CLIENT SATISFACTION WITH HEALTH INSURANCE IN UGANDA

TABLE OF CONTENTS

TABLE OF TABLES

GLOSSARY

bubondo: sub-groups of the Kamuli Muganzi Awongerwa Association (KMAA)

LIST OF ABBREVIATIONS

Abbreviation	**Explanation**
FGD	Focus Group Discussion
HC	Health Centre
KMAA	Kamuli Muganzi Awongerwa Association
MFI	Microfinance Institution
SACCO	Savings and Credit Cooperative
SHU	Save for Health Uganda
USD	United States Dollar
Ush	Ugandan Shilling

ACKNOWLEDGEMENTS

This report summarizes the results of research conducted on client satisfaction with health microinsurance clients in Uganda. Elizabeth McGuiness, Senior Program Officer of Microfinance Opportunities, provided oversight for this work. Fieldwork was conducted in Uganda in August 2007. The field research team consisted of Peter Mukwana, Henry Sempangi, Samson Udele, and Moses Muwanguzi from MicroSave Africa.

The research methodology was designed by Microfinance Opportunities. Ana Klincic, Consultant, Microfinance Opportunities, provided training and direction for the research team in Uganda. The MicroSave Africa team led the research in Uganda and prepared the draft report. Vanessa White, Elizabeth McGuinness, and Michael Ferguson of Microfinance Opportunities edited the report. Monique Cohen, President of Microfinance Opportunities, provided overall direction. The report is part of a series on client satisfaction with microinsurance.

I INTRODUCTION

Sickness is unpredictable and expensive when it strikes, and in developing countries few families have healthcare budgets to handle it. As a result, many resort to ineffective treatment options including failing to follow the full prescription course, self-medication with purchase of drugs from local pharmacies, using inappropriate traditional medicines, or ignoring the illness in the hope that it will go away on its own. These coping mechanisms often allow the disease to progress, causing additional complications that increase the cost of treatment in the long run. Poor coping mechanisms hence lead to lost productivity, increased absenteeism at work, and greater uncertainty and anxiety.

As an intervention against risk (health-related or otherwise), microinsurance is an increasingly common component of poverty alleviation strategies. While it is widely accepted that microinsurance can help the poor reduce their vulnerability and avoid falling into greater poverty after a shock,[1] the client perspective on microinsurance is less understood. Are clients satisfied with the products and services offered? Does the microinsurance industry provide good coverage at affordable rates, in a way that resonates with the policy holder? Moreover, do the insured understand the policy?

This study aims to shed light on the client perspective on microinsurance vis-à-vis two health microinsurance products in Uganda. The study will examine the implications for clients in terms of product coverage, accessibility, timeliness, and product appropriateness.

In addition, this research will serve as part of a larger project to develop a protocol for measuring client satisfaction with microinsurance—one that can be employed in many different contexts around the world. The lessons learned here will help inform that agenda.

II RESEARCH OVERVIEW

Research Objective

In assessing policyholders' level of satisfaction with two health insurance products in Uganda, this study had the following specific aims:

- To gain an understanding of the information and knowledge provided by the promoters and/or providers of the products.
- To understand the claims process, including the steps involved in these processes.
- To assess policyholders' knowledge of the importance of health insurance in their lives.
- To understand how satisfied policyholders are on issues of product coverage, accessibility, timeliness, and product appropriateness.
- To work from the client perspective to propose ways or strategies to improve the products, clients' understanding, and their delivery in the market.

Research Methods

The research methods consisted of a combination of individual interviews and Focus Group Discussions (FGSs) designed specifically to address the above research objectives. The FGDs employed the following three tools:

[1] Cohen & Sebstad. (2005). Reducing vulnerability: The Demand for Microinsurance. J.Int.Dev. 17 pp404 -405

- Tool 1: Relative Importance of Insurance Products in One's Life and Clients' Understanding of Insurance Products and their Affordability.
- Tool 2: Exploring Requirements for Taking an Insurance Product and Client Satisfaction with Information and Knowledge Provided.
- Tool 3: Exploring Client Satisfaction with Claims Process.

Research Sample

The study was carried out with policyholders from two institutions: Save for Health Uganda (SHU) and Microcare. A total of 82 respondents were interviewed in 12 FGD sessions, as shown in the Table 1 below. SHU policyholders interviewed in this study were drawn from the *Kamuli Muganzi Awongerwa Association* (KMAA). KMAA is the oldest of the SHU groups and currently has 555 members, who are further categorized in 5 sub-groups (known as *bubondo*). Microcare policyholders interviewed in this study were drawn from the Makindye Community Association, which serves about 1,000 Microcare policyholders.

Table 1: Sample Frame of Focus Group Discussions

	Save for Health		Microcare	
	Claims Experience	No Claims Experience	Claims Experience	No Claims Experience
Tool 1		1 (men) 1 (women)		1 (men) 1 (women)
Tool 2		1 (men) 1 (women)		1 (men) 1 (women)
Tool 3	1 (men) 1 (women)		1 (men) 1 (women)	

Report Outline

This report will present the findings from each research partner as a separate case study. Each begins with a short background of the organization and then summarizes the responses from the policyholders, which have been categorized as follows:

- Background.
- Product Features.
- Profile of Survey Respondents.
- Knowledge and Understanding of the Insurance Product.
- Client Satisfaction with the Product.
- Client Satisfaction with the Process.
- Client Recommendations for Improving the Insurance.

The report then provides a summary of the findings for the two institutions in terms of product appropriateness, product coverage, accessibility, and timeliness. The report will close with summary recommendations and conclusive remarks.

III SAVE FOR HEALTH UGANDA (SHU)

Background on Save for Health Uganda (SHU)

Save for Health Uganda (SHU) is an NGO with a mission to improve the quality of health of Ugandans. It has been promoting and supporting community-owned and managed health prepayment schemes since 1999[2]. SHU currently has three types of health-financing schemes in its portfolio: health credits, health insurance, and a mixed credit-insurance product. These are offered through two programs: the Luwero area and Bushenyi area programs. The Bushenyi area program, in Western Uganda, consists of only one scheme that offers an insurance product to 250 beneficiaries. In the Luwero Area program in Central Uganda, there are 13 community health pre-payment schemes that cover 5,198 beneficiaries. The programs have contracts with three health providers: Kiwoko Hospital and Bishop C. Asili Health Centre in the Central Region; and Ishaka Adventist Hospital in Bushenyi district.[3] Twelve of the 13 schemes in the Luwero program access healthcare services using a credit mechanism, while one scheme uses a hybrid credit-insurance mechanism. This latter scheme is the subject of our study.

With nine technical and five support staff, SHU forms and manages the community groups that operate the community-based health funds. SHU's main activities include:

Table 2: SHU Information

	Central Region	Western Region
No. of districts	3 (Nakasongola, Nakaseke, Luwero)	1 (Bushenyi)
No. of SHU schemes	13	1
Beneficiaries	5,198	250
Healthcare Providers	Kiwoko Hospital, Bishop C. Asili Health Centre	Ishaka Adventist Hospital

- Promoting the health prepayment concept and the designed health-prepayment schemes to the target communities;
- Providing support to communities to design appropriate healthcare prepayment schemes with appropriate healthcare benefit packages;
- Providing support to help identify, negotiate, and collaborate with good healthcare service providers for the schemes;
- Capacity-building among target communities and within schemes, as well among healthcare service providers, for self-financing, management, and sustainability of the program;
- Monitoring and evaluation activities.

The Kamuli Muganzi Awongerwa Association – Insurance/Credit Scheme

The *Kamuli Muganzi Awongerwa Association* (KMAA), which operates the hybrid credit-insurance scheme in the Luwero area, is the oldest of the SHU schemes. It currently has 555 members who belong to one of five village-level sub-groups (known as *bubondo*). The association is managed by three officials (Chairman, Secretary, and Treasurer), all of whom have been members and leaders of this association since its inception seven years ago. The groups are each managed by three officials (Secretary, Treasurer, and Mobilizer). The following village groups form the association: Kamuli Central Zone, Kajimu Zone, Kyebakazi Zone, Bumpewe Zone, and Nabikyakya Zone. SHU requires that each group have at least 100 members in order to participate in a scheme. This study was conducted in the Kamuli Central Zone.

[2] The program was started by CIDR, a French NGO in 1999 but continued as an independent Ugandan NGO starting in 2003.

[3] It is important to note that since these are community-based schemes, (i.e. not tied to a single facility), service standards are not uniform across the board.

In the KMAA scheme, as in other community-based schemes, members or policyholders are required to pay an annual premium (set by SHU and the healthcare provider) and an annual management fee (set by the individual scheme). Membership in the KMAA scheme and payment of premiums allows members to access healthcare at Kiwoko Hospital or Bishop C. Asili Health Centre for little or no cash outlay.

Product Features

Eligibility: The product is available to all households who have at least three members, reside in the Kamuli Parish, and belong to a group. The group must have 100 members to belong to the KMAA.

Coverage: Treatment, both in-patient and out-patient, is available at Kiwoko Hospital. All illnesses are covered except those that are self-inflicted or result from practices that are self-inflicted e.g. abortion, smoking, using drugs, and plastic surgery. The insurance coverage extends for one year and is renewable in subsequent years.

Table 3: KMAA Credit-Insurance Scheme

Product Feature	Current Terms
Type of Product	Credit-insurance hybrid
Eligibility	Households with at least three members and who belong to a KMAA group.
Premium Costs	Ush 12,900 (USD$ 8.06) for the first three members of the family. Ush 4,100 (USD$ 2.56) for each additional member.
Co-payment	Ush. 2,000 (USD $1.25) for in-patient treatment; Ush. 5,000 (USD $3.13) for out-patient treatment
Coverage	Medical treatment at Kiwoko Hospital or Bishop C. Asili Health Centre
Term	One year
Benefit	Medical treatment costing between Ush 30,000 (USD $18.75) and Ush 100,000 (USD $62.50) is covered by insurance. Amounts below Ush 30,000 (USD $18.75) are covered by a credit.
Claims Process	Cashless, see below.
Exclusions	Illnesses that are self-inflicted or result from practices that are self-inflicted such as abortion, smoking, and using drugs are not covered.

Premiums: Premiums (or contributions) are paid once per year during the period of December to February. The costs of membership are Ush. 12,900 (USD $8.06)[4] for the first three members of a family, plus Ush 4,100 (USD $2.56) for each additional family member. The per person price is allocated as follows:

Management fee	Ush 700 (USD $0.44)
Credit fund contribution	Ush 1,200(USD $0.75)
Insurance fund premium	Ush 2,200 (USD $1.38)

[4] An exchange rate of 1600 Ugandan Shillings to USD $1.00 is used throughout this report.

The management fee is used to support the day-to-day running of the *bubondo* group and materials such as passport-size photographs, pens, paper, and books. The credit fund contribution is made to a revolving fund that is used to cover treatment cost. The credit (or revolving fund) and insurance funds contributions are deposited with the Hospital in a KMAA account. For example, Kiwoko Hospital is holding Ush 1,800,000 (USD $1,125) as an Association reserve fund for the treatment of KMAA policyholders.

