community health insurance schemes in Ishaka and Bushenyi district, who are under the umbrella of Save for Health Uganda while the others were enrolled under Bushenyi Medical Centre.

3.5 Study unit

Was an individual that was a member of the scheme, and had been enrolled for at least six months.

3.6 Sample Size

A total of two hundred fifty (250) respondents were interviewed. This was determined using Kreijie and Morgan's table of sample size determination which gives a guide of how big a sample will be from a given population size.

3.7 Sampling Procedure

For purposes of this study, two sampling techniques were adopted to select the sample. The schemes were first selected using purposive sampling technique. This was to ensure that only CBHIS are studied. Participants were then selected using random sampling technique. This technique was employed purposely to minimize bias, enabling every member in the study to have equal opportunity to be part of the study.

3.8 Study Variables

Table 1: Study Variables

Dependent Variable	Independent Variables
Effectiveness of CBHIS in improving access to health care	Level of Coverage
	Level of Financial risk protection
	Clients satisfaction

3.9 Data Collection Techniques

Data obtained was collected from respondents using the following techniques.

3.9.1 Questionnaires

Questionnaires are lists of questions designed to collect the desired information. It may be structured or unstructured. Most of the questions were short requiring direct answers based on **Likert's (1932)** scale for quantitative data. Others were open ended questions by which the

respondents were asked to provide their own opinion to help the researcher get extra information of a qualitative nature from the respondents.

3.9.2 Key informant interviews

This involved asking the scheme management questions pertaining to the scheme and its operation. The person(s) that was interviewed was one that was knowledgeable about the scheme thus able to relay proper information on matters like the scheme management.

3.9.3 Using available information

This technique was used to retrieve any available existing data that had been already collected, by other people. This information could be got from published or unpublished sources e.g. newspapers, journals, text books and existing information of the internet. Some of this information was obtained from the scheme management office.

3.10 Data Collection Tools

Data was collected using;

3.10.1 Questionnaires

This bore a list of questions that the respondents were asked to respond to the best of their ability. While a few were self administered, most of the questionnaires were filled in by the researcher according to the response obtained as many of the members preferred that or were not able to read and write, (see appendix 1).

3.10.2 Key informant interview guide

A list of questions that were asked to the scheme management of someone well knowledgeable about the scheme, (see appendix 2)

3.10.3 Checklist

This was a list against which the researcher will mark while tallying the information sought to be obtained from the available information; for example from record books in the scheme office or from the health care centre, (see appendix 2).

3.11 Data Analysis

Data obtained was analyzed using SPSS version 16.5 software.

3.12 Quality Control

The questionnaire was pre-tested with some people enrolled in Save for Health, Luwero before administering it. This was aimed at ensuring appropriate questionnaires that the selected respondents would understand and also to allow the researchers to familiarize the terminologies used by the respondents. Pre testing also enabled the researcher to identify question ambiguity and response categories, as well as questionnaire length. The pre-testing exercise gave the researcher some insights of how the interview should be conducted, what should be the sequence of the question, how to persuade the respondents to answer the questions and appropriate length of each interview. This was also aimed at checking the validity and reliability of the tool.

3.13 Ethical Issues

The researcher obtained clearance from International Health Sciences University and from the scheme management. The researcher also gave assurance to the respondents that the information gathered from them was to be held with utmost confidentiality and their consent to participate in the interviews was sought.

3.14 Dissemination

The compilation of this study was submitted to IHSU and copied to all relevant and Ministry of Health with support of the University publication.

3.15 Limitation to the study

Whereas these findings are extremely beneficial to most stake holders, generalization may be limited as only two broad schemes were studied

Chapter Four

Results

4.0 Introduction

This chapter presents the results that were obtained while in the field. It is a collection of the details of responses obtained from the respondents through interviews and questionnaires. The chapter details information gathered in line with the objectives of the study.

4.1 Demographics of respondents

Table 2: Demographics

	Frequency	Percentage
Sex		
Male	150	60
Female	100	40
Age		
1-20	7	2.8
21-30	8	3.2
31-40	49	19.6
41-50	99	39.6
50+	87	34.8
Marital Status		
Single	12	4.8
Married	195	78
Separated	43	17.2
Occupation		
Business Person	50	20
Peasant Farmer	152	60.8
Civil Servant	30	12
None	14	5.6
Others	4	1.6
Religion		
Christian	238	95.2
Orthodox	5	2
Muslim	7	2.8

A total of two hundred fifty respondents were interviewed between 11th and 20th July 2012. Of these, 60% were male while the other percentage constituted females. The majority (74%) was aged 41+ and these were mainly peasant farmers with an average monthly income of less than two hundred thousand shillings. The greatest percentage of the respondents constituted Christians (95.2%) while the other percentage constituted of Muslims and orthodox.

Table 3: Number of dependants

Dependants	Frequency	Percentage
0	12	4.8
1-2	18	7.2
3-5	122	48.8
6-10	92	36.8
More than 10	6	2.4
Total	**250**	**100**

Source: **Primary Data, 2012**

The number of dependants per respondent is illustrated in the table above. Majority of the persons interviewed (48.8%) had between 3 and 5 dependants while only 2.4 % had more than ten dependants.

Table 4: Number of members covered per family

Variable	Numbers covered	Frequency	Percentage
Members covered	1-3	28	11.2
	4	85	34
	5	72	28.8
	More than 5	65	26
	Total	**250**	**100**

Source: **Primary Data, 2012**

Of the dependants, some the families have all or only part covered depending on their financial ability. Although previously any number of members per family could be enrolled, the scheme, at the time of the study, was in the process of implementing a policy where by a minimum of 5 members per family can be enrolled.

Table 5: Level of highest attained education

Education level	Frequency	Percentage
None	3	1.20
Primary	105	42.0
Secondary	113	45.2
Tertiary	26	10.4
University	3	1.20
Total	**250**	**100.0**

Source: **Primary Data, 2012**

As shown in the table, the majority of the respondents (45.2%) had gone as far as secondary school in their education. This group was closely followed by those who had only managed to attain a primary level education. The number of people that had attained a university education tied with those had had received no formal education at 1.2%.

