

East African Community

Situational Analysis and Feasibility Study of Options for Harmonization of Social Health Protection Systems Towards Universal Health Coverage in the East African Community Partner States





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August 2014

Objective

The first objective of this study was to provide a situational analysis on existing and planned social health protection (SHP) systems in the EAC Partner States, including:

- a comprehensive inventory of existing SHP schemes in the EAC Partner States: policies; legal framework and regulation; ownership structure; financing mechanisms; technological systems; human resource capacity;
- an assessment of the suitability of existing health facilities and other infrastructure to support provision of regional, cross-border social health protection; and
- an appraisal of the political commitment towards Universal Health Coverage (UHC) in the EAC Partner States.

The second objective entailed exploring the feasibility of SHP harmonization across the EAC and generating recommendations towards supporting such a process through the EAC Secretariat. This includes defining the priority areas for harmonization of SHP systems and providing human capacity development on SHP as well as developing recommendations on harmonization towards universal health coverage across the EAC.

Executive Summary

Context. The Treaty establishing the East African Community (EAC) calls for the promotion of health and the harmonization of policies, regulations, strategies, standards and systems in the Health Sector under Chapter 17 (Art. 104 (3)) and Chapter 21 (Article 118) of the EAC. In 2005, the World Health Assembly reaffirmed: “Everyone should have access to health services without having to suffer from financial hardship in the process.” Beyond strengthening the implementation of the common market and honoring the right to health, social protection is one of the mechanisms for achieving development goals. The Kigali Ministerial Statement was signed by Ministers of Health of the EAC Partner States and Zanzibar in September 2012. In the following month (October 2012), the 8th Ordinary Meeting of the EAC Sectoral Council of Ministers of Health approved the terms of reference of a study on social health protection in East Africa. The present study was implemented following those terms of reference.

Approach. The approach involved four components: (1) A literature review of documents related to social health protection in each of the countries and related to the region as a whole; (2) national consultative workshops with key stakeholders in each country held in each national capital in March and April 2014; (3) in-depth interviews with policy makers, beneficiaries, those uncovered, civil society, directors of schemes, and donors in each country; and (4) focus group discussions, both rural and urban with stakeholders and beneficiaries.

Terminology. To best understand the present study, it is important to clarify some of the terminology involved. According to the World Health Organization, social health protection (SHP) is a system “that ensures equitable access to essential quality health services at affordable prices, with contributions to the system based on capacity to pay and benefits based on need. Universal health coverage (UHC) is a system that also ensures equitable access to essential quality health services at affordable prices. However, UHC does not specify the type of financing. Universal health insurance is an approach to achieving UHC by ensuring that the entire population is covered through a health insurance system—a financing mechanism to cover part or all of the financial cost of health services.

WHO Cube on UHC. The study relied on a cube conceptualized by the World Health Organization (WHO) that conceptualized UHC as process. Progress can be measured along three dimensions: share of the population covered, share of services covered, and share of total costs of a covered service that are paid collectively. If all three dimensions reached 100%, then UHC would be achieved.

Overview of the current situation in East Africa. Pooling the data across the five Partner States the region's total population is 145 million people. The share of the population below the poverty line is 38%. The share of the government budget devoted to health is 9%, the share of total health expenditure that is private is 36%, life expectancy at birth is 58 years, and the current share of the population covered by any health insurance system is 25%. This coverage by country, according to official figures, is 65% in Burundi, 32% in Kenya, 95% in Rwanda, 15% in Tanzania, and under 1% in Uganda.

Recommendations. The study generated recommendations regarding the role of the EAC Secretariat in SHP, required harmonization of SHP and regional portability of benefits. Based on a final regional validation, the following 20 recommendations are proposed by all EAC Partner States.

On the Role of the EAC Secretariat in SHP

1. Propose that the Council of Ministers advocate for UHC to the EAC Summit of Heads of State and invite one of them to be the policy champion;
2. Create a commission, task force, or coordinating desk within EAC secretariat to guide and monitor SHP implementation;
3. Develop a regional policy towards SHP, including the informal sector;
4. Mobilize funds for support studies around SHP (e.g. identifying the poor, defining minimum benefit package);
5. Sensitize the population and decision makers about the value of SHP;
6. Discuss reorientation of health financing policy, progressively reorienting subsidies from the supply to the demand side;
7. Encourage and offer technical support to provider-based schemes;
8. Develop capacity regarding the promotion and management of community-based health insurance (CBHI), for example, by serving the poor by allocating more subsidy to poorer areas, and selecting poor households within them;
9. Exchange of best practices in the region with data collection comparison;
10. Develop a legal framework to operationalize health insurance within the EAC Partner States.

On What to Harmonize Across EAC Partner States

11. Harmonize SHP standards across Partner States;
12. Define minimum package;
13. Create consistent accreditation systems for human resources, technology, and infrastructure;
14. Establish consistent relative pricing across providers and countries;
15. Establish incentive mechanism (e.g. performance-based financing) to improve quality and quantity of services.

On Regional Portability of Benefits

16. Establish information and computer technology (ICT) systems to access member information across countries;
17. Create electronic universal health insurance (UHI) member card;
18. Encourage EAC summit to pass resolution requiring residents to have health insurance at home and in destination country when traveling regionally;
19. Offer regional option(s) with additional fee for members of public schemes to extend coverage to other countries in the region;
20. Create an agreement among Partner States to recognize one another's public schemes.

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Ambassador Dr Richard Sezibera

Foreword

The East African Community (EAC) is a regional inter-governmental organization of the five Partner States, namely; the Republic of Kenya, the Republic of Uganda, Republic of Burundi, Republic of Rwanda and the United Republic of Tanzania, with its Headquarters located in Arusha, Tanzania. The Treaty for the Establishment of the East African Community, under Articles 104 and 108 calls for Partner States to harmonize their “labour policies, programmes and legislation including those on occupational health and safety” and “national health policies and regulations...to achieve quality health within the Community.”

These principles were reinforced by the Kigali Ministerial Statement on social health protection (September, 2012). It affirmed the Partner States’ commitment for universal health care in the region. A month later, the 8th Ordinary Meeting of the Ministers of Health in Arusha approved the Terms of Reference for a Situational Analysis and Feasibility Study on Options for Harmonization of Social Health Protection Systems towards Universal Coverage in EAC Partner States.

The present study was implemented based on those specifications. The study team of national, regional and international consultants reviewed documents, held national consultative workshops in each country, conducted interviews and focus groups discussions with ordinary citizens, Government officials, local and regional policy makers. The findings were endorsed at a regional validation workshop in Kigali, July 7-8, 2014. The study participants from all five Partner States and from the region overwhelmingly supported the expansion of social health protection mechanisms through universal health coverage in Partner States.

The most widely successful way of achieving universal coverage has been through social health insurance, described by the World Health Organization as a “system based on prepayment and financial risk pooling that ensures equitable access to essential quality health services at affordable prices.” Currently, about 25% of the region’s 145 million residents are covered through private, community-based, or government run insurance. Higher coverage could benefit residents by reducing premiums and out-of-pocket spending as a share of total health expenditures. Higher coverage also benefits schemes by reducing administrative cost per enrollee and spreading risk more widely.

The study participants gave the EAC a strong role in advancing universal health coverage. Towards that end, the EAC Secretariat plans to bring this report to the attention of the Council of Ministers and to the Heads of States for high-level advocacy. The study participants also proposed the creation of a task force or coordinating desk within the EAC Secretariat to guide and monitor the implementation of the study recommendations. Additionally, the EAC Secretariat, with the support of development partners, will ensure that best practices are shared and policies and standards are harmonized with the support of strong information, communication technology across countries.

A large, stylized handwritten signature in black ink, which appears to be 'Richard Sezibera'.

Dr Richard Sezibera
Ambassador
Secretary General
East African Community



Deputy Secretary General Jesca Eriyo

Acknowledgement

This situational analysis and feasibility study on social health protection in the EAC Partner States is a result of the thorough work of a consultancy team under the guidance of the EAC Secretariat and in co-operation with various national, regional and international stakeholders. In this regard, the EAC Secretariat wishes to acknowledge the contributions of the EAC Social Sectors and the office of the Secretary General in helping to support this study.

Furthermore, the Secretariat wishes to acknowledge the participation, dedication and commitment of government and civil society representatives from all Partner States participating during national consultative workshops, interviews and focus group discussions. During regional validation workshop, the representative of all Partner States generously donated their time and participated with energy in providing recommendations for improvements.

Key national stakeholders were drawn from the Ministries of East African Affairs, Ministries responsible for health, provider organizations, labor unions, and representatives of existing national and private schemes, academia, NGOs, and development partners. The invaluable technical and financial support provided by the Federal Republic of Germany through the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH programme 'Support to the EAC Integration Process' is acknowledged and highly appreciated.

The EAC Secretariat would especially like to thank Global Health Issues and Solutions (GHIS) and her team of national, regional and international experts for their exceptional effort to collect comprehensive information from EAC Partner States and prepare this detailed report on the social health protection mechanisms in each Partner State. Recognizing the importance of this topic, these experts became an impressive community of shared learning. Surpassing the requirements of this study, they contributed their time freely in support of a comprehensive report on social health protection in the region.

A handwritten signature in black ink, appearing to read 'Jesca Eriyo', written over a circular stamp or logo.

Jesca Eriyo
Deputy Secretary General
(Productive and Social Sectors)
East African Community

List of Abbreviations

AC	Average Cost
ADB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ASAL	Arid and Semi-arid Land
CBHI	Community Based Health Insurance
CDF	Constituency Development Fund
CEDAW	Convention on the Elimination of Discrimination Against Women
CHF	Community Health Fund
CHUK	Centre Hospitalier Universitaire de Kigali
CPPs	Core Poverty Programmes
CTAMS	Cellule Technique d'Appui aux Mutuelles de Santé
CTB	Cooperation Technique Belge
DH	District Hospital
EDPRS	Economic Development and Poverty Reduction Strategy
ESCR	Economic, Social and Cultural Rights
GF	Global Fund
Ghc	Ghana Cedis
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
HC	Health Center
HFTWG	Health Financing Technical Working Group
HFU	Health Financing Unit
HIV	Human Immune Virus
ICT	Information Communication Technology
IHSSP	Integrated Health System Strengthening Project
KfW	Kreditanstalt für Wiederaufbau, Germany
KIHBS	Kenya Integrated Household Budget Survey
LATF	Local Authorities Transfer Fund
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSH	Management Sciences for Health
MTEF	Medium Term Expenditure Frameworks
NGOs	Non-Governmental Organization
NHIF	National Health Insurance Fund
NPR	National Pooling Risk
NRH	National Referral Hospital
NSA	Non-State Actors
NSHIF	National Social Health Insurance Fund
NSHIS	National Social Health Insurance Scheme
NSIPS	National Social Insurance Pension Scheme
OVC	Orphans and Vulnerable Children
RH	Referral Hospital
RSBY	Rashtriya Swasthya Bima Yojana
RSSB	Rwanda Social Security Board
RWF	Rwandan Francs
SHP	Social Health Protection
SOP	Standard Operating Procedures
SPF	Social Policy Framework
TC	Total Cost
THE	Total Health Expenditure
UHC	Universal Health Coverage
UN	United Nations
USAID	United States Agency for International Development
VAT	Value Added Tax
WHO	World Health Organization

Glossary of Terms

Following the core concept of social health protection, the subsequent terms appear in alphabetical order.

Social health protection (SHP):

different institutions present varying definitions of SHP. We are presenting four different definitions according to the International Labor Organization (ILO), the World Health Organization (WHO), the joint action GTZ-ILO-WHO and Barya:

The ILO defines SHP as a series of public or publicly organized and mandated private measures against social distress and economic loss or reduction of earnings, or the cost of necessary treatment that can result from ill health.¹

The WHO describes SHP as: “A system based on prepayment and financial risk pooling that ensures equitable access to essential quality health services at affordable prices, with contributions to the systems based on capacity to pay and benefits based on need; and a series of measures against ill health related cost of treatment, social distress, loss of productivity, and loss of earnings due to inability to work”.²

The joint action GTZ-ILO-WHO presents SHP as a variety of financing mechanisms. Besides tax-funded health financing, social health insurance in a broad sense is one important option for countries to ensure social protection in health thereby contributing to universal coverage.³

Social health protection is guaranteed when every individual has access to the needed services when facing a risk of catastrophic expenditure which might drive people into poverty.⁴ Guaranteeing social health protection implies making progress towards universal health coverage.

Accessibility to health services:

Financial accessibility was among the main hurdles preventing rural population from accessing primary health services. Rwanda, with the introduction of the CBHI, addressed the challenge of financial accessibility as evidenced by various studies.^{5,6,7} Other sectors have contributed to geographical access via improved rural infrastructures such as roads, rehabilitation of health facilities and building health posts to support communities living further from the health centers.

Adverse selection:

This is defined as the tendency of those individuals who are at greater risk of falling ill—members of high risk groups or those who are already ill—to enroll in an insurance scheme in larger numbers than those who are at less risk of becoming ill and who are not already ill. The premiums are calculated based on the target group’s average risk of illness, so if the majority of enrollees are at high risk, the tendency will be to use the services more than average. The insurance system might collapse or go bankrupt due to frequent high expenditures.

Community-Based Health Insurance:

CBHI schemes are voluntary health insurance systems managed and operated by an organization, other than a government or private for-profit company. CBHI schemes appear particularly appropriate for providing insurance coverage to persons with limited protection from other sources, such as those who are not engaged in formal sector employment. They also seem particularly relevant to low-income countries where government revenue is limited and there is currently extensive reliance upon out-of-pocket payment.⁸

¹ International Labour Organization (ILO). (2010). World Social Security Report 2010/11: Providing Coverage in Times of Crisis and Beyond. Geneva: ILO.

² Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH. (2010). Nepal at the Crossroads: Setting the Stage for Improved Social Health Protection. Final Report of a Joint Assessment of MoHP-GTZ. Kathmandu: GTZ.

³ http://www.socialhealthprotection.org/social_protection_health.php.

⁴ World Health Organization (2010). World health report 2010 - Health systems financing: the path to universal coverage. Geneva: World Health Organization (WHO).

⁵ Lu, C. (2013). Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in Its First Eight Years. *Journal.pone.0039282*, 7(6). doi: e39282

⁶ Schneider. (2001). Pilot Testing Prepayment for Health Services in Rwanda: Results and Recommendations for Policy Directions and Implementation.

⁷ World Bank. (2012). Gender Equality and Development Washington: World Bank.

⁸ Sarah Bennet, 2004: The role of community-based health insurance within the health care financing system: a framework for analysis. *Policy and Planning*. 19 (3) 147-158.

Cost escalation:

Cost escalation applies to conditions where an insurance scheme undergoes higher running costs than revenues. This may be caused by the providers and / or patients' behaviors towards use of the services, or can be due to high administrative costs incurred during implementation. Most often, providers knowingly choose to use expensive management protocols and patients opt for expensive health care. In both cases, the actors in supply and demand for health services know well that the insurance will pocket the bill.

Equity in access:

Paying premiums may not necessarily lead to access to health services because there are several other factors that can severely affect access, such as geographical availability of services, lack of transport facilities, and varying infrastructure.

Equity in financing versus regressive system:

Social health insurance implies that members make financial contributions to the scheme. Contributions can be via a formal taxation system, via pay-roll deductions for formal sector social health insurance (SHI) schemes or via direct voluntary premium payments by beneficiaries directly to a CBHI. It is important to account for people's capacity to pay for the system to be considered equitable, otherwise, if all are paying the same amount, the system is said to be regressive whereby poorest subsidize for the richer. An equitable system is progressive meaning the wealthiest groups subsidize the poor.

Equity in social health protection

Equity in social health protection programs is very critical for the poor to access and benefit from the public and social programs, particularly from the health preventive and curative programs. The equity in access to health care is fundamental in the sense that the poor and vulnerable segments of the populations have equal right to good health as the wealthy in order to be able to live longer and work towards improving their own livelihood and national development in general.

Equity in utilization:

Likewise, achieving effective financing and access might not necessarily lead to effective utilization. Normally utilization is a factor of not only financing and access, but also the quality of the health services. Utilization comes last when all components for service consumption are in place. Poor service provision either from providers or the system may prevent clients from utilizing the services (WHO, 2010). In Rwanda, CBHI has contributed significantly to improved utilization of health services, following improved equity in financial contribution and access. Two studies have documented these positive effects with some recommendation on how to improve the utilization even further.^{9,10}

Fraud and abuse:

This occurs among both insurance subscribers and healthcare providers. On the user side when individuals not subscribed to the insurance scheme access services. For example, this can happen when the insured individual capitalizes on the loopholes in the insurance system and uses someone's identity or data to obtain services for an individual not insured. In economics, these are termed as "free riders". These cases happen in situations where there are weak checks and can be dangerous to the scheme if the scale of the behaviors becomes extensive and unchecked. Fraud and abuse by providers consist of seeking payment for fictitious or unneeded services.

Harmonization:

As part of the integration process, the EAC Secretariat is championing an effort to align different policy documents and strategies, and legal frameworks with the aim of achieving uniformity in policy and planning as the EAC encourages free movement of people and services and moves towards a political federation. In the context of SHP, harmonization expresses the willingness of EAC Partner States to agree on common guiding principles that would define similar policies and programs aimed at benefiting the citizens of the EAC Partner States.

Health insurance:

This is a type of insurance against the risk of incurring medical expenses among individuals. An insurer has a pool of individuals, develops a routine finance structure and ensures that money is

⁹ Lu, C. (2013). Towards Universal Health Coverage: An Evaluation of Rwanda Mutuelles in Its First Eight Years. *Journal.pone.0039282*, 7(6). doi: e39282

¹⁰ Makaka. (2012). Towards Universal Health Coverage in Rwanda: A Report on Homegrown Innovations to Increase Enrolment in Community-Based Health Insurance. *Lancet*

available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business or not-for-profit entity.

Ibimina:

are village-level initiatives for paying the community-based health premium; a few community members get together, and use mobile money to support each other in the payment of the premiums as well as sensitize other members in the community about the importance of the CBHI benefits.

Moral hazard: This is defined as overuse of the health services by an insured person compared to the expected use if the person were not insured. This can be induced from either the demand or the supply side of the services. From the demand side, patients might seek health services even when no real need exists. From the supply side, providers attempt to induce demand for additional unnecessary services to augment their income that is billed to the insurance.

Mutuelles:

Refers in this report to community-based health insurance in Rwanda.

Portability of health insurance across the EAC:

This means the ability of people living in the community to access health care services using their health insurance benefits/schemes within and beyond the boundaries of their individual countries within EAC Partner States. Portability assumes EAC Partners States design policies and programs that are harmonized by principle and, to some extent, linked using appropriate information technology.

Social insurance:

Barya (2011) defines social insurance as “arrangements or schemes, usually defined and prescribed by statute where people receive benefits or services in recognition of their contributions to an insurance scheme including provision for retirement pensions, disability insurance, survivors’ benefits and unemployment insurance.”

Ubudehe:

is a socioeconomic population categorization mechanism applied in Rwanda based on assets and community participation, according to the national Umuganda policy of June 2005.

Umudugudu (village):

is the smallest unit of administration in Rwanda and is based on the number of households.

Umuganda:

according to Law No. 53/2007 of 17 November 2007 establishing community works in Rwanda refers to members of the community gathering to carry out a work of public interest, usually every Saturday of the last week of the month. Such gatherings serve as a platform for local leaders to pass key national policy priorities.

Universal Health Coverage (UHC):

The idea of UHC requires that every individual has access to needed quality and quantity of health care services without imposing financial risk to the people who seek such services. Ensuring access to needed services to every individual implies equity in access to health care. In this case, access to health care services should not be determined by financial ability but by need. Those with high income need to subsidize the poorest and those with good health subsidize those with poor health. This is what is considered to be cross-subsidization within the broad concept of social health protection and universal health coverage.

The WHO defines UHC as the desired outcome of health system performance whereby all people who need health services (promotion, prevention, treatment, rehabilitation and palliation) receive them, without undue financial hardship. UHC has two interrelated components: the full spectrum of good-quality essential health services according to need, and protection from financial hardship, including possible impoverishment, due to out-of-pocket payments for health services. Both components should benefit the entire population.

¹¹ Barya, John-Jean, Social Security and Social Protection in the East African Community, Fountain publishers Kampala, 2011, pg. 16.

¹² Monitoring progress towards universal health coverage: a conversation with civil society partners, 21 January 2014. Geneva: World Health Organization; 2014 (http://www.who.int/entity/healthinfo/universal_health_coverage/UHC_Meeting_CivilSociety_Jan2014_Report.pdf?ua=1, accessed 29 March 2014).



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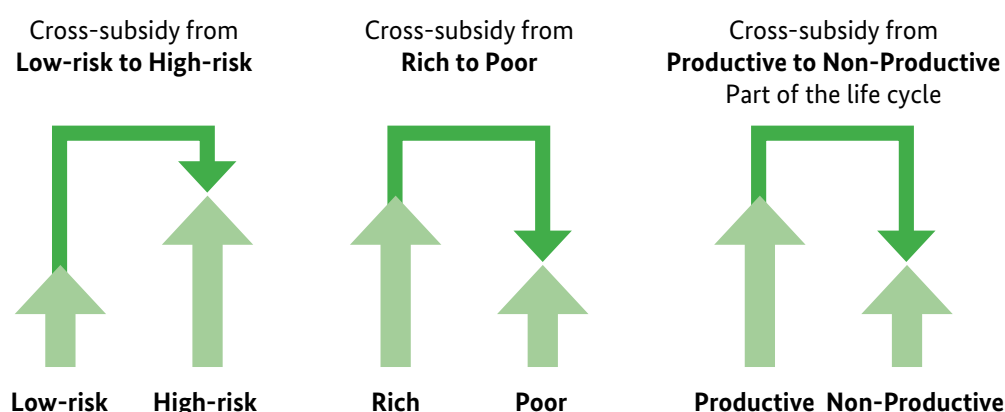
Introduction

1. Introduction

1.1 Historical and International Context

Social health protection aims, amongst other things, at providing universal health coverage for all people and protecting them from catastrophic health expenditures which might lead individuals to fall into poverty; it also provides financial protection for those who become sick or injured after accidents. With these core guiding principles, universal coverage aims at providing access to affordable quality health services¹³ needed by individuals. Social health protection implies using the principle of equity based on solidarity through cross-subsidies in which within a community the richer subsidize the poorer; the healthier, the sicker; the productive, the non-productive, whether no productivity is based on life-cycle stage or health. This can be done through government or social programs such as vouchers, free care and insurance. Figure 1 below illustrates these processes.

Figure 1: Equity Based on Solidarity



Source: Preker, Alexander S. Spending Wisely, World Bank: http://www.hifcorporation.com/files/pages/events_webinars/Session%20III%20Spending%20Wisely.pdf, accessed 17 Aug 2014

Chancellor Bismarck of Germany initiated the world's first social health protection system in the year 1881.¹⁴ Bismarck was mainly motivated to introduce insurance for the workers in order to promote their wellbeing as a way to keep the German economy operating at maximum efficiency. More than 120 years later, many countries have adopted the system in various contexts and forms. While most developed countries have come up with formal social health protection systems, the lower- and middle-income countries (LMIC) are still struggling to develop health protection systems based on the Bismarck model. Despite various efforts, however, a large section of population especially those in the informal sector have been left out of SHP.

Empirical studies have indicated that the CBHI of the 19th century was quite different from the current CBHI design, because in the 19th century, individual communities voluntarily came together to create community resource pooling. But today, the CBHI schemes are mainly the result of a top-down approach used by policy makers or by foreign donors.¹⁵ The LMIC have recently focused on developing health insurances that mainly cover the formal sectors (civil servants), and for other individuals capable of paying for private health insurance. After the inception of the Millennium Development Goals (MDGs) by the United Nations General Assembly¹⁶, many low-income countries (LIC) have tried to scale up high impact and low cost interventions to expand the coverage and access to the main health interventions reflected in the MDG, such as maternal and child services (MCH). But, with failure to design appropriate health insurance mechanism for the informal sector, the scale up of these interventions has proved to be unsuccessful.

¹³ Source: World Health Report 2010, www.who.int/whr

¹⁴ Health insurance was developed on the principle of occupational (labor) basis and it was a requirement that for every occupation, therefore the administration of health insurance was compulsory and jointly controlled by employers and employees who made their own contracts with particular doctors and hospitals for the provision of services. <http://www.britannica.com/EBchecked/topic/551402/social-security/38948/Social-insurance>

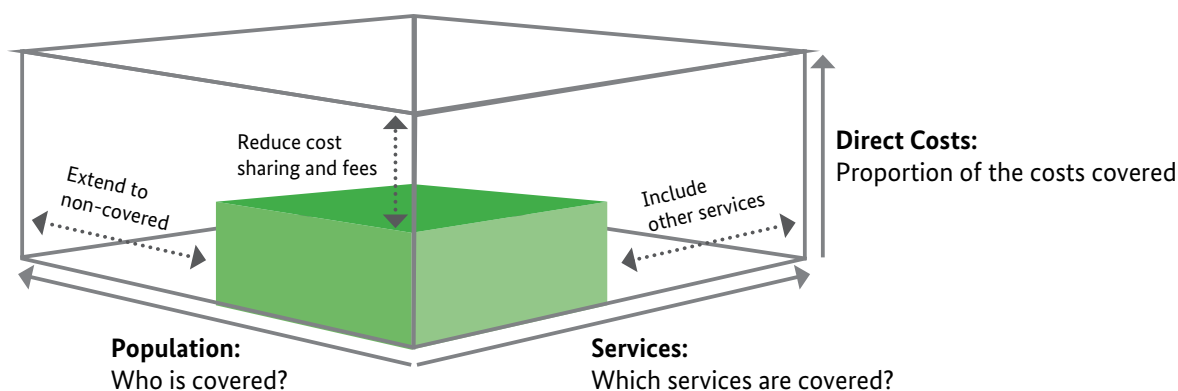
¹⁵ Meessen, 2012, Studying the link between institutions and health system performance: a framework and an illustration with the analysis of two performance-based financing schemes in Burundi.

¹⁶ United Nations. Millenium Development Goals and Beyond 2015. Available at: <http://www.un.org/millenniumgoals/>.

Social health protection and universal health coverage are important concepts for developing countries because they address the burden of many individuals who face high health expenditures when paying out of pocket for health services, thereby aggravating the poverty of the majority of the population. Because quality health services are relatively expensive, even in the rich nations, providing affordable health services to the population has become an ideal situation that more and more nations strive to achieve but have not yet reached fully. This makes SHP a process rather than a destination, as experts say, because it requires progressive and careful financing for health.

The World Health Report of 2010 conceptualized SHP as a three-dimensional cube with axes of population covered, types of services covered, and degree of financial protection provided, as shown in Figure 2. This framework will be used in this report both to describe the current situation in the five EAC Partner States, which are the Republic of Burundi, the Republic of Kenya, the Republic of Rwanda, the United Republic of Tanzania and the Republic of Uganda.

Figure 2: The Three Dimensions of Universal Health Coverage



Source: WHO Report 2010, WHO, <http://www.who.int/whr/2010/en/index.html>

The International Labor Organization (ILO) Convention No. 102, 1952, sets out the minimum standards and the right to social security in a broader sense to include the right to protection at old age, the right to health care, the right to sickness benefits, the right to unemployment benefits, the right to workers' compensation and the right to disability and maternity benefits, including: prenatal, child birth and post-natal care. Our concern in this report is SHP, as stated in the Terms of Reference of the study.

The EAC Secretariat, based in Arusha, Tanzania, is the organization's executive arm. The EAC has already achieved harmonization in other sectors, for example, a customs union allowing free movement of goods among Partner States. The EAC Secretariat seeks to harmonize resources, experiences and knowledge sharing to establish a sustainable system of SHP within the EAC region. A vibrant SHP system has the potential of protecting most households from catastrophic health care expenditures from very high out-of-pocket costs of health care.

The definition of UHC stated above embodies three related objectives:

1. Equity in access to health services - those who need the services should get them, not only those who can pay for them;
2. The quality of health services is good enough to improve the health of those receiving them;
3. Financial-risk protection - ensuring that the cost of using care does not put people at risk of financial hardship.¹⁷

¹⁷ Source: www.who.int/health_financing/universal_coverage_definition/en. Accessed 15 June 2014.

1.2 Legal and Institutional Framework

There are a number of international conventions and regional legal frameworks that underpin social security and SHP in the EAC Partner States. Key instruments are listed below:

- The Universal Declaration of Human Rights of 1948 stipulates that every human being has the “right to a standard of living adequate for health and well-being of himself and his family, including: food, clothing, housing and medical care and necessary social services and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”;
- The International Covenant on Economic, Social and Cultural Rights of 1966, Social and Cultural Rights (ICESCR) demands “the right of everyone to social security, including social insurance”;
- The Convention on the Rights of the Child guarantees the rights of children to health, proper nutrition and education; social security, including social insurance; development (physical, mental, spiritual, moral and social);
- The African (Banjul) Charter on Human and Peoples’ Rights of 1981 guarantees the right to physical and mental health among others;
- Chapter 17 (Art. 104 (3)) and Chapter 21, (Art. 118) of the Treaty establishing the EAC;
- Art. 39 (3) of the Protocol on the Establishment of the East African Community Common Market;
- Art. 12 (1) of the Convention on the Elimination of All forms of Discrimination Against Women (CEDAW);
- Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa (Maputo Protocol);
- Chapter 14 of the Common Market for Eastern and Southern Africa (COMESA).
- African Commission on Human and People’s Rights;
- African Peer Review Mechanisms;
- WHO Commission on Social Determinants of Health 2005-2008.

At the regional level, the harmonization of SHP systems was initiated by a series of events that included the following:

1. The 3rd (2006-2010) EAC Development Strategy;
2. The Kigali Conference on social health protection was organized in September 2012 and ended with a Communiqué signed by Ministers of Health of the EAC Partner States in order to support universal health care in the region i.e. the Kigali Ministerial Statement;
3. The 8th Ordinary Meeting of the Ministers of Health held in October 2012 in Arusha approved the Terms of Reference (ToRs) for the Situational Analysis and Feasibility Study on Options for Harmonization of Social Health Protection Systems towards Universal Coverage in EAC Partner States;
4. In the spirit of the implementing the Common Market Protocol, the 8th Ordinary Meeting of the EAC Sectoral Council of Ministers of Health held on 11th October 2012 in Arusha, Tanzania agreed to find ways of implementing the recommendations thereof;
5. The 4th (2012-2016) EAC Development Strategy.

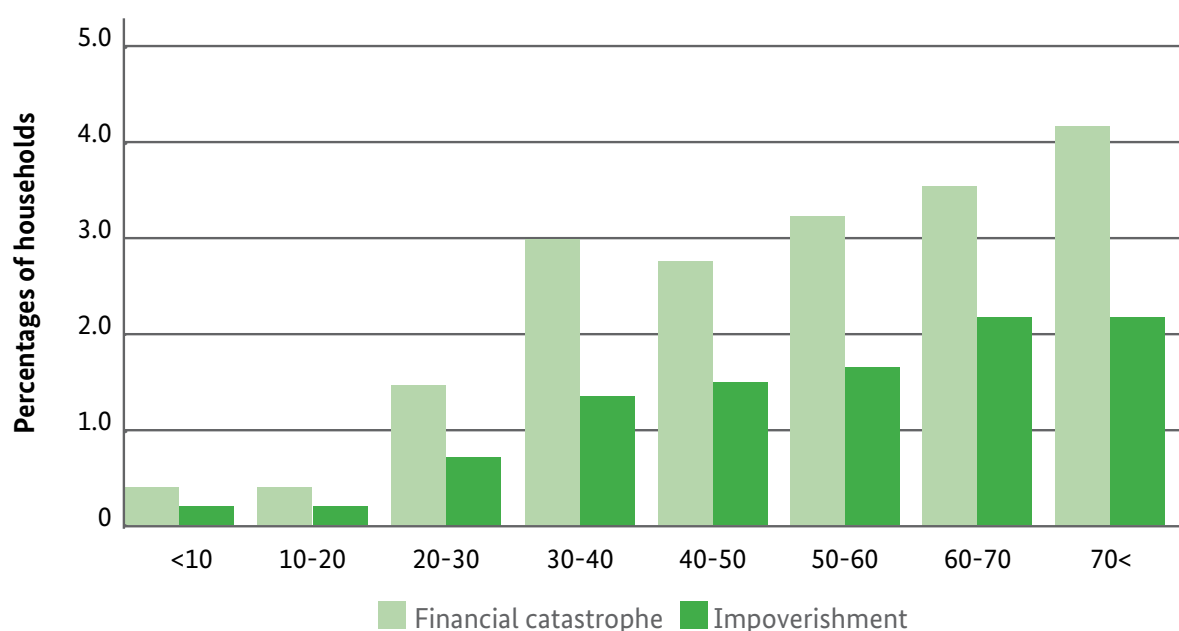
This assessment presents an understanding of current SHP mechanisms in EAC Partner States, challenges and potential options for improvements in order to prepare further steps for the harmonization of such mechanisms.