Renewals: These are also paid once per year. Renewing policyholders benefit from a 10 percent commission given to the scheme by the hospital for every individual case that is treated by the hospital. This commission accumulates over the year and is translated into savings for the scheme via reduced premiums in the following year. The premium varies from group to group and year to year, as the renewal premium is determined by how much money the group saved in its operational account by the end of year and the total commissions received from the hospital.

Benefits: The benefits of belonging to the KMAA scheme are that the policyholder can obtain treatment at the hospital without making a cash payment. The credit part of the scheme covers the first Ush 30,000 (USD $18.75) (minus the co-payment) of treatment costs. In effect, these costs are paid by the KMAA scheme account, to which policyholders are then indebted. Policyholders then have three months to reimburse the scheme for their treatment. Treatment costs that exceed Ush 30,000 (USD $18.75) but are less than Ush 100,000 (USD $62.50) are covered by the insurance component and paid for by the KMAA scheme account. Treatment costs in excess of Ush 100,000 (USD $62.50) must be paid for by the policyholder. Co-payments of Ush. 2,000 (USD $ 1.25) or Ush 5,000 (USD $3.13) (depending on the type of treatment) are due at the time of treatment, but these also can be covered by a credit.

The KMAA scheme insurance component is a semi-formal form of insurance in that there is no policy with a formal insurance company. The risk is retained within the KMAA scheme and among the policyholders of this scheme. The insurance fund consists of the accumulated insurance fund contributions minus any amounts that are paid out to the hospital. This is the reason that a credit component was added to the scheme—to ensure sufficient funds to cover more expensive illnesses (i.e., over Ush 30,000 [USD $18.75]). Although illnesses that involve large sums of money are less common, there must be sufficient funds to cover them whenever they occur, because they tend to deplete the fund very quickly.

Claims Processing: Claims are handled at the hospital. The process map on pages 18-19 illustrates the process policyholders follow when they visit the Kiwoko Hospital for services.

The claims process for SHU does not involve cash, but starts when a client is sick and requires medical attention. The policyholder visits Kiwoko Hospital and presents his/her membership card at the SHU dedicated desk. The desk officer records the member's biographical details and fills in Form 5.

After being seen by the doctor and receiving treatment, the patient must then present their card to the SHU Pre-payment Cashier and provide an initial payment. The Cashier retains the SHU member's card. If the scheme's Pre-payment Cashier is not around, he/she delegates his/her responsibilities to the general/hospital cashier. When done, the policyholder leaves the hospital with Form 5 and the medical cost receipt. This receipt is given to the Group Treasurer and a repayment agreement is signed between the Treasurer and the policyholder. The policyholder will then have three months in which to repay the group for the cost of the medical treatment.

Group Account Management: The groups and the KMAA reconcile their accounts with the hospital on a monthly basis. This is done at the monthly group meetings with the participation of the Hospital Cashier. At this time, the cashier returns the patients card to the group.

Profile of Sampled KMAA Policyholders

The KMAA members who participated in the research are primarily peasant farmers who raise crops for home consumption. Some of the members raise animals such as chickens, goats, and pigs. Only a few have other occupations, such as teachers or small shop owners. The average family size for respondents is 7.2 people, but on average only 5.9 family members are covered under the scheme. Overall, 53 percent of the survey participants have 100 percent of family members covered in the scheme.

Relevance of the Insurance for Policyholders' Lives

The policyholders agreed that the credit-insurance scheme is appropriate for them and relevant to their needs. They made several points regarding the appropriateness of the product:

1. Medical treatment costs are relatively high compared to members' household incomes, which are small and irregular. Moreover, hospitals expect to be paid in one lump sum[5]. For example, a bout of malaria, which recurs frequently in this area, can cost a family Ush. 50,000 (USD $ 31.25). It is not easy for a resident to raise the Ush.50,000 (USD $31.25) or Ush.70,000 (USD $43.75) needed for consultation fees and drugs, unless through a planned arrangement such as the KMAA Scheme. Policyholders find it much more affordable to pay the annual contributions to the credit and insurance funds than to suffer the pressure of having to pay a lump sum unexpectedly at the hospital.
2. The KMAA Scheme allows policyholders to access quality medical treatment through Kiwoko Hospital. The only free government hospital in the area is Nakaseke Hospital. Like many other government hospitals, it lacks drugs and adequate medical staff, making it unresponsive to people's needs. This leaves many residents in the area with only Kiwoko Hospital to turn to for services. Without this credit-insurance scheme, many poor clients would not be able to access the more expensive Kiwoko Hospital. Furthermore, the Kiwoko Hospital is closer geographically to the KMAA members' homes—many members can walk to the hospital—while the government hospital in Nakaseke is 20 kilometres away.
3. Guaranteed treatment has caused behavioral changes in that participating households seek earlier treatment. Since KMAA policyholders do not need to worry about how they will pay for their medical treatment, they are able to seek early treatment of their sicknesses rather than resort to self-prescribed drugs or herbal remedies. Research shows that lack of early treatment often leads to complex medical cases that are more expensive to treat.
4. At the household level, membership in the KMAA Scheme has helped members avoid using more disruptive coping strategies such as disposing of their assets, usually at distress-sale values, to raise the lump sums required for medical expenses. Replacement of distress-sale assets is challenging, and in many cases poor households are left even more vulnerable having reduced their fall-back options. With guaranteed treatment, household assets are preserved. Members of credit-based schemes have the advantage of obtaining treatment and paying back the loan gradually over a three-month period.

[5] One policyholder reported: "Kiwoko Hospital can retain a patient at their premises for a week to ensure recovery of their money. They carry out checks at the gate to ensure compliance."

5. Policyholders noted that the KMAA Scheme provides for ambulance service to provide transportation in the case of emergencies.
6. Membership in the village-level group and the KMAA Association provide other benefits to policyholders, aside from the credit-insurance scheme, which stem from the solidarity and community spirit that is part of the group experience (see discussion below).
7. Finally, policymakers noted that the scheme provides them with peace of mind.

Knowledge and Understanding of Insurance

Marketing of the Product

SHU has undertaken marketing to mobilize people and educate them on the importance of insurance and how it can be delivered feasibly in a group arrangement. In the initial stages, field staff from SHU go to villages and partner with the local authorities to conduct educational sessions. The topics covered in these sessions include:

- The requirements for joining and becoming a member of the scheme.
- The process of forming the group and how the members can select their leaders. The leaders' roles and functions are also clarified.
- Importance of insurance in healthcare and disease prevention.
- The strategic working relationship between the SHU and the various SHU associations, specifically in areas of management and support provided to the associations by SHU.
- Product information such as terms and conditions, coverage, health service providers, and claims process.
- How to negotiate with healthcare providers.

Once groups are formed, group leaders conduct marketing and awareness campaigns. They do this through community gatherings and door-to-door visits, conducted in local languages for effective communication.

People also learn about the product through union seminars—forums involving several associations and groups in Central Uganda. Sometimes referred to as "Save for Health Parliament," these seminars bring together executives of different SHU associations and groups to share new information about the product and to develop and share the best practices of the schemes. SHU uses its staff, invited health specialists, and/or fellow association executives to facilitate the meetings. The seminars, which are organized by SHU, may last 3-5 days.

Additionally, positive word-of-mouth marketing has greatly helped to propagate and popularize this product in the communities. Some respondents acknowledged having learned about the product from their colleagues. Additionally, Kiwoko Hospital staff promote the scheme to their patients: "The health workers encourage and recommend people to join the scheme to ease their healthcare challenges" explained one member.

Knowledge of the Product

Despite this multiplex effort at education and marketing, the level of knowledge amongst the policyholders varies widely.

By virtue of their positions and activities, group leaders have the best product knowledge. Others showed a more limited understanding. Women were reported to spend less time at the educational meetings, particularly in rural areas, where husbands always represent their wives at the meetings. Yet even among the attendees, knowledge was uneven; as one participant

commented, "Some people once they are out of the meetings, they tend to forget all that was taught."

Policyholders, particularly those who have used the hospital, appear to have substantial knowledge of the claims process, coverage, and service locations, as well as other aspects specific to the KMAA scheme. Areas where policyholders were less informed include premium costs and the requirement for a co-payment at the hospital.

Understanding of Insurance

Overall, policyholders have a very poor understanding of how insurance works in a general sense. This is evidenced by the fact that a significant portion of policyholders fail to renew their policies each year because they have not used the hospital and hence do not believe that they are benefiting from the program. The KMAA Scheme suffers from a 20 percent annual drop-out rate. This is in contrast to the SHU credit-only schemes that have drop-out rates of about 5 percent annually.

Client Satisfaction with the Product

Eligibility

Clients are pleased that they can join this insurance scheme with a membership in KMAA that costs them only Ush 500 (USD $0.31).

Coverage

There is general satisfaction with the coverage of the insurance and the insurance term. Most policyholders report that most treatment costs fall below the Ush 100,000 (USD $62.50) limit, so most people do not have any problems with that limit. The major exceptions are elderly policyholders, who have chronic conditions such as diabetes and often spend beyond the insurance maximum cover amount. There is dissatisfaction with the coverage in these cases.

Premiums and Renewals

There were mixed feelings as to whether the premium is affordable. Some policyholders stated that the premiums are so high that they cannot afford to insure all their family members. As a result, they only insured those who are prone to becoming ill. This raises the issue of adverse selection. On the other hand, respondents more familiar with how the scheme works tend to consider the premium amount affordable, given the ease with which significant medical bills are covered without any hassle. For them, the benefits of the scheme outweigh the costs.

On the whole, client dissatisfaction tends to be fueled by a general lack of understanding about insurance. Many people first want to witness the benefits before agreeing on its value. Those who have not accessed treatment at one of the participating healthcare institutions will sometimes drop out of the group because they do not see the risk-mitigation value. Others feel that repeat annual subscriptions are not fair to members that have not had any claims.

Other challenges and dissatisfaction relate to premium and renewal payment schedules. Membership fees and premiums are paid only during the December-March admission window period; for renewals, this window extends from November-March. This period is a challenging time for most households. Incomes are lowest at the beginning of the year, as a result of the dry season and the need to pay school fees. To ease this problem, the groups put in a provision to accept payments in installments. Some policyholders, however, were not aware that installment payments were an option. Whether the policyholders pay installments to their group or not, they usually start saving money for premiums as early as June when the income from farm

produce is still high. They, however, cannot access healthcare in this period when they are building their savings.

Most respondents have been in the program for some years[6] and are familiar with the renewal process. Policyholders stated that they renew premiums to ensure uninterrupted coverage for themselves and their families, but even experienced policyholders admitted that they found it challenging to come up with the annual renewal fee.

Group Experience

Policyholders value the social relationships and interactions that the group provides. They talked of a shared understanding that the members' welfare is paramount and that all members are responsible for each other. There have been cases where members have contributed for another member dealing with a crisis, or have provided funds for other needs like court fines or topping up medical bills that have exceeded the insurance fund's Ush 100,000 (USD $62.50).

