



INTERNAL END OF PROJECT EVALUATION **REPORT**

JULY
**20
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Project title:

***Enabling vulnerable families to equitably
access quality healthcare services, cont.***

Project period:

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2. LIST OF ABBREVIATIONS

BftW	Bread for the World
BURATS	Busoga Region Association of Tweidhandhabe Schemes
CRUMBS	Central Region Urban Munno Mu Bulwadde Scheme
HC	Health Centre
CHF	Community Health Financing
CHI	Community Health Insurance
CRA	Client Relations Assistant
CRD	Client Relations Desk
CSO	Civil Society Organization
HCP	Healthcare provider
IPC	In-patient care
MBUSO	Munno mu Bulwadde Union of Schemes Organization
MFI	Microfinance Institution
MGLSD	Ministry of Gender, Labour and Social Development
MoLG	Ministry of Local Government
MOH	Ministry of Health
MSCOM	Munno Mu Bulwadde Schemes Cooperation Mechanism
LDCHFS	Luwero District Community Health Financing Scheme
NHIS	National Health Insurance Scheme
OOP	Out of pocket
OPC	Outpatient care
SACCO	Saving and Credit Cooperative Organization
SHU	Save for Health Uganda
SHUF	SHU Finance Limited
SSA	Sub Scheme Agent
UGX	Uganda Shillings
WATSA	Western Ankole Tweragurize Schemes Association

3. EXECUTIVE SUMMARY

This report presents the findings of the internal end-of-project evaluation of the project “Enabling Vulnerable Families to Equitably Access Quality Healthcare Services (Continued),” implemented by Save for Health Uganda (SHU) with financial support from Bread for the World (BftW) from January 2024 to December 2026. The project was implemented in twelve districts of Uganda with the overall goal of contributing to Universal Health Coverage (UHC) through improved access to quality healthcare services and strengthened Community Health Insurance (CHI) systems.

The evaluation assessed project performance, achievement of intended results, sustainability of outcomes, institutional strengths, lessons learned, innovations, and strategic opportunities for future programming. The assessment utilized document review, analysis of routine monitoring data, stakeholder consultations, and key informant interviews.

Overall, the project achieved most of its planned objectives and made a substantial contribution to improving access to healthcare services among vulnerable households. Client satisfaction with services provided by contracted healthcare facilities increased from 94% at baseline to 96%, exceeding the 95% project target. Satisfaction with the performance of the CHI schemes among contracted healthcare providers also improved significantly, reaching the 90% target by 2025 from 80% in 2024. These improvements were largely attributed to the operationalization of Client Relations Desks (CRDs), strengthened collaboration between CHI schemes and healthcare providers, improved client awareness of services and procedures of coverage, and timely payment of medical claims.

The project strengthened financial protection for vulnerable households through five Community Health Insurance (CHI) schemes that collectively financed 3,961 healthcare cases and paid UGX 222.3 million in medical bills between January 2024 and April 2026. Notably, 100% of eligible medical bills submitted to the schemes were paid, and claims were settled in a timely manner, ensuring uninterrupted access to healthcare services for members. The prompt settlement of claims enhanced provider confidence, improved continuity of care, strengthened relationships between schemes and healthcare facilities, and demonstrated the schemes’ effectiveness in protecting households from out-of-pocket health expenditures.

The project also contributed significantly to enhancing the recognition of Community Health Insurance (CHI) as a national health financing strategy, and it is now acknowledged in most national health planning strategies. Support for CHI in Parliament also increased notably, rising from 28 members in January 2024 to 48, just 2 MPs short of the target. Additionally, SHU played a vital role in fostering discussions about health financing reforms. A key achievement was the development and submission of the first-ever draft of the Community-Based Health Financing (CBHF) Guidelines to the Ministry of Health, laying an important foundation for future policy and regulatory reforms.

A major institutional achievement was the successful development and deployment of a customized CHI Information Management System across all five schemes and 33 healthcare facilities. The system improved beneficiary identification, claims management, reporting, accountability, and operational efficiency while driving broader digital transformation, including the adoption of online banking systems by 3 of the 5 schemes.