There is consensus among policymakers in the EAC Partners States that social protection can be a powerful tool to address poverty issues and promote inclusive growth. This consensus is clearly articulated in the African Union’s Social Policy Framework (SPF), which was endorsed by African heads of state in 2009. The SPF commits governments to progressively realizing a minimum package of basic social protection that covers: (i) essential health care and (ii) benefits for children, informal workers, the unemployed, the elderly, and people with disabilities.

1.3 Social Health Protection and Development

There is a vicious cycle between poor health, expensive care and poverty. Figure 3 shows the link between a higher share of out-of-pocket expenditures worldwide and households annually suffering from financial catastrophe or impoverishment due to catastrophic health expenditures.¹⁸ Some efforts are being done internationally through the UN MDGs to reduce poverty using SHP as one efficient tool for inclusive development. Regional efforts are also being made mainly through the European Union with its Agenda for Change that sets out the European Union policy on future development cooperation and gives an understanding of the link between SHP and development. The Agenda for Change calls for a more comprehensive approach to human development and supports increased access to quality health among other social services for inclusive growth, which depends on “people’s ability to participate in and benefit from wealth and job creation”.¹⁹ The East African Community is now attempting to make the region embrace SHP as a mean to promote inclusive growth and attain the MDGs.

Figure 3: Out-of-Pocket Spending and Financial Impact – Worldwide



Source: World Health Report 2010, WHO, <http://www.who.int/whr/2010/en/index.html>

1.4 International Experiences with Social Health Protection (SHP)

Social Health Insurance in Ghana

Introduction: Ghana, which is among only few African countries to pass a national health insurance law, earmarked substantial amount of funding to establish a National Health Insurance Scheme (NHIS) as a viable alternative health care financing mechanism to provide universal health coverage for the entire population. The NHIS evolved from the few existing Community-Based Health Financing Schemes in various places dotted around the country. Based on the success of these community-based schemes, the national health insurance legislation (National Health Insurance Act 650, 2003) was enacted in 2003 to pave the way for the establishment of a coordinated and comprehensive pro-poor social health insurance scheme. A legislative instrument (LI1809) was adopted in 2004 to guide the implementation of the scheme.

The goal of the NHIS was to provide universal health insurance coverage for all people resident in Ghana by the 5th year of its establishment. The NHIS law made provision for the establishment of three different types of health insurance schemes: district mutual health insurance scheme, private voluntary health insurance scheme and private commercial health insurance scheme. However, only

¹⁸ Source: WHO report 2010, WHO, <http://www.who.int/whr/2010/en/index.html>

¹⁹ European Commission: Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, 2012.

the district mutual health insurance schemes are eligible for government subsidy. The government explored multiple sources of funding to finance the NHIS such as a 2.5% deduction from workers social security contribution, a 2.5% sales tax (value added tax) for health insurance, of Ghana cedis (Ghc) 12.00 (\$6.00) per annum, government budgetary allocation, donations and investment from accruals to the national health insurance fund. The NHIS has achieved moderate success since its establishment a decade ago. For the first five years of its implementation, it achieved an enrollment rate of more than two-thirds of the population and generated enough fund from multiple sources to finance the scheme, according to the National Health Insurance Authority.

A key factor in the success is a strong political will behind the implementation of the NHIS. The government in power was determined to have the NHIS succeed in order to retain power in the subsequent elections (NHIS was a campaign promise of the major political parties). Also, the government adopted a multifaceted and all-involving marketing approach that included social mobilization and marketing; community mobilization; local and national media campaigns; civil society, workers unions, NGOs, Ministry of Health involvement at the national and grassroots levels and also use of renowned religious and traditional leaders to voice the NHIS message in their jurisdictions. The fast growing success in enrollment in the NHIS has been eroded to 38% in 2013 from the estimated 67% in 2010 (MOH).²⁰

This is unwanted but not surprising because the NHIS faced major challenges that could have accounted for this decline. Some of the challenges included contradictory politics about NHIS, increased pressures on health facilities in terms of increased out-patient utilization of health care which resulted in poor quality services, increased waiting time, undercover payments, providers' delayed service or rejection of insured patients as a result of delayed claims payment to providers by the government and delays in the issuance of insurance cards to registered members (NHIA, 2010; Durairaj, D'Almeida and Kirigia 2010).

Despite these challenges, the NHIS of Ghana is moving towards universal health coverage in Ghana. East African countries, in their quest for developing their social health insurance, can draw on both the positive experiences and challenges of the Ghana NHIS to initiate their implementation process in their country-specific contexts.

Experience of India²¹

Introduced in several States of India, The National Health Insurance Scheme – Rashtriya Swasthya Bima Yojana (RSBY) – was created by the Prime Minister with the aim of improving poor people's access to quality healthcare. An insurance selected through tender by the Government was given subsidies for the poorest and it was supposed to reimburse hospitals. Members were provided with a smart card containing all information; they were not paying any fees in co-payment and were reimbursed with annual fixed amount for their transport. Six months after initiation in early 2010, an impressive 85% of eligible households in the sample were aware of the scheme, and 68% had enrolled.

As often happens with complex schemes, delays and challenges may arise. For the present scheme, too, not everything was perfect: at the beginning, the scheme was hardly operational and many hospitals complained of a lack of training and delays in the reimbursement of their expenses. Some evaluators suggested a road map should have been prepared in advance: The first problem was coordination between the various departments entrusted with the implementation of the scheme; the second was the need for improvement in RSBY. The third issue was the capacity of staff to use appropriate technology, and, finally, the issue of misaligned incentives has been important (Rajasekhar et al, 2011).

These two examples, in addition to Rwanda (discussed below) show that even poor countries can implement social health protection with the most important ingredient being political commitment. Another plus is to learn from others' past mistakes and come up with a stronger design, possibly including a roadmap in advance of implementation.

²⁰ Republic of Ghana, National Health Insurance Authority (2010). Annual Reports

²¹ Implementing Health Insurance: The Rollout of Rashtriya Swasthya Bima Yojana in Karnataka http://scholar.google.com/scholar?hl=en&q=Rashtriya+Swasthya+Bima+Yojana+&btnG=&as_sdt=1%2C5&as_sdtpr= (Accessed 15 June 2014).

1.5 Social Health Protection in the Context of the East African Community (EAC)

Social (health) protection is not a new concept to the East African Community. It has been part and parcel of the traditional African values based on solidarity and “the brother’s keeper” which date back to the pre-colonial era. Traditional systems of social protection were based on the traditional (extended) African family and clan. Many communities, both state or stateless relied on the traditional family, clan or communal systems to provide social (health) protection for themselves and handed it down to their descendants. In the East African context, according to Barya (2011), social protection was based on the social structure of a particular community. Even though formal social security systems did not exist, the society employed the traditional family and kinship relationships to provide social protection (Barya, 2011; Ouma, 1995).

To strengthen SHP in the EAC region, the Treaty establishing the East African Community calls for harmonization of policies, regulations, strategies, standards and systems in the Health Sector under Chapter 21 (Article 118) of the EAC. The third EAC Development Strategy 2006-2010 and the 19th Ordinary Meeting of the EAC Council of Ministers in November 2009, following the 2nd Forum of EAC Ministers responsible for Social Development in (EAC/CM 19/Decision 58), recommended a regional study on harmonization. The Kigali conference on SHP in the EAC, held from September 11-13, 2012, was attended by experts and ministers of the five east African countries. It ended with the Kigali Ministerial Statement on Universal Health Coverage and Long-Term Harmonization of Social Health Protection in the East African Community.

Partner States continue to strengthen regional cooperation and integration aimed at ensuring a fully functional common market; the five Partner States will endeavor to provide social protection to ensure portability of health services that will go along with the movement of people and services. As part of this endeavor the EAC initiated this study to make a baseline assessment of SHP mechanisms already existing in all Partner States before further steps are taken towards harmonization and further refinements of existing mechanisms. This is in line with the commitment of Partner States to allow access to health care services within the region as stipulated in the Chapter 21 (Article 118) of the EAC Treaty for the establishment of the regional body.

In addition to facilitating the implementation of the common market protocol, it is critical for the EAC to provide social protection in health from a human rights perspective. As reaffirmed by the World Health Assembly in 2005: *“Everyone should have access to health services without having to suffer from financial hardship in the process.”* Beyond strengthening the implementation of the common market and honoring the right to health, social protection is one of the mechanisms for achieving development goals.



2

Approach

2. Approach

2.1 Study Objectives

The solicitation specified the following goals for this study:

1. Review and analysis of documents (including actuarial studies) on existing and planned social health protection systems, services and implementation mechanisms in the five EAC Partner States, highlighting harmonization opportunities across the various policies and mechanisms;
2. Compile a comprehensive inventory and analysis of the existing public and private (including community-based schemes) social health protection systems, services and implementation mechanisms in the five EAC Partner States (including policies, legal framework and regulation, ownership structure, financing mechanisms, technological systems and human resource capacity);
3. Assess the suitability of existing health facilities and other infrastructure to support provision of cross-border social health protection services in the five EAC Partner States;
4. Analyze the feasibility of an automated regional SHP Management Information System for the EAC Secretariat;
5. Identify common guiding principles and guidelines for health coverage in the five EAC Partner States;
6. Assess the political commitment towards universal health coverage in the five EAC Partner States (through interviews and as far as possible through actual legislative documentation);
7. Define the priority areas for harmonization of and capacity development on SHP within the context of harmonization in the EAC (consultants to build in a learning function in their discussions, especially for those countries that are at the beginning of developing appropriate health insurance or pre-payment mechanisms);
8. Develop recommendations on harmonization and implementation of Social Health Protection systems/mechanisms towards universal health service coverage in the five EAC Partner States.

2.2 Overview

To respond to the objectives of the study, three analytical frameworks were used: the WHO policy cycle, the financing for health care and the quality of services.

Using the **WHO policy cycle framework**, the study will provide an understanding of each country's:

1. Vision of SHP and universal health coverage,
2. Current situation vis-à-vis its vision,
3. Analysis of the health financing system,
4. Barriers to achieving the vision,
5. Strategies for improvement,
6. Policies and implementation plans and the legal frameworks existing,
7. Monitoring and evaluation processes of progress towards realizing the vision.

The **financing framework** defines the generation, pooling, and allocation of resources:

1. Resource generation: this defines how the countries generate resources for health care.
2. Resource pooling: discusses the ways countries pool resources together to support health services.
3. Resource allocation refers to the avenues used to make available resources for health care.

The **quality framework** provides details of the structure, process and outcome for providing services:

1. The structure-framework will provide information on the infrastructure, human resource, equipment, etc. aimed at supporting SHP mechanisms.
2. The process-framework will provide information on how things are done and may be a useful tool to identify intermediate players. This will provide insight into improvements that could make SHP systems more efficient, scalable and regionalized.
3. The outcome-framework will provide information on the quality of SHP mechanisms in each country. The population, staff, donors and policy makers' satisfaction on current and planned SHP mechanisms will be explored, including the current strengths and constraints of the existing institutions in providing SHP.

2.3 Data Collection and Analysis

To achieve its objectives and provide evidence on the frameworks suggested, this study used a five-stage data collection process. To capture fully the varied experiences within each Partner State, the study triangulated quantitative and qualitative data. The consultants maintained close contact with the EAC Steering Committee, the EAC Secretariat, GIZ Arusha and Partner States' relevant institutions during the study period through meetings and/or teleconferences. During data collection at the country level, each team endeavored to follow the steps described below:

Step 1. Making an inventory of documents, relevant data sets, and related projects: The study identified documents and statistics on social protection, including private and public health schemes, the number of people covered and those not covered, level of contribution and level of financial status of each scheme.

Step 2. Reviewing identified documents, data sets and projects: Attention was paid to members of the population not covered by any mechanism and the reason why they are left out. All legal, policy, program ownership and oversight and financial (level of investment and financing) documents related to any type of social protection mechanism or insurance were consulted. Documents providing information on each country's capacity in terms of human resources and technology were identified and analyzed. A review of documents related to the quality and standards of existing health facilities was conducted.

Step 3. Assessing the on-the-ground reality against written documents: Qualitatively, multiple methods were used and included all stakeholders at the country level. A consultative meeting with key players was organized at national level. To ensure a fair dialogue of different segments of the population, focus group discussions were conducted in each country to capture the reality on the ground. Each country's stakeholders gave their suggestions concerning achieving universal coverage. Rural and urban areas were represented; the selection of where to conduct focus group discussions aimed at maximizing variations within each country.

Step 4. Data analysis: Quantitative and qualitative data collected during document review, interviews and focus group discussions were analyzed and a mapping of each country's experience completed. The analyses of the data available provide insight into the situation of each EAC Partner State's capacity with regard to SHP policy and implementation.

Step 5. Proposals for change and harmonization: Particular emphasis was placed on analyzing proposals for change obtained through interviews and focus groups in each country. Similarities and differences across these were assessed and considered in relationship to the unique experiences and circumstances of each country. The interviews and discussions explored potential steps to harmonization.



3

Comparative Overview of SHP in EAC Partner States

3. Comparative Overview of SHP in EAC Partner States

The current vision of SHP for EAC Partner States is outlined in the Kigali Ministerial Statement that re-affirmed the Tunis Declaration of July 4-5, 2012²² stating that health is instrumental to economic growth and to reducing inequality and poverty. Furthermore the Ministers of Health recognized that Partner States are moving towards UHC and are all united in a shared commitment to improving the health status of their populations. The Ministerial statement called upon the EAC, parliamentarians, donors and civil society to support the statement and proposed the establishment of a regional committee or body on SHP for guiding strategy, implementation and collaboration among EAC Partner States with three primary goals:

1. Promoting best practices aimed at universal health coverage across the region;
2. Defining a framework for the long-term harmonization of SHP mechanisms across the EAC Partner States;
3. Consolidating the development of partners' action plans to support the Kigali statement in line with the prevailing environment in each Partner State.

During regional interviews, respondents confirmed that SHP is a priority for the region:

"... when it comes to health policies, SHP is a regional priority... It is a regional concern but it should be a local issue. It is critical that Partner States provide safety net mechanisms that should be handled locally. National governments have the responsibility to provide protection for their citizens. This should come from national leadership; national leaders should create a supportive culture towards the development of SHP with the needed financing and accountability mechanisms..." (regional interviews).

"At EAC level, we are integrating further and implementing the common market protocol with free movement of people and services. With harmonization of SHP, people will be assured of similar services as we march towards political federation..." (regional interviews)

All EAC Partner States have tried different initiatives to promote SHP: some have harmonized programs at the national level, some have fragmented initiatives and others have just initiated comprehensive national programs. They are at different levels of policy-making implementation, and financing. Table 1 presents comparative data on key indicators that shed light on social health protection mechanisms in EAC Partner States. These indicators are: the percentage of the population living under the poverty line, government expenditure on health as a percentage of total government expenditure, private spending on health as a percentage of total spending on health, life expectancy at birth, the percentage of the population covered by some kind of SHP mechanism and lastly, stakeholders' opinion on whether the coverage is effective or not. This final column is aimed at crosschecking the current situation as reported in focus groups and interviews against statistical reports.

²² The Tunis Conference was a high-level dialogue between Ministers of Finance and Health on value for money, sustainability and accountability in the health sector. The conference gathered over 50 Ministers of Finance and Health and/or their representatives from 33 African countries and parliamentarians as well as over 400 participants from the public and private sectors, academia, civil society and media globally.

Table 1: General Indicators Related to SHP in all EAC Partner States

Country	Total population	% Poor (poverty line)	Gov. budget for health*	Private health spending	Life expectancy at birth	Population covered	Effective coverage
Burundi	9,373,882	67.0%	12%	40%	51	65%	Coverage not effective, insufficient subsidies. Poor quality of care and under the table payment
Kenya	44,037,656	45.9%	8%	37%	56	32%	Effective but limited in benefits
Rwanda	10,515,973	44.9%	17%	11%	64	95% ²³	Effective but fluctuating and moving towards sustainability
Tanzania	44,928,923	33.6%	10.3%	31%	60	15%	Low effective coverage
Uganda	36,345,900	24.5%	7%	49%	59 ²⁴	<1%	Limited coverage, Poor quality of care, Under the table payment
EAC	145,202,334	38.0%	9%	36%	58	25%	

Sources: Country Studies of the EAC Partner States (see Annex 1)

As illustrated in Table 1, most EAC Partner States have not yet met the Abuja commitment of allocating at least 15% of total Government expenditure on health. The Ugandan and Kenyan Governments are the lowest contributors to health, while Rwanda stands as the only country that has met the Abuja target. Tanzania and Burundi are approaching the Abuja commitment. Government expenditure on health is an indicator that shows how committed any government is towards improving the health status of its population. All EAC Partner States should strive to increase their spending on health to allow for the development of SHP mechanisms and meet UHC.

Each EAC Partner State is facing its own challenges when it comes to SHP; while Rwanda is advanced and currently discussing issues of fine-tuning its system towards sustainability, Uganda is enthusiastic to initiate its first public SHP system. Although Uganda currently has no public funded insurance scheme, it has the potential of using the current momentum built for SHP in the region to design a system based on best practices that meets the region's requirements. Burundi, Tanzania and Kenya have made significant efforts to target different segments of the population in need of care. However, participation of all stakeholders in designing and monitoring the schemes has not been effective: according to stakeholders, there is more on paper than there is in reality. Whereas in these countries,

²³ Rwanda Fourth Population and Housing Survey, 2012

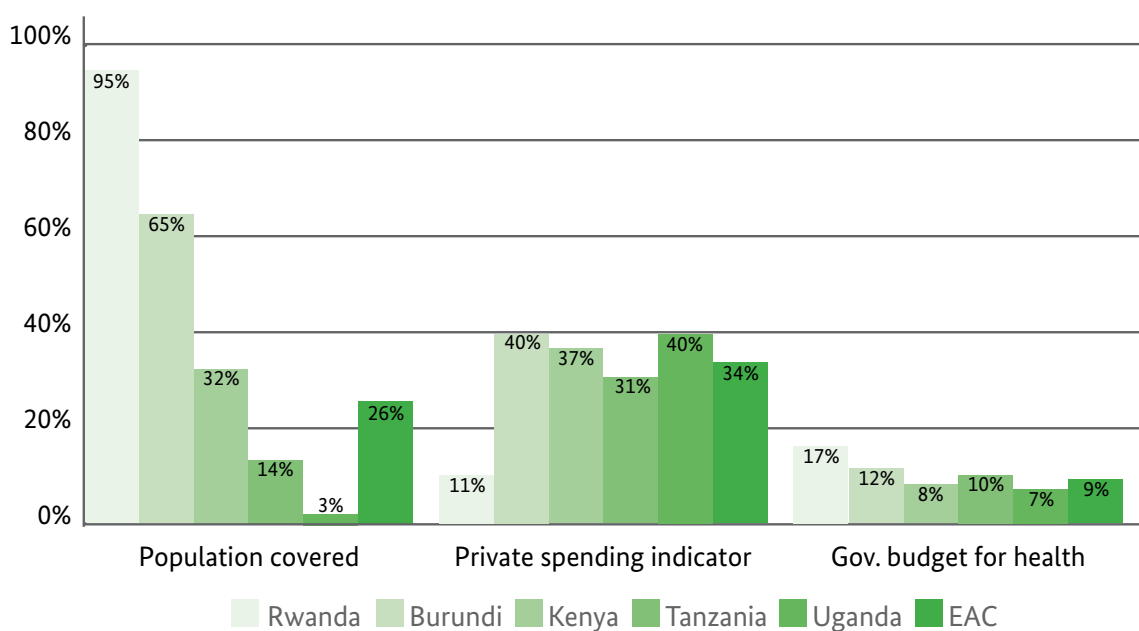
²⁴ www.countryeconomy.com/demography/life-expectancy/uganda (2012)

“free care is provided” for some segments of the population, in practice, there is little if any effective “free” care. Overall, in these three countries, as well as Uganda with its free care for military and police, documents and focus groups found the free care system went along with poor quality of services due mainly to unmotivated staff, drugs out of stock and the under-the-table payment system.

In addition to government spending on health, the percentage of the population covered under some kind of SHP scheme is an important indicator of the progress towards UHC. Figures 4a, 4b and Table 1 show the consistent positive association between increased government spending on health and the population covered and the level of private spending on health, respectively. Rwanda has the highest population covered with some kind of SHP scheme, but this does not come with zero cost to the government because it also has the highest government budget allocated for health. As a return on the investment, the country also has the lowest private spending on health, which allows the population to focus on development.

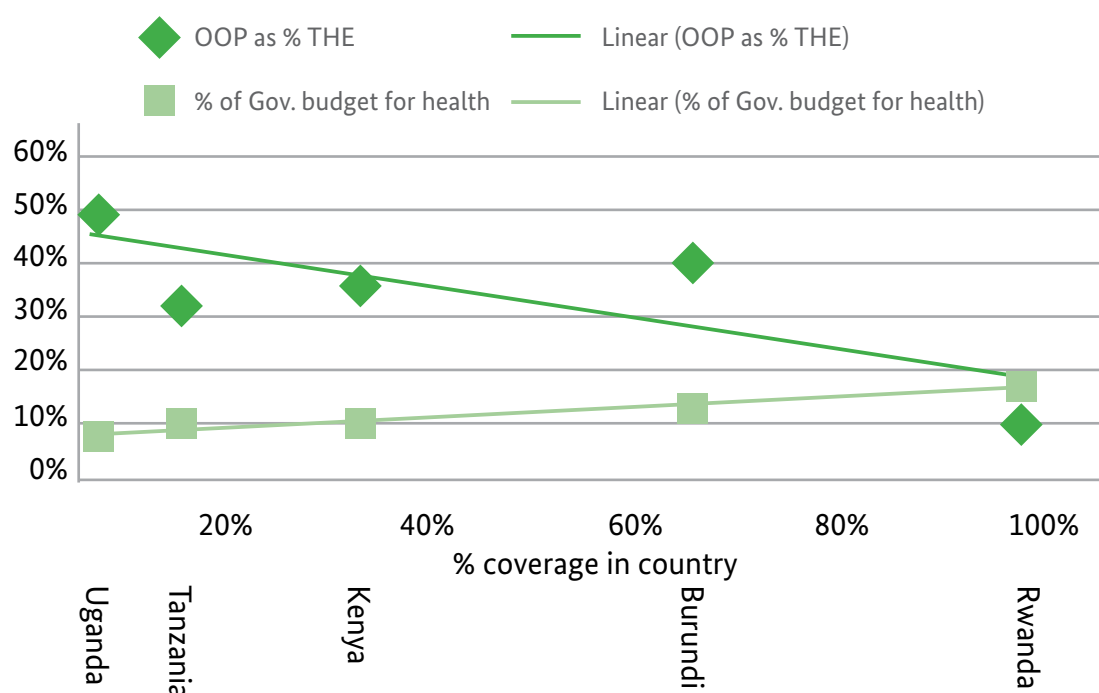
The Republic of Burundi has a comparatively high government budget allocated for health, and is the second performer when it comes to the population covered by some kind of SHP scheme, but these facts differ from country statistics which report it as having the second highest private spending on health. This was explained by stakeholders during consultative meetings “coverage is not effective and what is on paper does not reflect the reality...”. The high government spending on health shows that the system may not be efficiently using resources to allow for the careful targeting of subsidies to go to those most in need. This is consistent with the interviews that revealed the “lack of rational selection of the indigents with insurance cards sometimes being allocated by politicians during campaigns...”

Figure 4a: Financing Indicators in EAC Partner States



Sources: Country Studies of the EAC Partner States (see Annex 1)

Figure 4b: Out-of-Pocket (OOP) and Government Budget Relative to Insurance Coverage by Country



Sources: Country Studies of the EAC Partner States (see Annex 1)

Table 2: Number and Location of Health Providers

Country	Number of Providers		Population per Provider		% of Providers in Urban Areas*	
	Doctors	Nurses	Doctors	Nurses	Doctors	Nurses
Burundi	1,000	6,900	9,231	1,349	51%	21%
Kenya	7,900	33,900	5,600	1,300	50%	15%
Rwanda	700	8,800	15,428	1,200	50%	30%
Tanzania	4,000	13,600	11,100	3,300	n.a.	n.a.
Uganda	3,700	32,800	9,844	1,109	80%	60%
EAC	17,300	96,000	8,393	1,513	58%	35%

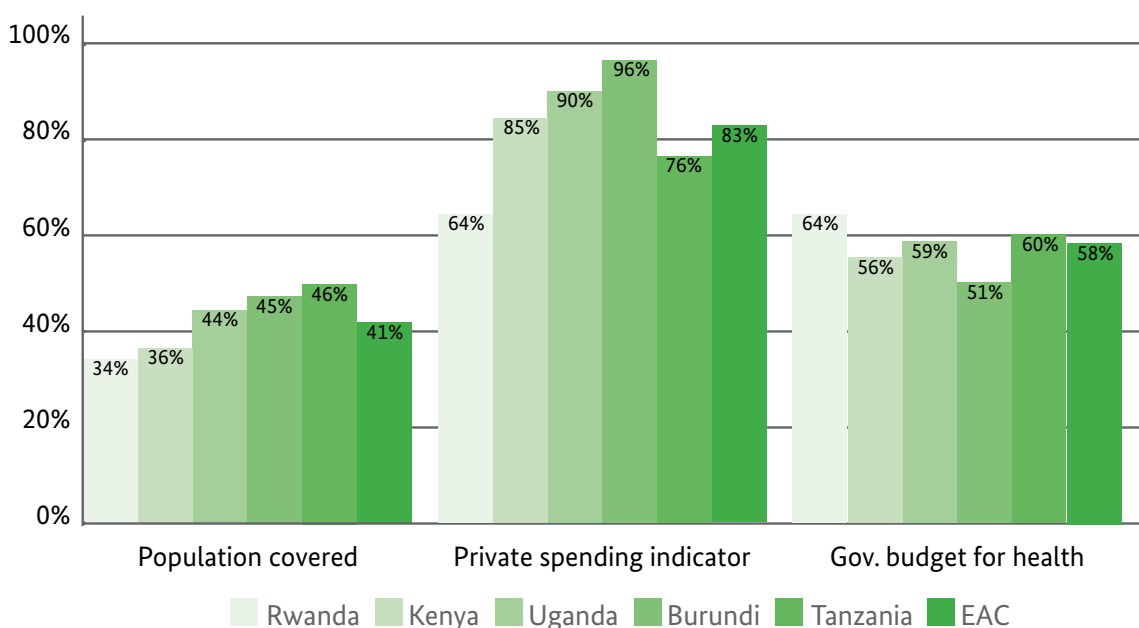
* Average for EAC excludes Tanzania, as data were not available. Sources: Country Studies of the EAC Partner States (see Annex 1)

Of the five EAC countries, Uganda has the lowest budget allocated to health and presents a population with highest private spending on health. When the government's contribution is low, individuals incur higher private spending on health with the associated risk of falling into deeper poverty when a family member gets sick. However, thanks to other factors, Uganda had the lowest rate of the population living under poverty line. This fact indicates the country has considerable potential for increasing enrollment in well organized community-based health insurance schemes. Kenya and Tanzania were next lowest both in the share of the government budget for health and in the percentage of the population covered.

The health system delivery in most EAC Partner States is characterized by insufficiency in terms of the quality and quantity of infrastructure, human resource and organization. Health providers are more available in urban areas than rural areas. Table 2 illustrates the availability of health providers in each country. With the current shortage and limitation, trans-boarder SHP will require improving the infrastructure and availability of human resource for health. Health financing and resources allocated to a health system are considered as inputs and expected to produce some indicators in term of outputs. It is thus important to look at key health system inputs.

In considering important health system output indicators, Rwanda has the lowest maternal and under-five mortality rates, as well as the highest life expectancy. With the lowest private spending on health, the country gets a return on its investment in health. Kenya comes next, followed by Tanzania, Uganda and Burundi. With the seemingly higher coverage of social health protection schemes in Burundi and Tanzania, one would expect these two countries to have better health indicators than Uganda, but surprisingly, the latter shows relatively better indicators. This contrast signals a need for further investigation, however. One explanation is that because Uganda has the lowest percentage of population living under the poverty line, those in need of care can afford it better than in Burundi and Tanzania. Another explanation is that respondents in focus groups suggested limitations in the design, financing and implementation of SHP schemes in Burundi and Tanzania, so the coverage may not have been effective. Finally, other factors outside of the health sector, such as education, could also play a role; infrastructure, and per capita income, are also important determinants. Figure 5 provides a picture of the performance of the five EAC Partner States on key indicators.

Figure 5: Comparison of Countries' Health Indicators*



*MMR*10 denotes the maternal mortality rate (deaths per 100,000 live births) scaled by a factor of 10, i.e. the column for EAC means 410 maternal deaths per 100,000 live births; U5Mort is the number of deaths of children under 5 per 1000 live births, and Life exp. is the life expectancy at birth in years.

Sources: Country Studies of the EAC Partner States (see Annex 1)

For the detailed country reports, please refer to Annex 1.