Customer Care

The level of customer service is considered to be very good, especially in dealings with the Pre-payment Cashier and the doctors. Members appreciate the very professional way the doctors treat them, mentioning the doctors' patience, attitude, friendliness, and quick service. The doctors were said to take time to understand the problem and the history behind the sickness, e.g. how long it has been present, past treatment, etc. Respondents, however, reported that on some occasions, nurses at the hospital were unfriendly and rude. This discourages members from asking the nurses for help. Overall the positive responses on customer care outweighed the negative responses.

Client Satisfaction with Processes

Application Process

The application process was said to be very easy for policyholders since it is handled by fellow community members who speak the same language. The group leaders provide all the necessary information to new members before joining, and the application details are then sent to KMAA for purposes of record-keeping and informing the hospital of the new policyholders. New members can only join during the December to February period, which some policyholders felt makes it difficult for new members to join.

Payment of Premiums and Renewals

Premiums are collected by Treasurers during the group meetings and then deposited with the KMAA Treasurer, who in turn deposits the funds with the hospital. Policyholders are satisfied with the premium payment method because it is convenient not to have to travel long distances to make the payments. Policyholders also trust their group and association leaders who handle the funds because: 1) these people have been in leadership positions for many years; 2) they are well-known to everyone; and 3) they have permanent residences in the communities.

Accessing Treatment at the Hospital and Claims Processing

Policyholders, with a few exceptions, were very satisfied with the quality of medical treatment and with the customer care they received at the Hospital. They particularly appreciated having a dedicated Pre-payment Cashier to facilitate their claims processing. Even though all policyholders are provided with an overview of the claims process at the time of entry into the scheme, many remain dependent on the guidance of the hospital health workers. For this

[6] See analysis in Annex 2

reason, the hospital set aside specific staff (a Desk Officer and Pre-payment Cashier) and created a SHU desk to expedite and guide SHU members through the claims process.

Clients expressed general satisfaction with the claims process at the hospital. Paperwork is minimal. Patients need only their card and the medical form. Most paperwork is handled by the Pre-payment cashier. As one respondent said: "It's easy; even most of us who have never gone to school can manage it".

Some aspects of the process were deemed less satisfactory. Only one membership card is issued containing a picture and names of all the beneficiaries. A conflict can arise if one member is using the card when another member needs treatment, or the card is forgotten. Patients who cannot present their membership card will experience delays in receiving treatment. As one respondent related:

> Last time I was bitten by a snake, as it was an emergency I was rushed to hospital without my card. The lady at the reception refused to book me in without the card. We requested they start with the treatment while it is brought. I sent some one back home to bring it and that's when I received treatment.

In cases when a patient's card is not available because it has not yet been brought back from the hospital by the Pre-payment Cashier, and the patient requires further treatment, the patient requires a letter from the Group Treasurer. This is done to prove that the patient has cleared the previous loan from the group. If a patient has an outstanding loan with the group, they must pay for the treatment out of their pocket or clear the outstanding loan first.

Group Management

Once a month, the group account is reconciled at the group meeting. Both SHU staff and the Pre-payment Cashier attend these meetings—the SHU staff to assess new applications and manage the group, and the Pre-payment Cashier to reconcile the accounts. After the group and the cashier have reviewed the costs for the month, the group issues a letter that gives the hospital the authority to deduct the medical costs from the group account. Also at this meeting, the cashier returns the cards of policyholders who received treatment at the hospital during the month.

Difficulties can arise at this stage in two ways. The first is when people need to go to the hospital but the membership card is not available to them because it is already in use. The second is when patients who have received treatment do not turn their treatment receipts over to their group, thereby delaying the booking of the policyholders' amount for refund. If the policyholder is late in submitting a receipt, then group records will fail to reconcile with the cashier's records at the end of the month.

Policyholder Recommendations for Improving the Credit-Insurance Scheme

Client Education

Many people are joining groups on the basis of anecdotal testimonies by existing program members; as a result, new members may not fully understand the salient features of the scheme. Additionally, current members who have not used the hospital recently may have forgotten some of the details of the scheme. Education and sensitization on the specific aspects of the scheme (product orientation) should be done on an ongoing basis. This will enable current and potential policyholders to understand how the whole system works and to pass on consistent messages to others in their community, thereby enhancing this informal marketing.

Client education is as necessary now as it was in the beginning of the program; the whole concept of insurance is still complex for many people. Only continuous education will impact their understanding to a sufficient degree. A well-crafted curriculum should cover such topics as:

- Diseases and their effects on household productivity.
- Current coping mechanisms and their limitations.
- The importance of seeking early medical treatment.
- Costs of accessing good healthcare.
- Possible ways of raising money to cover these costs.
- Introduction to health insurance and how it works.
- How savings over time can help raise the required lump sums.
- Places where people can receive good healthcare.

Application Process

SHU groups should establish mechanisms for admitting new members throughout the year, as long as they are ready to abide by the rules governing the scheme. An idea discussed with group members entailed a window period of one month before a new member starts accessing services. This will eliminate possibilities of new members registering after identifying a need for treatment. (The current practice stops admitting new members to the scheme in March and opens again in October, to eliminate the possibility of a new member registering after identifying a need for treatment.)

Support to Group Leaders

Group leaders are doing a commendable job in mobilization and client education on the benefits of insurance. They do all this on a volunteer basis. Facilitation of their work—for example, by providing them with bicycles or adding enrollment incentives—is likely to increase enrollment in the groups. A sustainable way to do this is to add a local contribution that is packaged with the premium at the time of enrollment or renewal of the membership. SHU can take a lead in helping the group members appreciate this need, thereby making it easier for the leaders to justify its collection.

The current management fee of Ush 700 (USD $0.44) is included in the Ush 4,300 (USD $2.69) paid by every new member. This amount, however, is not sufficient to cover some of the more expensive operational needs of the leader. A bicycle (costing Ush 80,000 [USD $50]) per leader would assist them in mobilization and managing group activities by reducing travel time between different areas in the community.

Building on the Providers Network

Operating in a vast area from Nakasongola District to Nakaseke District requires a greater number of healthcare providers, to make the program attractive to actual and potential policyholders as well as more manageable. The three districts are served by only two healthcare institutions: Kiwoko Hospital and Bishop Asili Health Center. An enhanced network would assure potential policyholders of reduced costs and easier access to the healthcare.

SHU should explore ways to assess the standard of the existing clinics in these areas and the possibility of having them added to the network of providers. Networking with other organizations interested in increasing the network of health service providers in the country (e.g. World Vision) also could be beneficial.

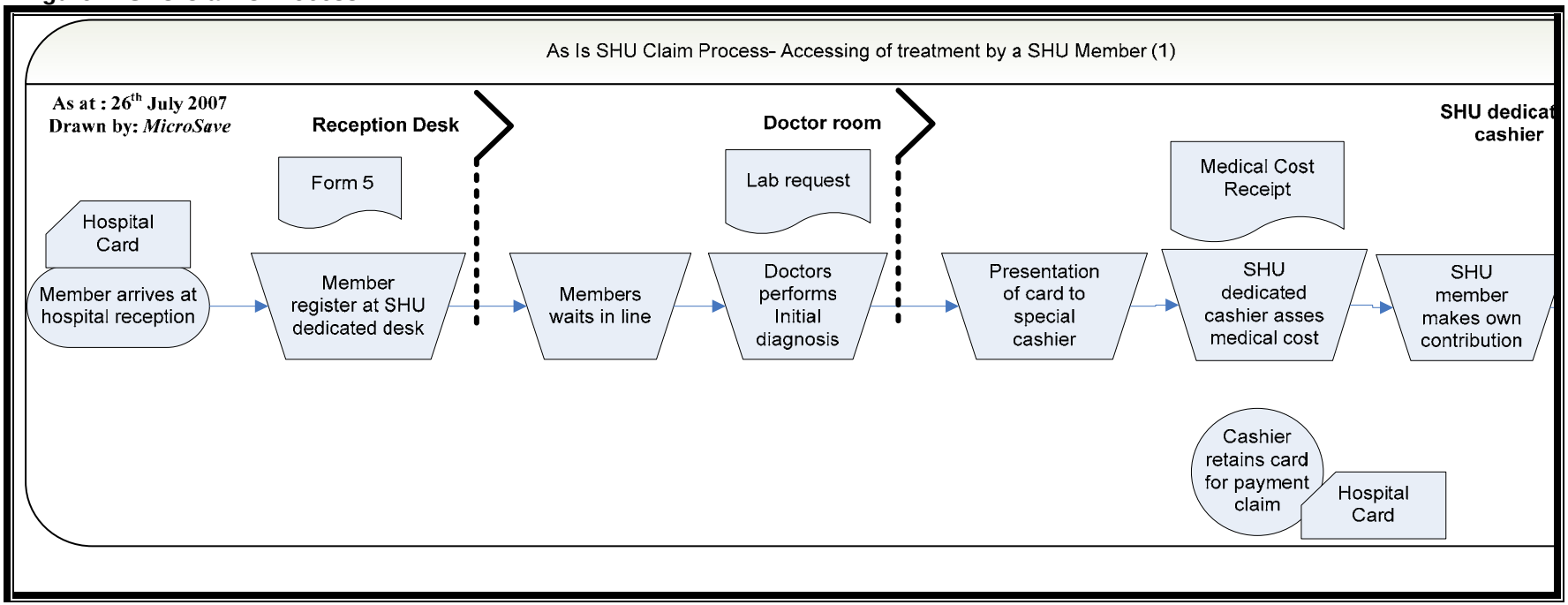
Capacity at Cashier's Desk

Members from the schemes wanting medical treatment have on some occasions been delayed if the specific cashier handling these cases is not available. SHU should consider the possibility of having someone permanently in this position to serve members, or alternatively, make arrangements to have another staff member step in when the one assigned to the case is absent. This change will increase the efficiency of service.

Reduced Premium

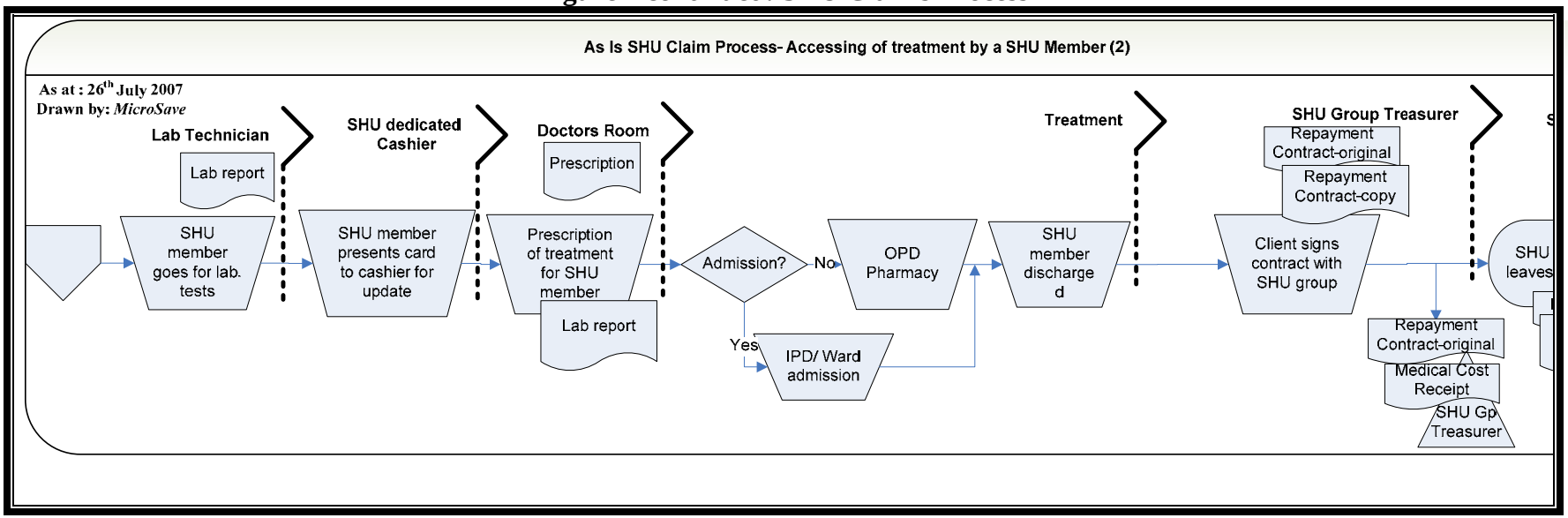
Several policyholders recommended that the premium be reduced from Ush. 4,100 (USD $2.56) per person to Ush. 4,000 (USD $2.50) per person.