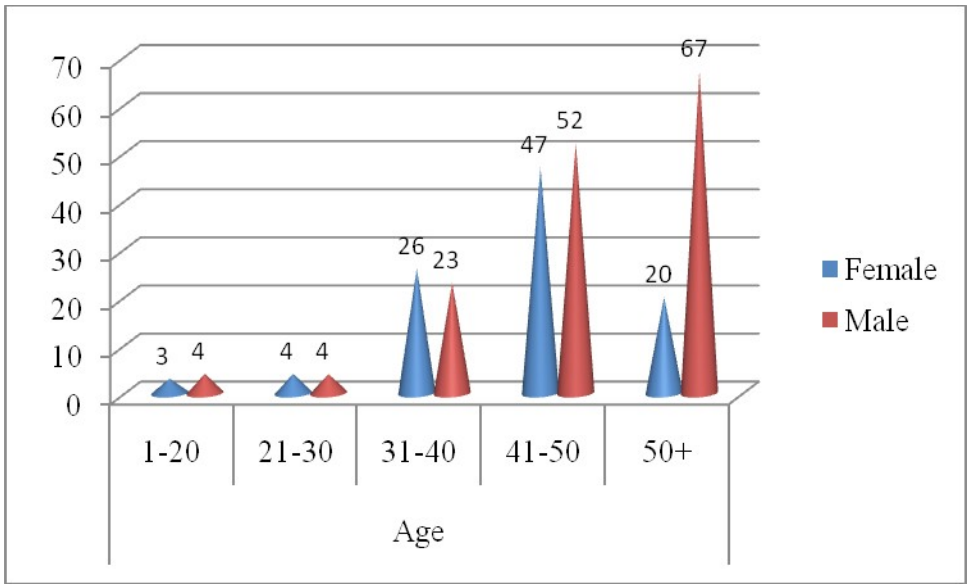

Figure 2: Relation between sex of respondents and their age

Figure 2 shows that overall, the number of men enrolled is higher than the women. Comparatively, the age group between 31 and 40 years constituted more females than males while the group aged 50 years and above had a significantly higher proportion of men than women.

For most of the scheme members, knowledge of the scheme and eventual enrollment was through community sensitization by management of umbrella organizations, particularly, in this region, Save for Health Uganda.

Table 6: Length of period enrolled into scheme

Period enrolled in the scheme	Frequency	Percentage
Less than 6months	22	8.80
6 months-1yr	12	4.80
1-2yrs	25	10.0
2-5yrs	159	63.6
Over 5yrs	32	12.8
Total	**250**	**100.0**

Source: **Primary Data, 2012**

63.6% of the members had been enrolled into a scheme for between two and five years while 8.8% had been enrolled into the scheme for just six months. The respondents said that the major reason as to why they had joined the scheme was to be able to utilize cheap or affordable healthcare and the perceived benefit they would acquire from it. The period of enrollment of members into the scheme is shown in the table 4 below.

4.2 Coverage of the scheme

For the study, members from the following schemes in the Bushenyi region were interviewed; Kitagata, Numba, Karaaro, Bumbeire, Kasaana, Kitabi, Kiyaga, Ruharo, Kibare, Bwera, Rutooma, Buyanja, Ryeishe and Kasaana.

Location			**Respondents**	
County	**Sub county**	**Scheme**	**Frequency**	**Percentage**
Igara	Bumbeire	Bumbeire	26	10.4
		Kiyaga	38	15.2
		Ruharo	22	8.8
		Kibare	13	5.2
		Numba	15	6
		Kitabi	21	8.4
	Kyeizoba	Bwera	24	9.6
		Rutooma	14	5.6
		Karaaro	9	3.6
		Kitagata	4	1.6
		Buyanja	28	11.2
	Ibaare	Ryeishe	19	7.6
		Kitabi	6	2.4
Sheema	Kasaana	Kasaana	11	4.4
Total			**250**	**100**

The schemes were named after the constituent parishes which comprise of several villages. The biggest contributor to the study was Kiyaga scheme while the least number or members interviewed were from Kitagata scheme. Under Save for Health Uganda, a total of eight

thousand sixty four (8,064) members were enrolled at the time the research was carried out in Bushenyi region.

The service providers for the scheme members were two hospitals (Ishaka Adventist Hospital and Kitagata Hospital) and two health centers (Laura HC II and AMG/ Hope Medical Center III). The average distance from home to the main hospital for the majority of the respondents was about 5Km. The commonest illness in the communities was reported to be malaria as well as cough and common cold amongst children. Countrywide, malaria is reported to rank highest among the leading causes of morbidity and mortality (AHSPR, 2010/2011), the other diseases of concern being respiratory tract diseases, TB, HIV/AIDS and malnutrition (UCBHFA, 2012).

The scheme is able to cover all the major outpatient services including provision of drugs, consultations and investigation, counseling and health education which is done on average once a month. Family planning services are also provided and the inpatient services when needed can be utilized. This includes minor and cesarean operations. Upon consumption of the services, the scheme covers payment up to a ceiling of a hundred thousand shillings. Any extra cost is met by the patient. A package is available for chronic illnesses, being much more expensive than the ordinary. Because many of the people do not ascribe to this, mainly because they cannot afford it, many of the respondents, when asked if chronic illnesses were covered by the scheme, their response was negative. Fortunately, the prevalence of these diseases is low. Apart from the chronic illnesses, the scheme also do not cover major surgery and self inflicted injuries. A summary of what is covered and not covered is shown on the membership card in the appendix.

Although these services are offered, it was pointed out that quite often; members incur out of pocket expenditure on purchasing drugs that are sometimes unavailable at the health facilities.

4.3 Level of Financial Leverage

At the time of the study, the premium paid for the scheme under Save for Health Uganda was seven thousand shillings per person annually, while the other group paid five thousands shilling per head per quarter year. For the majority of the scheme members, being peasant farmers, the source of money to pay for premiums was reported to be from sales of farm crops or other produce such as livestock. A few of them who earned a salary from their small businesses or salary were able to meet the costs thus.

Many of the people interviewed were the sole financers of their premiums while the 16.8% who were paid for by someone else had a relative (parent, husband or child) doing so.

Table 7: View of amount paid on premium

View on the payment paid	Frequency	Percentage
Fair	141	56.4
High	70	28.0
Good	16	6.40
Very good	12	4.80
Very high	11	4.40
Total	**250**	**100.0**

Source: **Primary Data, 2012**

Although the largest proportion of the members (56.4%) said the amount paid for premium was fair with regard to the services received, some felt the cost was rather high as their income levels were quite low. A few, however, felt this fee was quite good.

Initially, members were allowed to pay in installments over a period of about six months. Effective 31st July 2012, however, the schemes under Save for Health Uganda were to have all

their members fully paid up and new cards made that would allow them consume health services over a year when the cards are renewed.