4

Recommendations for
Harmonization and Portability
of SHP in EAC Partner States

4. Recommendations for Harmonization and Portability of SHP in EAC Partner States

The recommendations below were generated from ideas put forth in consultative workshops, in-depth interviews and focus group discussions. They address first the issue of harmonization and secondly the issue of portability. Participants suggested that before portability is organized, harmonization should first occur: *“Before implementing portability, it is important there is harmonization first. Portability should be seen as a second stage development of SHP, after all policies in term of SHP have been harmonized.”* (regional interviews)

4.1 Options for Harmonization

Harmonization will need a multiple step implementation process. Based on the results from documents review, interviews and FGD, the five steps below provide the EAC and its partner organization with concrete steps towards ensuring UHC in the region:

Step 1: Regional commitment for universal health coverage

The EAC Secretariat should ensure that all Heads of State sign binding commitment towards UHC with tasks forces at regional and national levels to facilitate and coordinate the implementation and monitor progress within a specified time frame. Committing to universal coverage means ensuring equity by making those who have more pay more, but it also means ensuring that governments pay for those who can't:

“Social health becomes mandatory when governments put in place mechanisms for all to be included, so if you cannot pay, the government will pay for you...” (national interviews)

“SHP is like a baby that needs both parents to grow, while it needs the Ministry of health for its social aspects, it very much needs the Ministry of Finance to provide resources and understands this is for the taxes benefits...” (regional interviews)

Respondents provided steps that may be followed at the regional level:

“Things should be done in phases:

- (1) At country level, there should be mandatory health insurance. Imihigo will be the way to enforce; sharing best practices, setting targets, achieving them and being rewarded;
 - (2) There should be harmonized SHP policies at EAC level;
 - (3) An ICT mechanism should ensure at EAC level inter-country collaboration and compensation;
 - (4) Public annual audit would show private company's earnings and contributions to SHP...”
- (regional interviews)

National leaders shared their experiences of leadership and commitment to UHC:

UHC comes as a result of a country commitment because it is a long and difficult journey:

“For UHC to be a reality in EAC, all States need to be committed. They need to be serious at it and say: “No matter what, this is what we want!” And once you have allowed yourself to move in forward, you should not say: “I have met a dead-end”. You should be ready to face all challenges because it is important for your economic development.” (regional interviews)

“Countries should make it a responsibility for everyone: “it is not only health or only social protection”. So, when issues come, everybody tries to find solutions... We met deficits for mutuelles but when we meet to see how to sort issues out, when we are seated in Government retreat or during budget discussions we do not say: “what will the MOH do?” we say “what do we do?” Around the table we discuss because it is a “multisector responsibility up to the Presidents”...” (regional interviews)

“EAC Partner States should not force people. It is important to make them understand but this takes time and States need to be patient. This is too complex because we have accepted the cost of not enforcing the law on the fine for not paying mutuelle premium. We know we have moved from 1,000 to 3,000 Frw per member per year. Progressively, we want to increase the premium until we reach the exact cost of care...” (regional interviews)

“When we started, mutuelles were under MOH because this was a very social issue. It is good to start this as a social issue but later it is important to consider it as a finance activity. Finance people may not understand at the start, they think “you want to collect money and you plea people?” and health people say “you want to take a social issue as a finance issue?”. It is good to see this as a seed that if left in the forest it will die. It needs protection. Other countries may move faster than us but it is important not to coerce people...” (regional interviews)

“The value added of the EAC should be:

- (1) To ensure commitment and facilitating the processes.*
- (2) To share lessons and continue to learn: although Rwanda has reached a good coverage level, if a neighbor is not doing well, all neighbors will not be OK. We can't in Rwanda segregate people living on the borders, we serve them.*
- (3) To speed up the process of integration of SHP. This region is becoming “one” it would be important to be one when we are already similar. Trade wise, work wise, money wise we are becoming one but health wise we are different. So, it is important to facilitate harmonization of all policies.” (regional interviews)*

“Other countries should have the political will to support the vulnerable. Rwanda subsidizes 25% of the population. It is critical for other countries to set mechanisms for rationally identifying the poor. Caution should be given to ensuring transparency and participation...” (regional interviews)

“Other countries should use cultural values to implement their policies, use elders and find solutions...” (regional interviews)

“The problem would be to put policies in place and not implement them. It is critical to ensure that the highest leadership owns the process, convince people to pay premium and not forcing them...” (regional interviews)

Step 2: Strengthening EAC Secretariat and EAC Legislative Assembly (EALA)

During interviews, regional stakeholders thought that EAC can't deliver on SHP with the current capacity in terms of human resource:

“The EAC with its current structure cannot deliver. The reasons are clear: they have currently limited funding and personnel. SHP should be an agenda with funding and own personnel to speed up the process...” (regional interviews)

One of the institutions that was targeted to spearhead the SHP agenda was EALA. Participants during regional interviews, including members of EALA thought that:

“SHP is a very good concept but we are afraid country leaders themselves are scared to implement because they think the Government will pay all... they don't understand that SHP is equity, that those who can should pay more but of course with the role of the Government...” (regional interviews)

Members of EALA in general agreed that SHP should be a priority. They suggested boosting the role of EALA especially the social commission with capacity to move forward the SHP agenda. They suggested creating appropriate institutions and legal framework to guide the process. They suggested that for SHP to happen, the Summit made of Heads of States should sign a binding document. For this to happen, they suggested:

“The Ministers of Health should work hand in hand with the Ministers of EAC, Local Government and Finance in each country who will work in collaboration with the Secretary General to present the decision to the Summit. From the Summit, things are easy because we are then obliged to work on relevant laws ...” (regional interviews)

Alternatively, EALA members suggested working on the issue from their side:

“EALA can own the process and push forward the SHP agenda. They can use the present report as a working document and organize an oversight activity aimed at visiting each country. This will help the EALA Social Committee to come up with their own recommendations. After discussing with each country’s parliament on their SHP issues, EALA can come up with a resolution that would be moved to the House and from the House to the Summit for decision making...” (regional interviews)

Ministries of EAC are key partners for SHP:

“... there should be a mechanism to lobby the Ministers of EAC to own SHP as a regional project because based on the common market protocol, education, labor and health must have mandatory regional approaches...health should be seen as a development issue...” (regional interviews)

SHP needs strong sensitization and behavior change programs. EALA can also help in this:

“Some policies get stuck sometimes not because people don’t want to implement them but rather because there are interest groups such as the private sector sometimes that block the process. You know there is a gap between what we say and what we do...SHP will require advocacy and national parliaments should own the process...” (regional interviews)

Step 3: Operational identification of the poor and collection of premiums

Developing well-functioning mechanisms within the economic, political and social context of each country is another key requirement of harmonization. A scheme needs to be able to classify households fairly, enroll them, and collect premiums. It needs to be simple enough so that local government staff or community health workers, who may have only limited literacy, could help implement the chosen scheme. In localities furthest from the nearest hospital, higher travel expense would likely reduce hospital utilization, so households would see less benefit from insurance. It is important to link social health insurance with ambulances and local organization for common transportation. As a step towards harmonization, it would be beneficial for all countries to use similar principles in classifying economic status and setting premiums based on the household’s status and the geographical area. A mixture of qualitative and quantitative research is needed to develop recommended schemes, recruit and train the workers who will implement it initially at a demonstration level, but gradually across all five countries, and monitor and incentivize implementation. Respondents provided some suggestions:

“Communities should be involved in selecting the poor who need subsidies, the SHP process should be owned at the lowest level of leadership. The village level leadership should look for local solutions and transfer only cases with clear criteria because when money and solutions come from afar, people tend to transfer problems to where money comes from. Leadership at local level should be accountable to the population. The process should be simplified...” (regional interviews)

“Resources for health care are in people’s hands; there is need for sensitization to ensure the money is released from those who can pay. Sensitization is critical, using all leaders: political, religious, elders, etc. EALA can be a great stakeholder when it comes to sensitization...” (regional interviews)

“Mutuelles have benefited from different strategies to collect premiums, for example the “ibimina” are good for those who can’t pay the entire premium at once. They pay progressively through a collector who is a member of the community...” (Regional. Interviews)

Step 4: Rethinking subsidies to achieve and sustain universal health coverage

For those countries that have reached some of the Millennium Development Goals in health (MGD4 and 5) such as Rwanda, there have been huge investments in the health sector through direct financing of health facilities and subsidies for mutuelles. The progress for most developing countries has come with huge costs for both the Government and development partners. Data on donor funding for health collected from national health accounts documents suggest all EAC Partner States are heavily relying on donor funding to make their health system work at present. Because these countries mostly rely on donor money to cover more than half of their total expenditure on health, sustainability is a major consideration for Governments in the EAC Partner States.

In an ideal situation, the health care market should have sellers and buyers and the price should be set out of the need to buy and the availability of goods and services ready to be sold. However, there are failures to the market in health because health is a necessity good and an important element for human development. Hence, the intervention of government in solving the incapacity of buyers to purchase critical health services is of great importance. Nevertheless, it is important to come close to a situation where there are buyers and sellers to maximize efficiency in using available resources.

Currently governments and donors provide direct financial support to health facilities, whereby the government and donors subsidize the richer at the same rate as the poorer. Governments and donors in all EAC countries subsidize public health facilities that deliver health services through paying the salaries of some or all the workers, paying for the buildings, equipment, and some of the supplies. The user fees paid by patients at public facilities generally cover only a small part of the economic cost of the services.

Rechanneling Government Subsidies: An alternative health financing model, with many advantages, would be for governments and donors to redirect part of this subsidy towards premiums for social health protection. Facilities would have to charge more than they do now. However, with most of the population covered by insurance (some with subsidies), out-of-pocket payments would still be limited and services would be affordable to consumers. Rechanneling subsidies to health facilities through health centers may be one of the strategies for:

- (1) **Strengthening the buyers** who are members of social health insurance schemes: In this context, health centers will be willing to increase the price of services to match cover for the loss of government and donor subsidies. This process will also facilitate the knowledge of real costs encountered at different facility levels.
- (2) **Improving equity:** As the country increases its GDP, with improvements in Ubudehe estimations aimed at making the richer contribute more than the poor, subsidies will be much more targeted to the poor while the poor can contribute more than they do currently.
- (3) **Sustaining high coverage** for health insurance: with the price of services being more or less closer to real cost incurred by health facilities, health will be more expensive, everybody will more likely join mutuelles and it will require less government efforts to maintain high enrollment rates.
- (4) **Avoiding mismanagement and fraud** in the health sector, which has been cited as one of the major issues facing the health sector.

The advantage of such a system is that the subsidies can be directed towards the consumers who need them most, services can be easily monitored, and additional resources are mobilized. Some subsidies already exist on a pilot basis. Kreditanstalt für Wiederaufbau (German Development Bank), Germany (KfW) is subsidizing premiums for pregnant women to enroll in the National Health Insurance Fund and for their families to join their Community Health Fund. These programs should be evaluated and their best elements used as the basis of large scale subsidy schemes. Potentially donors could also incentivize national governments, offering \$2 in premium subsidy for every \$1 contributed to that purpose by the national government. However, this would mean that governments meet their commitments such as the targets set by the “Abuja Declaration” that suggest that countries provide at least 15% of their government budget for health. Of all EAC countries, only Rwanda is meeting this target.

Progressive implementation: This process of rechanneling subsidies should be done first in pilot phases to learn from the processes and improve policy making. It is expected that health facilities will need assistance in coping with new changes; they will need technical support in creating a new pricing system. In a first phase of a few months, both health facilities and mutuelles should have half of the subsidies to ensure a smooth transition; for example, if the government and donors were giving 60% of health facility inputs, they may give 30% to health facilities and the remaining to mutuelles. This will need a very strong centralized and decentralized independent mutuelles structure to own the process, evaluate it and improve it.

Step 5: Ensuring the improvement of health systems management

Improved management: Another key element of a system of SHP is a well-functioning health system able to deliver quality services. An evaluation of the Community Health Fund in Kilosa, Tanzania by A Kihombo (unpublished report, Brandeis University, USA) found that only 5% of the residents joined the fund because the absence of medications at the district's health centers meant those facilities and the insurance contributed little to residents' health. Training and implementation of better management procedures could ensure that requisite medicines and supplies are ordered, monitored and stored to protect against damage and theft, and dispensed and replenished appropriately. These improvements could also be conducted on a regional basis, encouraging the countries to adopt regional procedures and, over time, perhaps developing regional sources of supply.

Improving management process is key to ensuring a successful implementation of SHP policies. Even as of now, Rwanda CBHI still face managerial challenges and other EAC countries could learn and avoid the same mistakes:

"...some delays are caused by the fact that an invoice may be having a small error for example related to RwF 5,000 and this stops a payment of ten million RwF". (national interviews)

"...delays are common on the district hospital levels not at the health centre level". (national interviews)

One notable example for improving the quality of health services is the performance-based payment for health professionals. The input-based system that pays for equipment and salaries has shown little success while the output-based system or paying for performance or performance-based payment (PBF) has shown tremendous results when incentives are well monitored and aligned. Because the increase of coverage with social insurance is expected to increase the demand of health service, it is very important to link health professionals' incentives to the services they provide. To ensure that health professionals are using their time efficiently, the management of health facilities would be decentralized to the board of the health facility holding the power to hire and fire health workers accordingly. To avoid abuses, the board would be composed of the head of the health facility, his or her assistant and local leaders such as the head of a church, school, etc. Again at this point, the experience of Rwanda with PBF can be assessed and the possibility of scaling that experience would be evaluated.

Improved human resource for health: The WHO recommendation is to have at least one doctor for 10,000 inhabitants and one nurse for 3,000 inhabitants. While Burundi, Rwanda and Tanzania have an alarming shortage of doctors, the number of nurses seems to meet overall the critical need as per WHO recommendation. Most doctors overall in the EAC are in urban areas. Uganda is the only country that has most nurses in urban areas while the rest of the countries have most nurses in rural areas. To allow for portability, there is need for an important effort to strengthen human resource for health.

Information system: A good ICT system is crucial for a smooth transformation towards SHP harmonization across EAC Partner States. This was another aspect of health system infrastructure that needs improvement:

"Without a good information system it will be difficult to handle claim reimbursement under a harmonized system. The system should be able to speak across each other for all Partner States in order to be able to handle cross boarder access to health services. There should be a clearly defined reimbursement mechanisms that will be similar across all Partner States." (regional interviews)

There is lack of appropriate information technology, critical to achieve SHP in the CBHI:

".... we are missing integrated software to perform nomenclature of clients." (national interviews)

Purchaser-provider split: It was thought that it is going to be a challenge to harmonize health insurance systems if there will be no clear separation of purchasers and providers. If people are going to access services from other countries there should be clear identification of the agent that is going to settle the bills on behalf of those individuals. At the moment there is no clear separation of purchasing and provision role for some of the health insurance schemes in Tanzania. It was highlighted during discussions that the government, especially local government, plays both roles, as a purchaser and a provider of health care at the same time. This is especially vivid under the CHF arrangement. There are currently no clear reimbursement mechanisms and the funds collected through CHF premiums are pooled at the district level and budgeted similar to other government fund sources. It will be difficult to move towards harmonization across EAC if there will be no clearly defined purchaser who will be responsible to settle claims arising from accessing services across countries. There is a need of harmonizing internal insurance schemes and establish a reimbursement mechanism that will facilitate payments of claims across EAC Partner States. Separation of purchase-provider roles is crucial for harmonization.

4.2 Portability of Social Health Protection

Participants were all supportive for portability of social health insurance. There are two important quotes from Rwanda that show the need to allow for cross boarder social health protection benefits:

“Our District is close to Burundi. People cross the border and for our brothers from Burundi, they often come to work here but they do not feel obliged to buy our mutuelle cards thinking that this is a program for Rwandans only. When they are very sick and it happens often, we give them care, from health center to district level. But who will pay for it? Nobody. Health centers and hospitals pay the price... with the ongoing increased movement of people, problems will get worse. We are very happy that this study can show the problems...”
(regional interviews)

“We live close to Uganda and our young people have more tendency to cross the border to look for jobs. Because they don’t live here, they don’t buy mutuelle cards. When they get sick in Uganda, nobody pays for their care, which makes them seek care at home, often when they are in a bad shape...they often come back in emergency. Without mutuelle card, we still receive them because an emergency is an emergency. Our hospitals and health centers can’t be paid back by the Government when the patient is not a mutuelle member.”
(regional interviews)

Portability and payments: Several points were raised during interviews:

- **Currency:** In order to facilitate transactions, it would be important to speed up the process of monetary union currency harmonization before harmonizing social protection schemes. Otherwise a mechanism should be established in order to protect the sustainability of schemes for countries that have weaker currencies so that they will not become insolvent as a result of settling high cost claims in countries that have strong economy and strong currencies.
- **Complementary premiums:** respondents shared their views on the need for additional premiums to sustain the cost of portability: *“There should be a complementary premium for expenses and increased risk that insurances accept by roaming in the region. There can be simple electronic cards and when people go to seek services in other countries, a bill will be done to insurance from the hospital that has used the electronic card...”* (regional interviews)

Regional interviews have provided for an idea to use cross boarder health services.

- a. Using regional insurance smart cards: It was suggested that members of all insurance could use smart cards that contain member’s identification and information of the scheme they belong to. The smart insurance card system should be regionally monitored. Each hospital should have a machine that should read smart insurance cards. Once a person crosses the border, the reimbursement could be linked to facilities bank accounts just as the use of Visa cards. Rwanda is promoting the use of an Identification Card in the form of a smart card with information on health insurance, passport number, etc. The lessons learned from the Rwanda Identification Agency could be helpful.

- b. **Progressive scale-up:** Portability could start with the formal sector because it is important to learn about the cost of such a system and because the formal sector is generally capable to pay such services. Once the system is fully functional the informal sector can join with subsidies for schemes such as community-based health insurance. The progress should be monitored by a regional task force to ensure all countries are meeting timely the requirements for scale up.
- c. **Ensuring national gate keeping mechanisms for cost containment:** There was a feeling from nearly all consulted stakeholders that the health care provision infrastructure in most countries is in bad condition. However, some countries like Kenya seem to provide higher quality of care in private institutions, hence would be most preferred place for the insured members to seek care. There is a feeling that going into harmonization with the current provision infrastructure will create more inequities in access to services because those who can afford to pay for transport and accommodation costs to travel to other EAC Partner States will be the ones benefiting most.

Further, for countries that have good provider networks such as Kenya, they will be facing large increases in the use of service due to influx of patients from other EAC Partner States where services are of poor quality. This might have negative consequences if there will be no strong control of cross-border access. It was proposed that the EAC supports the improvement of health provision infrastructure in order to raise each country above the minimum requirements in order to create fair ground before going to harmonization. Countries need to make sure that services within countries are provided in an equitable manner, by making sure that available services are of acceptable quality and good quantity that every individual in need can access before moving to harmonization. There is need for political power to make necessary changes in order to improve local health delivery; as we think regional, let's act locally. Recommendations for harmonization and portability of health services

All stakeholders, whether working in public and private sectors, policy makers in EAC Partner States are enthusiastic and supportive of the development and scale up of social health protection mechanisms within their countries and regionally. Participants gave several recommendations that are grouped here according to themes:

The Role of the EAC

All groups suggested and supported an increased role of the EAC in term of regulating and promoting regional social health protection schemes.

1. Mandatory social health insurance:

- EAC must support and ensure political willingness and governance of social health protection mechanisms in all EAC Partner States. Participants at all levels think EAC should set objectives to be achieved at the country level:

"We need to set benchmarks for EAC countries and before asking for donors' help, countries should show their own political commitment. National governments should ensure implementation and look for domestic and donor support..." (regional interviews)

- Ensure that all Partner States consider UHC as compulsory by mandatory contributions from informal sector, for example by using pin numbers (tax identification numbers);
- Enhance the role of EAC government's through legislation;
- Create an Autonomous Regional Health Insurance Regulatory Authority.;
- Since it is about social health protection, it is important to regulate the health insurance market;
- Set sustainability mechanisms for a social health protection regional pooling mechanism. The complementary package should be pooled at a certain level;
- Ensure that SHP benefits from subsidies coming from other institutions, a certain percentage should be determined. Existing health insurance schemes should contribute to a regional pooling mechanism;
- There should be harmonization of all health policies to support universal health coverage such as uniform codification of diseases and payment mechanisms (Diagnosis Related Groups) in the EAC Partner States;
- It is important to ensure a split in the purchaser-provider functions.

2. Sharing best practices:

- Provide funding for the development of a regional unit or task force and to put in place a centre of excellence for learning and sharing of best practice can be done;
- Ensure sharing knowledge and best practice across EAC States, for example in Burundi, they recommended to adopt Rwanda's SHP model as a best practice to avoid wasting time to "reinvent the wheel". Participants desired that countries learn from Rwanda because of the coordinated and high coverage that the country has achieved;
- Learning from European Union regional approach on SHP;
- Set a center of excellence for research and sharing best practices for UHC.

3. Quantity and quality of services

- Review and improve the existing infrastructure and human resource for health capacity to allow for portability of health services;
- Determine a minimum package of health services for the whole EAC population;
- Make cost estimates for the minimum package in order to inform decision about contributions;
- Review the structure of existing social health protection schemes;
- All EAC countries should set a minimum quality accredited system;
- Accreditation of the health facilities across the East Africa Community Partner States where insured members can seek care within and outside the country;
- There should be a harmonization of the essential medicines list and the basic medical services package so that subscribed members can access health care from any Partner State and the insurance carriers make claims from the parent insurance carrier.

4. The Issue of Indigents

1. The current situational analysis has found that Rwanda's system of SHP is among the most sophisticated in the region using the "Ubudehe". But even in that country there have been complaints of the inadequacy of the system with some individuals ranked amongst the wealthier while some of the wealthier were found in the category for poor. To improve the system, Rwanda has decentralized at the village level the wealth ranking system of its population or "ubudehe". To ensure that the system captures changes over time, the "ubudehe" will be reevaluated every six months. The "ubudehe" system is based on the principle of cross-subsidies from the wealthier to the less wealthy or simply put financially better off households pay more.
2. The system has seven levels of economic status, which include very poor, average, and above average. The very poor are those with little or no assets, such as land or livestock. They are expected to pay a premium of about 2000 RWF (US \$3) per person per year, while members of average households pay about 3,000 RWF (US \$4) per person per year and the better off pay 7,000 RWF (US \$10).
3. The obligation to pay the annual premium is enforced through peer sensitization and pressure using "ibimina"- groups of several households led by one inhabitant. They would collect and deliver premiums to cooperatives or bank accounts on behalf of members. This avoids long waiting lines at the point of payment, and the peer pressure is constructive in reminding members of the benefits of mutuelles and the need for paying premiums. In the past, enforcement has been based on requiring a mutuelle membership card when accessing other government services, such as a passport. A final enforcement mechanism is that coverage of members has been part of the mayors' performance-based contract with the President of Rwanda, whereby the mayors have promised to achieve universal coverage for mutuelles.
4. Each country should determine criteria to define its indigent populations. The poorest should be reached either by the government providing a subsidy or by earmarking tax contributions for health through the Kenya Revenue Authority. Learning from Rwanda to use traditional concepts that are more familiar and acceptable to the population is important

5. Unifying Systems for Portability

All groups recommended portability of health insurance across EAC countries. To accomplish this, participants highlighted the need for:

- Unifying through regulation all social health mechanisms in EAC Partner States, for example public schemes;
- Defining priorities for harmonization based on legal aspects;
- Enhancing cooperation through strong coordination among EAC Partner States;
- Setting uniform standards in the regional provider networks;
- Developing a single registry for social assistance with a synchronized automated information technology system;
- Providing cross border health insurance to be provided to all EAC Citizens; All EAC citizens must possess a valid membership;
- Enacting policies and regulations that provide for a complementary package of services to members who may seek health services in the region;
- Defining clearly cross boarder package of illnesses in legislation to avoid overuse of expensive out-of State medical services;
- Defining a clear mechanism at regional and national levels to ensure that providers are reimbursed for healthcare services given to an EAC Citizen;
- Creating a clear road map to be created for this process of harmonization in each EAC Partner State. It is important to organize processes for the feasibility of initiating the scale-up of SHP mechanisms;
- Improving linkages across sectors and the EAC regional secretariat;
- Putting in place a supportive for ICT social health protection mechanisms in countries and across the region. An integrated information system must be in place to facilitate the services (IT and Human Resource);
- Licensing health insurance services to operate in the region: Public (Regional cooperation/agreements to foster reimbursement) or Private (Licensing of Companies to operate).



5

Conclusions and Key Recommendations

5. Conclusions and Key Recommendations

This study found that all EAC Partner States are committed to improving the SHP in their countries. Some countries are far ahead, such as Rwanda, while Uganda is making the first steps towards a national health insurance system. Tanzania, Burundi and Kenya have made significant efforts to ensure their systems perform better in the future. Despite these efforts, more needs to be done. The present report was submitted to the EAC and delegates from all five EAC countries for validation in July 2014. The delegates agreed on the following 20 recommendations.

5.1 On the Role of the EAC in SHP

1. Propose that the Council of Ministers advocate for UHC to the EAC Summit of Heads of State and invite one of them to be the policy champion;
2. Create a commission, task force, or coordinating desk within EAC secretariat to guide and monitor SHP implementation;
3. Develop a regional policy towards SHP, including the informal sector;
4. Mobilize funds for support studies around SHP (e.g. identifying the poor, defining minimum benefit package);
5. Sensitize the population and decision makers about the value of SHP;
6. Discuss reorientation of health financing policy, progressively reorienting subsidies from the supply to the demand side;
7. Encourage and offer technical support to provider-based schemes;
8. Develop capacity regarding the promotion and management of community-based health insurance (CBHI), for example, by serving the poor by allocating more subsidy to poorer areas, and selecting poor households within them;
9. Exchange of best practices in the region with data collection comparison;
10. Develop legal framework to operationalize health insurance within the EAC Partner States.

5.2 On What to Harmonize Across Partner States

- a. Harmonize SHP standards across Partner States;
- b. Define minimum package;
- c. Create consistent accreditation systems for human resources, technology, and infrastructure;
- d. Establish consistent relative pricing across providers and countries;
- e. Establish incentive mechanism (e.g. performance-based financing) to improve quality and quantity of services.

5.3 On Portability of Benefits

- a. Establish information and computer technology (ICT) systems to access member information across countries;
- b. Create an electronic universal health insurance (UHI) member card;
- c. Encourage EAC Summit to pass resolution requiring residents to have health insurance at home and in destination country when traveling regionally;
- d. Offer regional option(s) with additional fee for members of public schemes to extend coverage to other countries in the region;
- e. Create an agreement among Partner States to recognize one another's public schemes.

As stated at the beginning of this report the development of SHP in the EAC is a journey, rather than an immediate destination. As such, policy studies, policy analysis, feedback, and ongoing dialogue between politicians and technicians are constantly needed. The current study is only the first step of a journey for the region towards SHP.

Annex 1: Country Studies – EAC Partner States

Annex 1.A: Republic of Burundi

History – Burundi

Before the independence, few laws referred to social protection for Belgians colons in Burundi, and were applied to all expatriates working in the private sector and living in the country. Later on, early decisions on social protection for nationals were discussed with a focus on public servants. The private sector benefitted from the July 20th 1962 law that created a scheme for social protection covering professional risks and retired workers with written employment contracts, and military personnel. The functioning of this scheme was given to the National Institute of Social Security (INSS). Other social protection measures were included in the Labor Code of Burundi (*Code du Travail Décret loi n°1-037 du 07 juillet 93*), particularly the laws concerning health, maternity and family services (1966). Workers without official contracts with the government have benefitted so far from free services paid through public treasury for retired and those with disability arising from the accidents and injury.

Years later, the law n°1/28 of June 27, 1980 created a scheme covering health services for all kind of public servants with its management placed under the Public Service Mutuelle (MFP). Other categories of workers such as those working in the private sector, health care services are covered by their employers following the guidelines provided in the Labor Code. In 1993, a feasibility study was conducted of the possibility of creating a health insurance scheme for the private sector in Burundi. This study was updated in 1996, 2003 and 2005, but the scheme was never implemented. Additionally, the law n° 1/002 of 29th February 2000 suggested the creation of insurance covering maternity services for women working in the private sector; despite the existence of the law, an institution has never been created to run the scheme. Due to this gap in covering those in need of services, different private initiatives have emerged.

The codification of CBHI or mutuelles in Burundi started in the colonial era with a legal document dated April 15, 1958. This legal document, however, has some important missing guidelines in terms of the law's capacity to fit into changing contexts over time and the lack of clear requirements for those joining the schemes. This law is also too general to cover all mutuelle associations because these are diverse due to being designed to fit specific associations of patients, accident victims, etc. There are only two functioning mutuelles, one is operational in Gitega Parish and another one belongs to a coffee farmers' association. The informal sector in Burundi has not yet benefitted from any kind of insurance coverage for professional risk or retired workers. In November 2002, new laws were enacted in an effort to harmonize the social security system in Burundi.

Legal Aspects - Burundi

The new national vision for SHP has its source in the country's constitution of March 18, 2005. The vision is based on the Universal Declaration of Human Rights and international binding agreements. The 30th article is clear on the rights of families; one of the core statements says, "Every child has the right to a special protection by his/her parents and the state. The 44th article recognizes the right to good health and well being to all children and the 52th, 53th, 54th, 55th and 66th articles refer to basic rights for individuals and families. All these laws constitute the basis for legitimate social protection in all its aspects including health and basic needs for existence. National institutions charged with regulating and promoting SHP services identified at the consultative workshop held in Burundi include:

1. Institut Nationale de la Sécurité (INSS) (National Institute of Security)
2. Office National des Pensions et Risques Professionnel (ONPR)

The following national legislation is related to SHP in Burundi.

- The Constitution of the Republic of Burundi of 2005 (Articles 19, 44, 55, 58)

The legal framework for the FBP-Free admission strategy is the following:

- Presidential Decree No. 100/136 of 16 June 2006 granting care for children under five and deliveries in public health facilities and similar facilities;

- Decree No. 100/38 of 16 March 2010 amending the Presidential Decree No. 100/136 of 16 June 2006 granting care for children under five and deliveries in public health facilities and affiliated facilities;
- Declaration on 16 and 17 March 2009 on Strategic Consensus on Financing for free and performance based funding;
- Procedures' Manual for the implementation of Performance Based Financing in Burundi, Revised in September 2011;
- Joint Ministerial Decree No. 630/677 of 20/04/2010 laying down modalities for application of the Decree No.100/38 of 16 March 2010 on amending the Decree No. 100/36 of 16 June 2006 governing subsidies for children under five years and deliveries performed in public health facilities and similar facilities.

The legal framework of the Public Service Mutual Health Scheme is determined by a set of texts namely:

- Decree-Law No. 1/28/ of 27 June 1980 on the establishment of a system of health insurance for public servants and similar agents;
- Ministerial Order No. 620/110 of 27/04/1988 establishing the list of medicines and medical dressing items to be reimbursed by the Public Service Mutual;
- Decree-Law No. 1/23 of 26 July 1988 establishing the Organizational Chart of the Burundian Professional public institutions;
- Decree No. 100/193 of 18.10.1989 amending the articles of the Public Mutual Service;
- Ministerial Order No. 750/078 of 27 March 1989 establishing a Monitoring Committee and price ceiling for pharmaceutical products;
- Ministerial Order No. 750/077 of 27 March 1989 capping prices of essential drugs and dressings objects reimbursable by Mutual of Public Service;
- Law No. 1° / 010 of 16/06/1999 on the Code of Social Security;
- Convention on the collaboration with private pharmacies;
- Law No. 1/05 / 10/09/2002 relating to reform of sickness and maternity insurance scheme for public servants and related agents.

The main legislation governing the creation and performance of a mutual community or non-profit mutual health is:

- Law N° 1/010 of 16/06/1999 regarding the Social Security Code;
- Decree of 15 April 1958 on Mutual Associations;
- Ministerial Ordonnance N° 570/519 of 9 May 2011 regarding setting the required conditions for approval of Mutual Health in Burundi;

Regarding the poor, the 2003 Ordinance also defines the roles of the different administrations in support of indigent to access to health care services. The determination of indigents' status belongs first to the municipal administrator (Article 2), but with the counter-signature of a representative of the health administration. However, the administrator must set up a committee in charge of the identification of these indigent (Article 6). The committee to which he or she belongs as president, is composed of hospital and health center heads in the area and district leaders and district directors (art. 7). Associations involved in the care of the indigent can also claim, and obtain the membership to this committee.

Legislation Governing Persons in the Formal Private Sector

The legal regimes of workers in the formal private sector is determined by a set of texts including:

- The Law of 1948 related to Work Accidents and Occupational Diseases (ATMP) of the said workers 'natives' of the Belgian Congo and Ruanda-Urundi;
- In 1957, a system of protection against the risk of invalidity, old age and survivors on one side, which complements the existing system of insurance against accidents at work and occupational diseases;
- The decree-law creating the National Institute of Social Security of 20/07/1962, but also the management of the risk of "non-diseases" which, at present, is the responsibility of the employer;
- The Decree- Law of 1983 No. 1/17 of 28.7.1983 organizing the provision of care to workers in commercial and private industry as well as parastatals which were not subject to the statute of public Service;

- The revision of the Labour Code by Decree-Law No. 1/037 of 07/07/1993 permanently expanding the responsibility of the employer vis-à-vis the health of its employees;
- The 1993 Decree- Law provides two rules to be respected by employers vis-à-vis the health of their employees, Art 140 and 301;
- The law on health insurance and maternity scheme for the formal private sector (Law No. 1/002 of 29 February 2000).

The Code marks an important milestone on the issue of SPH in Burundi. Section 1 does indeed recognize the right to social protection for “any person, as a member of society.” Health is an integral part of this law because under Article 2, the State is obliged to provide “any person a standard of living adequate for the health and well-being of himself and his family including food, clothing, housing required; and the right to security in the event of sickness, disability, widowhood, old age or other lack of livelihood as a result of circumstances beyond its control.”