Although most targets were achieved, performance varied across outputs. The project achieved full compliance with operational permit requirements for all CHI schemes and made significant progress in establishing Client Relations Desks and rolling out the digital Information Management System. However, recruitment and retention of Sub-scheme Agents and Scheme Managers, as well as the expansion of the Eastern Uganda CHI network, fell below target due to capacity-related and contextual challenges associated with introducing and managing CHI schemes in the new geographical area of Eastern Uganda.

The evaluation found strong prospects for sustainability. Institutionalized Client Relations Desks, digital management systems, online banking platforms, district recognition of CHI schemes, partnerships with Microfinance Institutions, indirect premium collection mechanisms, and the Third-Party Managed CHI model are likely to continue beyond donor support. In addition, the ongoing development of Community-Based Health Financing Guidelines and the Luwero District Community Health Financing Scheme provide important opportunities for scaling sustainable community health financing solutions.

The evaluation further confirms SHU's position as a national leader in Community Health Insurance Scheme promotion and management and health financing policy advocacy. The organization has developed strong technical expertise, innovative implementation models, extensive

stakeholder networks, and proven approaches that can support future health financing reforms and the expansion of financial protection mechanisms.

The evaluation concludes that the project has made a significant contribution to expanding equitable access to quality healthcare services, strengthening community-based health financing systems, advancing policy dialogue on health financing reforms, and positioning SHU as a key actor in Uganda's journey toward Universal Health Coverage. Future investments should focus on scaling the sustainable (Third-party Managed) CHI model, strengthening institutional capacities, supporting emerging national and district health financing initiatives, and diversifying SHU's resource base to maximize long-term impact.

4. INTRODUCTION

4.1. ABOUT SAVE FOR HEALTH UGANDA

Save for Health Uganda (SHU) is an indigenous non-governmental organization (NGO) established in 2002 and mandated to operate throughout Uganda. Guided by its vision of "Healthier families with simplified access to quality healthcare" and its mission "To enhance the quality of health of Ugandans through self-managed community health financing schemes," SHU works to improve equitable access to healthcare by promoting sustainable community-based health financing (CBHF) schemes, strengthening health systems, and supporting vulnerable families to overcome financial barriers to healthcare.

4.2. ABOUT THE END OF PROJECT EVALUATION

As part of its organizational commitment to accountability, learning, and continuous improvement, SHU routinely conducts end-of-project evaluations shortly before each project's completion. These evaluations provide an opportunity to systematically assess project performance, document achievements and challenges, identify lessons learned and good practices, and generate evidence to inform strategic decision-making.

This report presents the findings of the internal end-of-project evaluation for the current project. The evaluation reviewed the extent to which the project achieved its intended objectives and performance targets, examined the effectiveness of the implemented strategies, assessed SHU's institutional strengths and areas for further development, and identified unintended outcomes and emerging opportunities. Particular attention was given to the project's contribution to improving access to healthcare through Community Health Insurance (CHI) schemes and advancing policy dialogue on health financing in Uganda.

The findings and recommendations presented in this report are intended to inform the design and strategic direction of SHU's next programme phase (2027-2029) and beyond, strengthen institutional performance, and support evidence-based engagement with development partners, policymakers, and other stakeholders. By reflecting on both successes and areas for improvement, the evaluation contributes to SHU's ongoing efforts to enhance programme quality, sustainability, and impact.

4.3. THE PROJECT EVALUATED

4.3.1. Project overview.

The project evaluated is titled “Enabling Vulnerable Families to Equitably Access Quality Healthcare Services (CONT.)”. It is a three-year intervention funded by Bread for the World (BftW) and implemented by Save for Health Uganda (SHU) from January 2024 to December 2026.

The project is being implemented in twelve districts: Luwero, Nakaseke, Nakasongola, Mityana, Kassanda, Bushenyi, Sheema, Mitooma, Iganga, Bugweri, Mayuge, and Kampala. Its goal is to improve equitable access to quality healthcare services for vulnerable households by promoting and strengthening Community Health Insurance (CHI) schemes and advocating for a universal National Health Insurance Scheme (NHIS).

The intervention responds to the persistent challenge of limited access to quality healthcare among vulnerable populations in both rural and urban communities in Uganda. This challenge is driven by several interrelated factors, including inadequate financial resources at the point of illness, the high cost of healthcare services, poor reception and client care at health facilities, limited awareness of available services and patients’ rights, weak bargaining power among individuals, the limited availability of affordable Community Health Insurance schemes in many parts of the country, and the absence of an inclusive national social health protection mechanism for workers in the informal sector and low-income populations.