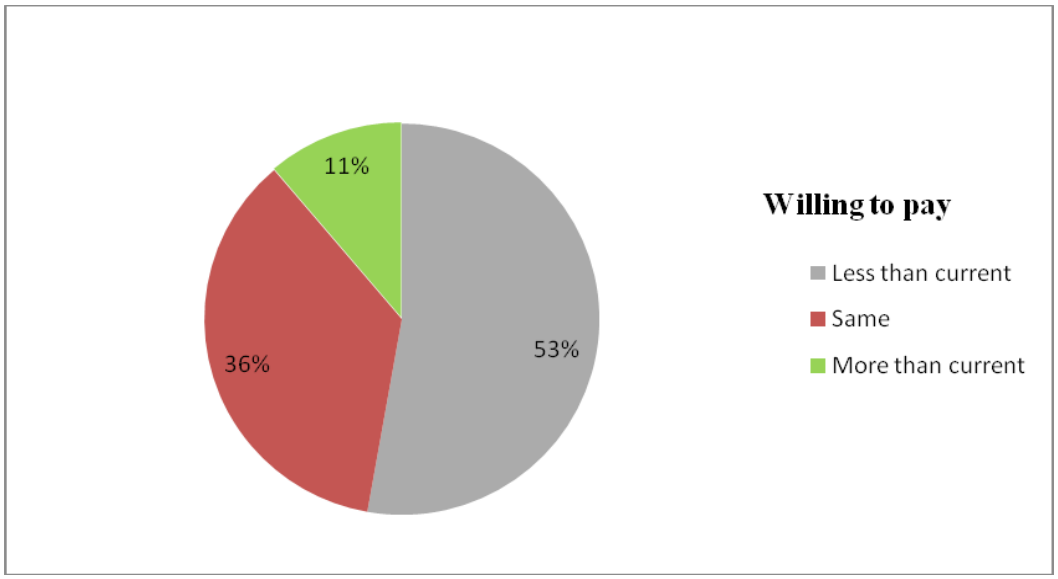

Figure 3: Chart showing willingness to pay premium amount with regard to the current fee

When asked how much premium they would be willing to pay, given an option, the majority quoted a much lower figure than the current, 36% said they were comfortable with the current fee, while a small section was willing to pay a higher fee as seen in figure 3.

At the time of consumption of healthcare, members are expected to make a copayment of four thousand shillings per visit for outpatient care and eight thousand shillings for inpatient care. They also must meet their transport cost.

During interaction with respondents, the researcher met some community members who had opted out of the insurance schemes. The reason for this, they said, was because they were unable to pay the premiums due to their low incomes. This was especially after the premium fee had been increased from five thousand shillings to seven thousand shillings per head per year.

Moreover, at the time of the study, the scheme management was proposing to set a minimum membership at five members per family yet some families were smaller than this or could only afford a small number.

4.4 Level of Satisfaction

Asked as to whether members were satisfied with the services received, many of them said they were satisfied. With the health education, 83.6% were satisfied, 14% took a neutral position, while 2.4% expressed dissatisfaction. When asked what could be done to improve the services, members made suggestions such as it being done more regularly, home visits being done and follow ups. Family planning services were reported to be satisfactory except for a few incidences of drug shortages. Although members said they were satisfied with the outpatient services, discomfort arose from drug stock outs or missing drugs, but more importantly the fact that health facilities tend to be very far away thus long distances to hospital of high transport cost. Members suggested more facilities be built, more staff recruited and possibly referrals made where need be.

Table 8: Perceived Benefit by Sex of the respondents

Perceived Benefit	**Sex**		**Total**
	Female	**Male**	
Very beneficial	74(29.7%)	103(41.4%)	**177(71.1%)**
Beneficial	25(10.0%)	45(18.1%)	**70(28.1%)**
Neutral	1(0.4%)	11(0.4%)	**2(0.8%)**
Total	**100(40.2%)**	**149(59.8%)**	**249(100.0%)**

Source: **Primary Data, 2012**

With regard to overall perceived benefit from the insurance scheme, 70.8% felt the arrangement was very beneficial, 28% felt it beneficial, while just 1.2% expressed neutrality. The table above shows a comparison between the overall benefit as perceived by the men versus the women.

4.5 Relationship between improved access to health care services and independent variables.

To further understand whether community based health insurance has contributed to improved access to health care services with in communities, a bivariate analysis was done using Pearson chi-square test(χ^2) to establish relationships between improved access to health care and independent variables as presented below.

4.5.1 Relationship between improved access to health care services and community based health insurance scheme coverage.

Table 9: Relationship between improved access to health care services and CBHI coverage

VARIABLE		IMPROVED ACCESS TO HEALTH CARE SERVICES			
COVERAGE		**Yes N (%)**	**No N (%)**	χ^2	**P-Value**
How did you learn about this insurance scheme (N=250)		210(84.0%)	40(16.0%)	**24.534**	**0.000****
	Community sensitization	194(85.5%)	33(14.5%)		
	Health centre	1(100.0%)	0		
	Through friend	12(100.0%)	0		
	Other	3(30.0%)	7(70.0%)		
Duration on the insurance scheme (N=250)		**210(84.0%)**	**40(16.0%)**	**17.167**	**0.002****
	Less than 6 months	19(86.4%)	3(13.6%)		
	6 months-I Year	11(91.7%)	1(8.3%)		
	1-2 Years	23(92.0%)	2(8.0%)		
	2-5 Years	138(86.8%)	21(13.2%)		
	Over 5 years	19(59.4%)	13(40.6%)		
Health Education services (N=250)		**41(19.3%)**	**171(80.7%)**	**1.206**	**0.547**
	Yes	1(14.3%)	6(85.7%)		
	No	40(19.5%)	165(80.5%)		
Family planning services (N=250)		**210(84.0%)**	**40(16.0%)**	**0.016**	**0.899**
	Yes	193(83.9%)	37(16.1%)		
	No	7(85.0%)	3(15.0%)		
Outpatient services available(N=250)		**210(84.0%)**	**40(16.0%)**	**0.956**	**0.812**
	Drugs	61(81.3%)	14(18.7%)		
	Counselling	55(85.9%)	9(14.1%)		
	Testing/Investigations	57(86.4%)	9(13.6%)		
	Consultation	37(82.2%)	8(17.8%)		
In-patient services available(N=250)		**210(84.0%)**	**40(16.0%)**	**0.823**	**0.050****
	Yes	192(83.8%)	37(16.2%)		
	No	18(85.7%)	3(14.3%)		
Operations covered under the scheme(229)		**192(83.8%)**	**37(16.2%)**	**0.982**	**0.036****
	Minor	148(84.1%)	28(15.9%)		
	Major	10(83.3%)	2(16.7%)		
	Caesarean Section	34(82.9%)	7(17.1%)		

Source: **Primary Data, 2012**

Table 9 above indicates a significant association between improved access to health care services and community based health insurance coverage; for instance, there was a significant association between source of knowledge about insurance scheme and improved access to health care services since the p-value(p=0.000**) was less than the critical value of 0.05 at 95% confidence interval.