Section 2 of the Code nevertheless differs slightly from Section 1 on universal principle, since it delimits the scope of this Code to all persons covered by the basic social security, that is to say the formal sector employees, whether in the public or private sector.

The basic system includes social security (Article 7):

- a) The health insurance maternity responsible for the benefits of medical care and sickness and maternity scheme;
- b) The system of occupational hazards in charge of providing benefits in case of accidents at work and occupational diseases;
- c) The pension charge for the benefits of old age, invalidity and survivors’ benefits;
- d) The system of family benefits, responsible service benefits.

Title 2 of the Code details the content of each of these plans. Regarding health, Chapter 1 confirms the process begun during the revision of the Labour Code by extending compulsory coverage provided by the employer to any person employed in the formal sector, “any morbid condition due a natural illness, accident of non-occupational origin, pregnancy, confinement and their consequences” and “a sickness benefit or maternity” in the event of interruption of work. The field of social security on a statutory basis is extended in these texts, to social health risk for employees in the formal sector.

Finally, in Section 3, the 1999 Code specifies the institutional arrangements required to make this right to social protection. As with other occupational hazards, risk management health maternity entrusted the management of this scheme to the INSS.

Other Developments:

1. National Policy on Social Protection validated in April 2011 by the Cabinet of Ministers. The implementation took a long time.
2. Decree of 2012 assuring the creation of the Executive Secretariat of the National Commission for Social Protection, 2014. The Commission is made of 11 Ministers and is chaired by the President of the Republic.
3. Decree of 2013 creating the National Technical Committee for Social Protection (made of sectoral experts).
4. Decree of January 2014 assuring the creation of Committees for Social Protection and the creation of Provincial and Communal Committees on Social Protection.

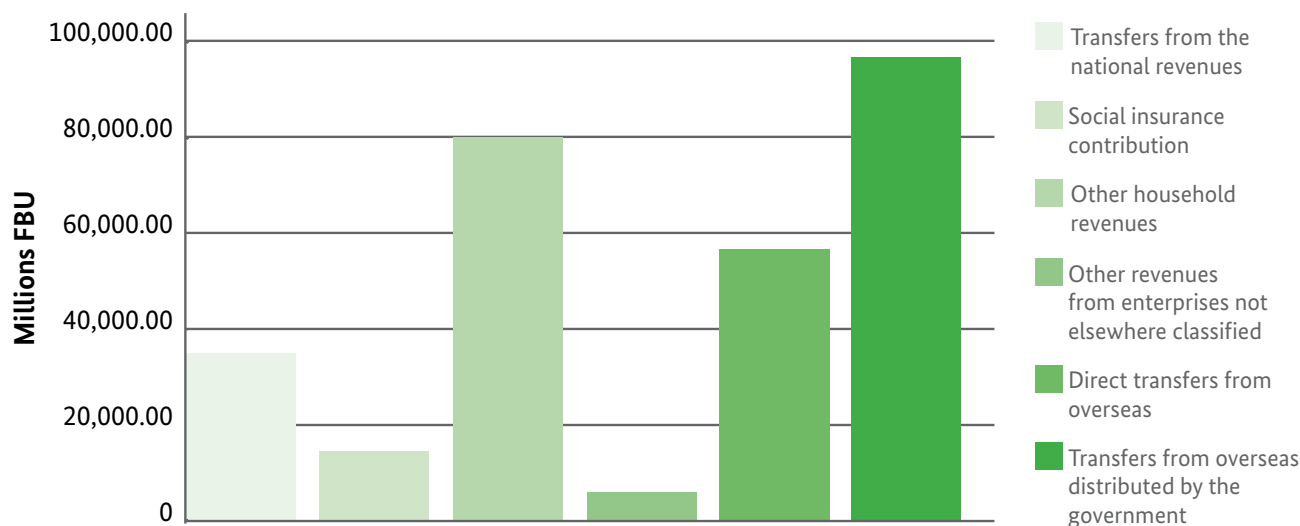
Since January 6th 2014 there has been a signed Ministerial Order creating the Mutuelles de Sante for private formal sector. The contribution will be equivalent to 10% of their salaries with 60% of the 10% coming from employers and 40% coming from employees. The co-payment has been set at 20%.

Health Care Financing Sources - Burundi

According to the latest data of 2012, total health spending increased to 308,4 Billion of FBu in 2012 from 304.2 billion FBu in 2010 and 147.1 billion FBu in 2007 or an average increase of 17.4% from 2007-2012. This increase is due to higher expenditure between 2007 and 2010. The 2010 NHA show that the health

system has been mainly supported by donor money with a total contribution of 150,649.19 million FBU or 52.7% of total health expenditure compared to 33,557.51 million FBU, or 11.74% coming from government funding and 33.65% coming from household's private spending on health. Non-government organizations and private companies spent during that period 1.91% of total health expenditure (THE) on health (Ministère de la Santé Publique et de la Lutte contre le SIDA, MSPLS, 2014). These figures show a heavy reliance on donor money and private spending. However, the current efforts of the government reduced the number of those who do not seek care when they need it from 52.9% to 36.9%.

Figure 6: Financing Sources for Health in Burundi, 2010



Source: MSPLS, 2014 (NHA 2010)

SHP Schemes – Burundi

Burundi has a fragmented SHP system with multiple programs all supported by the government.

1. **The Carte d'Assistance Médicale or CAM:** it targets rural and informal sector. Since its creation in 1984 to 2012, CAM failed to provide the coverage expected by its members due to different reasons: CAM's funding was diverted to support the communal decentralized level, the scheme was no longer providing any value for its members, adverse selection, insufficient premium, etc.²⁵ The failure of CAM led the Government of Burundi to promulgate a new CAM called Renovated CAM. The Ministerial Order of 25/01/2012, N° 01/VP2/2012 focuses on reorganizing CAM, a scheme that was targeting informal rural populations. Members pay 3,000 Burundian francs (about 2.00 USD) and the families with children less than 18 years are covered. The scheme requires a co-payment of 20% for every invoice for health services, with the government paying the balance of the cost (80%). Indigents are fully taken care of by the government. The package of care was defined at public and religious health centers and district hospitals. According to officials at the MOH, coverage in 2013 was estimated to be between 25% and 30%. This was estimated to be high coverage only after 18 months of implementation of the renovated CAM.
2. **The Free Care Program:** it targets pregnant women and under-five children since 2006, according to the Presidential Decree No100/136 of 16 June 2006. The programs cover children under-five and pregnant women who are 17.9% and 5% of the population respectively.²⁶ The scheme covers only Burundians who live in Burundi, including employees working in the private sector not covered by any scheme and members of the public service mutuelle. This scheme is linked with a performance-based financing (PBF) program. In 2006, the program started with coverage for children under five and normal deliveries in health centers. In 2010, the program was extended to caesarian section in district hospitals (Presidential Decree No100/38 of 16 March 2010).²⁷ In parallel, the MoH piloted PBF programs in three provinces since 2006, and then scaled to six provinces in 2009 up to nine out of the seventeen provinces in Burundi.

²⁵ Appaix O. et al. (2013), « Contribution au Chapitre III : Etude des mécanismes de financement de la santé au Burundi », Union Européenne, Projet PAPSBU « Amagara Meza », novembre, Bujumbura.

²⁶ MSPLS, Annuaire Statistique 2012

²⁷ Décret No100/38 du 16 mars 2010 portant révision de subvention des soins aux enfants de moins de 5 ans et des accouchements dans les structures de soins publiques et assimilées.

The free care program has faced several challenges including: government delays in reimbursing facilities, overbilling, health providers overwhelmed by the increases in the demand for health services without ensuring knowledgeable and motivated staff, stock-outs of drugs, and inadequate and insufficient medical equipment. To strengthen the supply side, the government implemented PBF in health to motivate staff and attract more to serve. In March 2009, the MoH coupled the two interventions (free program and PBF)²⁸ to improve the quality of services provided by health facilities. In April 2010, the MoH produced a manual of procedure for large scale-up of the free program coupled with the PBF.²⁹

3. **The Mutuelle de la Fonction Publique (MFP)** was created in 1980 by the Decree of 27 June.³⁰ All public servants are enrolled as they sign contracts, including armed forces and police, university students, and a few staff coming from the formal private schemes. Enrollees include spouses, children under 18 years, children with mental retardation, and children over 23 years who are still in school. Retired public servants and their spouses are covered for life. Co-payment is estimated at 20% of consultation and hospitalization costs, and 10% to 30% of the cost of medicine. The military, police and staff working for different ministries are in reality 100% covered because their co-payment is reimbursed by their Ministries. It is important to note that with the MFP, beneficiaries do not need to have a formal referral to seek specialized care, which inflates costs. Since 1999, premiums were estimated at 10% of salary with employer paying 6% and the member paying 4%. The MFP is now a well-established institution based on an active population. Despite all these gains, effective coverage of mutuelle is not well planned in written policy documents. Long waiting lists when paying co-payments or taking needed forms for its members results in bypassing the system by paying the totality of care out of pocket. Some members of the MFP are willing to pay CAM premiums to access care through the CAM.
4. **Community-Based Health Insurance (CBHI):** they started as community programs supported by Belgian mutuelles, the *"Mutualité chrétienne belge"* in 1992. CBHI in Burundi did not survive the long years of conflicts and war. In 1999, CBHI restarted the schemes with the previous support from Christians living in Belgium. From 2008-2009, the *"Mutualités socialistes belges"* initiated CBHI within cooperatives such as coffee cooperatives. CBHI in Burundi are seen as the most sustainable way of ensuring that the population is provided with quality affordable health services, while CAM is considered a short term program to bridge the gap in the access for health services. According to the latest data members of the fragmented CBHI schemes are estimated to be 22,304 enrollees for 124,191 beneficiaries for the year 2011/2012 (PAMUSAB)³¹. However, data is inconsistent as the source changes. According to rough estimates, CBHI covers 1.5 to 2% of the population in Burundi, it is the best plausible estimate as of now. There is variability in premiums and co-payments: co-payments are generally estimated to be 20% in public health facilities, but can vary between 40% and 50% in private religious facilities. The variability in premiums and co-payments also allows for different packages; some CBHI have a maximum benefit for hospitalization. In this context of fragmentation and incomplete coverage, most households are not covered or are partially covered from catastrophic health expenditures. One of the most important challenges faced by CBHI is competition with Renovated CAM, who experienced enrollment of 14% between 2011/2012 and 2012/2013. Despite this, the CBHI are planning to expand using their a competitive advantage of their independence from government bureaucracy by reimbursing better health facilities and offering better services, including medicines, than CAM, which is currently facing several operational difficulties. The leaders of health facilities who met during the course of the present study stated that CBHI can provide better security for reimbursement than any other government-sponsored scheme, such as CAM and Free care program.
5. **Coverage for indigents:** SHP coverage of the population's poorest was introduced at the same time as CAM. The Ministerial Order states that: *"health care services provided to indigents holding a certificate provided by the Communal Administration shall be reimbursed by the Government"*. However, the text did not define 'indigents', nor did it provide criteria for the identification of indigents.

²⁸ Déclaration de consensus stratégique sur le financement de la gratuité et le financement basé sur la performance des 16 et 17 mars 2009.

²⁹ Manuel des procédures pour la mise en œuvre du Financement Basé sur la Performance au Burundi, Version révisée, septembre 2011.

³⁰ Bulletin Officiel du Burundi. N°9/80. Décret n°100/107 du 27 juin 1980 portant création et organisation d'une mutuelle de la Fonction Publique.

³¹ Means Plateforme des Acteurs des Mutuelles de Sante au Burundi.

The gap was partially addressed in 2003 with the Ministerial Order N°630/530/445 that defined modalities for the management of the indigents. Thus indigents have been defined as:

- Children from poor families who have a student's card;
- Every individual unable to earn income, is without assistance, and is recognized as such by local authorities.

Despite this improvement in defining indigents, the criteria to select indigents were not set. The word "indigent" is complex because it implies economic and social criteria.³² Serious legal and coordination problems have arisen over who is "indigent" due to the vague and subjective criteria. The selection is thus left to the decision of different institutions, such as the health committee, local authorities, etc. It is important to differentiate between indigents and poor in a society where the majority of the population is poor.³³

A vague definition of who is an indigent increases the obstacles during the approval process from local authorities to communal levels. Even when indigents obtain their certificates, there are several points where they pay money out-of-pocket: (1) transportation to get their certificates approved and for travel to hospitals to receive care, (2) pictures and other payments to obtain the documents, (3) the referral process imposes a 20% co-payment for all consultations, for which indigents must go through a repetitive triage process. During the first triage, indigents are selected, in the second triage it is determined which indigents qualify for a subsidy for the 20% copayment. This second level of triage is an additional financial burden for poor households.

6. **Private SHP schemes:** This includes coverage for employment-related illness and injury paid by the employer through the National Social Security created in 1962. The payment may be made 1) directly to a dispensary supported by the employer, 2) payment through vouchers provided to health facilities, or 3) by paying premiums to private insurance schemes. It is difficult to know precisely the number of persons working in the formal private sector as: (1) there is no official registration for those working in businesses, (2) those working for temporary jobs are not officially reported, and (3) finally, there are no estimations of the population employed in the formal sector with their dependents. Rough estimates by the government suggest that the population in the formal sector is about 6%. Some of the private insurances are: Aga Khan Development, *Jubilee Insurance*, la Société d'Assurance du Burundi (SOCABU), etc. Table 3 below presents all SHP schemes in Burundi.

Table 3: Social Health Protection Schemes in Burundi

SHP/ Insurance schemes	Year created	Oversight	Premium	Co- payment	Population Targeted	Population Covered
Free care	2006	Ministry of Finance	none	none	All pregnant women and children<5 years	22%
CAM	1984, Revised 2012	Ministry of Finance	Frbu 3,000	20%	2/3 population. All population living under poverty line	31%
MFP	1980	Ministry of Public Service and Social Security		20%	11-13% of population. All public servants (1- 1.2 million)	10%
Private insurances including CBHI	In the 1990s Since 2008 for CBHI	Private organizations 3 5 private CBHI initiatives	Variable according to package	variable	2% of the population	2%

Source: Country Study Burundi.

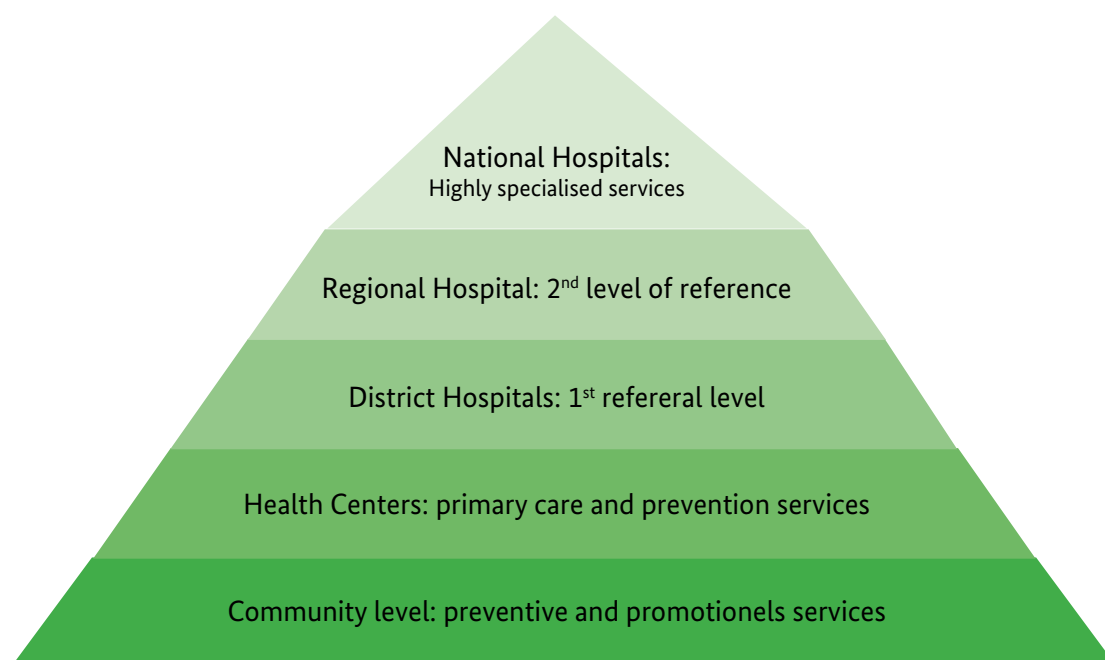
³² Kaddar et al. (2000) L'accès des indigents aux soins de santé en Afrique subsaharienne. *Revue Tiers Monde*. 41, 164, 903-925.

³³ Stierle et al. (1999) Indigence and access to health care in sub Saharan Africa. *Int J Health Plan Manag*.14(2), 81-105.

Health Facilities – Burundi

The health system in Burundi is organized as a pyramid with four levels: central, intermediate, peripheral and community level (Figure 7). The private sector represents a very insignificant share of care provided. The central level is primarily responsible for the formulation of sector policy, strategic planning, coordination, mobilization and allocation of resources as well as monitoring and assessment. The middle level consists of 17 Provincial Health Offices; each responsible for coordinating all health activities in the province. The peripheral level is composed of 45 Health Districts covering 43 hospitals and 851 health centers across 129 municipalities in the country. One Health District covers 2-3 municipalities and corresponds to the third administrative level in the health sector, which differs from the territorial administrative level, which is the municipality. This level includes community; there are 685 functional health centers, of which 63% are in the public sector. The country has 48 functional hospitals, for which 43 district hospitals and 5 are national hospitals. The non-lucrative private sector is essentially composed of health centers (33% of the total) belonging to religious denominations. Eight district hospitals among the 39 that are functional at the national level belong to churches. The private lucrative medical and pharmaceutical sector is mainly present in urban areas, particularly in Bujumbura. This sector plays a progressively increasing role in the health care system although the absence of statistical data on its activities are lacking.

Figure 7: Pyramid of Care in Burundi



Source: Base de Données de la Gratuité-FBP au Burundi (www.fbpsanteburundi.bi)

Human Resources for Health – Burundi

According to data from the Ministry of Health, the total number of staff is estimated at 15.937 comprised of 418 medical doctors, 5.957 nurses, 16 midwives and other support staff. The quality and quantity of human resources for health are alarmingly low and negatively impact the provision of health care services. The paramedical personnel are also limited in number and quality especially in the hard-to-reach areas. This deficiency is mainly due to poor quality of training in public and private teaching institutions, inappropriate selection of students, lack of updates of training materials and lack of proper planning for human resource for health. Doctors tend to move to administrative jobs heading national, provincial and district hospitals. Table 4 below shows that the majority of health providers are confined in urban areas and provides the ratio of provider to population in comparison with WHO recommendation (1/10.000 for doctors 1/3.000 for nurses).

Table 4: Challenges Faced by SHP Schemes in Burundi

Schemes	Challenges
Free care	<ul style="list-style-type: none"> • Government financial constraints • Government's delays in paying facility bills (3-6 months) • Poor quality of care received by members • Unavailability of drugs • Population less confident in the system • Unknown number of indigents
CAM	<ul style="list-style-type: none"> • Under financed (>3 bn of debts) • Limited involvement of technicians • Limited involvement of development partners • Delays in reimbursing facilities • Beneficiaries do not receive promised services in all facilities • Selection supposed to be done at communal level; however, lack of objective criteria to select indigents • Widespread poverty making indigent a large group to support with very limited government subsidies • No trust in the program: 20-25% facilities do not accept CAM
MFP	<ul style="list-style-type: none"> • Correct number of beneficiaries unknown • Does not cover all entitled • Limited managerial capacity (use of ICT, statistics, quality services) • Does not operate well in all provinces
CBHI	<ul style="list-style-type: none"> • Seems in competition with CAM • Stock outs of drugs and poor quality of health services seems to discourage adhesion • Absence of adequate communication between CBHI with members and authorities • Lack of financial support and limited human resource capacity
Private insurance	<ul style="list-style-type: none"> • Lack of management information system that would monitor members • Lack of clarity on how much employers are supposed to contribute • Low coverage and lack of an appropriate legal framework

Source: Country Study Burundi

Challenges to SHP Programs – Burundi

SHP schemes in Burundi are fragmented. The lack of consistency of the current SHP schemes creates a counterproductive system, which is fragmented, with limited coordination, duplications and gaps.

1. Free care and MFP can cover the same population with facilities billing both for services provided to members who belong to the two schemes at the same time.
2. CAM has created disincentives to join mutuelles for those segments of the population that qualify for both; this policy does not encourage those who can pay through CBHI to do so.
3. Increased transaction costs: 20% administrative costs compared to 16% that goes to health centers.
4. There is no separation of important functions with confusing roles and responsibilities: the MOH is the regulator, the buyer, the seller and the provider. This creates a situation of lack of accountability and conflict of interests.
5. Lack of a clear legal framework and monitoring systems resulting in low coverage and limited capacity for improvement.
6. Insufficient contributions of members to satisfy the needs of retired workers and the exclusion of members from managing bodies of the national social security institutions.
7. Wide spread poverty and insufficient subsidies. The CAM is in debt for more than 3 billions Burundi Francs.
8. Lack of a rational mechanism to identify the indigents.
9. Lack of confidence in insurance schemes on the part of the population because they have failed to provide services in the past.

10. Limited managerial capacity with lack of tools and appropriate information technology.
11. Negative impact of some religious groups and traditional healers against the campaigns aimed at increasing enrollment in mutuelles.
12. Mismatch between what is written on paper and the reality; the content of policies is not reflected in implementation on the ground.
13. Limited package offered by health services.
14. Difficulties for indigents to access quality care due to a cumbersome referral system with gate keeping mechanisms and co-payments at each level
15. Unclear guidance for the implementation of subsidies for indigents that allows for local interpretation and abuse.
16. Lack of baseline data, limited geographical coverage of the MFP: not all hospitals have MFP staff.
17. Easy cheating because of lack of strong Monitoring Systems resulting from:
 - a) Low rate of adherence in all schemes.
 - b) Inadequate and insufficient essential medicines.
 - c) Insufficient human resource in both public and private health facilities.

Table 4 presents a summary of the challenges faced by the different SHP schemes. The “Free care” program and the Carte d’Assistance Maladie are facing sustainability issues as the design and implementation did not consider: the capacity of the government to pay for free care, the rational selection of poor people in need for subsidies, etc. The Mutuelle de la Fonction Publique (MFP) is faced with trust issues as the scheme cannot provide an exact number of members, meet its debts estimated at more than two billions of Burundi francs and hence most public and private facilities are not willing to sign contracts with the MFP. The private sector is not very developed and faces limitations in its legal framework.

Specific Recommendations - Burundi

Stakeholders in Burundi provided recommendations aimed at improving services in the country and in the EAC region:

1. Establish a conducive regulatory framework to support UHC and SHP.
2. Elaborate a clear financing strategy for Burundi. Ensure proper implementation of the new SHP initiatives.
3. Increase efficiency through improved harmonization of schemes that focus on the same population (e.g. CAM and Free care).
4. Consider that free care is not free because poor people need money for insurance cards, for pictures, for travel, etc. Therefore, creating an equitable scheme where those who can pay and subsidize for those who can't is crucial.
5. Provide a simple and clear referral system that does not overcharge indigents.
6. Increase efficiency through training of competent human resources and adequate infrastructure.
7. Ensure fair allocation of resources across provinces and regions.
8. Provision of mechanisms for identification of indigents.
9. Increased government budget for health that provides criteria for the distribution by level.
10. Improve management of public and private SHP schemes with appropriate tools for management and budgeting, and information technology.
11. Improve motivation of health providers and quality of services on the supply side.
12. Improve the accreditation system to ensure the provision of quality services.
13. Ensure appropriate referral of patients between higher and lower levels of facilities to provide access to specialized services while containing costs.
14. Enhance emphasis on some forgotten public health areas such as the fight against malnutrition.
15. Improve quality and quantity of the available human resources for health.
16. Ensure sharing knowledge and best practices across EAC Partner States, for example, adopting Rwanda’s SHP model as a best practice to avoid wasting time to “reinvent the wheel.”
17. Determine a minimum package of health care for the whole population.
18. Make cost estimates for the minimum package in order to inform decision about contributions.
19. Create an autonomous National Health Insurance Regulatory Authority.
20. Review the structure of existing SHP schemes.
21. Permit each country to determine criteria to define indigent populations.
22. Insure monitoring and evaluation of SHP policies and programs.

Annex 1.B: Republic of Kenya

Kenya's Vision towards SHP

Since independence fifty years ago, the Government of Kenya has attempted to reduce levels of poverty and vulnerability among its people, as reflected in its development policies and plans.³⁵ In August 2010, Kenya adopted a new Constitution, which contains the government's commitments to provide for vulnerable populations that are unable to meet their basic needs, including women, children, older persons and youth. The 2010 Constitution of Kenya provides for basic rights to health, education, and decent livelihoods and is the legislative cornerstone for social protection in Kenya. Articles relating to social protection within the Constitution include: Article 43 on Economic, Social, and Cultural (ESC) Rights; Article 53 on Children; Article 54 on Persons with Disability.

In addition, the country's main development strategy, the Kenya Vision 2030 is to provide high quality of life for all citizens in the country. The Vision is divided into 3 pillars—the economic, social and political pillars. The objective of the social pillar, specifically, is to build “a just and cohesive society with social equity in a clean and secure environment”. The key areas identified under the social pillar are education and training, health, water and sanitation, the environment, housing and urbanization, gender, youth and vulnerable groups, equity and poverty elimination. These key areas are all inter-related, hence, support to one factor will contribute to solving the challenges related to all other factors, health included.³⁶

The second Medium Term Plan is currently being drafted and associated reforms have been initiated in key contributory schemes. In the civil service pension, the National Hospital Insurance Fund and the National Social Security Fund, strategies to expand coverage and improve governance systems and practices are being developed. To achieve its vision, the country developed a National Social Protection Policy (NSPP) in 2010 aimed at creating a coordinated national framework for social protection. The NSPP provides a broad-based framework to guide the design, implementation, and national oversight of social protection programs in the country.

Kenya has been implementing various social protection programmes, but these programmes have been limited in scope and coverage. They have also been implemented by various ministries, agencies and development partners, which have often led to coordination challenges. Social protection is at an important stage in Kenya. The overall goals for Social Protection Strategy are to:

- Protect the vulnerable and poorer households from the impact of adverse shocks to their consumption that are capable of pushing non-poor households into poverty, and poor households into deeper poverty;
- Support households to manage these shocks in ways that do not trap them into poverty through reducing their exclusion and strengthening their agency;
- Promote key investments in human and physical assets by poor households capable of ensuring their resilience in the medium-term and of interrupting the intergenerational cycle of poverty in the long term.

It is notable that, policy interventions in the area of social protection have concentrated in the past largely on the supply side, e.g. via subsidizing public health care facilities, providers and MOH. Recently, however, a change can be observed and the demand side of the health care system is coming increasingly into the focus of policy makers. Patients are more and more considered as economic agents instead of purely as beneficiaries or target groups and are seen as actors who interplay with other stakeholders such as providers and government authorities, among others.

To enhance health programmes in the country, several social health protection programmes were developed. Some of the programmes included the National Social Health Insurance Fund (NSHIF) through the Ministry of Health, which provides health services to the vulnerable people in Nairobi Province. The other notable schemes include the National Health Insurance Fund (NHIF), hospital fee waivers, and voucher schemes in health, among others. The welfare of orphans and vulnerable children (OVC) and their supporting guardians have also been improved through cash transfers for their up-keep. These cash transfers have also been provided to the elderly (above 65 years old) to enhance their welfare. The Hunger Safety Net, a food security program for the arid and semi-arid areas (ASAL)

^{35,36} Government of Kenya (2007). Kenya Vision 2030: A Globally competitive and prosperous. Kenya. Ministry of Planning and Vision 2030, Nairobi.

has been provided by the Ministry of Special Programs. Additionally, Kenya has developed a Health Care Financing Strategy, which aims at the establishment of a health financing system to provide the highest attainable standard of health for all Kenyans.

Legal Framework for SHP - Kenya

In an effort to identify the legal framework for social health protection, the 2010 Constitution of Kenya provides for basic rights to health, and is the legislative cornerstone for social protection in Kenya. Articles relating to social protection within the Constitution include:

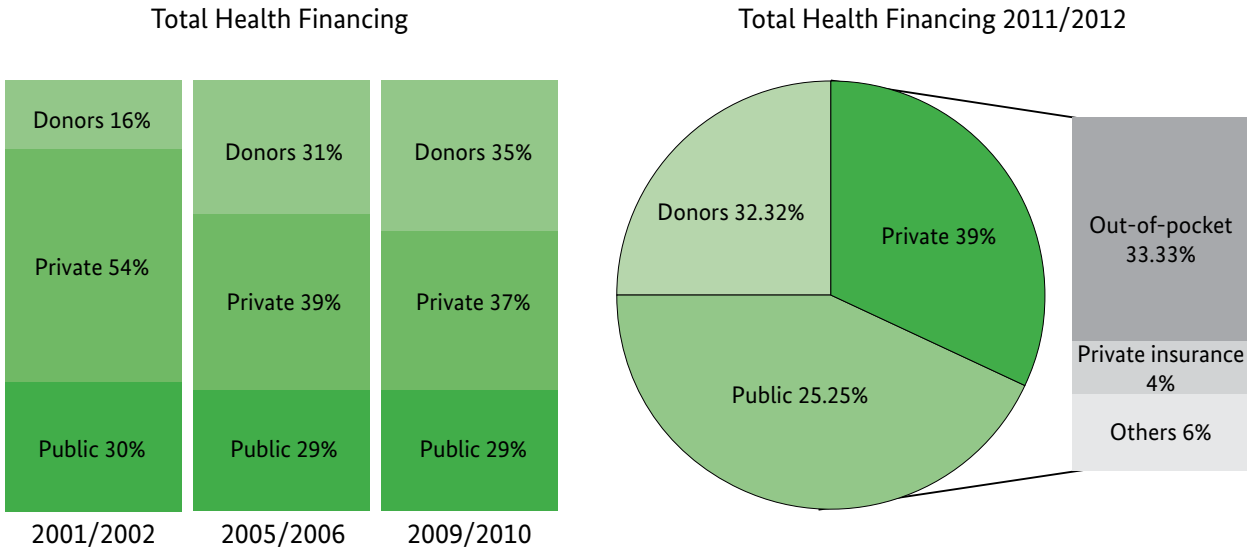
1. The Constitution of Kenya of 2010, (Articles 43. (1) (a), 53(1)(a), 56 (e),
2. The National Social Security Fund Act 1965,
3. The National Hospital Insurance Fund Act No. 9/1998,
4. The Pensions Act (Cap 189),
5. The Retirement Benefits Act No. 3/1997,
6. Sessional Paper No. 12 of 2012,
7. Insurance Act Cap 487; Regulated by IRA under Ministry of Finance,
8. The Work Injury Benefits Act No. 13 of 2007,
9. The Reproductive Health Care Bill, 2014.

Health Care Financing Sources - Kenya

The main sources of finance in Kenya, as shown in Figure 8, include the government (public) sector, the private sector and the donors as financing agents. According to the 2009/10 NHA the financing agents and funds were as follows:

- The public sector (funds managed by the Ministry of Health, NHIF, local government and other public bodies) contributed 25% of the funds in 2011/12.³⁷ This is a decline from 29% in 2009/10.
- The private sector, including employers and private insurers, contributed the largest proportion of the funds at 37%. Private sector funding increased to 43% in 2011/12. Private health spending contributes the largest share of health care financing. It accounted for about 42% of the total funding for the sector.
- Donors: There was a dramatic increase in the proportion of funds originating from donors rising from 31% in 2001/02 to 35% in 2009/10 with much of it being off-budget. This increase is largely due to PEPFAR and Global Fund for HIV/AIDS, Malaria and TB. There is an opportunity to channel some of these funds into a more sustainable and broad based risk pooling mechanism.