Figure 1: SHU Claims Process



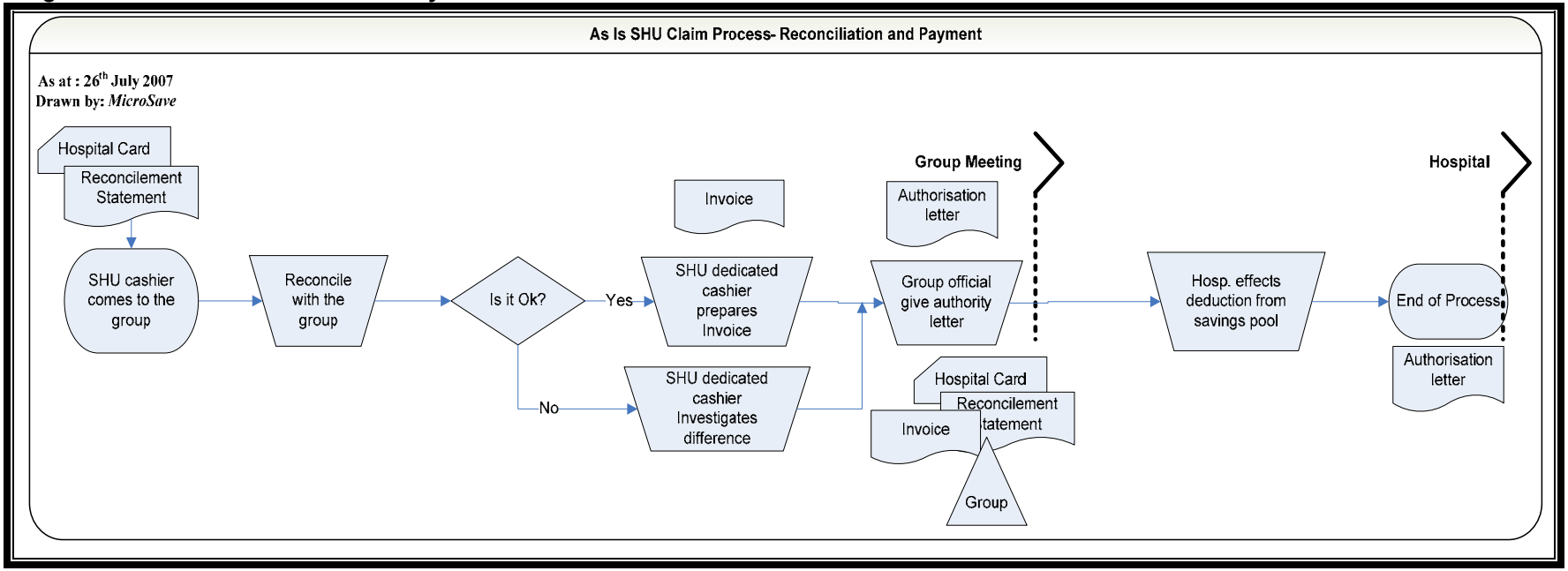
Process Description	• The client (SHU member) proceeds to hospital (Kiwoko) with their SHU card. • The SHU member presents their SHU card to the SHU dedicated desk officer. • Desk officer records the member's bio data details and fills in form 5. • Client is thereafter advised to go to see the doctor. **Process time: 1 – 20minutes**	• The SHU member queues to see the doctor. • Inside the doctor's office, the doctor investigates the illness of the member by inquiring about the symptoms. • The doctor may advise and request a laboratory test. • The doctor advises the SHU member to see the cashier to settle any payments. **Process time: 5minutes**	• The SHU member once again presents the SHU card to the cashier. • Cashier assesses the required amount for treatment-based drugs/tests advised by the doctor. • Details of the member on the card and hospital database are verified by cashier. • The SHU member makes initial payment of Ush 2,000 or Ush 5,000 (USD $1.25 or $3.13) as own contribution towards the treatment cost. • The cashier retains the SHU member's card. • The cashier advises member to go for laboratory tests if needed. **Process time: 10 – 60 minutes**

Figure 1 continued: SHU Claims Process



Process Description	• The SHU member proceeds to the laboratory for test. • A laboratory report is provided to the member for the doctor's final prescription. **Process time: 60 – 120 minutes**	• The cashier computes the entire treatment cost and updates the computer. **Process time: 5 – 10 minutes**	• The doctor carries out the final prescription with the help of the laboratory findings. • Doctor advises the SHU member to be admitted or go to OPD pharmacy for treatment and drugs. **Process time: 5 minutes**	• Depending on the members condition, she or he may be admitted (IPD). • OR may be sent to the OPD pharmacy for treatment and provision of the drugs. • The member leaves hospital with form 5 and medical cost receipt and takes it to the group treasurer. **Process time: 5 – 20minutes**	• The group member takes the receipt to the SHU group treasurer; a repayment agreement is signed between the treasurer and the member. • The contract specifies: o The amount of money to be paid to the group o Number of installments • The treasurer retains the original contract and the hospital medical cost receipt. • The member retains the contract copy, prescription. and form 5. **Process time: 20 – 30 minutes** **Possible delay of 1- 7 days for a member to go to the treasurer**

Figure 2: SHU Reconciliation and Payment Processes



Process Description	• The cashier proceeds to the group (village), where they carry out the monthly reconciliation using the cards retained, hospital treatment register, and group receipts provided by the members. • If all the transactions reconcile, then the cashier prepares the invoice for the group. • If it does not reconcile, the cashier is sent back for additional checking of entries. • If the group officials are satisfied with the reconciliation, the group prepares an authorization letter for the cashier. • The group is then given the invoice, hospital cards for the members, and the monthly reconciliation statement for their records and filing. **Process time: 1 month**	• At the hospital, the cashier (finance department) uses the authorization letter provided by the group officials to offset the entire monthly treatment cost for the group against the reserve amount being held by the hospital. **Process time: Not known to the respondents**

IV MICROCARE

Background on Microcare and its Services

Microcare Insurance Limited (Microcare) is a Ugandan insurance company that offers health insurance, health fund administration, and microinsurance products to facilitate access to quality healthcare for corporate employees and low-income groups. Microcare contracts with selected hospitals and clinics throughout Uganda for the provision of medical care to its policyholders.[7]

This study explored client satisfaction with Microcare's health microinsurance products targeted at the low-income informal-sector market. The products available to this market include Social Basic and Social Plus. They are part of a cashless system in which the healthcare providers bill Microcare directly. To be eligible, a household must belong to an association, such as the Makindye Community Association (see below).

In these plans, for a modest annual premium, insured persons can access a wide range of services at pre-agreed prices, from over 150 approved hospitals and clinics throughout Uganda. In Kampala, for example, Microcare works with reputable service providers like Case Medical Clinic, Savannah Sunrise Clinic, The Surgery, Louis Memorial, Kampala Family Clinic, and most of the hospitals in Kampala. Microcare also collaborates with key pharmacies around Kampala. Among these are Maria Assumpta Pharmacy and Friecca Pharmacy-Wandegeya, where policyholders can be referred for drugs that cannot be obtained in the hospitals or clinics.

Background on Makindye Community Association (MCA)

Participants in this study are members of the Makindye Community Association (MCA). This association encompasses a variety of interest groups including women's groups, youth groups, FINCA groups, and Microcare insurance groups. A member in the association can belong to any or all of these groups—e.g. policyholders in this study belonged to the microinsurance group as well as the women's group and FINCA microfinance groups. Membership in MCA requires payment of a membership fee (Ush 10,000 or USD $ 6.25) and the opening of an account with the MCA SACCO. The SACCO, where most of the microinsurance activities take place, is managed by a team of three people: the Manager, the Treasurer, and the Secretary.

Product Features

Eligibility and Application

As with SHU, Microcare's insurance policy is available to all households belonging to an association (such as MCA). At the moment, most Microcare policyholders in the MCA already belong to FINCA Uganda.

The following are needed to purchase Microcare insurance:

- Two passport photos for every person to be covered by the insurance.
- A completed Microcare application form.
- Payment of the premium.

Upon fulfillment of these requirements, Microcare issues a membership card for the family, which can be presented at any of the contracted healthcare providers for treatment. The current microinsurance membership is made up of both old and new policyholders who have participated in the program for an average of four years.

[7] Adapted from Microcare's website: www.microcare.co.ug

Coverage

Coverage extends for one year and is renewable in subsequent years. Most common diseases, such as malaria, cough, typhoid, etc, are covered under this insurance policy. Depending on the type of coverage purchased, the costs for diagnosis, drugs, and other services are met by the insurance cover up to a limit of Ush 3,000,000 (USD $1,875) per family under the Social Plus product or Ush 2,000,000 (USD $1,250) per family under the Social Basic product. High blood pressure is covered up to a limit of Ush 100,000 (USD $62.50). Consultation form fees are not covered.