Results also revealed that 85.5% of the respondents reported an improved access to health care services because the people learnt about insurance scheme through community sensitization while others said that they had learnt about insurance scheme through friends.

The duration on the insurance scheme was also found out to be statistically significant with improved access to health care since the p-value (p=0.002**) was less than the critical value of 0.05 at 95 confidence interval. The majority of the people (86.6%) who had spent between 2-5 years in the insurance scheme had improved access to health services. Similarly, a statistical significance was found between in-patient services available and improved access to health care services (p=0.050**).

It was further discovered from the findings that the relationship between operations covered under the insurance scheme and improved access to health services were statistically significant (p=0.036**). The results indicated that the majority of the respondents (84.1%) with minor operations had improved access to health care services.

On the other hand, health education services, family planning services and out-patient services available were found to be statistically insignificant since their p-values were greater than the critical value of 0.05 at 95% confidence interval.

4.5.2 Relationship between improved access to health care services and community based health insurance scheme level of financial leverage.

The relationship between improved access to health care services and community base health insurance scheme level of financial leverage is presented in presented in table 10.

Table 10: Relationship between improved access to health care services and community based health insurance scheme level of financial leverage

VARIABLE	IMPROVED ACCESS TO HEALTH CARE SERVICES			
FINANCIAL LEVERAGE	**Yes N (%)**	**No N (%)**	χ^2	**P-Value**
Premium paid (N=250)	**210(84.0%)**	**40(16.0%)**	**54.304**	**0.000****
7000 per head	190(91.8%)	17(8.2%)		
5000 per head	20(46.5%)	23(53.5%)		
Frequency of payment (N=250)	**210(84.0%)**	**40(16.0%)**	**47.778**	**0.000****
Quarterly	21(48.8%)	22(51.2%)		
Yearly	189(91.3%)	18(8.7%)		
Source of income(N=250)	**41(19.3%)**	**171(80.7%)**	**7.830**	**0.020****
Farm/crop sales	150(86.7%)	23(13.3%)		
Salary	17(94.4%)	1(5.6%)		
Other	43(72.9%)	16(27.1%)		
Willing to pay(N=250)	**210(84.0%)**	**40(16.0%)**	**4.131**	**0.127**
Less than Current	105(79.5%)	27(20.5%)		
Same	80(88.9%)	10(11.1%)		
More than current	25(89.3%)	3(10.7%)		

Source: **Primary Data, 2012**

Findings in table 8.0 indicates that there was a significant relationship between community based health insurance level of financial leverage and access to improved health care services for example there was a significant relationship between the premium paid and access to health care services since the p-value (p=0.000) was less than the critical value of 0.05 at 95% confidence

interval. There were (91.8%) of the people who were paying 7000= per head for the insurance scheme who had improved access to health services and (46.5%) of the clients paying 5000 per head had improved access to health services.

There was a significant association between frequency of payments and improved access to health services because the p-value (p=0.000**) was less than the critical value of 0.05. The results show that the majority of the people (91.3%) paying yearly had improved access to health services while only (48.8%) of clients paying quarterly had access to improved access to health services.

The association between the source of income and access to health services was discovered to be significant. Results showed that the majority people whose income was salary (94.4%) had improved access to health services.

There was no statistical association between willingness to pay and access to improved health care since the p-value was p=0.127.

4.5.3 Relationship between improved access to health care services and community base health insurance scheme level of satisfaction.

Table 11: Relationship between improved access to health care services and community based health insurance scheme level of satisfaction

VARIABLE	IMPROVED ACCESS TO HEALTH CARE SERVICES			
CLIENTS SATISFACTION	**Yes N (%)**	**No N (%)**	χ^2	**P-Value**
Health Education (N=250)	**210(84.0%)**	**40(16.0%)**	**2.428**	**0.000****
Very satisfied	7(100.0%)			
Satisfied	202(100%)			
Neutral	1(2.9%)	34 (97.1%)		
Dissatisfied		6(100%)		
Outpatient Department services (N=250)	**210(84.0%)**	**40(16.0%)**	**5.238**	**0.155**
Very satisfied	8(88.9%)	1(11.1%)		
Satisfied	188(84.7%)	34(15.3%)		
Neutral	9(64.3%)	5(35.7%)		
Dissatisfied	5(100.0%)	-		
In-patient Department services (N=250)	**210(84.0%)**	**40(16.0%)**	**3.847**	**0.278**
Very satisfied	7(100.0%)	-		
Satisfied	182(84.3%)	34(15.7%)		
Neutral	17(73.9%)	6(26.1%)		
Dissatisfied	4(100.0%)	-		
Perceived benefit before & after enrolment in the scheme(N=212)	**209(83.9%)**	**40(16.1%)**	**5.341**	**0.051****
Very beneficial	154(87.0%)	23(13.0%)		
Beneficial	54(77.1%)	16(22.9%)		
Neutral	1(50.0%)	1(50.0%)		

Source: **Primary Data, 2012**

Results from table 11 above, indicate a significant relationship between level of satisfaction from health education and access to improved health services since the p-value (p=0.000**) was less

than the critical value of 0.05 at 95% confidence interval. Findings revealed that (100%) of the respondents who said that they were very satisfied with health education had improved access to health services and none of those who were dissatisfied had improved access to health education.

Findings further indicated a significant association between the perceived benefit to the insurance scheme and the improved access to improved health services. Results indicate that the majority (87.0%) of the respondents who anticipated it to be very beneficial had improved access to health services and it was discovered that on average (50%) of respondents who we neutral about the perceived benefit had improved access to health services. This means that the higher the benefit expectation, the more the improved access to health services.

Indeed, the rest of the variables that included among others; the level of satisfaction to out-patient department services and in-patient department services did not have a significant association with improved access to health care services.