Figure 8: Sources of Health Financing in Kenya



Source: Computations based on The National Treasury Budget data (2011/12); NHAs (2009/10); and WHO database data

³⁷ National Treasury calculations

SHP Schemes - Kenya

There are different types of Social Health Protection mechanisms in Kenya under different organizational frameworks, structures and regulation. The assessment has identified the following Social Health Protection mechanisms: The National Hospital Insurance Fund (NHIF), Output Based Approach (OBA), Performance Based Financing (PBF), private insurance such as the Changamka Service, Community Based Health Insurance and HISP. From the above list of mechanisms, only NHIF is set up with appropriate infrastructure to reach beneficiaries and collaborators.

- The National Hospital Insurance Fund (NHIF) pays part of the hospitalization cost with payment generally being done as a fixed amount per day. It is generally adequate to cover care in lower level government hospitals (such as district hospitals), but covers only a small portion of the costs in private hospitals. The Fund pays for the costs of bed and subsistence charges during the member's (or their dependent's) stay in hospital. Membership is compulsory for salaried workers. Workers in the private sector are required to contribute through a payroll deduction.

The NHIF covers the worker and his or her immediate family i.e. spouse and children. The scheme covers an estimated 2.7 million contributing members 7.5 million dependents i.e. about 5% of the population. Informal sector workers and retirees, of whom the Fund currently covers approximately 700,000, can join the NHIF voluntarily. Also, an NHIF-sponsored indigent program currently has about 5,000 members. Policy makers are concerned about the large share of premium payments consumed by administrative expenses (estimated at 35%) and are looking at ways to reduce this share. Ongoing reform efforts work to align the NHIF more closely with the Constitution and ensure that health care coverage is extended to all Kenyans.

- Health Insurance Subsidy Programme (HISP): This is a Government of Kenya initiative (through NHIF) with support from the World Bank that will cover health costs for the poor (indigents) by extending an insurance cover to them to cover both outpatient and inpatient services. Year one of the programme is planned to be a pre-test phase to test the planned institutional arrangements and identify design problems and likely bottlenecks at low monetary risk prior to a larger roll-out. The beneficiaries who will participate in the programme have been identified with the support of the Social Protection Secretariat and mainly cover households with orphans and vulnerable children (OVC). In the first year, the programme plans to cover 90,000 poor Kenyans in 23,500 households. This translates to approximately 500 households in each of the 47 Counties. The number of persons covered will be progressively expanded to reach 9 million by 2020.

The key objectives of the pre-test phase are:

- Test the effect of HISP on the level of out-of-pocket expenditure and subsequently the incidence of catastrophic health expenditures among the poor;
- Test the effect of HISP on access to and utilization of healthcare services among the poor;
- Test the effect of HISP on the health status and outcomes of the poor;
- Test the effect of HISP on patient experience and satisfaction;
- To determine whether the planned institutional arrangement would work, identify design problems and likely bottlenecks.

HISP proposes to use existing NHIF accredited facilities, with a plan to continue accrediting more facilities to have a large enough provider network. There is also a proposal to carry out partial accreditation for some low level facilities which will then be allowed to provide some (basic) services and refer patients to higher level facilities for services they are not able to offer.

- Occupational schemes: These are run by employers for their employees and are underwritten by private insurance companies. Individual schemes (these are private schemes designed for the employed, self-employed and/or for those in non-pensionable employment). About 2 million Kenyans (5% of the population) are covered through private insurance and employer schemes. In general, these tend to be the workers in the best established organizations, such as major international companies, international NGOs, and government and international organizations.
- Voucher schemes in health: The Government of Kenya (GOK), in collaboration with UNICEF, has been implementing a voucher scheme based on issuance of reimbursable vouchers to pregnant women in North Eastern Province (NEP) Garissa, Wajir and Mandera, on a pilot basis since 2005. The aim of the scheme is to improve maternal and neonatal health outcomes in terms of reduced

morbidity and mortality by increasing skilled deliveries and prompt referrals in case of complications.

- The Output-based Approach (OBA) Voucher Programme: The GOK and the Federal Republic of Germany (KfW and GIZ) entered into an agreement in 2005 to finance a high impact intervention to enable the country to meet the MDG 4 and 5 on maternal, neonatal and child health (MNCH). Through implementation of the health care financing programme Output-based Approach (or OBA). The system functions as a type of social health insurance for pregnant women and their newborn children. The OBA is considered to be an interim programme until the proposed National Health Financing Policy and Strategy is operational and acceptable health insurance for universal coverage is in place. For those who are poor, donors fund the vouchers. Community workers also provide funds to poor women to fund their transportation to ensure that they can access services. Policy makers would be interested in exploring possible links between this scheme and SHP. The aim of the program is to increase access for poor women to reproductive health services such as safe motherhood, long and permanent methods for Family Planning and Gender Based Violence Recovery services. It follows a public-private partnership implementation model and reimburses facilities (public & private for profit and not for profit) directly based on the services provided. The program is currently not covering the whole country; it is being implemented in Kiambu, Kilifi, Kitui, Kisumu, and Nairobi in Korogocho and Viwandani.
- HAKI Program: Health for All Kenyans (HAKI) is a Government of Kenya initiative to provide access to healthcare through Social Health Insurance and a waiver mechanism, among others. The Ministry of Health with support from the German Development Cooperation has been piloting the Health for All Kenyans through Innovations – Waiver Mechanism (HAKI-WM) programme in Matuga Sub-county in Kwale County. Phase I of the pilot was implemented between August 2012 and February 2013. The second phase had originally been planned to run between March and December 2013, but was temporarily suspended to allow for conceptual adaptations to the original design based on recommendations from the evaluation of Phase I. Phase II was subsequently reprogrammed to run from September 2013 to June 2014. HAKI has a total of 7,679 households (approximately 40,000 individuals) that were selected through a comprehensive community based targeting process. The beneficiary households are issued with a HAKI card and registered in the nearest primary health facility where they receive health care services at no cost.

The main objectives of HAKI are to: i) increase access to quality health care services for the poor by removing all user fees from the KEPH, ii) generate evidence for the Health Care Financing Strategy towards UHC in targeting poverty, defining a basic benefit package, and costing the basic benefit package. HAKI currently has a total of 23 participating facilities that could be incorporated into the HISP programme. Of these 3 are district hospitals, 3 health centers, and 17 dispensaries. 22 out of the 23 are public facilities and one an FBO facility. Currently, only the district hospitals and one health centre are accredited by NHIF. There will therefore be need for NHIF to accredit the remaining HAKI facilities for them to participate fully and allow better access for the beneficiaries. In the initial stages, the proposal is to undertake partial accreditation, as most of the remaining facilities are lower level facilities.

- Free Maternity Services: The GOK announced an initiative to offer free maternity services at public health facilities on 1st June 2013. The initiative is expected to increase deliveries under skilled birth attendants and therefore reduce maternal morbidity and mortality. There is a proposed mechanism for channeling funds based on the number of cases handled in the medium-term and long-term:
- All funds for the dispensaries and health centers for free deliveries are to be channeled through the Health Sector Services Fund (HSSF). Maternity services at dispensaries or health centers are to be paid Kshs 2,500 for each delivery.
- Hospitals receive funds through the Hospital Management Services Fund (HMSF). Hospitals will receive Kshs 5,000 which includes a payment for an estimated 20% complications and Caesarean Sections.
- As the county structures get established, the scheme will be coordinated from the Ministry of Health Headquarters while keeping the counties informed about the processes. As of July 2013, all the funds for services are being disbursed as conditional grants to the health facilities based on the workload numbers. Given that the facilities will be reimbursed on a per output basis, the approach is essentially an Output-based Approach (OBA).

Work in groups revealed that the total insurance coverage in Kenya was around 32%. However it was noted that other initiatives towards social protection such as free primary health care in public facilities, free maternity care, the OBA voucher scheme and the HAKI programs were in place which in turn covered another 2%, thus bringing the total coverage to approximately 22%, while the majority of the population is not covered.

Table 5 discusses SHP mechanisms in Kenya. The main one involves the National Hospital Insurance Fund (NHIF). While the country has several pilot initiatives, the performance for NHIF is very limited because it covers only hospitalization. The country has the most developed private health insurance sector in the region, which protects those in need for care employed in the flourishing corporate sector. The grassroots population receives limited care of poor quality due to fragmented free primary and maternity care schemes. There are also several pilot programs championed by donors, such as the voucher system and the output-based programs.

Table 5: Social Health Protection Schemes in Kenya

Social health protection/ Insurance Schemes	Year created	Oversight	Premium	Co-payment	Population Targeted
NHIF include: <ul style="list-style-type: none"> Formal Sector Informal Sector Civil Servants HISP 	1966 (NHIF), Civil servants (2012), informal-evolved over time, HISP (under consideration)	MOH	KES 30-320	No defined co-payment but patients meet the expenditure over and above the expenditure met by NHIF	2.8 million Formal Sector 15,000 households HISP 1.1 million Civil Servants 2.7 million Informal Sector
Private health insurance: <ul style="list-style-type: none"> Private commercial CBHI 	Developed over the years, became more visible early 80s	Insurance ACT Cap 487. Regulated by IRA under the Ministry of Health	For private insurance, the premium varies depending on one's income	A number of out-patient schemes (private insurers, MIPs and employer schemes) apply varying forms of co-payments ranging from KSh. 50 to 500 per visit.	Approximately 700,000 people covered by private health insurance. CBHI covers approximately 470,000 people
Other Initiatives: <ul style="list-style-type: none"> Free Primary Health Care Free Maternity Care OBA programme HAKI programme 	1 st July 2004 1st June, 2013 2005 Nov, 2013	MOH MOH MOH MOH	Free No premium No premium No premium	KES 10 in dispensaries, KES 20 in HCs No co-payment No co-payment No co-payment	All Kenya population 4 million 4 million Unknown

Source: Kenya Social Protection Sector Review, 2012, Strategic Review of the National Hospital Insurance Fund – Kenya, 2010, NHIF fact sheet, 2010

The Kenyan National Community Based Health Insurance (KNCBHI) only covers in-patients. Out patients pay out-of-pocket at 100%.³⁸

Health Service Delivery - Kenya

Health Service Delivery is organized around 6 levels of care, from the community (level 1), to the national level (level 6). Each level has both service delivery, and management functions. The services delivered at each level are defined according to the norms and standards. The management function is physically distinct from the service delivery function at level 4 (district – Office of the District Medical Officer), level 5 (province – Office of the Provincial Medical Officer), and level 6 (national – MOH Headquarters). The service delivery function is rationalized, based on the need to efficiently, but effectively deliver the defined set of services in the Kenya Essential Package for Health (KEPH). A referral system is being strengthened, to improve linkages across the service levels and thereby ensure a more wholesome health care seeking effort by the population (see Figure 9).

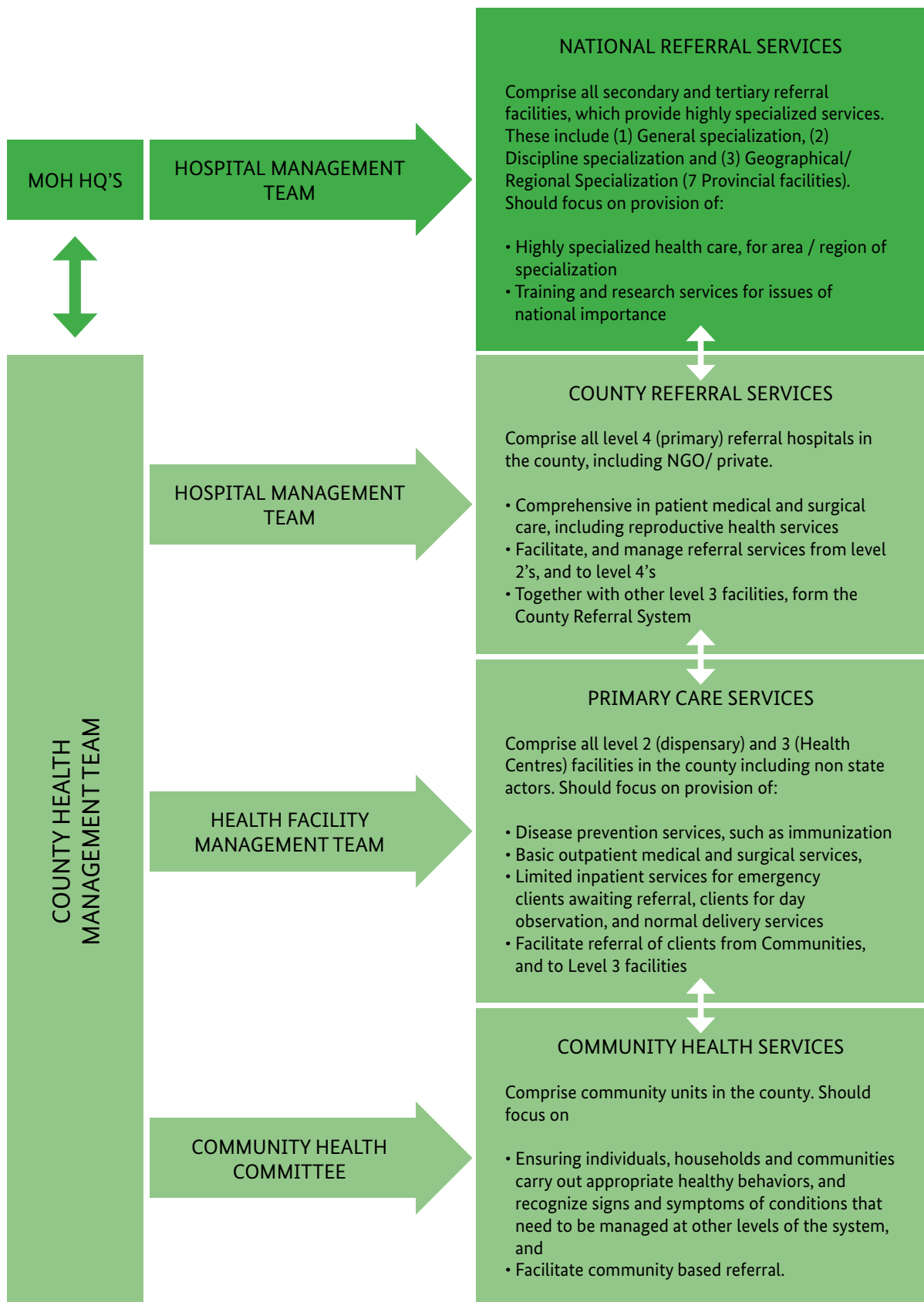
County Health System - Kenya

County Health Services are organized around 3 levels of care: community, primary care, and referral services. The community level focuses on organizing appropriate demand for services, while (Primary Care and primary referral services) focus on responding to this demand. The National and County Governments are expected to prioritize investment to ensure that all health facilities have the capacity to provide primary care, including emergency services.

- The Community services comprise of all community based demand creation activities, organized around the Comprehensive Community Strategy defined by the Health Sector.
- The Primary care services comprised of all dispensaries, health centers and nursing homes for public and non-public providers.
- The Primary referral services include all level 4 hospitals (district hospitals), currently referred to as County Referral Hospitals. They are expected to provide specialized services. The county referral system is comprised of all the County Referral Hospitals located in all the counties.

³⁸ <http://palsoftgroup.com/kcbhfa/programs.php>

Figure 9: Health Care Delivery in Kenya



Source: Ministry of Public Health and Sanitation (2010); Position paper on implementation of the constitution in the health sector, 2010

Human Resource for Health - Kenya

Table 6 summarizes data on health personnel.

Table 6: Kenya Health-Personnel in Public Sector Health Facilities

Category	Provincial Hospitals	District Hospitals	Health Centers	Dispensaries
Number of facilities	7	132	440	1,536
Doctors	306	547	9	3
Registered Nurses	528	2,049	393	230
Enrolled Nurses	1,571	6,123	1,902	2,416
Clinical Officers	210	1,427	318	82
All Nurses	20,199	8,172	2,295	2,646
Medical Personnel	2,615	10,146	2,692	2,731

Source: Country Study Kenya

The Challenges - Kenya

The challenges faced by social health protection mechanisms in Kenya are multiple; while the Government of Kenya is trying to scale up social health protection systems to reach the whole population, the systems in general are facing major challenges listed below and in Table 7:

1. Issues at the Government level:

- a. Lack of ownership and leadership from the Ministry of Health which leads to too many policies without any actual implementation.
- b. Low funding for the health sector although any increase should go hand in hand with ensuring that inefficiencies are reduced in the sector.
- c. Lack of trust by the population in the Government's schemes ability to provide quality services and scale up and manage transparently the programs opens the systems to abuse and wastage.
- d. Lack of standardization and coding of healthcare services and no regulation or policy guidelines for cost effectiveness of healthcare services. Healthcare provider regulation has traditionally focused on technical quality only.
- e. Delay of reforms within NHIF: the NHIF should cover preventive and out-patient care in addition to hospital care.
- f. Lack of cohesion and coordination between development partners: this an important impediment to the effective delivery of social health services. In order to coordinate the roles and contributions of different stakeholders, an integrative SHP strategy is required.
- g. Significant political interference and conflicting interests especially in reforming NHIF and other political decisions in the sector.
- h. Limited general population awareness of benefit of risk pooling.

2. Issues with regulatory framework:

- a. Lack of specific health insurance laws in Kenya. It is assumed that the law that applies to general insurance products (specifically personal accident cover) also applies to health insurance.
- b. Fragmented regulatory approach. Several prepaid schemes are under very different regulatory frameworks as already mentioned.

3. Issues with SHP programs:

- a. Lack of appropriate structures to identify the poor who need benefits. The same cohort ends up receiving all benefits for the poor

- b. Fragmentation of private risk pools. Most of the private health insurance pools are small and fragmented. The largest pools have about 100,000 lives covered. Small insurance pools lead to sub-optimal risk pooling and cross subsidy and deviate widely from actuarial risk estimates. They suffer diseconomies of scale and hence high administration expenses. They have weak bargaining power with providers. Such pools therefore tend to be relatively expensive and offer narrow benefit packages either in terms of range of services covered, financial limits or provider choice.
- c. The predominant mode of provider compensation is fee for service, which incentivizes providers to oversupply health services and hence drive up costs (provider induced demand).
- d. Reluctance of the private sector to engage in efforts towards SHP.
- e. Poor image of the insurance industry in general.

Table 7: Challenges Faced by Health Protection Schemes in Kenya

Schemes	Challenges
NHIF include: <ul style="list-style-type: none"> • Formal Sector • Informal Sector • Civil Servants • HISP 	<ul style="list-style-type: none"> • High administrative costs • Covers only those in the formal employment sector and a few in the informal sector-low coverage • Allocation of resources skewed towards curative services in urban facilities, • Frequent stock-outs of drugs, especially in public health facilities
Private Health Insurance: <ul style="list-style-type: none"> • Private Commercial • CBHI 	<ul style="list-style-type: none"> • CBHI lacks legal framework • Lack of long term sustainability plan • Lack of management capacity and limited financial resources, no subsidies • No clear mechanism for selecting indigents • Offers limited financial protection to members
Other Initiatives: <ul style="list-style-type: none"> • Free Primary Health Care • Free Maternity Care • OBA programme • HAKI programme • Other programmes 	<ul style="list-style-type: none"> • Free primary health care--insufficient funds earmarked for level 2 and 3 facilities, hence they end up charging patients • Frequent drug stock-outs (free primary health care), understaffed, lack some essential inputs e.g. lab • Limited capacity to submit claims • Free maternity care--funds only cover delivery but not other inputs • Serious shortage of health personnel, other challenges to accessing health care e.g. transport costs among the poor • Poor quality of services provided because of overcrowding • Lack essential non-medical and medical supplies, lack of adequate rooms to accommodate increased number of patients • Low motivation of staff, sustainability of the program not guaranteed, HAKI program-is heavily donor dependent

Source: Country Study Kenya

Specific Recommendations - Kenya

Kenyan stakeholders proposed several strategies for needed change if UHC and SHP are to be achieved. There should be:

1. Enhance role of the government's through legislation, collection of revenue and provision of subsidies to the poor;
2. Improve ownership and leadership of MOH;
3. Coordinate and clarify roles and responsibilities of all stakeholders;
4. Improve the legal structures for SHP in the country and M&E programs;
5. Increase coverage within the informal sector and subsidies to the poorest by the government;
6. Establish compulsory SHP by mandatory contributions from informal sector, for example by using pin numbers (tax identification numbers);
7. Earmark tax contribution for health through the Kenya Revenue Authority;
8. Define standard minimum benefit package for health services accessed by all;
9. Establish portability of health insurance across EAC countries with:
 - a. Unify regulation of all social health mechanisms in EAC Partner States,
 - b. Enhance cooperation with strong coordination among EAC Partner States,
 - c. Institute uniform standards in the regional provider networks,
 - d. Provide funding for the development of a regional unit and to put in place a centre of excellence where learning and sharing of best practice can be done;
10. Improve governance structure: The NHIF should be expanded further in order to reach the poor through the Health Insurance Subsidy Program (HISP);
11. Extend coverage: The NHIF should be expanded further in order to cover both inpatient and outpatient services. The programme currently gives a daily rebate on inpatient patients covered;
12. Enhance operational efficiency: Efficiency in the operations of the institution were noted as key in achieving their goals and would thus require improvement to curb problems in operations;
13. Develop a single registry for social assistance with a synchronized automated information technology system;
14. Define priorities for harmonization based on legal aspects;
15. Create an insurance scheme to cover EAC based on a legal framework;
16. Set a minimum quality accredited system for all EAC countries;
17. Learn from neighboring countries. The participants desired that Kenya learn from Rwanda the coordinated and high coverage that the country has achieved.

Annex 1.C: Republic of Rwanda

Background of SHP in Rwanda

The trace of the first social health protection initiatives in Rwanda goes as far back as 1960s when small communities gathered to pool resources and uses them to purchase health services.³⁹ The earliest social health protection mechanism was initiated in the 1960 the former *Kibungo* prefecture, and at same time, *Butare* prefecture also started the scheme. The two schemes were aimed at social health protection by increasing access to health care services at the community level through pooled resources. These *mutuelles* worked until 1994. The period during and after the 1994 genocide, there was no social health protection mechanism in the country. The period during and after the 1994, Rwanda received significant financial support from the international community and as result; the cost of the health care services was free due to the post-genocide emergency. Three years later (1997), the government introduced user-fees to purchase health care services, and as a result, there was dramatic decline in utilization where majority of the households faced hardships to cover health care costs due widespread out-of-pocket (OOP) health care costs.

The first formal health insurance for the civil servants—Rwandese Assurance Maladie (RAMA) was introduced in 2001 to cover the civil servants. Before 1998, the only formal insurance schemes were private and covered private individual, formal employers of the non-governmental organization (NGOs), parastatal institutions like banks, insurance enterprises, etc. The introduction of the civil servants insurance has led to a remarkable improvement in the access and utilization. After the introduction of RAMA, there was Military Medical Insurance (MMI) introduced in 2005 to cover military, and their dependents. Members of these insurances enjoy comprehensive service coverage with a co-payment of 15%.

To further overcome financial barriers that mostly affected the informal sector population to access health care services, in 1999, the government of Rwanda officially introduced CBHI in the three districts of *Kabgayi*, *Kabutare* and *Byumba* as pilots. These schemes covered 52 health centers in these three district hospitals. During the pilot, many management tools, modules, procedure manuals and mobilization tools were developed. Towards end of 2004, prospective studies conducted showed positive results in the context of access and utilization of the health services in the three pilot districts.⁴⁰ As a result, the MoH with support from partners developed the first “*Mutuelle Policy*”, which underscored the country support to the implementation of *mutuelle* to protect the local population health care out-of-pocket expenditures as well as increasing access to health care services. The policy was aimed at among other things, institutionalizing *mutuelles*, and setting up organizational management structures in order to strengthen *mutuelles* at all levels and improve partnership with all actors involved in the scheme. More than a decade ago, the Government made a decision to expand the CBHI scheme to cover the country. The scaling up was accompanied with development and approval of tools such laws establishing the CBHI; put in place membership rules, volume of the package of services, and options for the provider payments.

The positive development of health insurance in Rwanda is based on several advantages, namely:

- Strong political commitment by central and decentralized government (CBHI coverage is an important indicator in district performance contracts)
- A decentralized health system; made possible by MINALOC
- MINECOFIN which pays for indigents' contributions
- An excellent network of health facilities in all districts
- The small size of the country and the existence of a broad banking system
- Community led initiative such as, creation of Ibimimina (groups of few members in each village with a leader responsible for collecting premiums)

Legal Framework for Social Health Protection - Rwanda

Rwanda has put in place a number of legislations regarding the legal aspects of SHP. The government has promulgated a key law obliging all Rwandans and foreigners living in Rwanda for more than fifteen (15) days, to possess a health insurance card i.e. Article 33 of Law N° 62/2007 of 30/12/2007 “Establishing and determining the organisation, functioning and management of the mutual health insurance scheme.” However, Rwanda has been hesitant to enforce this provision, and prefers to encourage the eligible population to enroll for their own benefits.

³⁹ Ministry of Health/CBHI. (2012). Community-Based Health Insurance Annual Report. June 2012.

⁴⁰ Ministry of Health. (2011). Health Sector Strategic Plan 2009-2012, external evaluation report.

The major official legal documents on social health protection in Rwanda are:

1. The Constitution of the Republic of Rwanda of June 4, 2003

In 2003, a new Constitution was adopted by referendum to replace the older Constitution of 1991. Article 14 stipulates that “The State shall, within the limits of its capacity, take special measures for the welfare of the survivors of genocide who were rendered destitute by the genocide committed in Rwanda from October 1st, 1990 to December 31st, 1994, the disabled, the indigent and the elderly as well as other vulnerable groups.” The Constitution also focuses on children through Article 28: “Every child is entitled to special measures of protection by his or her family, society and the State that are necessary, depending on the status of the child, under national and international law.”

2. Social Protection Policy of 2005

In 2005, the Ministry of Local Government developed a social protection policy through a participatory analysis of defining poverty, which helped to categorize degrees of vulnerability.

3. Social Protection for Survivors of the 1994 Genocide against Tutsis

The Fund for the Support and Assistance to the Survivors of the Tutsi Genocide and Other Crimes against Humanity (Genocide Survivor Assistance Fund (Fonds d'aide aux rescapés du génocide, FARG)) was established by Law No. 02/98 of 22 January 1998 to provide assistance to victims of genocide perpetrated against Tutsis in Rwanda from 1 October 1990 to 31 December 1994. This law was reviewed by Law No. 69/2008 of 30 December 2008 (OG. N° Special of 15 April 2009). It created a fund that provides health insurance coverage for the survivors of the genocide, among other social services.

4. Child Protection Rights (Law N°54/2011 of 14/12/2011 relating to the rights and the protection of the child)

The Child Protection Law was published in the Official Gazette N°. 54/2011 on 14 December 2011. It provides rights to the child, including the right to be provided with health services through the *Mutuelle de sante* structure under Articles 35, 41 and 44.

5. Persons with Disabilities (Law N° 01/2007 of 20/01/2007 Relating to Protection of Disabled Persons in General)

Rwanda has made varying progress in supporting the rights of persons with disabilities and ensuring that people with disabilities benefit from and contribute to national development. The Government has committed itself through the adoption of the law to protect the rights of persons with disabilities (2007) and has passed eight ministerial orders in order to implement this law (2009).

6. Community-Based Health Insurance Scheme (Mutuelle de santé)

(Law N° 62/2007 of 30/12/2007 Establishing and Determining the Organization, Functioning and Management of the Mutual Health Insurance Scheme).

In 2007, upon publication of the Law governing the CBHI, the Government of Rwanda embarked on a strategy to formally establish and organize the CBHIS. The schemes cover wide range of the population i.e. more than 75% of eligible population. They are organized from the Sections at the administrative Sectors i.e. *Umurenge Section* up to the administrative District (*Akarere*) where the we find the Director of the Scheme and the CBHI management staff has offices and administrative autonomy. The CBHI structure at the District is managed by a Board of Directors composed of members of the District administration. At the national level the CBHI is coordinated by a Cell in the Ministry of Health under the Health Financing Unit.

7. Military Medical Insurance

(Law N° 23/2005 of 12/12/2005 Establishing Military Medical Insurance and Determining its Organization and Functioning). In 2005 the Government of Rwanda established the military medical insurance scheme (MMI). Members of the Rwanda Defense Forces and their eligible family members are covered under the Military Medical Insurance scheme.

8. Rwanda Social Security Board (RSSB): Medical Benefits scheme (Ex-RAMA)

(Law N°45/2010 of 14/12/2010 Establishing Rwanda Social Security Board (RSSB) and determining its mission, organization and functioning. RSSB still recognizes and enforces Law N° 24/2001 on the establishment, organization and function of a health insurance scheme for government employees, as amended to date, providing for the management and functioning of the public service health insurance scheme in Rwanda.

The body collects premiums or contributions from all public servants and enters into agreements with providers of healthcare services whether public or private at providing health insurance coverage, among other social services.

Healthcare for Public Servants (Law N° 86/2013 of 11/09/2013 establishing the general statutes for public service).

Article 69 of the law on General Statutes for Public Service provides that the "The Government shall provide a healthcare support to its employee and other people under his/her care in accordance with relevant laws."

9. Associations for Health Insurance Provider

Although not many, there exists one known association that provides health insurance services i.e. the Association of University Students that provides health insurance services at the University of Rwanda (Formerly known as UNR).

10. Health Insurance Law (draft)

The Government of Rwanda approved a Draft Law that will regulate all health insurance services in the country. The draft is in the final stages of approval by the Parliament hence publication in the Gazette. The draft law requires all employers to participate in the health insurance of their employees and establishes a national Council that will be in charge of regulating health insurance services in the country.

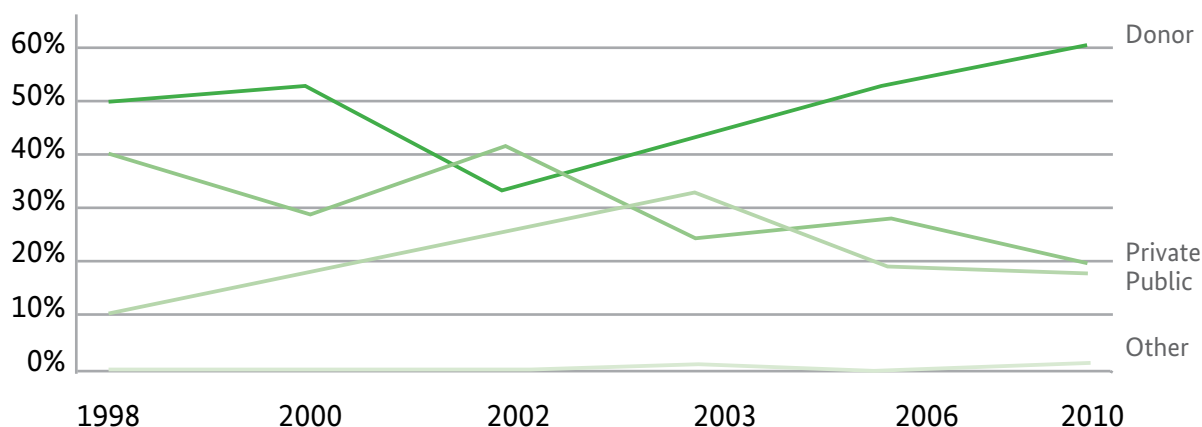
11. Community-based Health Insurance Law (draft)

The Law governing CBHI is under revision to transfer the management of CBHI from the Ministry of Health to RSSB a body under the Ministry of Finance and Economic Planning. This move will ensure that the purchaser of health services (RSSB) is separate from the provider of health services (Ministry of Health).

Health Financing - Rwanda

Similar to Burundi and Kenya and according to the draft NHA of 2010, donors contributed the most towards health (RWF 148,958,380,403) followed by the private sector (RWF 49,457,137,241), including households and employers, and then the public sector (RWF 43,326,845,636).

Figure 10: Distribution of Financing Sources as Percent of THE, 1998-2009/10



Source: Country Study Rwanda

As compared to 2006, the public sector contributed 51% more funds in 2009/10 and donor contributions increased by 57% during the same time period in real terms, whereas the contributions from the private sector decreased by 8%. The figure above shows that 61% of THE came from donors, 18% came from central government revenue and 20% came from private sources (75% was from households). Contrary to Burundi and Kenya, Rwanda's share of private spending on health decreased over time as shown in Table 8.