Premiums

Social Basic and Social Plus each have a specific premium. The current premium of the Social Basic product is Ush 149,000 (USD $93.13) for the first four family members. Additional family members cost Ush 52,000 (USD $32.50) per adult and Ush 36,000 (USD $22.50) per child below 14 years. The table below shows the payments under the two types of policies:

Table 5: Premiums for Microcare Community Insurance Products

Category	Family Premium	Additional Adult	Additional Child
Social Plus	Ush 199,000 (USD $124.38)	Ush 72,000 (USD $45)	Ush 36,000 (USD $22.50
Social Basic	Ush 149,000 (USD $93.13)	Ush 52,000 (USD $32.50)	Ush 26,000 (USD $16.25)

Benefits

The table below summarizes the services and benefits available to Microcare policyholders:

Table 4: Benefits of Microcare Community Plans

TABLE OF BENEFITS – COMMUNITY PLANS	SOCIAL PLUS	SOCIAL BASIC
SECTION 'A': IN-PATIENT TREATMENT OVERALL LIMIT	USH 3,000,000 (USD $1,875) PER FAMILY	USH 2,000,000 (USD $1,250) PER FAMILY
Hospital accommodation	Bed Limit – USH 25,000 (USD $15.63) per night	Bed Limit – USH 15,000 (USD $9.38) per night
Physician's, Surgeon's, Consultant's & Anesthetist fees	Covered	Covered
Cost of prescribed medicines and dressings	Covered	Covered
X-rays, ECGs, CT Scans, Pathology, Diagnostic Tests, and Procedures	Covered	Covered
Radiotherapy and Chemotherapy	Not covered	Not covered
Surgery	Covered	Covered
Diagnostic consultations or Specialist's, Pathologist's fee;	Covered	Covered
Physiotherapist's fee	Not covered	Not covered
Maternity	Covered	Covered
Chronics (ulcers, diabetes, sickle cells, hypertension, asthma, etc) With drugs/medicine for one week.	Covered	Covered
SECTION 'B': OUT-PATIENT TREATMENT OVERALL LIMIT	UNLIMITED	UNLIMITED
Physician's, Surgeon's Consultant's, and Anesthetist's fees	Covered	Covered
Cost of prescribed medicines and dressings	Covered	Covered
X-rays, ECGs, CT Scans, Pathology, Diagnostic Tests, and Procedures	Covered	Covered
Radiotherapy and Chemotherapy	Not covered	Not covered
Outpatient Surgery	Covered	Covered
Emergency Road Ambulance within Uganda	Covered (Ush 75,000/USD $46.88)) @ Event	Not covered

TABLE OF BENEFITS – COMMUNITY PLANS	SOCIAL PLUS	SOCIAL BASIC
Hypertension	Up To Ush 100,000 (USD $62.50) PER FAMILY	Up To Ush 100,000 PER FAMILY
SECTION 'C': DENTAL TREATMENT LIMIT	Ush 50,000 (USD $ 31.25) PER PERSON	Ush 50,000 PER PERSON
Consultation & Treatment	Covered	Covered
Anesthetist's fee and Operating Theatre costs covering extractions and filling.	Covered	Covered
SECTION 'D': OPTICAL CONSULTATION	Covered	Covered
Premiums	SINGLES **Ush 110,000 (USD $68.75)**	SINGLES **Ush 99,000 (USD $61.88)**
	FAMILY PREMIUM **Ush 199,000 (USD $124.38)**	FAMILY PREMIUM **Ush 149,000 (USD $93.13)**
	ADDITIONAL ADULT **Ush 72,000 (USD $45)**	ADDITIONAL ADULT **Ush 52,000 (USD $32.50)**
	ADDITIONAL CHILD **Ush 36,000 (USD $22.50)**	ADDITIONAL CHILD **Ush 26,000 (USD $16.25)**
Extra Benefits	Two treated mosquito nets per family, at every enrollment and renewal. Net treatment tablets in the subsequent years.	

Note: Family is defined as head of household plus spouse plus two children.

Microcare has service agreements with over 150 health service providers in Uganda (government, private and mission hospitals, clinics, and pharmacies), enabling service delivery at pre-established prices. Policyholders are at liberty to consult any clinic within their scheme for outpatient and inpatient medical care without needing a referral from Microcare.

Microcare offers two additional benefits to its policyholders: 1) an ambulance is available in the event of an emergency; and 2) the plan provides two treated mosquito nets per family upon enrollment and upon renewal of the policy.

Claims Process

The claims process for Microcare starts when a policyholder visits any of the approved service providers. Members present their cards to the dedicated Microcare desk officer, who then enters the patient's information into the computer system and issues a receipt to proceed to the reception desk. The client pays the Microcare desk officer a fee of Ush 2,000 (USD $1.25) or Ush 3,000 (USD $1.88) for Consultation Form 5, which is given out at the reception desk. The patient can see the doctor once they receive the form.

After the patient has been seen, he/she returns to the reception desk, and the related itemized costs of drugs and treatment are assessed. The policyholder then goes to the Microcare desk to determine what costs are covered by Microcare. The client is instructed to go the reception desk to pay (in cash) for all items excluded from the insurance coverage.

The process map on pages 30-31 details the claims process for Microcare policyholders.

Group Management

Microcare staff visits the MCA group monthly to check on operations and brief members on new developments. The visit is also used to address outstanding problems that members have with the program and functions generally as an opportunity for Microcare to field complaints about the claims process.

Renewals

Renewal is done for the entire group at once, and it usually occurs at the end of the period of existing coverage. Different groups have different renewal dates, depending on the date they began coverage.

Profile of Sampled Microcare Policyholders

The policyholders who participated in the survey were predominantly female (36 out of 41). Many of the respondents were businesswomen, some were traders or vendors, a few were farmers, and only a handful reported that they were professionals. Collectively, this occupational data suggests that the Microcare survey respondents are better-off than the SHU survey participants. The Microcare group had an average of 3.8 years of experience in the insurance program, with a range of experience from seven years to four months. The participants and their household members were 291 people in total. Average household size was 7.5 people. A total of 183 people are covered by the Microcare insurance, indicating that an average of 4.6 members per household are beneficiaries. Only 31 percent of households had covered all members.

Relevancy of Insurance to Policyholders' Life

As was the case with the groups associated with SHU, the research team wanted to understand how the microinsurance product was relevant to Microcare policyholders.

Guaranteed Access to Medical Treatment

Average Ugandans rarely have a specific plan for healthcare—e.g. a savings account to take care of healthcare needs. It is common to see people struggle to raise funds whenever sickness hits a household. Uncertainty in cash availability is one of the reasons households are attracted to insurance, in that it provides confidence that they can cope with a health emergency without delay and without disrupting household finances. Without insurance, households often resort to coping strategies that are cumbersome and unreliable, leaving households more vulnerable than when they started.

Policyholders indicated that guaranteed treatment provides peace of mind. Work is not disrupted whenever a family member falls ill, and members can continue to work under no pressure. This arrangement has encouraged clients to seek early treatment, which is more effective and manageable than waiting until the sickness progresses and treatment costs increase. Under this arrangement, clients need either Ush 2,000 or Ush 4,000 (USD $1.25 or $2.50) for a medical form, which they can afford. More importantly perhaps, with health insurance, patients can receive full and complete treatment. Without insurance, patients have a tendency to discontinue care when they start to feel some relief, even if they are not better, to forestall expenses.

Additionally, people in the community have realized that healthcare costs are lower for people with insurance than for those without, even for the same level of treatment and care. Policyholders pointed out that the cost of the premium is less than the cost of treatment in cases when major illness strikes. They feel that they put a little money in but they gain considerably in the form of treatment.

Variety of Healthcare Providers

Microcare has selected hospitals like Rubaga, Kibuli, Nsambya, Kampala International Hospital, etc., which are known for their quality of service; clients perceive this as a great benefit. Additional providers have been contracted by Microcare, including clinics and health centers. This combination of providers gives clients a wide range of options and geographical coverage, bringing services close to many clients while minimizing transport costs. Many of the high-quality service options could not have been accessed if clients needed to pay cash on each of the visits. Additionally, policyholders are able to use select pharmacies for prescription drugs.

Coverage

The microinsurance policy allows coverage beyond a nuclear family of four people. Clients view such flexibility as responsive to the needs of many Ugandan families, characterized by

the inclusion of extended family members. This gives members an opportunity to cover as many people in the family as they can afford to include.

Associated Benefits

Microcare provides two treated mosquito nets per family upon enrollment and upon renewal of the policy. Clients see this as a positive gesture in trying to prevent what is a big problem for most households—malaria inflections. As a result, households save both in terms of not having to purchase mosquito nets and in terms of reducing the incidence of malaria in their families.

Social Status

Microcare policyholders also report additional social status and social privileges as a result of their enrollment. "It is prestigious to hold a Microcare identity card" explained one client. Members are able to access services in prestigious medical facilities like Kibuli and Kampala International Hospital—services rarely accessed by people from the low-end market. Moreover, clients use the card as a form of identification in banks and other formal contexts where identification is required. These effects have been noted by the community, and most agree that enrollment creates an enhanced social status for policyholders.

Knowledge and Understanding of the Insurance Product

In 2001, FINCA Uganda introduced Microcare staff to members of FINCA's village banking groups; Microcare, in turn, introduced the product concept to these groups. The sessions covered several topics:

- Diseases and their effects on households.
- How to prevent certain diseases (malaria, typhoid, HIV/AIDS).
- What insurance and insurance benefits are, and how one subscribes to the scheme.
- How Microcare health insurance works and the process of getting treatment.
- Where to obtain treatment (hospitals/clinics).
- Requirements for accessing the insurance product.

Respondents felt that the information provided by Microcare during these sessions was sufficient to enable them to make informed choices.

Product Knowledge

The Microcare promotional materials include a level of detail intended to make the policy easier to comprehend. This understanding, however, is not borne out among many policyholders. New policyholders had some misunderstandings about the premium, although the majority knew the required payment. Most did not have a good understanding of the coverage and exclusions to the insurance product. Most respondents thought that chronic diseases like ulcers, diabetes, and hypertension were not covered at all—in fact, these conditions are partially covered by the policy. The group leaders, on the other hand, had a much better understanding of the product.

Some respondents noted that many policyholders get information about insurance exclusions during the claims process at hospitals.

Understanding of Insurance

Although many respondents did not have a solid grasp of some features of the product, they seemed to understand the concept of insurance. During the Microcare information sessions, those in attendance readily understood that with this health insurance policy they would receive guaranteed medical treatment at any time, even if they did not have money. This was seen as a big advantage over having to seek out money in times of sickness. Unlike many members of SHU program, who still feel that annual subscriptions are not justifiable if one

does not fall sick, most people in the Microcare group had no problem with this premise. As a result, many continue to renew their membership, and many more are joining the scheme.

Client Satisfaction with the Product

Coverage

Policyholders were satisfied that the insurance covered all family members and that the policy was for one year. They were less satisfied with the medical conditions covered by the insurance. Policyholders felt that the Microcare policy excludes some diseases that current policyholders suffer from in their old age—ailments such as asthma, diabetes, and backaches. Policyholders also disliked that some types of vitamins and medicine (e.g. diabetes and blood pressure treatments) are excluded. Policyholders were sometimes misinformed, however, about what the policy excludes. Some respondents erroneously reported that chronic conditions like asthma and diabetes are not covered, when in fact they are (although limits such as Ush 100,000 for high blood pressure treatment sometimes apply).

Other complaints included the Consultation Form Fees of Ush 2,000 or Ush 4,000 (USD $1.25 or $2.50), depending on the hospital used, which serve as a co-pay; these are considered an unfair and undue burden by policyholders. At the same time, policyholders reported that they can afford these fees.

Premium Costs/Affordability

The current premium of Ush 149,000 (USD $93.13) for the first four family members can be difficult for policyholders to afford. There are many conflicting demands for money, and household heads must prioritize, e.g. school fees or health insurance. This strain on limited resources has caused some people to drop out of the scheme. In spite of these tradeoffs, most people have come to realize the importance of healthcare and the need to prepare for it. People seem to recognize the value of the insurance as well.