4.6 Key informant interviews

Information from the key informant interview revealed that scheme members are the core managers, with the umbrella organization giving technical guidance and capacity building to them. The interviewee said the scheme offered four different packages: Basic, Essential, Comprehensive and Advanced. Amongst these packages, members in a scheme choose what they feel is affordable and helpful to them.

An annual premium is paid and a probation period of three months set. Members are allowed to pay the premium in installments over a period of six months. When asked if there was an alternative source of financing for the schemes like the government or some donors, the response was negative, saying the schemes were entirely funded by the members themselves.

4.6 Challenges faced

Overall, CBHI may seem to benefit communities through risk pooling that allows, in most cases, for timely access to health services. However, a number of challenges are faced, reducing the effectiveness or realization of the intended goal. From the study, the most outstanding were the following;

Premium payment: many a time, people within the communities find it rather difficult to collect the required money on time. This is escalated by the fact that while the money is collected annually, the timing is not favorable. Most of the schemes do not cover chronic illnesses, which although not very prevalent, are incident. Although a package is offered for these illnesses, the cost is fairly high that many people, even those suffering from those diseases opt not to enroll for it as they are not able to meet the expense.

The health centers are still too few compared to the population size. As a result waiting time at the time of health service consumption is rather long. This is further coupled with understaffing.

Furthermore, because of the few health centers, distance to these is usually quite long, yet members must meet own transport cost. This sometimes discourages them from going for treatment in time. Although community health insurance by far reduces healthcare expenditure, the access in itself is not satisfactory as the distance that has to be covered to the health centers is way too long. Sometimes, the members are left no choice but to resort to self medication or none at all, or to go to nearby health facilities where they have to part with some money for the services.

Some of the schemes face administrative challenges. While the leaders are chosen by members and work on voluntary basis, they are often demoralized because the facilitation is inadequate. They called for remuneration of their work, yet this would impart an extra cost on member because the schemes are entirely funded by the members themselves. It is reported that because of their small scale, their voluntary nature, and their low premiums, CBHI schemes face severe limitations in terms of financial sustainability and managerial capacity and this was evidenced by the comments made by the members.

Members pointed out that sometimes they are not accorded the deserving treatment while at the health facility, citing that staff under looked them and did not pay special attention.

Chapter 5

Discussion of Results

5.0 Introduction

This chapter is a discussion of the results that were obtained, making use of supporting literature from previous studies

5.1 Demographic data

The respondents were more male than female because generally, men are family heads and sole providers and decision makers of the home. It is therefore their responsibility to meet health care costs. Since CHI provides a cheaper alternative for health care, it would only be wise of them to have their families enrolled in order to meet the health care needs.

Being a rural community, the people are characterized by peasant occupation and as a result their incomes are rather low and mainly seasonal. This also translates into low literacy levels and usually fairly large families.

The households with lower income levels may seem to have more members enrolled. This can be explained by the fact that being a rural setting, families are usually fairly large. And although they not so well of in terms of income, they desire to have a much of their families as possible covered to be able to protect them against ill health, having understood the concept of insurance.

5.2 Coverage of the scheme

Knowledge and understanding of the concept of community health insurance may seem to still be low, but the umbrella organizations have made effort to sensitize communities on the benefits of this mechanism of covering health expenses. The majority of the respondent said they had gotten to learn about the arrangement through community sensitization, only a few through family and friends. This is because of the effort taken to reach out to the community by the schemes. Major outpatient and inpatient services such as drug provision and diagnosis are provided as is with most CHIs.

Basaza *et al* (2009) reports that the schemes in Uganda are characterized by high dropout rate, as high as 10% of the membership per annum. Another challenge is having small numbers as well as adverse selection. This means that the resource pool is narrow and thus unable to effectively cover the medical requirements. To counter this, the scheme management decided to have a minimum number per family of five. The study, found out that some members who had previously been enrolled but had left the scheme. And the major reason for this, they said, was because they could not afford to pay the premiums. Polonsky *et al* (2009) report as some of the problems of CHI as lack of affordability for many of the rural as well as packages not being all inclusive, particularly not covering chronic illnesses. A few members sighted issues with scheme management and luck of trust in their leaders, as well as the fact that the facilities that were in cooperation with the scheme were often distant which posed difficulty in getting to the facility to utilize the services. This, they pointed out, imposed an extra cost of transportation, which often a time, they could not afford to incur.

5.3 Level of Financial Leverage

Controls put in place such as copayment at the time of service consumption ensure that services are not misused (avoidance of moral hazards). Several studies on community based health insurance have reported the presence of adverse selection and moral hazard problems. Adverse selection problems normally arise when an individual who anticipates needing medical treatment chooses to buy insurance more often than others, resulting in a higher insurance premium which drives out those persons who anticipate needing less medical treatment from the scheme. For this reason, there is need to establish a probation period, which in the study was found to be between three to six months.

For a number of people, the premiums were quite high and making up the required payment in time was quite challenging. Carrin *et al* (2005) report that premiums levied as flat rates pose a disadvantage to the poorest since the rates are regressive and do not favor low income earners. As a result, individuals with small families are excluded.

It is important to understand that in reality, much as is desired, preferred benefit packages may not be actualized. This is because they are mainly dependent on the resource availability which is determined by the number of people enrolled and how much money they pay for premiums (Onwujekwe *et al*, 2010). However, packages for target communities need to cover major causes of morbidity and mortality to ensure that people in need are able to benefit optimally from the health services and also receive value for money.

The Ministry of Health acknowledges that for a health system to protect the poor against unaffordable healthcare and avoidance of impoverishment that is as a result of excessive health care costs there is need to raise funds. It therefore proposed in the AHSPR- 2010/2011as a means of doing so, increasing government per capita expenditure on health and raising the proportion of

household financing mobilized through prepayments under which community health insurance fall.

In a study similar to this particular one in assessing the impact of Rural Mutual Health Care, a form of CBHI, on access to healthcare by Yip *et al* (2009), it was discovered that these insurance schemes increased outpatient visits by up to 70% and reduced incidences of self medication and were thus successful in improving access to health care. In another study in Rwanda by Saksena *et al* (2010), mutual health insurance coverage was reported to be strongly associated with a reduction in unmet need as well as risk of catastrophic expenditure

In a study by Ahuja and Jutting (2003), it was noted that although the schemes appear to extend coverage to low income populations who would otherwise be excluded from the benefits, the poorest of the poor are often not covered by the schemes. This explains the high dropout rates witnessed in some of the schemes.