Table 8: Percentage Change in Terms of Funding Source from NHA 2009/2010

Financing Sources (Billions RwF)	2006	2009/10	% Change
Public	28.6	43.3	51%
Private	54.0	49.4	-8%
Donor	94.9	148.9	57%

Source: Country Study Rwanda

SHP Schemes - Rwanda

Rwanda has targeted different segments of the population with different types of schemes. However, the country is now moving towards merging the formal government employees insurance with the CBHI scheme.

Rwanda social security board (RSSB): Previously called RAMA (Rwandaise d'Assurance Maladie) was created in 2001 based on the law N°24/2001 from 17 April 2001. It is a parastatal organization that disposes of juridical personality and enjoys administrative and financial autonomy. Initially, RAMA was under the authority of the ministry in charge of public administration, it has since been transferred under the Ministry of Finance and Economic Planning (MINECOFIN). In December 2010, RAMA was merged with the Social Security Fund of Rwanda (SSFR) to create the Rwanda Social Security Board (RSSB). The new institution branches manage pension, occupational risks and health insurance. RSSB as a financial institution is supervised by the National Bank of Rwanda according to the banking law N°55/2007 of 30/11/2007, whereas its activities are overseen by the Ministry of Finance and Economic Planning. The total contribution rate for RSSB members is of 15% with contribution shared equally between employer and employee at 7.5% of the base salary. Contributions are directly deducted from employees' payrolls and paid by employers every month. Co-payments of 15% are due by RSSB members at all levels of the public and private health facility networks.

RSSB provides a comprehensive list of curative and preventive services without specification and at all levels of the public and private health facility network. Its benefit package includes: medical consultation, medical surgery, dental care and surgery, medical radiology and scanning, laboratory tests, physiotherapy, nursery care, hospitalization, drugs based on a list accepted by RSSB; pre-natal, perinatal and post natal care, glasses. RSSB's benefit package excludes medical services provided abroad, prosthesis, ARV treatment, plastic surgery and drugs and other consumables having generic equivalents. These services can be provided by any health facility or provider which has signed a "partnership convention" with the RSSB. The scheme disposes of the largest service provision network in the country after the military. This includes all public health centers (including privately-owned non-for-profit facilities), all district and referral hospitals, public specialized services, private clinics and pharmacies, a military hospital and its own pharmacies.

The MMI's benefit package basis on the services provided by the RSSB but is in some extent broader. As such, it includes prostheses but excludes plastic surgery for aesthetical purposes. As for the RAMA, these services can be provided by any health facility or provider which has signed a "partnership convention" with the MMI. The scheme provides the same service provision network than the RSSB through conventions with individual service providers and with RSSB's own pharmacies. The Rwanda Military Medical Insurance (MMI) has developed to cover armed forces and the police. Its management is trying now to expand and include private companies and individuals.

Community-based health insurance (CBHI): For the majority of the population employed in the rural sector and the informal sector, an incremental approach was followed for the development of health risk pooling mechanisms. In 1999 the Ministry of Health with the technical support of the Partnerships for Health Reform (PHR) project, initiated a pilot community health insurance in three districts. In December 2004, after the success of CBHI in these pilot districts, Rwanda developed the strategic policy document, "Community-based health insurance in Rwanda" as a basic tool for the implementation and development of CBHI and extended the CBHI schemes to all the thirty districts in 2005. In December 2007, the law establishing the CBHI and describing the membership rules, package of services, provider payment options and financing mechanisms was elaborated and then promul-

gated on March 20th 2008. In April 2010, a new CBHI policy was elaborated with the goal of providing Rwandan population with universal and equitable access to quality health services. A contribution system based on the capacity to pay of households was introduced to assure equity and solidarity among its members. In early 2014, the decision to move CBHI under RSSB was taken and by July this year, the scheme will no longer operate under the MOH.

CBHI administrative and executive structures are present at each level where funds are to be pooled, i.e. at sector, district and central/national level. At the central level, a “Cellule Technique d’Appui aux Mutuelles de Santé” (CTAMS) provides support for the development of CBHI, by contributing to policy formulation and strategy development in regard to CBHI and by taking charge of CBHI monitoring and evaluation. In addition, CTAMS is responsible for the development, updating, and dissemination of management, monitoring, and training systems and tools. At district level, the CBHI has two bodies: a board of directors and management. The mandate of the board of directors includes general supervision of the management and monitoring of CBHI operations. Partnership between Government and the community is reflected in the board of directors, which is composed of seven persons: a district representative, two representatives of CBHI sections working in the district, a representative of district associations, and a representative of religious denominations, a health facility representative, and a sector representative. Members of the board of directors are elected to a three-year term and may be reelected only one time consecutively. At sector level, CBHI section has a management committee composed of five persons: a president, a vice-president, a secretary, and two councilors who are each from a different sector. Members of the management committee are elected to a two-year term and may be reelected just one time consecutively. In every village, cell and sector, there is a mobilization committee for CBHI, consisting of members elected by the population for a two year renewable mandate.

CBHI schemes have a three-tiered structure corresponding to the three levels of the country’s health pyramid: the section, the district, and the national level. Sections operate at the health center level; they are mainly funded by household contributions and Government and partners funds towards the indigents. The sections will use 55% of the total contributions to finance the health center minimum package. At this level, CBHI patients pay a flat fee of 200 RWF (\$ 0.3) referred to as “ticket modérateur” each time they visit the health center. At the district level, there is a solidarity fund- “pooling risk” that receives 35% of the total contributions collected at the section level. This level receives also funds from the national pooling risk fund to pay invoices from district hospitals. At the national level, there is a national risk pooling set up to co-finance the district hospital complementary package, finance the national hospital package (PTA) and pay invoices of patients' roaming system (portability). This national risk pooling fund receives 10% of the total contributions collected at the health center but also additional funding from the Government and partners. It receives also funds (1% of total revenues) from the formal sector health insurance scheme (RAMA) and other private health insurance operating in Rwanda. At hospital level, a copayment is due for CBHI members for each visit.

CBHI members are by law entitled to a comprehensive list of curative and preventive services at all levels of the public health facility network, including: vaccination, medical consultation, medical surgery, dental care and surgery, medical radiology and scanning, laboratory tests, physiotherapy, hospitalization, drugs based on a list accepted by CBHI, pre-natal, perinatal and post natal care, reimbursement of ambulance transportation fees, prostheses and or those not exceeding a value approved by the CBHI. However, the use of hospital services is controlled by a gatekeeper system i.e. CBHI members are entitled to use hospital level care if they have been referred by the lower level.

Medical military insurance (MMI): The MMI was created in 2006 based on the law N°23/2005 from 12 December 2005. It is a parastatal organization that disposes of juridical personality, enjoys administrative and financial autonomy and is under the authority of the Ministry of Defense. The MMI has a similar governing structure to the RAMA. The highest governing body of the MMI is its board of directors which members are appointed by ministerial decree. The total contribution for MMI members is of 22.5% with 5% covered by affiliates and the remaining 17.5% by the employer, i.e. the government. Contributions are directly deducted from employees' payrolls and paid monthly.

The new CBHI policy was implemented to address challenges in financial sustainability and improve equity and fairness. Also it made possible the inclusion of identified poor and vulnerable groups in subsidizing the premiums and co-payment. However the implementation of the new premium schedule has threatened the scheme as a decrease in the CBHI coverage was observed. CBHI members complain about the high rate of premium they have to pay especially when they have large number of

members to cover. Also recent stock-outs of drugs at health facilities have also been observed leading to CBHI members not getting the prescribed treatment or having to pay more money as they have to get drugs from private pharmacies. The current provider payment mechanism “fee for service” combined with the limited capacities of control and management of the scheme creates a major risk for the financial sustainability of the scheme. In particular, as providers can bill any service provided to the scheme in absence of a detailed benefit package

Managed under the Ministry of Health, the national CBHI scheme faced managerial and design challenges in term of conflict between the purchaser and provider for health services. Currently, the mutuelles have moved under the Rwanda Social Security with the aim of ensuring better management, a split in the provider-purchaser role of the ministry to ensure accountability and transparency, and finally a cross subsidy between the formal and informal sector.

The current CBHI system was fragmented with schemes facing a bigger financial risk and also including a greater share of more "needy" population compared to RSSB and other schemes. Additionally, there was limited managerial capacity at the MOH for CBHI, that is why the Government of Rwanda has moved CBHI under RSSB, the details on the reasons of the move can be found on a special New Times article.⁴¹ This was done in the spirit of assuring cross-subsidization between the various health insurance schemes in Rwanda.

Table 9 presents in summary the different social health protection mechanisms in Rwanda. Rwanda presents a social health protection system inclusive with the aim of ensuring universal health coverage. RAMA which stands for “La Rwandaise d’Assurance Maladie was a separate entity from the social security institution but was merged in 2011 to constitute the Rwanda Social Security Board.

Table 9: Social Health Protection Schemes in Rwanda

Social health protection/ Insurance Schemes	Year created	Oversight	Premium	Co-payment	Pop Targeted
RAMA	1999	RSSB / MINECOFIN	15% of salary (7.5% employee, 7.5% employer)	15% of costs generally 30% at KFH	Public servants, now accepts private large enterprises
CBHI	2004	First MOH, now RSSB	According to income: RwF 2,000; 3,000; 7,000	RwF 200	Informal sector, majority rural
MMI	2005	Ministry of Defense	22.5% (5% employee, 17.5 employer)	15% of costs of service	Military, police and now plans expand to private people and entities
Private • insurance: Mutuelle/UR • SONARWA, CORAR, etc.	2001 Prior to 1994	National insurance council to be created	Varying with information considered confidential	Variable according to packages	Students and staff of the University of Rwanda. Corporations and now plans expand to private people and entities

Source: Country Study Rwanda

⁴¹ <http://www.newtimes.co.rw/news/index.php?i=15659&a=75217>

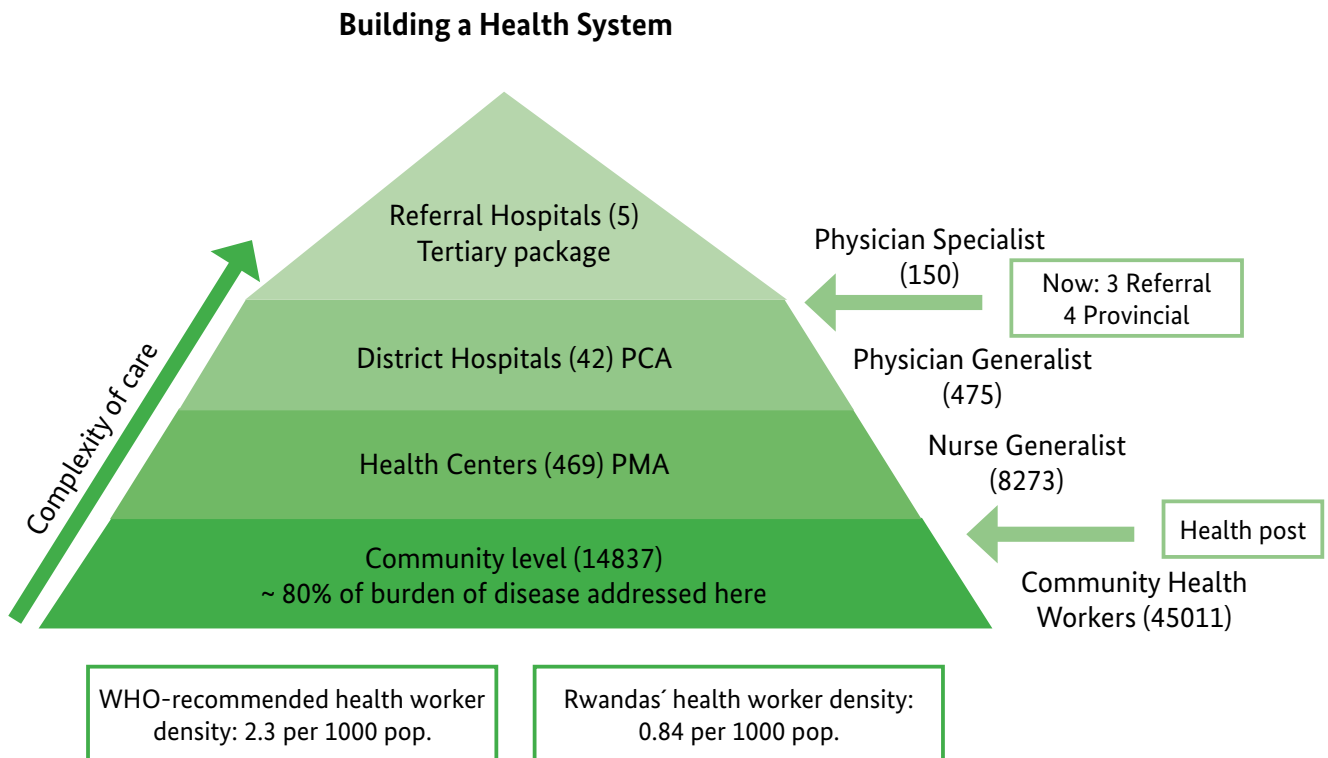
Health Service Delivery - Rwanda

The Rwandan health care system is structured as a pyramid with the base providing primary health care at the community and health center level. Above these levels there are district and tertiary care systems as well as different types of private providers (public, confessional, private-for-profit and NGO). At each of these system levels, there are corresponding political administrative structures.

At the village level, CHWs provide preventive, promotive, and selected curative services. CHWs are administratively supervised by the staff in charge of community health at the health centers. CHWs have been trained in several interventions and they receive financial compensation through PBF for delivering certain health services. At sector level, health center provides primary health care services and support CHWs in carrying out their tasks at the community level. At the district level, there are several agencies providing different health services. These include: district hospitals (DH), District Pharmacies, community based health insurance (CBHI), HIV/AIDS, and PBF committees. Health related activities are reported to the director of the district hospital. Each has got a district health unit (DHU), which is an administrative unit in charge of the provision and supervision of health services in the entire district and is responsible for planning and monitoring of implementing agencies, inter-sectoral collaboration and coordination with development partners working in the district. The DHU is composed of two technical staff members (Planning and M&E) and reports to the staff in charge of social affairs or to the district council if necessary. The director of the district hospital reports to the DHU on progressive performance of the district hospital.

At the national level, there are currently 4 recognized referral hospitals. The national level (tertiary) is the top most level of health care where district hospitals transfer patients for further care such as medical complications requiring advanced care. Generally, Rwanda has got: 4 referral hospitals, 444 district hospitals, 438 health centers, and 45,011 CHWs operating in 14,873 villages. All CHWs are organized into cooperatives called Community Health Worker's cooperatives. Each health center oversees one CHW cooperative; therefore the number of cooperatives is the same as the number of health centers in the country. The pyramidal care is provided below.

Figure 11: The Structure of the Health Care Delivery in Rwanda



Source: MoH PowerPoint presentation 2012

Human Resources for Health - Rwanda

According to the Rwandan Medical Council, the majority or 70% of physicians work in public facilities; about 80% of those working in public facilities are in district hospitals (see Table 10).

Table 10: Health Workers to Population Ratios⁴²

Health Workers	Proportion per inhabitants
Doctors	1/15,428 inhabitants
Nurses	1/1200 inhabitants (78% in rural and 22% in urban)
Midwives	1/66,749 inhabitants, or MW 0.01 / 1000 pop.
Health workforce density	0.85 / 1000 Pop

Source: Country Study Rwanda

Currently, A1⁴³ nurses represent less than 10% of the total pool of nurses (Table 11). A2 nurses are relatively evenly spread throughout the country, though there are still disparities between districts, with a number of districts being under-served.

Table 11: Nurse Distribution

Nurses	Health center	District Hospital	District Pharmacy	Total
Nurse A0	2	18	0	20
Nurse A1	186	271	0	457
Nurse A2	3935	2175	42	6152
Total	4123	2464	42	6629

Source: Country Study Rwanda

Table 12: Doctor Distribution per Specialty

Specialty	Numbers
General practitioners	470
Specialists	133
Expatriates doctors	58
Total	661

Source: Human Resources for Health Strategic Plan, 2011-2016

The Challenges - Rwanda

Table 13 presents the challenges of the social health protection system in Rwanda. Overall, CBHI is the most challenging SHP in Rwanda; three major challenges faced by CBHI in Rwanda are:

The first is to sustain the schemes that rely on Government subsidies because of the 25% of the poor population receiving free insurance. Now that CBHI has moved to RSSB, there are fears but a feeling of determination to succeed:

“While RSSB with its medical and pension schemes are well shaped now, mutuelles represent a challenge. We recover premium from regular salaries. We have no experience with mutuelles. Bringing us mutuelles means bringing us 10 million people with their premium depending mainly on rainfall... this is a big challenge! By this

⁴² MoH website: <http://www.moh.gov.rw/index.php?id=3>

⁴³ A0= 4 years university level, A1=3 years university level, A2= Secondary level.

July, we are now starting to manage mutuelles. The danger is to merge all institutions without cautious, the very weak may pull back those somehow ahead..." (Regional Interview)

The second is the fluctuating coverage throughout the financial year because members renew their enrollment at different time every year. Enrolment depends on community sensitization by local Government, religious leaders, etc. because the Government is reluctant to apply the legal fines related to late payment of premium. The reality is that for some important part of the financial year, almost half of the population targeted by CBHI is not covered by any of social health protection.

"First, it is important to understand Mutuelles: they are community led initiatives with encouragement from local authorities, individuals give premiums but adhesion is at family level. Payment is often fragmented, contributions are irregular, very low..." (Regional Interview).

Persisting issues:

- Overbilling and over prescription by some health facilities.
- Financial management of CBHI pools.
- Problem of adverse selection.
- Ubudehe was also criticized nationally because they were not meeting the goals of selecting rationally those in need for subsidies. More was said in a national newspaper.⁴⁴
- Abuse of the referral system and frauds.
- Issues of affordability of 10% co-payment charged at tertiary level by CBHI members.
- CBHI Sustainability issues.

Table 13: Challenges Faced by Health Protection Schemes in Rwanda

Schemes	Challenges
RAMA	<ol style="list-style-type: none"> 1. Facing challenges in accommodating CBHI. Looking for strategies to work with CBHI 2. Beneficiaries complain for high premium that does not allow for covering parents 3. Beneficiaries complain for limited service coverage e.g.: cost of glasses 4. Beneficiaries propose investment in promoting higher and better coverage and including parent of working age members and subsidies for CBHI
CBHI	<ol style="list-style-type: none"> 1. Financial sustainability and fragmented CBHI now more or less addressed by merging with RSSB to improve equity and fairness 2. Challenges with the identification of poor and vulnerable groups. Although best in the region, Ubudehe system faced challenges and is under revision 3. Decreased coverage once increased premium 4. Large group of the population not converted throughout year 5. High premium for large families 6. Stock-outs of drugs at health facilities 7. Fee for service mode of payment with the limited capacities of control and management of the scheme represents a risk for overbilling. 8. Do not support funeral services
MMI	Beneficiaries overall very happy with the scheme. Services generally comprehensive with low co-payment. Transfers allowed, even outside the country
Private institutional insurances: Mutuelle/UR	So far meeting the demands for the population covered. Difficulties accessing care at KFH
Private insurances: CORAR, SONARWA	Faced with competition with RSSB and CBHI Do not enroll families but large companies but start thinking about it.

Source: Country Study Rwanda

⁴⁴ <http://www.newtimes.co.rw/news/index.php?i=15742&a=77285>

Specific Recommendations - Rwanda

The following are a few strategies being implemented to address challenges in the area of SHP in Rwanda:

- The progress and process of moving the CBHI managed to the RSSB;
- On-going computerization of the CBHI system process;
- Strategies to strengthening community sensitization on CBHI;
- Accreditation of all health facilities to strengthen health care quality and linked to PBF;
- Strengthening the role of CHWs in delivering health care;
- Review of the provider payment reforms to strengthen purchasing mechanism;
- They could benefit with innovative progressive payment through mobile money;
- Implementation of the Rwanda Health Insurance Council to regulate all health insurance schemes.

Recommendations for a regional SHP program were also provided and participants suggested:

1. All EAC Partner States should ensure that health insurance coverage is mandatory. The EAC cross border health insurance should be provided to all EAC Citizens. All EAC citizens must possess a valid membership;
2. EAC must support and ensure political willingness and governance of social health protection mechanisms in all EAC Member States;
3. Best practices on social health protection should be shared;
4. There should be a regulatory mechanism in the EAC region to effectively regulate health services;
5. Since it is about social health protection, it is important to regulate the health insurance market instead of opening public schemes for competition;
6. Policies and regulations must provide for a complementary package of services to members who may seek health services in the region;
7. There should be a clear mechanism whether at regional or national level to ensure that providers are reimbursed for healthcare services given to an EAC Citizen;
8. The cross boarder package of illnesses must be clearly stated in legislations to avoid abuse of some EAC citizens going to seek care where services are more expensive;
9. It is important to propose sustainability mechanisms for a social health protection regional pooling mechanism. The complementary package should be pooled at a certain level;
10. Social health protection should benefit from subsidies coming from other institutions, a certain percentage should be determined. Existing health insurance schemes should contribute to a regional pooling mechanism;
11. Monthly contributions or yearly premiums for CBHI must be enforced effectively;
12. There should be an actuarial study to measure the needed contribution to the program, to determine the cost and ensure sustainability of social health protection in the region;
13. There should be harmonization of all health policies to support universal health coverage such as uniform codification of diseases and payment mechanisms (Diagnosis Related Groups) in the EAC Partner States;
14. Gaps that were identified during the revisions of the social health protection laws in Rwanda should be considered;
15. A clear road map to be created for this process of harmonization in each EAC Partner State;
16. There should be a validation meeting of the study findings.

All participants agreed that regional harmonization of SHP is a good idea. According to participants, a regional comprehensive quality Health Care package should be defined and challenges of harmonization of SPH mechanisms in the EAC Partner States must be documented, highlighted and addressed. Participants expressed their interest to also be invited in the dissemination meeting to discuss findings of the baseline study.

Annex 1.D: United Republic of Tanzania

Background of SHP in Tanzania

Tanzania, like other East African countries, has a long history of successes and challenges when it comes to SHP. After independence, health care was free for all, but by the early 1990s, the State's inability to pay for all free care represented a financing challenge that led to the introduction of user fees, with exemptions for some groups and services. In a few years user fees were among the major barriers to health care access and hence led to the introduction of pre-payment mechanisms, including the National Health Insurance Fund (NHIF) for formal public employees, Community Health Fund (CHF) for the informal sector and Social Health Insurance Benefit under the National Social Security Fund (SHIB). Currently initiatives are underway to improve SHP mechanisms such as the initiative to harmonize formal and informal sector schemes; the introduction of facility bank accounts, and the development of the National Health Financing Strategy, which aims to define the vision of the financing system in Tanzania. Therefore, national focus of social protection is to comprehensively address structural and multi-causal vulnerabilities that can lead to persistent poverty and generalized insecurity. The framework of social protection in Tanzania is constructed with the guidance of a number of international conventions that the country has also agreed to sign. Among these are The Universal Declaration of Human Rights 1948; The International Covenant on Economic, Social and Cultural Rights 1966; and The African (Banjul) Charter on Human and Peoples' Rights of 1981. Social health insurance in Tanzania is highly fragmented with a multiple number of small pools covering different segments of the population. There are five social security schemes that provide a wide range of benefits guided by the ILO social security framework. These are:

- National Social Security Fund (NSSF) for employees of the private sector and non-pensionable parastatal and government employees;
- Public Service Pension Fund (PSPF) for central government employees eligible to receive pensions;
- Parastatal Pension Fund (PPF) for employees of both private and parastatal organizations;
- Local Authorities Pensions Fund (LAPF) for local government employees;
- Government Employees' Provident Fund (GEPF).

Legal Aspects of SHP - Tanzania

The following documents relate to SHP in Tanzania:

1. An Existing National Insurance Policy that will be part of the health policy (under discussion by Minister of Finance, Minister of Labour, Reforms).
2. A Social Security Reform Policy: to harmonize Social Security Systems to include all those left out of SHP (Ministry of Labour).
3. National Social Protection Framework will set up national guidelines to identify the vulnerable groups (MoF).
4. Health Financing Strategy by MoH.
5. Revisions to the National Constitution may take into account elements of SHP.

National legislative acts considered:

1. The Constitution of the United Republic of Tanzania 1977
2. The Political Parties Act No. 4/1992: In force, yet to verify what it states about SHP
3. The National Social Security Fund Act No. 28/1997
4. The Public Service Retirement Benefits Act No. 2 of 1999
5. The Parastatal Pensions Act No. 14/1978: The Local Authorities Pensions Fund Provident Fund Act No. 9/2006: The National Health Insurance Fund Act No. 8/1999: The Judges (Remuneration and Terminal Benefits) Act 2007: The Social Security (Regulatory Authority) Act No. 8/2008
6. Insurance Act # No.10 of 2009 - Tanzania Insurance Regulatory Authority
7. Zanzibar Constitution
8. The Zanzibar Social Security Fund Act No. 2/2005

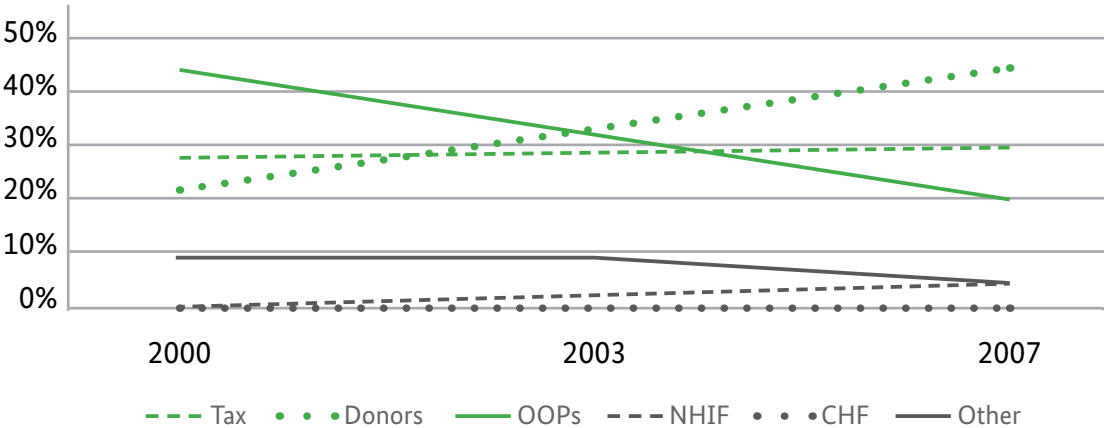
International Conventions Considered

1. The Universal Declaration of Human Rights, 1948
2. The International Covenant on Economic, Social and Cultural Rights, 1966
3. The African (Banjul) Charter on Human and Peoples’ Rights, 1981
4. Employment Injury Benefits Convention No. 121 of 1964
5. The Invalidity, Old Age and Survivors’ Benefits Convention No. 128 1967
6. The Equality of Treatment (Social Security) Convention No. 118 of 1962
7. The Employment Promotion and Protection Against Unemployment Convention No. 168 of 1988
8. The Maintenance of Social Security Rights Convention No. 157 of 1982
9. The Social Security (Minimum Standards) Convention No. 102 of 1952

Health Care Financing - Tanzania

Tanzania has a mix of health financing sources: government through taxes, donor funds, out-of-pocket payments, and health insurance. In Tanzania Mainland, public funding as a proportion of total financing accounted for about 28% of THE in 2007, an increase of about 1 percentage point from 2000. Donor funding accounted for about 44% of total health sector funding in 2007, an increase from 23% in 2000. Out-of-pocket payment had been the major source of health financing (about 43%) in 2000 but accounted for only about 18% of THE in 2007. Health insurance funding accounted for about 4% of the total health care funding in 2007.

Figure 12: Contribution of Different Health Financing Sources to THE 2000-2007 in Tanzania Mainland



Source: Mtei, 2012

Recent statistics show that in 2010 donor funding accounted for about 40% of THE in Tanzania Mainland, while public and private spending accounted for about 26% and 34% of THE respectively. In Zanzibar, donor funding accounted for about 33% of THE in 2013, while the government’s contribution was 37%. Private spending and voluntary prepayment insurance accounted for about 26% and 2% respectively.

SHP Schemes - Tanzania

The approaches towards guaranteeing financial protection in Tanzania Mainland and Zanzibar differ. In Zanzibar, free health care is provided in public health facilities through funding from general tax revenue. Although the government’s policy is for free health care, the allocation of general tax to finance health care is limited. In 2000 some health care facilities informally introduced user fees, which still exist in Zanzibar, but in an uncoordinated manner.

The Zanzibar Social Security Fund (ZSSF) is the sole institution that provides health insurance. This benefit is financed through the deduction of 3% out of a 15% contribution to this social security fund. By law ZSSF is a compulsory scheme covering all employees in the formal sector. Currently the Ministry of Health Zanzibar is in the process of introducing health insurance which aims at enrolling both the formal and informal sector populations. A simulation study that included the assessment of willingness to pay has been completed; the design and actuarial studies are ongoing. The aim is to start implementation early next year. The government will take responsibility to pay premiums for the poor and retirees when this program is launched.

Tanzania Mainland's policy provides waivers and exemptions to provide free health care to those with chronic illness and vulnerable groups, including under-five children, pregnant women, the elderly and the poor. In addition to general tax funding, there are a number of health insurance mechanisms targeting different small segments of the population. Below is a description of these prepayment mechanisms:

National Health Insurance Scheme (NHIF): NHIF was introduced in 1999 under the NHIF Act No. 8 of 1999. This scheme was originally designed to compulsorily cover formal public employees and their dependents. Members contribute 3% of their monthly salaries, automatically deducted from the payroll, which is managed by the Treasury. Employees' contributions are matched by an equivalent contribution from the government, as their employer, making total contribution of 6% of employees' salaries. All contributions are pooled together and the fund is centrally managed by the Director General, who is selected in a competitive process and is overseen by the NHIF Board, which is responsible for all activities of the fund. Recently, the original act has been amended to allow the option of enrolling other individuals working outside the formal public sector employment. Members are entitled to access both outpatient and inpatient care from accredited facilities, including government, not-for-profit, and for-profit providers. All public facilities have umbrella accreditation, but the non-government facilities need to be assessed before they qualify for accreditation. Facilities are reimbursed through fee for service after claims are submitted. Estimates for 2011 show that the NHIF covers about 7.1 percent of the total population (Humba 2011),⁴⁵ an increase from 5% coverage in 2008 and 5.3% in 2009.^{46,47}

Social Health Insurance Benefit (SHIB): SHIB is among seven benefits which are supposed to be provided to the members of the National Social Security Fund (NSSF). Other benefits under this fund include retirement pension, invalidity pension, survivor's pension, funeral grants, maternity benefit, and employment injury benefit. Most of the NSSF members, hence SHIB members, are private formal sector employees. The NSSF members are supposed to register before they can be awarded a card which will entitle them to health insurance benefits. There are no additional contributions to access health insurance apart from the statutory contribution of 20% of employee's salary, equally shared between the employee and employer. Members are supposed to register with one health facility where they will be seeking health care, and the facility is paid through capitation. Similar to the NHIF, the SHIB provides coverage for inpatient and outpatient care and covers the spouse and up to four dependants below age 18. It currently covers about 1% of the Tanzanian population.

Private Health Insurance: Private health insurance is also a growing industry in Tanzania, though at a slow rate. Insurance firms are urban based and mainly provide health care coverage for private firms' employees and a few individuals.⁴⁸ While a few firms are pure private health insurance companies, the majority integrate health insurance with other types of insurance coverage. There are currently about seven insurance firms providing health insurance or life insurance benefits, excluding insurance agents and brokers.⁴⁹ Most private firms get private health insurance with limited enrollment on an individual basis. There are variations in the premium rates and benefit packages across schemes, and much of this depends on the risk composition of the employees and other individuals who enroll to the private schemes and on negotiation between employers and management of the private insurance schemes. There are a limited number of private for-profit health specific insurance firms. In most cases, health insurance or life insurance benefits are provided together with other insurance benefits, such as insurance coverage for accident and fire. Generally, members of private health insurance schemes have comprehensive access to outpatient and inpatient care. Most of the accredited facilities are private for-profit providers, who are generally perceived to be of higher quality compared to public facilities.