Cost of the Members' Card

A card must be replaced after loss or changes in a household's enrollment. Some respondents complained that they had to get new cards even without loss or changes in enrollment. In all these cases, the new card costs Ush 10,000 (USD $6.25), which policyholders feel is rather expensive; they suggest the replacement fee be reduced to Ush 4,000 (USD $2.50).

Benefits

Policyholders are pleased with what they consider to be "very good" payouts. The benefit amount has exceeded policyholders' expectations. One respondent recounted this positive claims experience: "My father was admitted in Rubaga hospital, although he died, the bill was Ush 1,200,000 (USD $750). All the relatives were worried where we were going to get that amount to pay the hospital bills before the body could be taken for burial. Everyone was shocked when I told them that it has already been paid!"

Client Satisfaction with Processes

The below sections summarize client responses in each process area; note that client's views have been triangulated with responses from healthcare providers and Microcare.

Marketing & Education

As mentioned above, Microcare first introduced and marketed the insurance product to the members of the MCA association in 2001. Policyholders who received the product education from Microcare were satisfied with it and felt it was sufficient to make a decision about the product. Recently, however, Microcare has reduced its role in direct marketing efforts, leaving the responsibility of marketing to affiliated groups and policyholders. According to policyholders, the role of Microcare staff is now limited to passing on information about new

products or changes in the program during their monthly visits to the groups. The Microcare marketing officer also will visit the group when invited to market the product.

Given Microcare's minimal marketing efforts, recruitment is now driven primarily by word-of-mouth marketing on the part of satisfied policyholders and SACCO leaders. This is apparently succeeding, as there are about 1,000 policyholders who joined on the recommendation of the first group.

The message about the Microcare program is getting out in other ways as well. Respondents reported that the community mobilizer informs people about the product, its benefits, and how it can be accessed during community gatherings. Information is also shared at MCA forums that raise health awareness in the communities. Many members have recently joined the scheme as a result of these activities.

There are limited print marketing materials. These include photocopied product brochures that can be accessed at the SACCO office. Previously, they were given directly to both new and old policyholders, but not anymore.

There is a strong feeling that, although the groups are doing well, they need additional support from Microcare. The policyholders want more information about the product, particularly on the claims processes and exclusions. Microcare support could entail strengthening the capacity of the groups with training on product conditions and/or provision of training materials like brochures or flyers. Respondents noted that Microcare needs to send officers who know the local language and understand the dynamics of the local community.

The hope is that product education will reduce the variation in product knowledge among policyholders and assure consistency in the messages intended for the public. Additionally, policyholders expressed a wish for Microcare to market to the wider community, so that more people can benefit from the insurance.

Application

Members are pleased with the application process because it is short and hassle-free. However, some clients report problems acquiring the membership card. Some members have been without cards for six months, and this poses a major problem when they try to obtain medical treatment. When the patient does not have a card, a manual search of the records must be performed, which means more delays. Although a hotline number has been given members for help in such situations, there are still problems such as airtime costs and additional delays.

Payment of Premiums

The FGDs revealed that policyholders raise the premium payments in a variety of ways:

- Daily savings at home until the installment amount is raised.
- Loans from FINCA.
- Drawing cash from business operations.
- Savings with the SACCO, followed by transfer of the full premium when it is needed.

FINCA, a Ugandan MFI, extends loans to Microcare policyholders who are not able to raise required premiums at the time of registration or renewal. This loan is paid back over the following four months. These loans are paid back to FINCA in the same manner as their business loans.

The option of saving with the SACCO was praised by the respondents. Using this account, members have found it easy to accumulate savings with which to pay premiums. The practice helps avoid last-minute withdrawals from businesses and helps keep money away from the home, where it is subject to impulse spending. It is important to note that this practice is limited to the MCA group, because they are the only association operating their own SACCO.

Premium payments are collected from the policyholders and banked in a Microcare account at Standard Bank. This method of paying premiums is considered safe because there is no

middleman involved. Having been in the group for a long time, the policyholders know each other well, and they trust transactions in the SACCO. By banking the money, they have proof (e.g. the banking slip) that the money was paid into a Microcare account.

Claims Process

The claims process was the least liked aspect of the Microcare insurance.

Clients described a need for recurring education on claims, as people tend to forget the process over time. At present, there is no formal guidance for policyholders on this process, other than that provided in the initial training. In practice, the ease of use of the health insurance depends on the hospital or healthcare provider that the policyholder visits. Some of the hospitals have a dedicated Microcare desk to guide policyholders through the claims process. Kibuli Hospital, for example, has an officer who understands the Microcare scheme and serves policyholders well.

The paperwork involved in using a hospital is minimal. Most hospitals maintain computerized data bases that make it easy to identify the policyholders based on their membership smart cards (i.e., containing biometric data to identify the cardholder). Policyholders appreciate the convenience of this arrangement. One respondent remarked, "...you don't need to be educated to go through the process." However, the same membership card is shared by all members of the family, which can create logistical difficulties. Respondents suggested that each individual in a family should have their own cards. Receiving service without a card is always problematic. Sometimes staff at the reception desk are not willing to serve policyholders without cards. It is possible but cumbersome to retrieve members' personal details manually without the cards.

Respondents with claims experience commented on the low level of customer service at some hospitals. According to one focus group, frustrated Microcare desk officers vent their anger on misinformed or uninformed patients, and vice versa. For example, a policyholder may go to a hospital under the assumption that Microcare covers all illnesses, only to be told that his/her particular illness is excluded from the policy. A conflict then ensues between the desk officer and the patient.

The claims process is complicated if the patient is treated at night, when the Microcare staff are not on duty. In these cases, which are usually emergencies, the patient has to pay in cash.

The hospital treatment phase generated dissatisfaction as well. Treatment can take varying amounts of time, often related to the claims process. Kisubi Hospital, for example, is relatively fact, though there is no Microcare desk and patients must call the Microcare head office in order to receive clearance (up to a 30-minute delay). Unclear processes at Rubaga and Nsambya hospitals can contribute to delays in treatment. Sometimes treatment processes are just cumbersome. In one hospital, the Microcare desk, the cashier, the laboratory, the doctor's room and the pharmacy are all far apart, and patients have to move around these places for the entire treatment period. Explained one respondent: "By the time you leave the hospital you are feeling worse than when you came in." The time taken for treatment also depends on the length of the queue and the time taken for laboratory tests. Some policyholders reported that Microcare patients are delayed treatment so priority can be given to patients with cash.

(The process map on pages 30-31 details the claims process for Microcare policyholders.)

Renewal Process

Most respondents have been in the program for some years and are well-versed in the renewal process. New members are guided through the process by the old members, Microcare marketing officers, and/or community officials.

Renewal is done for the entire group, and it usually occurs at the end of the period of existing coverage (which depends on when coverage began). In preparation for the renewal date, most MCA members start saving their money with the SACCO, putting aside small amounts

to accumulate the required lump sum. For others, FINCA loans are used to meet the renewal deadline and avoid interruption in coverage.

Those respondents with claims experience indicated that they would certainly renew their membership and will encourage others who do not know Microcare to sign up for the scheme. "The benefits are great ...we cannot afford not to renew our membership" said one member. Some families that did not submit a claim during the course of the year consider renewal of the policy to be a burden; they believe that those policyholders who did not have any claims should renew at a lower premium. Even these policy members, however, indicated that they would renew their policies and will encourage others unfamiliar with Microcare to sign up for the scheme.

Policyholder Recommendations for Improving the Insurance

Educate Policyholders

Policyholders feel that there is need for recurring product orientation. Although diseases like diabetes, high blood pressure, and asthma are partially covered under the Microcare policy, many respondents thought they were excluded and suggested that coverage be extended to these conditions. There needs to be clear communication about the policy coverage to policyholders to help them understand and seek medical treatment to which they are entitled. Respondents also requested additional guidance regarding the claims process, as people tend to forget the protocol over time.

Card Processing Time

Microcare should investigate and remedy the causes for the delays in card issuance. Additionally, policyholders asked if the cost for replacement cards could be waived.

Additional Coverage

Policyholders would like to see better dental coverage. In light of the large family sizes, they would also like to receive five treated mosquito nets per year rather than two.

Expansion of Program

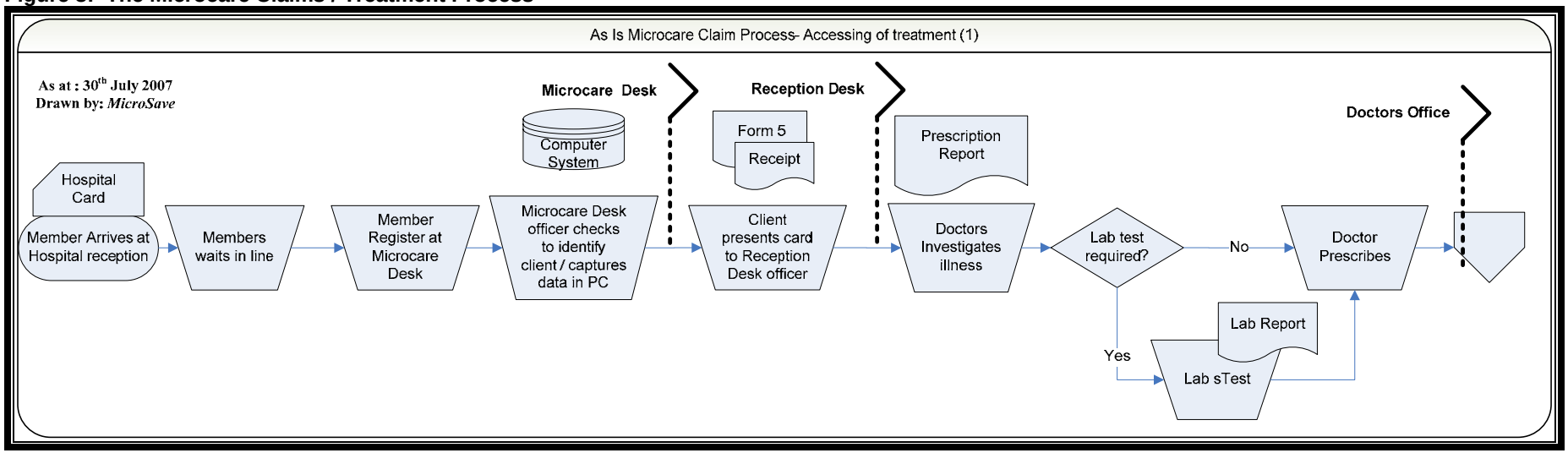
Policyholders requested that Microcare increase the number of hospitals in their network, particularly in up-country locations. Respondents said that they would like to include their relatives at these locations in the insurance coverage.