5.4 Level of Satisfaction

Patients' feedback, including their level of satisfaction with the services provided, is necessary to identify problems that need to be resolved in improving the health services. According to Sodani *et al* (2010), patient satisfaction is dependent on many factors including the quality of clinical services provided, availability of medicine, behavior of doctors and other health staff, cost of services, hospital infrastructure, physical comfort, emotional support as well as respect for patient preferences.

Moreover, the quality of care is an important determinant for utilizing health services and thus needs to be evaluated (Devadason *et al*, 2011). The same authors recommend that if CHI schemes want to improve the quality of care for their clients, so that they adhere to the scheme,

the scheme managers need to negotiate actively for better quality of care with empanelled providers.

In a study to evaluate client satisfaction under community health insurance in India, the quality of health care in both public and private facilities was found to be unsatisfactory with major problems being non-availability of staff and medicines as well as rude behavior of the staff (Devadason *et al*, 2011). According to Vialle-Valentin *et al* (2008), medicines are the largest reported component of out of pocket expenditure so if drugs are missing the goal of CHI is not achievable.

Furthermore, Mladovsky & Mossialos (2006) point out as one of the major obstacles to CBHI, the poor quality of health services. This, they note, can be improved through strategic purchasing. These problems were pointed out by some as some of the challenges faced within in the schemes and needed to be addressed. As reported by Carrin *et al* (2005), in many developing countries, lack of geographical access to inpatient facilities and the ensuing costs of transportation can also be a major impediment to inpatient care.

In the UCBHFA annual report for 2011, it was reported that scheme members under SHU-Bushenyi were faced with the challenge of low quality health care (poor reception). To deal with this problem, it was decided that information desks for scheme members be placed at all participating health care facilities. This was evident at the Ishaka Hospital where an individual is place to be a link between members and the hospital management.

5.5 Key informant information

A probation period is necessary before members start accessing healthcare. This is aimed at avoiding adverse selection whereby an individual who anticipates needing medical treatment chooses to buy insurance more often than others. This often leads to higher insurance premiums which will further result in some people being driven out, particularly those who anticipate needing less medical treatment.

From the interviews, it was clear many of the respondents did not even know that a package was available to cover chronic illnesses. This was probably because the majority did not even as much as give it a thought as the package premium was much higher yet they were already finding trouble meeting the needs of the basic package. The four different packages provided are to enable one make a choice that will meet their needs and also according to financial ability. For instance the Basic package is able to cover the common illnesses which may be occurring frequently but can be treated at a fairly low cost.

5.6 Challenges faced

It is reported that as a social protection mechanism, CBHIs are effective in reducing out-of-pocket payments of their members, and in improving access to health services. However, failure of many arises from problems such as weak management, poor quality government health services, and the limited resources that local population can mobilize to finance health care (Tabor, 2005).

Financial sustainability of schemes is rather challenging and they are also faced with poor managerial capacity (Oxfam, 2008). According to Cripps *et al* (2000), charges for the poor ought

to be seasonal such that even for the poorest of the poor, advantage can be taken of the harvest season when they are able to make some income from their sales.

Chapter 6

Conclusions and Recommendations

6.1 Conclusions

From the study, it was established that this policy is workable and can be of great help in reducing catastrophic expenditure on health. This however needs to be supported through various channels like proper education and mobilization.

Although CBHI is perceived as very beneficial by those currently using it, the challenges presented hinder or slacken its success.

Currently, MoH is in the process of sensitizing the nation about the planned NHIS hoped to be rolled out next year. The social health insurance scheme is to start with the formal sector and eventually incorporate everyone else, with each individual making a 4% contribution and then the government making an additional 4% to make up 8% per person.

It is hoped that with implementation of this system, controls put on the utilization of services in the CHI schemes will reduce substantially or be removed and catered for by the government hence improving access.

6.1 Recommendations

The communities need to be thoroughly sensitized on the benefits of CHI and encouraged to take it up as a means of curbing the extreme levels of health care expenditure, especially when it is catastrophic.

It is essential that communities and the schemes find means of addressing these challenges. For instance, with the issue of volunteers lacking morale due to lack of remuneration, the communities could make as part of their collection, a small addition to give to their leaders as a means of motivating them and encouraging good leadership.

A member pointed out the necessity for packages to be more disease preventative than treatment targeted.

Managers also need to make the premium collection timing appropriate to ease payment. This should preferably be at the time of harvest when the peasants are able to make some sales from the yields and therefore have sufficient money to pay up. This would also enable members to pay in full rather than in installments thus better resource planning and management.

Others areas of study

Basing on the results and experiences of this study, the researcher feels it would be essential to undertake studies in three major areas identified below.

- Study the current timing of premium collection in CBHI schemes so that it can be aligned to the rightful and practical timing.
- There is need to study the reasons for drop outs in CBHI schemes.
- As the MOH plans to roll out the National Health Insurance Scheme, it would be helpful to study how CHI can contribute to the success of intended policy.

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Appendix 1

QUESTIONAIRE FOR SCHEME MEMBERS

This questionnaire is aimed at gathering information about community health insurance. Please fill in the questionnaire to the best of your knowledge and be honest. Please note that this information is purely for study purposes and your consent to participate is sought through provision of your signature.

Tick where necessary

Date: .....

Name of scheme.....

Demographic characteristics of respondents

1. Name of respondent..... Signature.....
2. Sex
   - ☐ Female
   - ☐ Male
3. Age.....years
4. Marital Status
   - ☐ Single
   - ☐ Married
   - ☐ Separated
   - ☐ Divorced
5. Occupation
   - ☐ Business person
   - ☐ Peasant farmer
   - ☐ Civil servant

- ☐ None
- ☐ Other (specify).....

6. Average monthly income in Uganda Shillings
   .....
7. Number of dependants
   - ☐ Zero
   - ☐ 1 – 2 dependents
   - ☐ 3 – 5 dependents
   - ☐ 6 – 10 dependents
   - ☐ More than 10 dependents
8. Total number covered by the scheme
   .....
9. Religion
   - ☐ Christian
   - ☐ Orthodox
   - ☐ Muslim
   - ☐ None
   - ☐ Other
10. Highest education level attained
    - ☐ Primary
    - ☐ Secondary
    - ☐ Tertiary / technical
    - ☐ University
    - ☐ None

SECTION A: COVERAGE OF THE SCHEME (by region and services)

1. Where do you live?
   County.....

Sub county.....