⁴⁵ Humba, E. Pioneering Social Health Insurance in Tanzania: The Case of the National Health Insurance Fund (NHIF). Presented at 'Improving Access through Effective Health Financing', 2011.

⁴⁶ McIntyre et al. (2008). Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania. *Bull World Health Org*, 86:871-876.

⁴⁷ Mdee, I. (2009). Challenges and opportunities of community based health funds (CBHF) in the emerging social health insurance policy environment in East Africa. National Health Insurance Fund act no.8 of 1999. [Tanzania].

⁴⁸ Mtei & Mulligan (2007). Community Health Fund in Tanzania: A literature review. Ifakara Health Institute, Dar es Salaam, Tanzania.

⁴⁹ Tanzania Insurance Regulatory Authority. Annual Insurance Market Performance Report. Website: www.tira.go.tz

There are an increasing number of community-based or micro health insurance schemes covering the informal sector:

Community Health Fund (CHF): Community Health fund (CHF) is the largest and most well known health insurance scheme for the informal sector, currently covering about 1% of the Tanzanian population. The scheme was introduced as a pilot in mid 1990s and was formally enacted in 2001 under the CHF Act No. 1 of 2001. The act requires all districts to establish such a fund.⁵⁰ Mainly rural councils are currently operating CHFs while the urban districts are supposed to introduce TIKA (an abbreviation for Tiba kwa Kadi) which is an equivalent of a CHF, but is expected to have a slightly different design.⁵¹

Enrollment in CHF is voluntary and families are supposed to contribute an agreed flat amount of premium per year, which allows the principal contributors, their spouses and dependants less than 18 years of age free health care access from a pre-identified primary health care facility. For many districts, the premium is 5000 Tanzania shillings (equivalent to about \$2) per household per year. Contributions from the members are matched by a 100% grant from the health sector basket fund. Members' contributions are collected at the facility level under the administration of the facility in charge. Although access to health care benefit for CHF members is limited to primary facilities, there have been variations across districts, with some giving CHF members access to hospital care (example Mbulu and Singida districts). The CHF revenue is not used to reimburse health care costs at the facilities, but facilities are allowed access to use the CHF collections to purchase drugs.

Since its introduction, the CHF has been struggling to expand coverage across districts. Only a few have managed to reach coverage of above 15% (e.g. Iramba, Singida rural, and Rombo) but the majority have very low enrollment. It was expected that by 2003, CHF would have been implemented in all districts in Tanzania and approximately 60% of households would be CHF members.⁵² However, as of mid 2010, only 99 councils had already established CHF, with about 38 councils remaining inactive. Recent estimates show that CHF members account for about 7.9 percent of the total population⁵³ which is an increase from 4% coverage in 2008 (Borghi, Mtei et al. 2012). The reasons suggested for the observed low CHF coverage include low knowledge of the concept of insurance, poor quality of health services, little sensitization of the scheme, weakness in the management system in the districts, low trust of government managed schemes, and lack of money for premium payment.^{54,55,56,57,58} In order to improve the operation and effectiveness of CHF, the government has recently shifted its central management role from the Ministry of Health and Social Welfare (MOHSW) to the NHIF.⁵⁹ The districts retain the task of managing CHF at the local level.

Other informal sector schemes: In 2012, Tanzania was estimated to have about 43 community-based health insurance schemes which bring together individuals who work in similar informal activities. Normally, the schemes are not specific for funding health care services and may also include other needs such as burial assistance or other individual problems. There are variations in the financial contribution across these schemes, but in many cases the contribution rate is minimal, allowing provision of only limited health care benefits. The schemes enter into agreement with providers, who will be responsible for providing health services to the members of the schemes.

In conclusion, the Tanzania SHP system is fragmented with the National Health Insurance fund (NHIF), the Community Health Fund (CHF) and Social Health Insurance Benefit or SHIB, all championed by the Government. The government covers only 8% of the population with some kind of social health insurance system. Participants in workshops report that the SHP mechanism is a subject of po-

⁵⁰ Community Health Fund (CHF) Design, Ministry of Health, Dar es Salaam, 1999; Legal Rules/Regularions, United Republic of Tanzania, Dar es Salaam, 2001

⁵¹ Borghi et al. (2012). Modelling the implications of moving towards universal coverage in Tanzania. Health Policy Plan, 27(suppl 1):i88-i100.

⁵² Beraldes, C. and L. Carreras (2003). Willingness to pay for community health fund card in Mtwara Rural District, Tanzania

⁵³ Humba, E. Pioneering Social Health Insurance in Tanzania: The Case of the National Health Insurance Fund (NHIF). Presented at 'Improving Access through Effective Health Financing', 2011.

⁵⁴ Chee, G., K. Smith, et al. (2002). Assessment of the Community Health Fund in Hanang District, Tanzania. Dar es Salaam, PHR plus.

⁵⁵ Laterveer, L., M. Munga, et al. (2004). Equity Implications of Health Sector User Fees in Tanzania: Do we retain the user fee or do we set the user f(r)ee? Leusden, Netherlands, ETC Crystal for REPOA.

⁵⁶ Musau, S. (2004). The Community Health Fund: Assessing Implementation of New Management Procedures in Hanang District, Tanzania, Bethesda, The Partners for Health Reformplus Project, Abt Associates.

⁵⁷ Kamuzora & Gilson (2007). Factors influencing implementation of the Community Health Fund in Tanzania. Health Policy Plan 22(2):95-102.

⁵⁸ Mtei & Mulligan (2007). Community Health Fund in Tanzania: A literature review. Ifakara Health Institute, Dar es Salaam, Tanzania.

⁵⁹ Ministry of Health and Social Welfare, PMORALG, et al. (2009). Memorandum of understanding for the management and administration of Community Health Fund. Dar es Salaam, MOHSW.

litical discussion and becomes polarized when one political party prefers implementing social insurance schemes, while another proposes free care as a responsibility of the government. This is an area where the East African Secretariat could set political, financial, legal, and organizational standards that all Partner States could be requested to comply. Table 14 presents different mechanisms aimed at providing some level of coverage to the population of Tanzania.

Table 14: Social Health Protection Schemes in Tanzania

Social health protection/ Insurance Schemes	Year created	Oversight	Premium	Co-payment	Population Targeted
National Health Insurance Fund (NHIF) <ul style="list-style-type: none"> Covers up to 5 dependants Mandatory for public servants 	1999	Board and MOHSW	3% from employee and 3% from employer	member shall be required to pay excess costs beyond the set prices	100% of civil servants
Community Health Fund <ul style="list-style-type: none"> Uniform premium Funds pooled at district level Central procurement Limited benefit package (varying across districts) 	2001	NHIF and Local governments	Varying across districts. Majority pay 5000 Tanzania shillings (TZS)	Depends, ceiling of 15,000 TZS per single referral. Excess paid out of pocket	Voluntary for informal sector
Social Health Insurance Benefit <ul style="list-style-type: none"> Part of NSSF Mainly private sector Access limited to one chosen facility No additional premium for SHIB 	1997 ⁶⁰	Social Security Regulatory Authority & Ministry of Labor	Reimbursement taken out of 10% employee's and 10% employer's contributions to the National Social Security Fund.	Outpatient and inpatient care up to 80,000 TZS at selected facilities	Mainly formal sector employees but also accepts informal sector employees
Private for profit health firms <ul style="list-style-type: none"> Mainly in urban areas Comprehensive benefit package 		Tanzania Insurance regulatory authority	Vary depending on risk, benefit chosen and contractual agreement with employers	Depends with the scheme and the benefits	Mainly private firms but also accept private individuals
CBHI: > 40 schemes in 2010		none	variable	variable	Informal sector

Source: Country Study Tanzania

⁶⁰ <http://healthmarketinnovations.org/program/national-health-insurance-fund-tanzania>

Tanzania Mainland is currently in the process of developing its first national health financing strategy (HFS) which aims to restructure the health insurance market in Tanzania with the objective of achieving UHC. Among other things, the strategy aims to reduce the degree of fragmentation in its health insurance market. Three health insurance market restructuring proposals are currently under discussion: the first is to merge NHIF, SHIB and CHF into a single insurance pool; the second is to allow competition between NHIF and SHIB and let CHF members choose among the two; and the third is to establish a national health fund that will be responsible for pooling premiums and allow competition among the existing insurance schemes that will receive revenue from this national health fund.

Health Service Provision - Tanzania

Formal health services provision in Tanzania Mainland follows a pyramidal pattern from the primary level comprised of health post, dispensary and health centers; the secondary level comprised of district and regional referral hospitals; and a tertiary level comprising zonal and national referral hospitals together with treatment abroad. The dispensary covers a population of around 6,000 to 10,000, while a health centre covers a population of approximately 50,000 (Ministry of Health and Social Welfare and World Health Organization 2007). Of the 5,718 health facilities in Tanzania in 2006, 86% were dispensaries, 10% health centers and 4% hospitals (see Table 15).

Table 15: Distribution of Health Facilities by Level and Type of Ownership in Tanzania Mainland in 2006

Category	Government	Private not for profit (NGOs)	Parastatals	Private for profit	Total
Hospitals	89	90	8	36	223
Health Centres	379	125	12	49	565
Dispensaries	3348	658	123	801	4930
Total	3816	873	143	886	5718

Source: (Ministry of Health and Social Welfare 2008)

The available statistics show that in 2006 the government owned about 67% of all health facilities while non-governmental organizations (NGOs) and the private for profit sector each owned 15% of facilities (Table 16). Distribution of health facilities vary across urban and rural areas, with private facilities and hospitals being much more concentrated in urban areas, while rural areas are mainly supplied with a network of public dispensaries and health centers (Ministry of Health and Social Welfare 2006; Ministry of Health and Social Welfare and World Health Organization 2007).⁶¹ The provider network is also comprised of pharmacies and drug shops, together with a number of traditional healers. About 76% of the population was located within 6 kilometers from a primary health facility (dispensary or health centre) in 2007 (National Bureau of Statistics 2009). About 8% of the 19% of the total population who were sick in 2007 sought care from the traditional healers and 42% and 17% sought care from public and private facilities respectively in 2007.

Table 16: Distribution of Health Facilities by Level and Type of Ownership in Tanzania Zanzibar in 2013

	Government	Private (not for profit and for profit)	Total
Hospitals	6	4	10
PHCCs	4		4
PHCUs+	34	82	116
PHCUs	97		97
Total	141	86	

Source: Ministry of Health Zanzibar, NHA 2014

⁶¹ Mtei, Mulligan et al. (2007). An Assessment of the Health Financing System in Tanzania: Implications for Equity and Social Health Insurance. Report on Shield Work Package 1 (May 2007). iHEA 2007 6th World Congress: Explorations in Health Economics Paper. <http://ssrn.com/abstract=993421>.

Similar to Tanzania Mainland, Zanzibar's health facilities are divided into three levels: primary, secondary and tertiary levels. At the primary level there are 135 PHCUs (of which 4 are Primary Health Care Centers (PHCCs) 34 are PHCUs+ and the remaining 97 are PHCUs). At the secondary level there are only three district hospitals and all are in Pemba Islands. The tertiary level is composed of three hospitals.⁶² There are only 4 private hospitals and 82 private clinics/dispensaries. Similar to Mainland Tanzania, most of private facilities are located in urban areas.

Human Resources for Health - Tanzania

Human resources in the health sector are a major crisis for Tanzania, affecting all levels of health facilities. The available workers suffice for only about 33% of the required level in public facilities and 14% in non-government facilities (see Table 17). There is a much greater shortage in public dispensaries among the government owned facilities, while for private facilities the shortage is higher in hospitals (Table 17). The government is the major employer of health sector human resources, employing about 83% of the total available workers.

Tanzania Zanzibar's health system is similarly challenged with insufficient human resource availability. There is a health worker shortage of 25% at the hospital level and 58% at the primary health care units (Table 18).

Table 17: Status of Human Resource for Health by Facility Level and Type of Ownership

	Public facilities			Private facilities		
	Required staff level	Available staffs	Shortage	Required staff level	Available staffs	Shortage
Hospitals	38,270	14,322	-63%	26,004	3,251	-87%
Health centres	11,916	4,908	-59%	5,400	758	-86%
Dispensaries	30,380	9,384	-69%	11,487	1,842	-84%

Source: Health Statistics Abstract 2008

Table 18: Human Resource for Health by Facility Level and Type of Ownership in Zanzibar

	Public facilities		
	Required staff level	Available staffs	Shortage
Central Level	1,156	986	25%
PHCUs	1,794	748	58.3%
PHCCs	815	707	26.6%

Source: Ministry of Health Zanzibar, NHA 2014

In 2007, the government adopted a 10 year primary health care strengthening reform program with the objective of improving primary health care delivery by reducing the distance to primary facilities, especially in rural areas, and increasing the availability of human resources, medical supplies, and equipments. It is expected that the program will help to reduce the crisis in human resources in Tanzania.

⁶² Ministry of Health Zanzibar, NHA 2013

The Challenges - Tanzania

The overall challenges faced by the social health protection schemes in Tanzania include:

- Limited health insurance coverage
- Large informal sector difficult to expand coverage
- Formal sector growth at slow rate
- Limited cross-subsidization (schemes operate in isolation)
- CHF schemes risk self selection due to voluntary nature of the scheme
- Design targets the poor and the 'unhealthy'
- High administration costs for informal sector schemes
- Admin costs for CHF is about 30% of its revenue, NHIF is about 12%
- Provider and purchaser functions are interlinked under CHF
- Limited incentive to improve service availability
- Service availability is a major challenge
- Frequent drugs and supplies stock-outs
- Poor services discourage enrollment to voluntary community based schemes
- Government funding still low below 15% Abuja target
- Limited human resource availability more than 30% HR gap
- Infrastructure system needs improvement
- Limited availability of health facilities (especially referrals)
- Poor information system (ICT)
- Problems with hospital equipments and supplies, especially in remote areas

Recommendations – Tanzania

More work is needed to ensure that services are available and financially accessible. Specific suggestions include improvements in financing arrangements, and regulatory and policy frameworks. With the on-going efforts to further integrate EAC policies and programs, the workshop provided the following recommendations discussed different topics:

- The group discussions identified areas of concern and determined that the harmonization of SHP in the EAC Partner States is a good idea that needs to be promoted. All participants agreed on the need for harmonization of SHP mechanisms that would allow free access of health services when crossing borders into the Republics of Uganda, Kenya, Rwanda and Burundi. Participants noted a need to ensure that health insurance services are portable within each country first, before advancing to the regional level.
- Countries should learn from each other: Learning from each other was emphasized as a vital process, with a prerequisite of dealing with the contextual to successfully work toward a harmonized system of social protection.
- Participants hoped that the present study would provide the basis for future discussions and the implementation of decisions within and between countries.
- The workshop underscored that to achieve universal health coverage, the informal sector should be prioritized, with Rwanda's *mutuelles* schemes appearing as the best approach for providing health care the informal sector.
- The participants emphasized political will as the most important factor for achieving a sustainable regional SHP mechanism because it determines how countries will prioritize health in the planning and budgeting processes.
- It was observed during the discussion that achieving social health protection for all individuals is not part of a policy driving agenda. One example is the "Big Results Now" (BRN) initiative which focuses on enhancing productivity and performance across different sectors. This initiative is currently not giving priority to the improvement in SHP; rather its attention is focused on the areas of education, agriculture and infrastructure. It was further observed that the Ministry of Finance has no interest to influence SHP in the country and it has no authority to use in order to improve efficiency. It was observed that the available resources could be enough to improve SHP if initiatives to improve efficiency were put in place. Although the MOHSW is committed to achieve UHC, its current practice does not indicate it is making progress to achieve it.

- The existing health financing system is highly fragmented. A recent political commitment to reduce fragmentation would merge health insurance schemes, as proposed in the scenarios for health insurance reform in Tanzania as part of the development of the health financing strategy. However, some issues remain unresolved. First the cost of covering the poor, who cannot contribute to health financing, is not well assessed. Also the financial ability of existing health insurance schemes to fund the poor has also not been explored. Finding a way to ensure that everyone has health insurance coverage is needed before moving to the harmonization of SHP outside of national borders.

“I don’t think, we are ready to go into that direction, more efforts need to be put in place first to support the Tanzanian population on many things not only health” (IDI, with DMO, TZ)

“We still need to strengthen our insurance system, to benefit all not only civil servants like how it is now. Civil servants benefit more compared to other groups. They say elders can access free services, but in practice it is not true, they still pay, especially when it comes to drugs” (FGD, with Community representative, TZ)

“We need to first improve access within the country before going that far, despite the importance, but there is no point moving to that step while our people are still dying here” (FGD, with health provider, TZ)

- It was also observed that the government, especially local government plays both roles, as a purchaser and a provider of health care at the same time. This is especially evident under the CHF arrangement. There are currently no clear reimbursement mechanisms, and the funds collected through CHF premiums and government budget are pooled at the district level. It will be difficult to move towards harmonization across EAC if there will be no clearly defined purchaser who will be responsible to settle claims arising from accessing services across countries. There is a need to harmonize internal insurance schemes and establish a reimbursement mechanism that will facilitate payments of claims across EAC Partner States. Separation of purchase-provider roles is crucial for harmonization.
- It was noted that there is a need to improve coordination across ministries when establishing policies towards improvement of SHP. Different ministries and agencies are in one way or another involved when it comes to establishing SHP policies. The Ministry of Labor is important when it comes to establishing policies related to social protection of employees, which in some cases includes health protection, as the case of Social Health Insurance Benefit (SHIB) under the National Social Security Fund (NSSF). Likewise the Ministry of Health and Social Welfare’s role in SHP concerns the establishment of health insurance. The Ministry of Finance is also important in allocating resources for SHP. There is a need to identify clear roles and responsibilities.
- An effective information communication technology (ICT) system is crucial for a smooth transformation towards SHP harmonization across EAC Partner States. It is the view of the group that without a good information system it will be difficult to handle claim reimbursement under a harmonize system. The system should be able to network between all Partner States in order to be able to handle cross boarder access to health services.
- The IT system will help when it comes to defining reimbursement mechanisms. It might be necessary to have a central EAC body that will be responsible for handling reimbursements.
- The EAC Secretariat should be at the core of facilitating the process of harmonization by bringing countries together and defining the terms for harmonization.
- There is a need to improve the infrastructure, including a provider network and ICT, in order to benefit from the harmonization process. An effective ICT system to assist in verifying the services rendered to clients (time, dates, types of service etc), can be feasible within and across Partner States. Coordination across ministries also needs to be strengthened. It is important to note that variation of regulation in different insurance schemes makes it difficult to bring them together under one umbrella. There is a need to review these regulation/rules before planning for harmonization. Independent bodies/institutions such as the Social Security Regulatory Authority and the Tanzania Insurance Regulatory Authority should work together to ensure they have a common understanding of the SHP mechanisms. Accreditation of health care providers should be reviewed nationally and later on across Partner States. Each provider has standards of provision of care in relation to the agreement with the insurance scheme. Political commitment toward the harmonization process within the Partner States is also critical and it is a core pillar if this dream is to be achieved.

Regional Recommendations from Tanzania

- Ensuring political commitment toward social health protection in Tanzania and in the region, with the first emphasis on improvements in Tanzania:

“It is a good idea to have insurance, nowadays people cross borders for business especially young men. I think it is important if they can easily access health care at an affordable cost, like using a CHF card” (IDI, CHSB member, TZ)

- Ensuring that there is a law that makes it mandatory for people to have a health insurance for Tanzania and in the region.
- Organizing processes for the feasibility of initiating the scale-up of SHP mechanisms.
- Increasing pool size and funding for the poor: The existing health financing system is highly fragmented with many small pools.
- Promoting the portability of health insurance and ability to cover the Minimum Benefit Package within Tanzania and EAC.
- Ensuring there is a purchaser-provider split.
- Improving linkages across sectors and the EAC Regional Secretariat.
- Putting in place support for ICT social health protection mechanisms in countries and across the region. An integrated information system must be in place to facilitate the services (IT and Human Resource).
- Licensing health insurance services to operate in the region: public (regional cooperation/agreements to foster reimbursement) or private (licensing of companies to operate). Licensing and agreements was thought to be critical in guiding the employer or government to participate/contribute towards the cross-border health insurance.
- The EAC Secretariat should ensure the sustainability of the scheme by championing reforms such as:
 - Encouraging political willingness in the region.
 - Setting guidelines and standards;
 - Ensuring appropriate regulations are in place and enforced;
 - Determining the minimum package of health services;
 - Sharing best practices;
 - Monitoring and evaluation.

Annex 1.E: Republic of Uganda

Background of SHP in Uganda

The social protection portfolio in Uganda is under the Ministry of Gender, Labour and Social Development. There is a secretariat spearheading development of social protection in the country. The country has a draft social protection policy that provides for a framework for social protection.⁶³ The Constitution of the Republic of Uganda provides a firm basis for social protection interventions. The social protection policy framework is consistent with the National Development Plan (NDP), which recognizes SHP as one of key strategies for transforming Uganda from a peasant society to a modern and prosperous country. The NDP emphasizes diversification and provides comprehensive social protection measures for the different categories of the population as a measure to reduce vulnerability and enhance productivity of human resource.⁶⁴

The 1995 Constitution of the Republic of Uganda as amended states that *'the state shall take all practical measures to ensure the provision of basic medical services to the population'*.⁶⁵ It does not provide for health as a right to all citizens. The ruling party, National Resistance Movement 2011-2016 Presidential manifesto places a development of a health insurance scheme as one of the work programs in the health sector. The futuristic country planning framework, Vision 2040 provides for universal health insurance as one of the pillars to development to a middle and upper-income state.⁶⁶ The 5 year country planning framework, the National Development Plan, 2010/11-2014/15 provides for national health insurance and aims toward universal coverage and social health protection.^{67,68} The 2010 National Health Policy enlists promotion of sustainable alternative health financing mechanisms. The health sector strategic and investment Plan of 2010/11-2014/15 places social health insurance and community health insurance as financing mechanisms for this plan.^{70,71}

The country has neither a specific health protection policy nor a social health protection research agenda. The health sector is in the process of drafting a health sector financing strategy that shall include broader aspects of social health protection and health care reforms. The country has a draft national health insurance bill that provides for establishment of a national health insurance scheme with provisions for a social health insurance scheme for the formal sector workers (in government and private), private commercial health insurance and community based health insurance schemes co-currently. The country has been working on this bill since 2006 and is yet to be tabled in the Cabinet and Parliament. There is limited political support to social health insurance and the passing of the NHI bill will be one of the indicators of government commitment.⁷²

The country does not have a specific health insurance act. The only current framework hinges on the Insurance (Amendment) Act 2011 which put in place the Insurance Regulatory Authority (IRA) of Uganda. This Act provides for regulation of Private Commercial Health Insurance Schemes (PCHIS). These are Health Management Organizations (in Uganda they are called Health Membership Organizations) and insurance companies which provide health insurance as one of the schemes, (Health Insurance Organizations). This Act provides for regulation of any other premium-receiving institution including CBHI schemes. IRA is in the process of developing regulatory instruments and guidelines for the PCHIS and CBHIs. Currently, all the CBHIs in Uganda are registered with the Registrar of Companies, NGO board and with districts as community based organizations (CBOs).

According to respondents, the Government needs to take up its role of policy making and regulator:

"The biggest barrier is policy. We need a clear policy (change the free health care and introduce the cost sharing). Make it mandatory that each person is covered. People will have no choice but to enroll into the schemes. Even if it was to remain optional, the government should come out clearly to support it" (KI, CBHI umbrella organization in Kampala).

⁶³ Ministry of Gender, Labour and Social Development. The National Social Protection policy framework for Uganda. Second draft 2013. [Uganda]

⁶⁴ National Planning Authority Uganda: National Development Plan 2010/11-2014/15. Kampala: National Planning Authority, Uganda; 2010. [Uganda]

⁶⁵ Ministry for Justice: National Health Insurance Bill. Kampala: Ministry of Health, Government of Uganda; 2013. [Uganda]

⁶⁶ National Planning Authority Uganda: Vision 2040. Kampala: National Planning Authority, Uganda; 2013. [Uganda]

⁶⁷ National Planning Authority Uganda: National Development Plan 2010/11-2014/15. Kampala: National Planning Authority, Uganda; 2010. [Uganda]

⁶⁸ National Planning Authority Uganda: Vision 2040. Kampala: National Planning Authority, Uganda; 2013. [Uganda]

⁶⁹ Ministry of Health: The Second National Health Policy: Promoting People's Health to Enhance Socio-economic Development. Kampala: Government of Uganda; 2010. [Uganda]

⁷⁰ Ministry of Health: Health Sector Strategic and Investment Plan 2010/11-2014/15. Kampala: Ministry of Health, Government of Uganda; 2010. [Uganda]

⁷¹ Ministry of Health (a): National Health Accounts Report FY 2008/09 and FY 2009/10. March 2013 edition. Kampala: Ministry of Health, Government of Uganda; 2013. [Uganda]

⁷² Basaza R., Cornell T., Chapcokora I., 2013, The players and the processes behind the National Health Insurance Scheme: A case study of Uganda, BMC Health Services Research. 2013;13:57.

Legal Aspects of SHP – Uganda

From regulatory perspective, Uganda is the only EAC country that does not have a national insurance scheme but there is a draft bill under scrutiny before implementation. There is need for strong political will for Uganda to do well. Uganda seeks to learn from best practices in Africa, such as those in Rwanda and Ghana. Below are presented legal documents and frameworks on social health protection in Uganda.

1. The 1995 Constitution of the Republic of Uganda as amended states that ‘the state shall take all practical measures to ensure the provision of basic medical services to the population’ (Ministry of Justice 1995). It does not provide for health as a right to all citizens.
2. Universal Declaration of Human Rights, 1948: Uganda is a signatory to this framework which guarantees everyone the right to social security in the event of unemployment, sickness, disability, widowhood, old-age or other lack of livelihood in circumstances beyond a person’s control.
3. International Covenant on Economic Social and Cultural Rights, 1966: obliges Government to put in place measures to ensure access to social security, including social insurance, for everyone.
4. The Convention on the Rights of the Child, 1989 compels Government to help children who are poor and in need either directly or through their guardians.
5. The UN Convention on the Rights of Persons with Disabilities, 2006: Government should ensure access to social protection by persons with disabilities.
6. The Livingstone Call to Action, 2006: obliges African States to put in place costed plans for the implementation of direct income support programmes.
7. The African Union Social Policy Framework, 2008: Uganda is also a signatory to this framework which calls on member governments to recognize that social protection is a state obligation, with provisions in national legislations (MOGLS, 2013).
8. Insurance (Amendment) Act 2011: which put in place the Insurance Regulatory Authority (IRA) of Uganda. The country does not have a specific health insurance act This Act provides for regulation of Private Commercial Health Insurance Schemes (PCHIS). These are Health Management Organizations (in Uganda they are called Health Membership Organizations) and insurance companies which provide health insurance as one of the schemes, (Health Insurance Organizations). This Act provides for regulation of any other premium-receiving institution including CBHI Schemes.
9. The ruling party, National Resistance Movement 2011-2016 Presidential manifesto: places a development of a health insurance scheme as one of the work programs in the health sector.
10. The futuristic country planning framework, Vision 2040 provides for Universal health insurance as one of the pillars to development to a middle and upper-income state.
11. National Development plan, 2010/11-2014/15: This 5 year country planning frame work provides for national health insurance and aims at universal coverage and social health protection.
12. The 2010 National Health Policy: enlist promotion of sustainable alternative health financing mechanisms.
13. The health sector strategic and investment Plan of 2010/11-2014/15: places Social health insurance and community health insurance as financing mechanisms for this plan.

The country does not have specific health protection policy. The health sector is in the process of drafting a health sector financing strategy that shall include broader aspects of social health protection and health care reforms.

The drafts laws/bills and regulations and key policies under consideration:

1. The health insurance bill is the only draft currently considered; it provides for establishment of a national health insurance scheme with provisions for a social health insurance scheme for the formal sector workers (in government and private). The bill has not progressed much since 2006. There is limited political support to SHP (Basaza et al 2013).
2. Regulations for private commercial schemes and CBHI: IRA is in the process of developing regulatory instruments and guidelines for the PCHIS and CBHIs. Currently, all the CBHIs in Uganda are registered with the Registrar of Companies, NGO board and with districts as community based organizations (CBOs).
3. The draft National Social Protection policy framework for Uganda 2013: The Ministry of Gender, Labour and Social Development is in the process of drafting a comprehensive social protection policy upon which social health protection shall be anchored.
4. Draft health sector financing strategy: The health sector is in the process of drafting a health sector financing strategy that shall include broader aspects of social health protection and health care reforms.

Other legal documents and frameworks on SHP in Uganda:

1. The Uganda Vision 2040 provides for universal health insurance through a public-private partnership as one of the pillars to development to a middle and upper income state.
2. The NDP 2010/11-2014/15 provides for national health insurance and aims at universal coverage and social health protection.
3. The National Resistance Movement (NRM) Presidential Manifesto 2011-2016 provides that in the next five years, NRM will put up a social health insurance scheme.
4. The 2010/11-2019/20 National Health Policy enlists health insurance as a financing mechanism for the health sector.
5. The Health Sector Strategic and Investment Plan 2010/11-14/15
 - Indicates that health insurance shall be introduced gradually and eventually leading to universal coverage.
 - Health Insurance shall increase financial access to health care and contribute to reduction of catastrophic expenses that impoverish households.
6. The Uganda Vision 2040 provides for Universal health insurance as one of the pillars to development to a middle and upper income state.
7. The NDP 2010/11-2014/15 provides for national health insurance and aims at universal coverage and social health protection.
8. The National Resistance Movement (NRM) Presidential Manifesto 2011-2016 provides that in the next five years, NRM will put up a social health insurance scheme.
9. The 2010/11-2019/20 National Health Policy enlists health insurance as a financing mechanism for the health sector.
10. The Health Sector Strategic and Investment Plan 2010/11-14/15
 - Indicates that health insurance shall be introduced gradually and eventually leading to universal coverage.
 - Health Insurance shall increase financial access to health care and contribute to reduction of catastrophic expenses that impoverish households.

COMESA Treaty

Article 16

- (1) Every individual shall have the right to enjoy the best attainable state of physical and mental health.
- (2) Parties to the present Charter shall take the necessary measures to protect the health of states parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.
- (3) Draft Protocol on East African Community Regional Cooperation on Health.
- (4) Chapter IV, Article 7 provides for commitments that the EAC Partner States will be required to commit in order to attain Universal Health Coverage.
- (5) Chapter IV, Article 7 provides for commitments that the EAC Partner States will be required to commit in order to attain Universal Health Coverage.

Other Conventions Considered:

1. The Universal Declaration of Human Rights, 1948.
2. The International Covenant on Economic, Social and Cultural Rights, 1966.
3. The African (Banjul) Charter on Human and Peoples' Rights, 1981.
4. Employment Injury Benefits Convention No. 121 of 1964.
5. The Invalidity, Old Age and Survivors' Benefits Convention No. 128 1967.
6. The Equality of Treatment (Social Security) Convention No. 118 of 1962.
7. The Employment Promotion and Protection Against Unemployment Convention No.168 of 1988.
8. The Maintenance of Social Security Rights Convention No. 157 of 1982.
9. The Social Security (Minimum Standards) Convention No. 102 of 1952.

Health Care Financing - Uganda

In 2010, the government health expenditure was 22% of the total health expenditure (THE) while household expenditure on health was 42% of the THE, and the balance of 36% came from donors and NGOs (Table 19). In terms of financing sources as a percentage of THE, private spending provides 49%, donors and non-governmental organizations (NGOs) 36%, and public government 15%. Uganda provides data on the impact of high private spending on impoverishment of the population, the 2006 NHA shows that the proportion of households that incurred catastrophic health expenditure was 28% and concentrated mostly in poor households; 2.3% of all households were newly impoverished as a result of OOP spending in 2006.