Working Together with Group Leaders

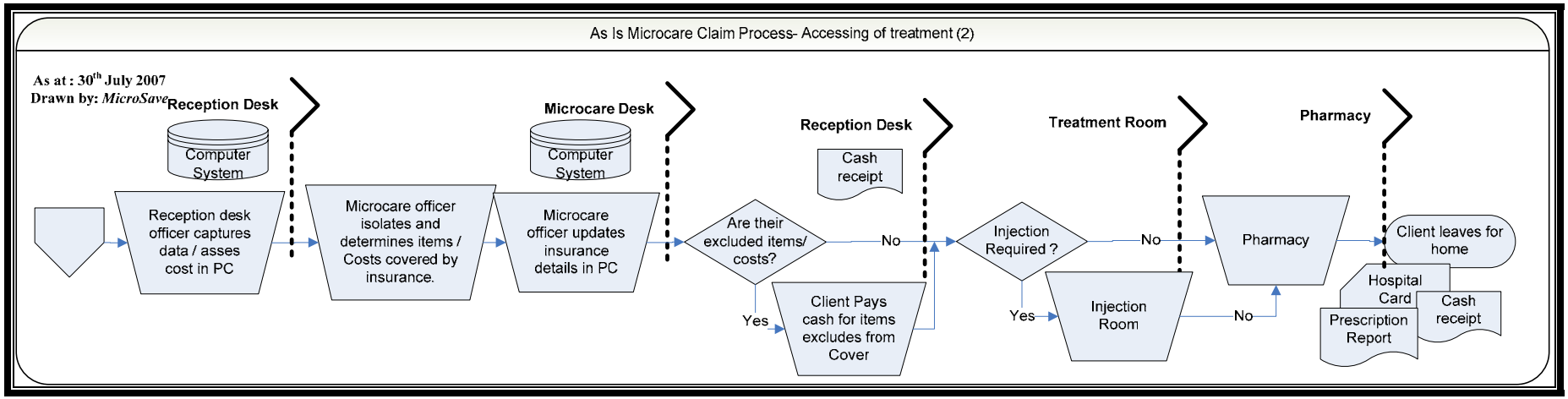
In order to improve sales, the Microcare staff should work together with the community members/officials to increase insurance awareness. At the same time, they should help to increase product knowledge among policyholders, especially on the processes and exclusions.

Policyholders understand the Microcare staff may not have time to visit every group. They suggested that Microcare provide a training of trainers (ToT) course to the group officials, who would in turn train their members/policyholders. This system potentially would reduce Microcare's operational costs, while increasing the product knowledge among the policyholders.

Figure 3: The Microcare Claims / Treatment Process



Process Description	**Microcare Desk** • On arrival in the hospital, the client proceeds to the Microcare help desk. • Client presents and hands over a card to desk officer for purposes of identification, using the computer data. • In case the client has not yet received the insurance card, he or she provides personal details that may include name, group name, head of group, date of entry, to help the desk officer to locate and identify him/her in the system as a policy holder. **Process time:3 – 20 minutes**	**Microcare Desk** • The Microcare desk officer captures his/her details in the computer and gives him/her a receipt to proceed to the reception desk. • The client pays the Ush 2,000 (USD $1.25) or Ush 3,000 (USD $1.88) for the form 5. A cash receipt is given. **Process time: 2 – 3 minutes**	**Reception Desk** • The client presents the receipt to the reception desk officer *(this receipt substitutes for the cash receipt for ordinary policyholder/ patients).* • The reception desk officer then provides a letter (form 5) to the client. • The client is advised to go and see the doctor. **Process time:2 – 15 minutes**	**Doctor's Office.** • The doctor carries out clinical investigations on the client. • The doctor writes the treatment prescription for the client and sends the client to the reception desk to determine cost of treatment prescribed. • The doctor may advise that the client be admitted. **Laboratory** (*If Laboratory tests are required)* • The client is given a laboratory test request form, and then directed to the laboratory technician for tests. • The client provides materials or is subjected to laboratory tests. • The lab technician provides laboratory report to the client and sends him/her back to the doctor for final prescription. **Process time: 4-10 minutes with doctor and 10 – 30 minutes at the lab**



Process Description	**Reception Desk**	**Microcare desk**	**Reception Desk**	**Treatment Room**	**Pharmacy Window.**
	• The client presents the prescription to the reception desk officer. • The reception desk officer enters the following data into the computer: details of illness, drugs required. • The related itemized costs of drugs and treatment are assessed and determined. **Process time: 5 minutes**	• The client goes to the Microcare desk to determine which costs are covered by Microcare. • The information and data concerning costs is entered into the computer. • The client is instructed to go the reception desk to pay for all items that are excluded from the insurance coverage. **Process time:4 – 10 minutes**	• The client makes cash payment for items or costs that are excluded from the insurance coverage. A cash receipt is provided. • The client is directed to a treatment room for injection and/or pharmacy for drugs. **Process time: 5 minutes**	• Client presents the prescription form to the nurse. • The nurse injects the client and instructs the client to go the pharmacy if there are other drugs to collect. **Process time:4 – 10 minutes**	• The client receives all the drugs. • If some drugs are not available, the client is referred to an outside pharmacy (e.g. Nsambya refers them to Maria Assumpta Pharmacy). **Process time: 5 minutes**

SUMMARY OF FINDINGS

Save for Health Uganda

General Satisfaction

Save for Health policyholders are reasonably satisfied with the program. Participants in the survey recommend the insurance to people they know. Most reported that they will renew their policies next year. As one client put it: "You have to eat salt even if its price is increased" meaning that now that they have experienced the benefits of insurance, they cannot give it up even if there are increases in the premium.

Appropriateness

Health risks are one of the most common risks facing households in Uganda, where debilitating illnesses such as malaria are common. Costs of treatment can range from Ush 50,000 to Ush 70,000 (USD $31.25 to $43.75). Thus there is significant need for mechanisms to reduce risks stemming from healthcare costs. For policyholders, membership in SHU provides easy access to high-quality healthcare and good customer service. It helps them to avoid stressful coping mechanisms such as selling household assets. They have also gained peace of mind.

Product Coverage

In general, policyholders are well-covered, with some exceptions. The viability of the SHU scheme requires that the insurance component be capped at Ush 100,000 (USD $62.50), and patients with chronic illnesses or expensive medical conditions must pay any expenses above this limit out of their pocket. Some clients felt that coverage should be extended beyond this limit, particularly for the elderly suffering from chronic disease.

Accessibility/Affordability

Though some clients felt the premiums are high, most SHU policyholders find it more affordable to pay the annual premiums and finance their heathcare with a SHU credit or insurance than to pay large lump sums for medical treatment. Respondents appreciated that they are now able to access good-quality healthcare without worrying about the sudden costs.

Timeliness

The insurance allows policyholders to access healthcare in a timely way. As a result, patients do not wait until their condition worsens. This means that patients can have better health outcomes and incur lower costs. One area of dissatisfaction here is the policyholder membership card. Cumbersome processes surrounding the membership card can delay treatment. There was also some discussion of delays caused by absent staff at the hospitals.

Microcare

General Satisfaction

The Microcare policyholders are very satisfied with the health insurance product. The benefits of the product have exceeded the expectations of most who have used it. The processes associated with applying for, paying for, and renewing policies are considered satisfactory by most clients.

Appropriateness

The insurance provides the policyholder access to high-quality and convenient healthcare providers. Risks due to ill health and associated medical expenses are consistently ranked among the highest facing low-income groups. This product was considered very relevant for the policyholders.

Product Coverage

The policyholders value being able to cover a large number of family members. The insurance covers illnesses that occur frequently such as malaria, typhoid, and diarrhea. Policyholders have a poor understanding of the conditions that are not covered by the insurance. They said they would like to see more coverage of chronic conditions that affect older people, such as diabetes.

Accessibility/Affordability

Policyholders evaluate affordability in comparison to experiences with the ordinary way of dealing with sickness, where lump sums are required immediately. Though some felt the premiums are high, most considered them affordable compared to the amount of money otherwise spent on hospital bills by families. Respondents acknowledged that the amount of money spent by Microcare on their hospital bill as of now exceeds their premium contribution.

Clients liked the various options for those who have difficulty coming up with the premium amount all at once, e.g. savings accounts facilitated by the MCA SACCO or loans from FINCA.

Timeliness

As a cashless insurance product, the Microcare Health Insurance policy allows policyholders to access healthcare when they need it. The claims process takes place in the hospital starting at admittance. Some problematic aspects of timeliness include delay in receipt of membership cards, which makes access to care difficult for policyholders at some hospitals, and cumbersome treatment processes at certain hospitals. Clients generally felt that stronger product knowledge, especially on claims processing, would help reduce the time expended at some hospitals.

SUMMARY RECOMMENDATIONS[8]

Save For Health Uganda

New Enrollment

SHU groups should establish mechanisms for admitting new members throughout the year, as long as they are ready to abide by the rules governing the scheme. A suggestion discussed with group members involved a window period of one month before a new member starts accessing services. This will eliminate possibilities of new members registering after identifying a need for treatment. The current practice stops admitting new members to the scheme in March and opens again in October, to eliminate the possibility of a new member registering after identifying a need for treatment.

Support to Group Leaders

Group leaders are doing a commendable job in mobilization and client education on the benefits of insurance. Facilitation of the group officials with transport (e.g. bicycles) and any other form of incentives to help them effectively manage and mobilize people for the scheme is likely to increase enrollment in the groups. A sustainable way to do this would be to solicit for a local contribution that is packaged with the premium at the time of enrollment or renewal of the membership. SHU can take a lead in explaining this fee to group members, making it easier for the leaders to justify collection.

The current management fee of Ush 700 (USD $0.44) is included in the Ush 4,300 (USD $2.69) paid by every new member; however, this is not sufficient to cover some of the more expensive operational needs of the executives. A bicycle (costing Ush 80,000 [USD $50]) per executive member would assist them in mobilization and managing group activities, because they will be able to reduce time traveling between different areas in the community.

Client Education

Client education is as necessary now as it was in the beginning of the program; the whole concept of insurance is still complex for many people and only continuous education will improve their understanding. A well-crafted curriculum will outline key topics such as:

- Diseases and their effects on household productivity.
- Current coping mechanisms and their limitations.
- The importance of seeking early medical treatment.
- Costs of accessing good healthcare.
- Possible ways of raising money to cover these costs.
- Introduction to health insurance and how it works.
- How savings over time can help raise the required lump sums.
- Places where people can receive good healthcare.

Many people are joining groups on the basis of encouraging testimonies from existing program members; as a result, new members are beginning with secondhand, incomplete information. They too need to understand how the whole system works. Such knowledge in turn will enable them to pass on consistent messages to the market—a major boost to marketing the product in these communities.

Increasing the Providers Network

Operating in a vast area from Nakasongola to Nakaseke requires a greater number of healthcare providers to make the program attractive to current and potential policyholders. The three districts are served by only two healthcare institutions: Kiwoko Hospital and Bishop Asili Health Center. SHU should explore ways to assess the standard of the existing

[8] This section synthesizes policyholder recommendation with researchers' own observations.

clinics in these areas and consider adding them to the network of providers. Networking with other organizations interested in increasing the network of health-service providers in the country (e.g. World Vision) also could be beneficial. The increased network will assure policyholders of reduced costs and easy access to these institutions.

Capacity at Cashier's Desk

Members wanting medical treatment have on some occasions been delayed because the specific cashier handling these cases has not been available. SHU should consider having someone permanently in this position to serve members, or make arrangements to have a staff member step in whenever the appointed staff member is absent. This will speed up the delivery of services.