Parish.....

Village.....

2. How did you learn about the scheme?
   - ☐ Through community sensitization
   - ☐ From the health centre
   - ☐ Through a friend
   - ☐ Other (specify).....

3. How long have you been in the scheme?
   - ☐ Less than 6 months
   - ☐ 6months – 1year
   - ☐ 1 – 2 year
   - ☐ 2 – 5 years
   - ☐ Over 5 years

4. What made you join the scheme?
   .....
   .

5. What are the common illnesses you suffer?
   - ☐ Malaria
   - ☐ Common cold
   - ☐ Typhoid
   - ☐ Cough
   - ☐ Other (specify).....

6. Do you receive health education services at the health facility?
   - ☐ Yes
   - ☐ No

7. How often?
   - ☐ Weekly

- ☐ Monthly
- ☐ Every 2 months
- ☐ Every 6 months
- ☐ Once a year

8. Are there family planning services at the facility?
   - ☐ Yes
   - ☐ No

9. What out patients services do you receive?
   - ☐ Drugs
   - ☐ Counselling
   - ☐ Testing/ Investigations
   - ☐ Consultation
   - ☐ Other (specify).....

10. Do you get in patient treatment?
    - ☐ Yes
    - ☐ No

11. Does the scheme cover operations?
    - ☐ Yes
    - ☐ No

12. What kind of operations?
    - ☐ Minor
    - ☐ Major
    - ☐ Caesarean section

13. Do you have any chronic illness?
    - ☐ Yes
    - ☐ No

14. If yes, which one(s)
    - ☐ Diabetes
    - ☐ Hypertension
    - ☐ Sickle cell anaemia
    - ☐ Other (specify).....

15. Do you receive treatment for them under the scheme?
    - ☐ Yes
    - ☐ No

16. If yes, do you feel it is sufficient?
    - ☐ Yes
    - ☐ No

17. How would you like for it to be improved?
    .....
    .....
    .....
    ...

18. Which services are not covered?
    .....
    .....
    .....
    ...

SECTION B: LEVEL OF FINANCIAL LEVERAGE

1. How much money do you pay into the scheme as premium?
   .....
   .
2. What is the source of this income?
   .....
   .....
   ..
3. Do you pay the money yourself?
   - ☐ Yes

☐ No

4. If not, who pays for you?
   .....
   .

5. What is the regularity of payment?
   ☐ Per visit
   ☐ Monthly
   ☐ Quarterly
   ☐ Yearly

6. What is your view about this amount?
   ☐ Very high
   ☐ High
   ☐ Fair
   ☐ Good
   ☐ Very good

7. How much premium would you be willing to pay?
   .....

8. Do you have to make any other payments directly to the health centre?
   ☐ Yes
   ☐ No

9. If yes, on what?
   .....
   .

10. How much do you have to pay?
    .....
    .

SECTION C: LEVEL OF SATISFACTION

1. Level of satisfaction with health education services.
   - ☐ Very satisfied
   - ☐ Satisfied
   - ☐ Neutral
   - ☐ Dissatisfied
   - ☐ Very dissatisfied
2. What do you feel needs to be changed?
   .....
   .

3. Level of satisfaction with family planning services?
   - ☐ Very satisfied
   - ☐ Satisfied
   - ☐ Neutral
   - ☐ Dissatisfied
   - ☐ Very dissatisfied
4. What do you feel needs to be changed?
   .....
   .

5. Level of satisfaction with outpatient services?
   - ☐ Very satisfied
   - ☐ Satisfied
   - ☐ Neutral
   - ☐ Dissatisfied
   - ☐ Very dissatisfied

6. What do you feel needs to be changed?

.....

.

7. Level of satisfaction with inpatient services?
   - ☐ Very satisfied
   - ☐ Satisfied
   - ☐ Neutral
   - ☐ Dissatisfied
   - ☐ Very dissatisfied
8. What do you feel needs to be changed?

.....

.

9. What is your perceived benefit before and after ennoblement into the scheme?
   - ☐ Very beneficial
   - ☐ Beneficial
   - ☐ Neutral
   - ☐ Not beneficial
   - ☐ Not beneficial at all

Thank you very much for your time

Appendix 2

KEY INFORMAT INTERVIEW

1. How long has the scheme been running?

.....

2. How many members are currently enrolled into the scheme?

.....

3. How many health centers are used by the scheme members?

.....

4. Which are these health centers?

.....

.....

5. What package is offered to members?

.....

.....

.....

....

6. What is the rate charged on members?

.....

.

7. What is the probation period for premium payment?

.....

.

8. How regularly do they have to pay?

.....

.

9. Are members usually able to pay in time?

.....

.

10. Does the scheme cover chronic illnesses like diabetes?

☐ Yes

☐ No

11. If not, why?

.....

.....

..

12. How is the scheme managed?

.....
.....
.....
.....

13. Is the money collected from premiums enough to run the services?

☐ Yes

☐ No

14. Are there any alternative sources of financing?

☐ Yes

☐ No

15. What are these sources?

☐ Government

☐ Donations

☐ Others (specify).....

16. What proportion of the financing is covered by these alternatives?

.....
.

17. What challenges do you face in the management of this scheme?

.....
.....
.....
.....
.....