Table 19: Financing Sources in Uganda

	2008/9	%	2009/10	%
Public	449.98	16	472.35	15
Private	1,392.08	50	1,571.66	49
Donors and NGOs	966.42	34	1,190.68	36

Source: MOH, Uganda National Health Accounts Report, 2013

Overall, health-sector financing in Uganda is project and vertically oriented, with low investments in overall system improvement. The incidence of catastrophic health expenditure among the poor steadily increased from 1996 to 2006 despite the abolition of user fees, which was partly due to the greater use of private providers by the poor. Another factor was medicines frequently being unavailable in public facilities, obliging patients to pay higher prices to acquire medicines at private pharmacies.^{73,74,75,76,77} The government allocates 7.4 % of the budget to the sector. Other than revenue collected through taxation and budget support, there is no any other resource-pooling mechanism at the national level. The Private Commercial Health Insurance Schemes are obliged by the IRA to reinsure the collected premiums and have reserves. At CBHI level, the schemes lack a pooling mechanism except for the Save for Health supported schemes in greater Bushenyi and Luwero districts that have the district pool and district representatives.⁷⁸

SHP Schemes - Uganda

The health sector is responsible for social health protection in the country but within the broader framework of social protection. Below are presented SHP in Uganda.

Free care in government facilities

In 2001, the government of Uganda abolished user fees in government facilities except the private wings in hospitals; a result of the recognition that the poor could not utilize health services because of the fees. Free care is also accessed in uniformed services such as the military, prisons and police facilities for the disciplined forces and their dependents totaling to 700,000 people. It is for the entire population and for only services available in these units. The population below the poverty line at that time was 46.5%, currently this stands at 24.5%. Payment for services remains in the private sector. There are challenges such as poor quality of care for example stock outs of medicine, understaffing, poor infrastructure and inadequate funding. In addition issues are: some segment of the population does not believe in free care and there are under the table payments. Despite the free care, catastrophic health expenses have risen from 5% to 30% between 2001 and 2010 respectively.^{79,80}

⁷³ Basaza R., Cornell T., Chapcokora I., 2013, The players and the processes behind the National Health Insurance Scheme: A case study of Uganda, BMC Health Services Research. 2013;13:57. [Uganda]

⁷⁴ Ministry of Health (a): National Health Accounts Report FY 2008/09 and FY 2009/10. March 2013 edition. Kampala: Ministry of Health, Government of Uganda; 2013. [Uganda]

⁷⁵ Ministry of Health (b): Health Sector Performance Report 2012/13. Kampala: Ministry of Health, Government of Uganda; 2013. [Uganda]

⁷⁶ Providing for Health: Health Financing Reform & Social Health Protection, Specifying the options; Follow up visit and dialogue between Ugandan Stakeholders and a P4H Team. Providing for Health. Uganda: Republic of Uganda; 2010. [Uganda]

⁷⁷ Orem J, Zikusooka C: Health financing reform in Uganda: how equitable is the proposed National Health Insurance scheme? International Journal for Equity in Health 2010, 9:23 [Uganda]

⁷⁸ Save for Health Uganda: Community Solidarity for Quality Health. www.shu.org.ug

⁷⁹ Basaza R., Cornell T., Chapcokora I., 2013, The players and the processes behind the National Health Insurance Scheme: A case study of Uganda, BMC Health Services Research. 2013;13:57. [Uganda]

⁸⁰ Orem J, Zikusooka C: Health financing reform in Uganda: how equitable is the proposed National Health Insurance scheme? International Journal for Equity in Health 2010, 9:23 [Uganda]

Free care is not really free as suggested by one of the respondents:

“... There is a lot of suffering, for example malaria is endemic in this region. Many times, deaths are due to lack of money that cause delay in seeking care. Last week a child died of malaria because of delay to access care. For this child, the grandmother who was taking care of her called the mother who lives in the Toro region to send money so that they take her child to the health centre. By the time money was sent (five days later), the situation had worsened and the child died as she was being bathed to go to the health centre...” (FGD, CBHI scheme).

Government subsidy and donations to private health providers

The private not for profit providers (PNFP) provide about 30% of the health services in Uganda.⁸¹ The government provides subsidies through the public – private partnership which about 10% to 20% of their operational costs. This has enabled PNFPs to lower user- fees. Social health protection forms an integral part of the PNFP principles of protecting the poor and other vulnerable populations. Also, some private for profit providers receive government subsidies in the spirit of providing free public health services like immunization.

Community-based health insurance schemes

Community based health insurance schemes were first created in 1995 in Kisiizi Hospital. There are 26 schemes with the majority are in the southern part of the country. The south has relatively better built solidarity structures and higher income compare to the rest of the country. Most schemes operate in PNFPs facilities and have an umbrella organization, Uganda Community Based Health Financing Association (UCBHFA).⁸² Services offered are only those available at the contracted facilities and exclude referral and portability. Even in those areas where CBHI exist, the poor are not subsidized and so the premium is still considered expensive as suggested by several participants:

“... Like when you tell them the premium is just annual, they fail to pay...” (FGD, CBHI).

“In 2010, we used to be 4135 members but when the premium was increased, the number reduced to half. The term beginning in July 2014 will register more members because the premium has not been increased” (FGD, CBHI scheme).

“We lost about five schemes because people failed to pay. Like in Bushenyi and Sheema, the banana bacterial wilt disease affected the schemes badly when people lost their matooke shambas” (KI, CBHI umbrella organization in Kampala).

There is a waiting period ranging from 2 weeks to 2 months within which a member cannot access services after enrollment. Most schemes exclude chronic illness with a few of them providing care within a ceiling. One CBHI scheme (Kisiizi) stands out prominently in excluding normal deliveries as part of the benefits on the basis that the parents have nine months to plan for the pregnancy. However, this scheme covers complicated deliveries. There is no specific legislation or regulatory instruments covering the operations of CBHI. Most of the schemes have changed ownership and currently owned and managed by the community and few are still managed by the providers. The schemes target individual families within existing social groups like the burial, schools and farmers groups. They cover about 5% -10% of the population where they are located. They are micro care schemes and the total enrollment in the country is 140,000 people.⁸³

There is a co-payment for both in and out-patient care which is up to 20% of the health care bill. The schemes target the rural poor who have some income to pay the premium. Those who cannot afford to pay the premium are excluded. Women, children and the elderly who can afford the premium are included. The schemes lack a mechanism of enrolling the indigent who form 24.5 % of the population. The challenges of the schemes include lack of a legal framework, free care in government facilities, poor quality of care, most of the care is hospital care (no gate keeping), poor understanding of insurance principles by the population and scheme managers, poverty, lack of trust, poor design (60% of a group must join as a measure against adverse selection, no portability of benefits etc).⁸⁴

⁸¹ (MOH (c) The Private Public Partnership Health Policy, 2013)

⁸² Uganda Community-Based Health Financing Association: Path to Better Health. www.ucbhfa.org

⁸³ www.ucbhfa.org

⁸⁴ Basaza R, Criel B, Van der Stuyft P: Low enrollment in Ugandan Community Health Insurance Schemes: underlying causes and policy implications. BMC Health Services Research 2007, 7:105. [Uganda]

Private commercial health insurance schemes

The first scheme, African Air Rescue (AAR) was started in 1994. The majority is employer based schemes and 75% of the schemes have their own facilities, with the remaining schemes run by insurance companies. These schemes target private formal sector workers and their dependents. Very few members join as individual families. The formal sector is easy to enroll in and can afford relatively higher premiums compared to the rural informal sector workers. They enroll children over three months, exclude the elderly (over 65 years of age unless previously enrolled) and cover about 1% of the population mainly in urban areas. They face major challenges like lack of tariffs and rates in Ugandan health care systems (providers charge the amount they want), weak regulation and poor quality of care. Both CBHI and PCHIs do not cover immunization, treatment for HIV or tuberculosis because they are provided free by vertical government programmes. The quality of care for both scheme and non scheme patients is the same. Patients are only identified at the point of payment.⁸⁵

Other informal community health insurers

The country has informal community health insurers like funeral groups which also lend money for health care and transportation of the sick like “Engozi”. They are localized, small in scale and voluntary. Also, there is family assistance where family members contribute money for health care for the sick. Like all small homogenous entities, they are unable to diversify risk across the population and are susceptible to adverse selection.^{86,87}

Proposed national health insurance scheme

The national health insurance (NHI) scheme is being spearheaded by the Ministry of Health and will initially target coverage for people in formal employment. The scheme will require both the employee and the employer to contribute each 4% of the employee’s salary with no co-payments. The scheme will begin with 10% of the national population (formally employed and their dependents) and later expand to cover the whole population. The informal sector will be required to pay a prescribed premium which has not been decided. Though the scheme is supposed to be an autonomous organization, currently there is lack of capacity in the Ministry of Health to design the scheme. Other challenges are: abolition of user fees in Government units and poor quality of care in both private and public units. NHIs are one of proposed practical instruments towards universal coverage.

Table 20 presents the status of social health protection mechanisms in Uganda. The country has made the least efforts to create nationally owned social health protection systems. However, faced with the need to do more, the country is in the process of creating the national health insurance system. The major challenge is that the initiative is taking too long to kick off. Participants thought that the EAC Secretariat could set standards in terms of a time frame for national governments to make all required steps towards ensuring a fully functional social health insurance system. While Uganda may be seen to be worst off in term of social health protection safety nets, the country can capitalize on this weakness to become stronger by designing systems that account for regional standards and EAC countries’ best practices.

⁸⁵ Communication from Insurance Regulatory Authority of Uganda

⁸⁶ Mwesigye, F., & Pearson, M. (1997). Kisiizi hospital health society: pioneering rural social health insurance MOH journal. Uganda Health Bulletin, Ministry of Health Journal, 1(4), 60-64. [Uganda].

⁸⁷ Masiko, A. (1998). Community-Based Health Financing - The Kisiizi experience can it be sustained? A dissertation submitted for the award of Masters of Arts degree of Leeds University. [Uganda].

Table 20: Social Health Protection Schemes in Uganda

Social health protection/ Insurance Schemes	Year created	Oversight	Premium	Co-payment	Population Targeted
NHIS	In process of being created	Not yet operational	Not yet operational	Not yet operational	Formal sector
Private health insurance schemes	1994	Collective bargaining by trade unions		Variable and not available to researchers	Formal and informal sector
CBHI	First schemes around 1995. Existence of 26 schemes	Community or Private –Not for Profit		up to 20%	rural, poor
Military and Police <ul style="list-style-type: none"> • Have their own health centers • Free care when on duty • OOP for specialized treatment 	Since Government's existence	Ministry of Defense	Free care	None	Military and police

Source: Country Study Uganda

Health System Delivery - Uganda

According to the current Health Sector Strategic and Investment Plan and its predecessor Uganda Health Sector Strategic Plan II, they are restructuring the organization and management of the Ministry of Health and the District Health System aims at ensuring an effective harmony and linkages between the centre and the districts on the one hand and the public and private components on the other. It further calls for the establishment of “a network of functional, efficient and sustainable health infrastructure for effective health care delivery closer to the people”. In pursuit of this objective, Government shall:

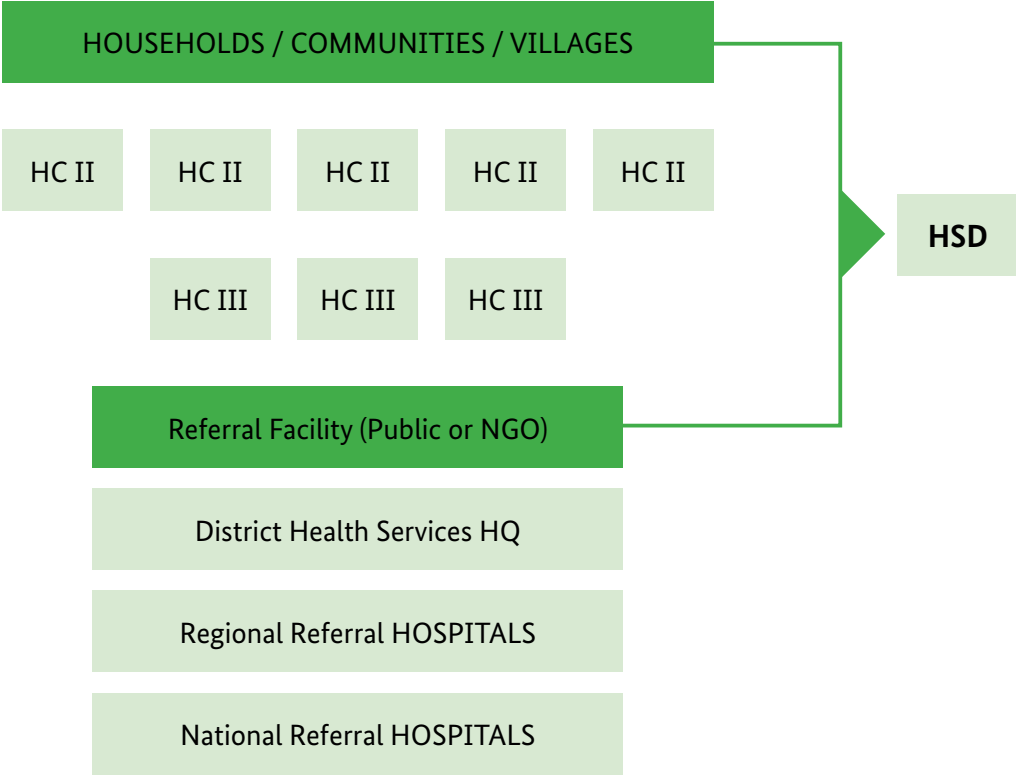
- Develop mechanisms to ensure equity in access to basic services for the most life-threatening health problems, particularly to avert pregnancy and birth-related deaths and childhood killer diseases.
- Build and strengthen the capacity of health facilities to improve health service provision.
- Strengthen and rationally expand the national health infrastructure through a medium term health facility development plan.
- Establish an appropriate and efficiently functioning referral system.

The national standard is to have the following structures in place and functional:

- Ministry of Health and other National Level Institutions
- National Referral Hospitals (27,000,000 population)
- Regional Referral Hospitals (2,000,000 population)
- General Hospitals (District level, 500,000 population)
- Health Sub-District
- Health Centre IV (County level - 100,000 population)
- Health Centre III (Sub-country level - 20,000 population)
- Health Centre II (Parish Level – 5,000 population)
- Health Centre I (Village Health Team - 1,000 population)

The functions and responsibilities of each level of the delivery system have been defined. Minimum service standards and staffing levels have been set for each tier of service delivery. These will be updated in light of HSSIP II orientation. The national health delivery system is getting organized as shown in Figure 13.⁸⁸

Figure 13: Structure of the Health System Delivery (HSD) in Uganda



Source: Country Study Uganda

Human Resource - Uganda

Uganda has around 3,692 active doctors providing care mainly in urban areas with 80% concentrated in cities while the nurses are estimated at 36,031 with still the majority located in urban areas. The ratio of providers to population is 1/9,844 and 1/1,009 for doctors and nurses respectively.

The Challenges – Uganda

There are several challenges for Uganda as it considers its first social insurance scheme:

1. Nothing is really free with the Free Care Program in Uganda: poor quality of care, stock outs of medicine, understaffing (staffing level at 62%), poor infrastructure, and under the table payments. Indeed, despite the free care, catastrophic health expenses have risen from 5% to 30% between 1996 and 2006 respectively.^{89,90}
2. Although CBHI were created with the aim of covering the poor, the poorest are left out due to unaffordable premiums: “... every pregnant woman pools UGX 20000 (US\$80) and they are happy with that. Remember the deliveries are many and every woman will want to be insured and in Kisiizi Hospital CBHI scheme, because of our quality services, they can choose to come to the hospital” (FGD, Hospital CBHI scheme).
3. The few existing CBHI are not effectively protecting the population from catastrophic health expenditure as said a participant: “... We also feared the selling of property for the patients that we were billing for the consumed health services. At some point the term “Kagirita” was used to mean the cutting off of land for sale, every time someone was discharged from the health facility. So we wanted to pool and save people’s properties” (UG, FGD, CBHI scheme).

⁸⁸ 2005/6-2009/10 Health Sector Strategic Plan and 2010/11-2014/15 Health Sector Strategic and Investment Plan
⁸⁹ Basaza R., Cornell T., Chapcokora I., 2013, The players and the processes behind the National Health Insurance Scheme: A case study of Uganda, BMC Health Services Research. 2013;13:57. [Uganda]
⁹⁰ Orem J, Zikusooka C: Health financing reform in Uganda: how equitable is the proposed National Health Insurance scheme? International Journal for Equity in Health 2010, 9:23 [Uganda]

4. The Government needs to play its role because the population has no clear understanding of the existence of social health protection scheme. One participant in FGD said: "... People don't know or they lack the money... I think there is no sensitization and the government has not come up to do the sensitization" (UG, FGD, Hospital CBHI scheme).
5. The Government's ability to organize the health system as a proper referral system seems out of reach: "There are referral challenges because the scheme has no referral system and we lack an ambulance. So people choose to go and start with higher level health facilities like hospitals" (FGD, CBHI scheme).
6. Lack of trust in the insurance concept because of past experiences:

"... these guys (insurance companies) need very tough regulations and not mere words. We lost a lot of money as each of those companies vanished with providers money. Talk to any provider who has been in this business in this town and they will tell you the same story." (national interviews)

Table 21 presents the summary of challenges faced by social health protection schemes in Uganda. The major challenges are three-fold: to make operational the first government subsidized national health insurance, to scale the community-based health insurance and ensuring a progressive system where the richer are subsidizing the poorer, and the healthier subsidizing the sicker. Currently, the junior armed forces have their care paid only when they are in line of duty while the senior officers have their health care fully subsidized.

Table 21: Challenges Faced by Health Protection Schemes in Uganda

Schemes	Challenges
NHIS	Not yet operational. Major challenge is to initiate the scheme. The process has taken years to quick off. It targets only 10% of the population. The MoH lacks capacity to design the scheme.
Private health insurance schemes	Exclusion of children < 3 months and elderly. Cover only 1% of urban formal sector. Lack of tariffs and rates. Weak regulation and poor quality of care.
CBHI	High co-payment, 20% of costs. Still cover limited population. Target rural families that can pay, the poor are excluded. Lack of regulation and subsidies for the poorest. Free care in government facilities with poor quality of care. Most of the care is hospital care (no gate keeping). Poor understanding of insurance principles by the population and scheme managers, poverty, lack of trust, poor design.
Military and Police	Basic health services are paid only when sick in line of duty. Specialized care paid out-of pocket. Higher ranked fully subsidized for their care. System is regressive.

Source: Country Study Uganda

Specific Recommendations – Uganda

1. Accreditation of the health facilities across the EAC Partner States where insured members can seek care within and without the country.
2. Harmonization of the essential medicines list and the basic medical services package so that subscribed members can access health care from any member state and the insurance carriers make claims from the parent insurance career.
3. Uganda should learn from other EAC countries best practices in setting up a social protection schemes, particularly from Rwanda.
4. There should be clear guidelines on how to shift members of the formal sector who are covered by private insurances.
5. Uganda should focus on the informal sector, especially groups at risk such as commercial motorcycle riders, street children, and indigents.
6. The government should have tariffs and rates for health care as one of the crucial step in stabilizing the health care market.

Annex 2: Regional Delegates and Key-Informants

Annex 2.A: Delegates at National Consultation Workshops

Burundi (March 24, 2014, Chez-Andre, Bujumbura):

Bugingo, Spencer; GHIS
Haenel, Danielle; GIZ-Burundi
Kazihise, Pierre Claver; Directrice des Affaires Sociales, MINEAC
Mbonigaba, Glorioso; Cabinet du Ministre, Conseillère du Ministre et Point Focal EAC, MSPLS
Mpeberane, Immaculée; Directrice des Affaires Sociales, MINEAC
Munezero, Landry; Société Commerciale d'Assurance et de Réassurance (SOCAR)
Musoni, Olivier; Médecin Chef de District sanitaire de Mukenke
Ndayishimiye, Valère; Conseiller, Direction de l'Offre et de la Demande de soins, MSPLS
Ndikumana, Clovis; Hôpital RWIBAGA/ Directeur
Ndikumana, J. Christophe; Conseiller Intégration Sociale, Direction Générale de la Solidarité Nationale
Nicimpaye, Anglebert; Expert en appui à la coordination des PTF de santé, Ambassade de Belgique
Niyongabo, Elie-Deus; Vice-Présidence de la république/Conseiller
Niyongabo, Réverien; Directeur-Adjoint chargé des Soins, Centre Hospitalo-Universitaire de Kamenge
Nkunzimana, Alphonse; Médecin Provincial, Province Sanitaire de Kirundo
Nsabimana, Idesbald; Administrateur, Mutualité Nationale de Santé Conseiller
Nshimayezu, Maximilien; Juridique, Présidence de la République du Burundi
Ntadambanya, Cassien; Président, Ordre des Pharmaciens du Burundi
Ntakabanyura, Joseph; Secrétariat Exécutif de la Commission Nationale de la Protection Sociale/ Conseiller Technique, MFPTSS
Ntiburuburyo, Moïse; Représentant Légal, Association pour les Droits des Malades
Ntimarubusa, Frédéric; Université du burundi: enseignant-Chercheur /Expert en Protection Sociale
Ntirampeba, Simon Pierre; UCODE ASBL/ Chargé des projets de Santé et Mutualités
Nzambimana, Joseph; INSP
Ouattara, Oumar; Assistant Technique Financement, Programme Amagara Meza (10ème FED UE / AEDES)
Ruberintwari, Frère Albin; Organisation pour le Développement de l'Archidiocèse de Gitega (ODAG)
Rwiyereka, Angélique; GHIS
Tsafack, Crystelle; Chargé de la protection sociale, UNICEF
Uwamahoro, Alice; Chargée de la communication, Observatoire pour la Promotion de la Santé et les Droits des Malades
Uwineza, Marie-Noelle; Directrice des Prestations, Mutualité Nationale de Santé

Kenya (April 10, 2014, Panafric Hotel, Nairobi):

Abya, Thimothee; Population Council
Baltazar, Billy; MOH
Birungi, Charles; UNAIDS
Bugingo, Spencer; GHIS
Chebet, Hellen; MOH
Chemiyot, Stephen; WHO
Cornel, Luis; UNREF
Gatete, Frederick; MDP-Treasury
Kaboro, Stephen; MOH-OBA
Kahuittu, Robinson; USAID-HPP
Kamau, Lydia M.; MOH
Khampisi, Evelyne; NHIF
Kihuha, Zipporah; EPOS
Kinuthia, Peter; NACC
Kioko, Urbanus; UON

Kirigia, Doris; Kemi-WT
Krwiyereka, Angelique; GHIS
Macharia, Cynthia; PMU-HAKI
Mariaria, Jane; MOH
Nzoya A. M.; MOH
Ogola, Sarah; MOH-OBA
Ondera, Joanne; GIZ
Ruhara, Charles; University of Nairobi (UON)
Sila, Agnes K.; MEAACT
Waiyaki, Isabel; UON

Rwanda (March 31, 2014, Lemigo Hotel, Kigali):

Bitega, Jean Paul; Director Geneal, MMI
Bugingo, Spencer; Legal Advisor, MOH
Dushimimana Pierre; Financial specialist, MSH
Dushimimana, Pierre; Vice President, BLAO
Hakizamana, Jeand de Die; IN-Charge of Health, MINEAC
Kakoma, Jean Baptiste; Dean and Chair of the UR/CMHS/SPH
Kamanzi, Collins; UR/CMHS/SPH
Karuhanga, David; State Attorney, MINIJUST
Kayihura, Felix; Consultant, CORAR
Kibibi, Christian; CBHI National Supervisor
Krwiyereka, Angelique; GHIS
Lane, Jessica; Advisor, NCW
Mahwa, Aloys; Financial specialist, MSH
Muhongerwa, Diane; Health Economist at WHO
Murenzi, Jusper; Medical Advisor, RSSB
Musabyimana, Angele; National Consultant UR/CMHS/SPH
Ndizeye, Cedric; Health Financing Advisor, MSH
Nsengumuremyi, Diogene; Head of commercial Department, RADIANT Insurance
Nyandekwe, Medard; PhD student&Consultant, UR/SPH
Nyandwi, Aypio; Research Officer, MOH
Nyrazinyoye, Laetitia; Lead National Consultant, UR/CMHS/SPH
Rudakemwa, Emmanuel; Representative of CEO KFH, Kigali
Rusa, Louis; Consultant, Private
Safari, Innocent; Permanent Secretary and Guest of Honor MINEAC
Shema, Joseph; PBF MoH
Siboniyo, Alexandre; Managing Director, LIKEWISE Ltd
Tumwine, James; Social Protection Economist, World Bank
Umutoni, Nathalie; Clinical Services, MOH
Uwera, Florence; IT/Data manager, MOH
Uwiragiye, Clement; Director of Health, Burera District
Uwiragiye, Priscille; Vice Mayor, Bugesera District

Tanzania (April 3 2014, JB. Belmont, Dar-es-Salaam):

Athuman, Rehani; NHIF
August, Joachim; Researcher IHI
Bugingo, Spencer; GHIS
Focus, Josephat; GIZ
Ghumpi, William; SCDO-MOF
Ipuge, Yahya; World Bank
Kivuyo, Mbarwa; IHI
Krwiyereka, Angelique; GHIS
Liganga, Lucas; The Citizen
Macha, Jane; Researcher IHI
Maluka, Stephen; Academician UDSM
Mandani, Masuma; ESRF
Manzi, Fatuma; IHI
Masanja, Honorati; IHI

Massaga, Julius; NIMRI
Mawzi, Fatuma; MOH
Mayamba, Daisy; Co-CMC
Mbulumi, David; IHI
Mishra, Usha; UNICEF
Mohamed, Mohamed; MOHSW
Mtei, Gemini; Ifakara Health Institute (IHI)
Muganyizi, Adelaida; TIRA
Mushi, Ansgar; SSRA
Mwasha, Anna; DPE/MOF
Ngabo, Ibrahim; SSRA
Ngilangwa, Richard; ESRF
Nyalusi, Winniefrida; IHI
Rosenberg, Nicolas; GIZ
Rwiyereka, Angélique; GHIS
Siegert, Nina; P4H
Smithson, Paul; IHI

Uganda (April 15 2014, Imperial Royale Hotel, Kampala):

Baine, Sebastian Olikira; Makerere University School of Public Health
Baleka, Moses; GIZ
Basaza, Robert; Ministry of Health
Bugingo, Spencer; GHIS
Buyinza, Nasulu; Deputy Executive Director, Uganda Muslim Medical Bureau
Hajara, Nasolo; Liberty, Social protection
Kabaniha, Grace; World Health Organization Country office
Kaganda, Pascal; Makerere University School of Public Health
Kamukama, Saul; Makerere University School of Public Health
Kasasa, Simon; Makerere University School of Public Health
Krwiyerereka, Angélique; GHIS
Nakyanzi, Dorothy; Uganda Protestant Medical Bureau
Oumo, Peter Omms; Head of Public Health, Uganda National Police
Walter, Thomas; GIZ

Annex 2.B: Key Informants and Participants of Focus Group Discussions

Abuya, Timothy; Population Council, Kenya
Andrea, Michael M.; Ikungi district council, Tanzania
Arineitwe, Sam; Kyozi, Uganda
Asiimwe, Anita; Hon. Minister of State in the Ministry of Health, Rwanda
Augustino, John; Ikungi district council, Tanzania
Bararufise, Juvénal; Mutualité Nationale de Santé, Burundi
Batsigaire, Fred; Rugarama sub-county, Uganda
Bazivamo, Christophe; Hon. Vice Chair, East African Legislative Assembly (EALA)
Biramahire Constance; Kishanda, Uganda
Birungi, Charles; Ministry of Devolution and Planning, Kenya
Burunde, Patrick; Kebisoni group, Uganda
Busingye, Placidia; Binyena, Uganda
Casmini, Mathiasi; Ikungi district council, Tanzania
Chitama, Derick; Muhimbili University, Tanzania
Chodota, Eliapi ; MEACA, Tanzania
De, Susna; USAID, Tanzania
Eriyo, Jesca; Hon. Deputy Secretary General, Social Sector, EAC Secretariat
Gakwaya, Innocent; Director General Medical Schemes, RSSB, Rwanda
Hajebakiga, Patricia; Hon. Member of the East African Legislative Assembly (EALA)
Haji, Abdul Larif K.; DPPR, MOH Zanzibar
Hakimaana, Bonifasi; Kacence, Uganda
Harerimana, Aline; MSPLS/Direction Générale des Ressources, Burundi
Hucheda, Evaline N.; Ikungi district council, Tanzania
Ihonde, Jared; Ikungi district, Tanzania

Isaka, Irene; Social Security Regulatory Authority, Tanzania
Itangishaka, Théodomir; Direction Générale des Ressources; Division du Budget et de l'Approvisionnement/ Chargé du paiement des factures (CAM rénovée) , Burundi
Jamaldin, Ismail; Kinondoni Municipal, Tanzania
Kagyenzi, Fred; Kisiizi Scheme, Uganda
Kahuthu, R.; Senior Policy Advisor, Kenya
Kamau, James; Executive officer, Kenya
Kamikazi, Josiane; Ministère des Finances/ Chargée du Secteur santé, Burundi
Karenzi, Ben; Col. Rwanda Military Hospital, Board Member MMI
Keriri, Nellie; NHIF, Kenya
Kwehangana, Matthias; Catholic Parish, Uganda
Kyomukama, Bonny; Kikunda, Uganda
Lumbano, Kizito; UNES, Kenya
Majoli, Paul; Kisiizi Scheme, Uganda
Maluka, Stephen; University of Dar es Salaam, Tanzania
Manirakiza, Colonel Elie; Hôpital Militaire/ Responsable des statistiques médicales et du FBP, Burundi
Mbonigaba, Glorioso; MSPLS/ Cabinet du Ministre/ Conseillère du Ministre et Point Focal EAC, Burundi
Mdim, Hadija S.; Ikungi district council, Tanzania
Memba, Dausi H.; Ikungi district council, Tanzania
Mgongolwa, Ajala E.; Kinondoni Municipal, Tanzania
Mmbando, Henry; Ikungi district, Tanzania
Mohamed, Mohamed; MOHSW, Tanzania
Mpeta, Abdul Shomvi; Kinondoni Municipal, Tanzania
Mugisha, Zepher; Kihhi, Uganda
Muna, Annastasia A.; Ikungi district council, Tanzania
Munezero, Landry; Société Commerciale d'Assurance et de Réassurance (SOCAR), Burundi
Munguti, Dhimn; Ministry of Health, Kenya
Mutai, Rael; Ministry of Health, Kenya
Muzehe, Pierre Claver; MUNASA Twitwararikane/ Coordinateur région Centre, Burundi
Muzerwa, Paulin; Pharmacie SALAMA, Burundi
Mwai, Daniel; Health Policy Project – Futures Group International, Kenya
Mwaisela, Martha L.; Ikungi district council, Tanzania
Mwaisengule, Osca G.; Kinondoni Municipal, Tanzania
Mwangola, Ada; Vision 2030 Secretariat, Kenya
Nahabwe, Karanzi Pius; Kabale Diocese CHIS, Uganda
Nahayo, Jean Berchimas; CEPEBU (Eglise de Pentecôte) , Burundi
Ndagijimana, Uzziel; Hon. Permanent Secretary, MOH, Rwanda
Ndayirereye, Dieudonné; Mutuelle de la Fonction Publique, Direction Régionale Centre-Est/ Chef antenne Région Sud Centre Est, Burundi
Ndayirobere, Sœur Jeanne d'Arc; CDS GASURA, Burundi
Ndayishimiye, Valère; MSPLS/ Direction de l'Offre et de la Demande de soins/ Conseiller, Burundi
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