Microcare

Educate Policyholders on Coverage

Although diseases like diabetes, high blood pressure, and asthma are partially covered under the Microcare policy, policyholders mistakenly thought they were excluded. There needs to be some communication about this coverage to policyholders to help them understand and seek medical treatment to which they are entitled. Education such as also will serve as a marketing opportunity, letting policyholders know that Microcare is an institution responsive to their needs.

Given the widespread expressed desire for more instruction, financial education can be used as a marketing opportunity to show policyholders that Microcare is responsive to their needs. The education can be coupled with periodic market research, which may be necessary to find out if changes are needed in the policy e.g. increasing the premiums to raise the level of coverage.

Cost of the Members' Card

A card replacement fee is incurred for lost cards and cards that require changes. Some respondents also claimed that they were required to replace their cards for no apparent reason. In all these cases, the new card costs Ush 10,000 (USD $6.25), which policyholders feel is rather expensive; they suggest the replacement fee be reduced to Ush 4,000 (USD $2.50). Microcare should review the cost of producing these cards and define circumstances under which new cards need to be issued. This should help to justify the cost to policyholders/members.

Card Processing Time

For policyholders to access medical services, they must be issued a membership card for identification and treatment. Yet policyholders complain that it can take up to six months to be issued a card. Policyholders stated that access to services without the membership card is difficult and time-consuming. Microcare should investigate and remedy the causes for the delays in card issuance.

Working Together with Group Leaders

In order to improve sales, the Microcare staff should work together with the community members/officials to increase market awareness. They should help to increase product knowledge especially on the processes and exclusions. If Microcare staff find it very difficult to attend to all the groups, they could provide a training of trainers (ToT) course to the group officials, who would in turn train their members/policyholders. This potentially would reduce Microcare's operational costs while increasing product knowledge among the policyholders.

Additional Note: Process Mapping

Both providers should work with hospitals to process-map the key claims processes in detail. This exercise will inform the insurers and the heath-service providers of problem areas and processes that do not add value. It also will provide an assessment of risk at any of these points and suggest mitigation strategies. At the same time, the exercise will help hospitals develop clear standard processes that can be easily communicated to policyholders. All of these are in the interest of enhancing efficiency in service delivery.

CONCLUSIONS

Understanding of the Insurance Concept

Health insurance in Uganda is a new phenomenon that even well-educated Ugandans struggle to comprehend. Insurance is usually perceived to cover motor vehicles, fire, accident, and death. During the FGDs the explanation of insurance as a protection against future loss was well-received.

For the most part, understanding of insurance in Uganda is poor and uptake has met with much resistance. To many Ugandans, insurance represents nothing less than gambling. Perceptions have been influenced by previous negative experiences with insurance, especially in the claims process. It is often during the claims process that policyholders are made aware of the exclusions that should have been explained before buying the policy. This situation is exacerbated by the fact that sellers of policies are more focused on bringing in commission income than communicating pertinent issues to policyholders. Salesman often only market the benefits of insurance to potential policyholders, failing to educate people on the "how" of the insurance.

Insurance providers have not been explicit enough on the benefits, terms, and conditions of their policies and, consequently, they have negatively influenced public perceptions. During the research it was clear that many participants in the schemes failed to understand the insurance concept well.

Moreover, it is not easy for someone who has not had a successful claim to appreciate the benefits of insurance. Many members question why they should renew their policies every year when the year has ended without claims being presented. The concept of pooling of risks is not well-understood.

Clearly much work remains in developing a comprehensive client education program. A comprehensive program would address both the general concepts (insurance and risk pooling) and product orientation, to provide specific detailed information on product terms, benefits, claims process, exclusions, etc.

Research showed that people are beginning to appreciate the importance of insurance (or at least health insurance) and how it works. The medical bills that individuals could not generally afford can now be met with ease. More and more individuals are seeking early treatment, as opposed to waiting and/or self-treatment, and this favorable trend is likely to be advanced with continued success and growth of these insurance programs.

Toward a Client Satisfaction Protocol

In many ways, this research can be viewed as an experiment. It employed newly-developed tools and took place over a short period of time with a limited budget. Methodologically, many lessons were gleaned from this project. For example, future investigations will likely include additional examination of the supply-side perspective of insurance provision, for further complement of client commentaries. This experience also showed the value of process-mapping, a tool introduced by the consultants on the project and shown to be highly demonstrative.

As noted in the introduction, this project is but an initial step in a long-term project by Microfinance Opportunities and its partner agencies to develop a standardized protocol for measuring client satisfaction with microinsurance. The intent is to shed a consistent light on the oft-overlooked client perspective on microinsurance. Our goal is to ask clients what they want and need rather than to presume, and to make explicit links between client perspectives and product development. In this way, we hope to encourage sound program development and a bright future for microinsurance as a poverty alleviation and risk-management intervention.

ANNEX 1: RESEARCH TOOLS AND AREAS OF INVESTIGATION

Tool	Key Areas of Research	Rationale
Focus Group Discussion Guide 1	Relative importance, policyholders' understanding of the insurance product and its affordability	This tool provides a detailed analysis of selected products offered by the micro – insurance provider. The tool provides an understanding of what policyholders actually know about the product and what they understand about its individual components. The components include product name, group or individual product, term, eligibility requirements, renewal requirements, voluntary or compulsory, product coverage (benefits), premium collection method, key exclusions, price – premiums, price – co-payments and deductibles, price – other fees)
Focus Group Discussion Guide 2	Information and knowledge provided	To understand how policyholders learned about the insurance product/group scheme, the type of information received about the product or group scheme before deciding to take the product or join the group, necessary requirements to join and satisfaction with the information given
Focus Group Discussion Guide 3	Claim process	To assess policyholders' knowledge of the claim process; the key steps involved, advice and guidance provided and their satisfaction levels at each point in this process
In-depth Individual Interview Guide	Structure, organization and management of the program	This tool was used to solicit information from; Healthcare providers Group leaders It was used to obtain a detailed explanation of the program / scheme, costs, the claim process, the benefits to the community and the providers, satisfaction levels, challenges and suggestions for improvement

ANNEX 2: ANALYSES MATRICES

	Scheme	Tool	Gender		# of respondents	# people in HH	# of People insured in HH	How Long in Insurance (years).							
			Male	Female				1month -1 year	2	3	4	5	6	7	> 7
1	Save for Health	Tool # 1	0	4	4	37	31								4
		Tool #2	4	0	4	30	29								4
		Tool #3	0	6	6	49	40	0	2	4					
		Tool #1	6	0	6	46	36	3	1	1	1				
		Tool #2	0	6	6	34	27	4	2						
		Tool #3	0	6	6	31	26	1	1	3	1				
2	Microcare	Tool #1	0	6	6	41	35								6
		Tool #2	0	6	6	29	12	1	3	2					
		Tool #3	4	2	6	51	23	5		1					
		Tool #1	0	8	8	67	42				1	7			
		Tool #2	0	6	6	30	22				6				
		Tool #3	1	6	7	72	49		3		1		1	1	1
3	Microcare (Test groups)	Tool #1 (Test gp)	0	5	5	36	34						5		
		Tool #2 (Test gp)	0	6	6	58	43					3	3		
Totals			15	67	82	611	499	14	12	11	10	10	9	1	15

ANNEX 3: GENERAL RESEARCH SCHEDULE

Date	Time	Type of Activity	
Monday 23rd July 2007	7.00AM - 4.00 PM	Visit to SHU, Luwero (Henry Sempangi, Peter Mukwana and Ana Klincic).	
Tuesday 24th July 2007	11:00 – 5:00 PM	Insurance Training – By Ana Klincic	
Wednesday 25th July 2007	10.30 – 12.30 PM	**Team 1** Pre-testing of Tool #1: Exploring Relative Importance of Insurance Products in One's Life and Policyholders' Understanding of Insurance Products and their Affordability	**Team 2** Pre- Testing Tool # 2: Exploring Requirements for Taking an Insurance Product and Client Satisfaction with Information and Knowledge Provided
Wednesday 25th July 2007		Reviewing Pre-tested guides	Reviewing Pre-tested guides
Thursday 26th July 2007	8.30 – 10.00 AM	In-depth interview with Savings for Health Group leaders	In-depth interview with Health Service Provider
	10.30 – 12.00 AM	**Team 1** FGD # 1: Pre-testing of Tool #1: Exploring Relative Importance of Insurance Products in One's Life and Policyholders' Understanding of Insurance Products and their Affordability	**Team 2** FGD # 2: Pre-testing of FGD #1 tool: Exploring Relative Importance of Insurance Products in One's Life and Policyholders' Understanding of Insurance Products and their Affordability
	12.30 – 2.00 PM	**Team 1** FGD# 3: Exploring Requirements for Taking an Insurance Product and Client Satisfaction with Information and Knowledge Provided	**Team 2** FGD# 4: Exploring Requirements for Taking an Insurance Product and Client Satisfaction with Information and Knowledge Provided
	2.30 – 4.30 PM	**Team 1** FGD# 5: Exploring Client Satisfaction with Claims process	**Team 2** FGD# 6: Exploring Client Satisfaction with Claim Process
Friday 27th July 2007	8.00 AM- 1:00 PM	Notes	Notes
	2.00 – 5.00 PM	Notes	Notes
Saturday 28th July 2007	8.00 AM- 1:00 PM	FGD Analysis	FGD Analysis
	2.00 – 5.00 PM	FGD Analysis	FGD Analysis
Sunday 29th July 2007			
	10.30 – 12.00 AM	**Team 1** FGD # 7: Exploring Relative Importance of Insurance	**Team 2** FGD # 8: Exploring Relative Importance of Insurance

Date	Time	Type of Activity	
		Products in One's Life and Policyholders' Understanding of Insurance Products and their Affordability	Products in One's Life and Policyholders' Understanding of Insurance Products and their Affordability
Monday 30th July 2007	12.30 – 2.00 PM	**Team 1** FGD# 9: Exploring Requirements for Taking an Insurance Product and Client Satisfaction with Information and Knowledge Provided	**Team 2** FGD# 10: Exploring Requirements for Taking an Insurance Product and Client Satisfaction with Information and Knowledge Provided
	2.30 – 4.30 PM	**Team 1** FGD# 11: Exploring Client Satisfaction with Claims process	**Team 2** FGD# 12: Exploring Client Satisfaction with Claims process
Tuesday 31st July 2007	8.00 AM- 1:00 PM	Notes	Notes
	2.00 – 5.00 PM	Notes	Notes
Wednesday 01st Aug 2007	8.00 AM- 1:00 PM	FGD Analysis	FGD Analysis
	2.00 – 5.00 PM	FGD Analysis	FGD Analysis
Thursday 02nd Aug 2007	Report Writing		
Friday 03rd Aug 2007			
Saturday 04th Aug 2007			
Sunday 05th Aug 2007			
Monday 06th Aug 2007	9.00 AM- 11,00 AM	Peter: In-depth interview with Health Service Providers.	Henry: In-depth interview with Microcare officials.
	2.00 – 5.00 PM	In-depth Interview - Analysis	In-depth Interview - Analysis
Tuesday 07th Aug 2007	Report Writing		
Wednesday 08th Aug 2007			
Thursday 09th Aug 2007	Submission of the First Draft of the Report to Ana Klincic		