CHECKLIST

Records of schemes history

Register for scheme members

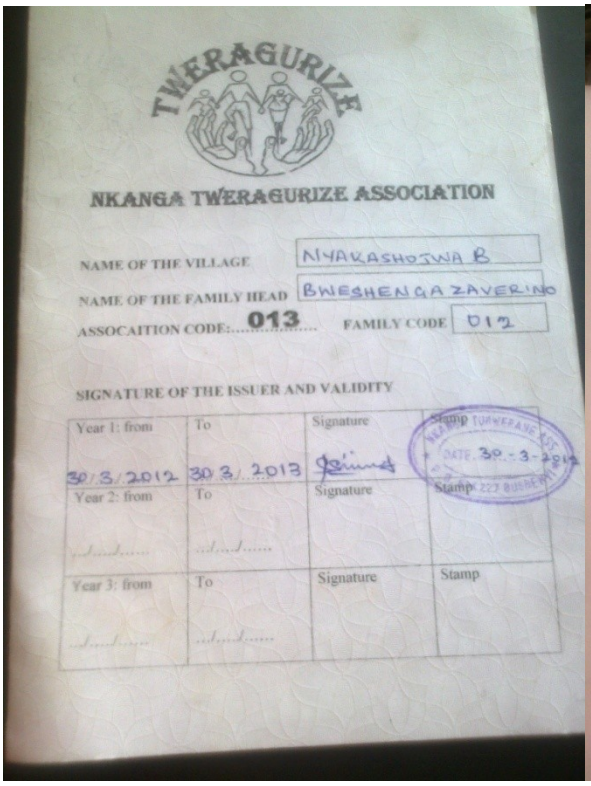
Payment schedules

Figure 4: Save for Health Bushenyi office

Figure 5; Scheme members in a meeting at a HC

Figure 6: Tweragurize info at Ishaka Hospital

Details captured on a Membership card



TWERAGURIZE

NKANGA TWERAGURIZE ASSOCIATION

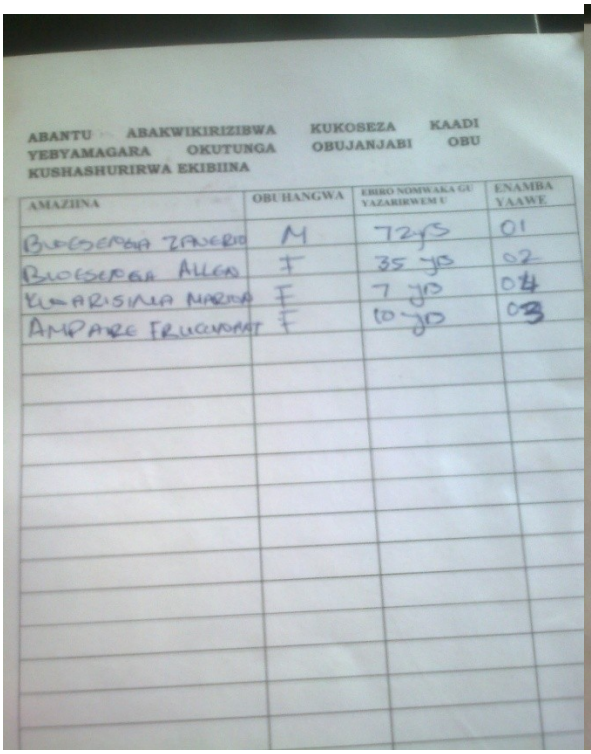
NAME OF THE VILLAGE: NYAKASHOJWA B

NAME OF THE FAMILY HEAD: BWESHENGA ZAVERINO

ASSOCAITION CODE: 013 FAMILY CODE: 012

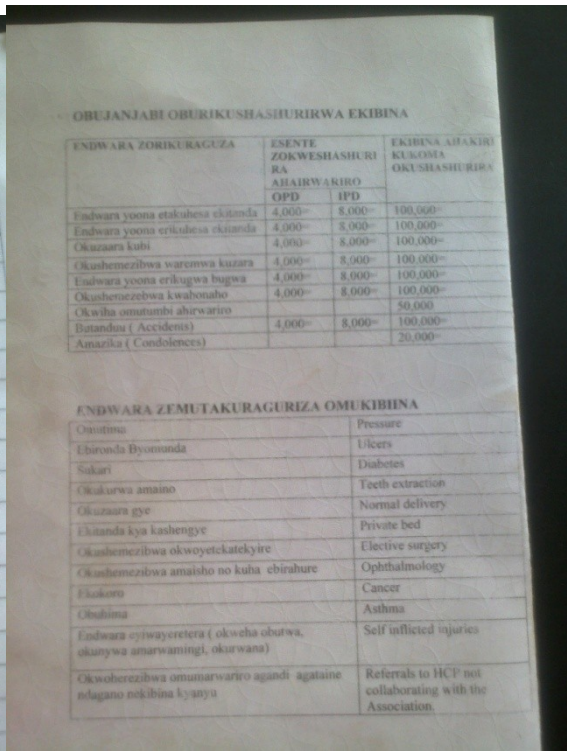
SIGNATURE OF THE ISSUER AND VALIDITY

Year 1: from	To	Signature	Stamp
30/3/2012	30/3/2013		DATE 30-3-2012
Year 2: from	To	Signature	Stamp
../...../.....	../...../.....		
Year 3: from	To	Signature	Stamp
../...../.....	../...../.....		



ABANTU ABAKWIKIRIZIBWA KUKOSEZA KAADI YEBYAMAGARA OKUTUNGA OBUJANJABI OBU KUSHASHURIRWA EKIBIINA

AMAZIINA	OBU HANGWA	EBIRO NOMWAKA GU YAZARIRWEMU	ENAMBA YAAWE
BWESENGA ZAVERO	M	72/3	01
BWESERGA ALLEN	M	35 YO	02
KWARISIMA MARIA	F	7 YO	04
AMPARE FRUCUOSAT	F	10 YO	03



OBUJANJABI OBURIKUSHASHURIRWA EKIBINA

ENDWARA ZORIKURAGUZA	ESENTE ZOKWESHASHURIRA AHAIRWAKIRO		EKIBINA AHAKIRI KUKOMA OKUSHASHURIRA
	OPD	IPD	
Endwara yoona etakuhesa ekitanda	4,000=	8,000=	100,000=
Endwara yoona erikuhesa ekitanda	4,000=	8,000=	100,000=
Okuzaara kubi	4,000=	8,000=	100,000=
Okushemezibwa waremwa kuzara	4,000=	8,000=	100,000=
Endwara yoona erikugwa bugwa	4,000=	8,000=	100,000=
Okusheraezebwa kwahonaho	4,000=	8,000=	100,000=
Okwiha omutumbi ahirwariro			50,000
Batandiu (Accidents)	4,000=	8,000=	100,000=
Anazika (Condolences)			20,000=

ENDWARA ZEMUTAKURAGURIZA OMUKIBIINA

Omutima	Pressure
Ebironda Byomunda	Ulcers
Sukari	Diabetes
Okukurwa amaino	Teeth extraction
Okuzaara gye	Normal delivery
Ekitanda kya kashengye	Private bed
Okushemezibwa okwoyetekatekyire	Elective surgery
Okushemezibwa amaisho no kuha ebirahure	Ophthalmology
Ekokoro	Cancer
Obuhima	Asthma
Endwara eyiwayeretera (okweha oburwa, okunywa amarwamingi, okurwana)	Self inflicted injuries
Okwoherezibwa omumarwariro agandi agataine ndagano nekibina kyanya	Referrals to HCF not collaborating with the Association.

Map of Bushenyi region.