Without effective financial risk protection, many households continue to experience inequitable access to healthcare services and are exposed to catastrophic health expenditures that further deepen poverty and socioeconomic vulnerability.

4.3.2. The project Goal, objectives, and performance indicators

Goal: To contribute to the attainment of Universal Health Coverage (UHC) in Uganda.

Objective 1: Vulnerable families (CHI members) in the target districts gain the capacity to access healthcare services. The Performance indicators are:

1. The proportion of clients satisfied with the quality of services at the 40 contracted healthcare providers increases to 95% at the end of the project.
2. The CHI networks pay all (100%) of the schemes' medical bills on time to the 40 contracted health care providers.
3. The proportion of contracted healthcare facility managers satisfied with the performance of CHI schemes in their catchment areas is at least 90%.

Objective 2: A position paper on the inclusion of CHI in the NHIS law and/ or implementation regulations and on its importance, particularly for informal workers, has been submitted to the health committee of parliament. The Performance indicator is:

4. The number of members of parliament who recognize CHI and support its inclusion in the NHIS law and/ or implementation regulations has increased to 50

4.3.3. The Project outputs

1. A total of 180 Sub-scheme Agents (150 serving existing schemes and 30 supporting the new Eastern Uganda scheme) contracted and facilitated to manage day-to-day operations in the 90 sub-schemes.
2. The new scheme/ network in Eastern Uganda operates with 30 sub-schemes in total (15 newly formed and 15 old).
3. A customized and functioning Information Management System for CHI schemes.
4. All 40 contracted health care providers operate Client Relations Desks at their reception areas. (25 CRDs to be institutionalized, while 15 new CRDs are to be set up for the first time at 15 facilities).
5. A total of eight (8) Scheme Managers contracted and facilitated to perform technical roles of the 4 old schemes/ networks.
6. A valid operational permit for each CHI scheme.
7. A total of 50 Members of Parliament express commitment to support the inclusion of CHI in the NHIS law and/or regulations.
8. A policy brief and position paper submitted to parliament.

4.3.4. The project implementation approach/ strategy

Overall approach	Sub approach
1. Promote member-managed CHI schemes to communities in all the target districts, to authorities at the local level, and to authorities at the national level	1. Partnership with MFIs to finance family income projects and collect premiums 2. Educate and sensitize families about CHI and schemes 3. Support communities to form new CHI schemes 4. Share experiences with partners and authorities
2. Build the institutional and management capacity of CHI networks and scheme managers for program sustainability	1. Contract, train, and facilitate scheme managers to run the 4 old schemes after 2026 2. Contract, train, and facilitate sub-scheme agents to perform day-to-day roles at the sub-scheme level
3. Advocate for the provision of quality HC services by the partner health care facilities and support them to improve their reception services	1. Promote CRDs at new health facilities 2. Sensitize health workers on PCC practices at all partner health facilities
4. Advocate for the introduction of a fair universal NHIS that recognizes CHI and provides for the role they can play in the implementation of a national scheme	1. Form a coalition 2. Write position papers 3. Host a national conference

5. EVALUATION PURPOSE, OBJECTIVES, AND METHODOLOGY

5.1. PURPOSE OF THE EVALUATION

The purpose of this internal end-of-project evaluation was to assess the overall performance, effectiveness, and sustainability of the project and to generate evidence-based lessons and strategic recommendations to inform organizational learning and the design of the next phase of programming.

5.2. OBJECTIVES OF THE EVALUATION.

The evaluation was guided by the following specific objectives:

1. To assess project performance and achievement of results. Evaluate the overall performance of the project during the implementation period (2024-2026), including the extent to which the intended objectives, outputs, outcomes, and performance targets were achieved.
2. To assess the sustainability of project results. Examine the likelihood that key outcomes, systems, capacities, and benefits established by the project will be sustained beyond the period of donor support, and identify practical measures required to strengthen sustainability where gaps exist.
3. To assess SHU's institutional strengths and competitive positioning. Evaluate the institutional capacities, comparative advantages, and organizational readiness of Save for Health Uganda (SHU) to design and deliver effective, scalable, and sustainable health financing and other interventions.
4. To assess organizational learning and adaptive management. Review how SHU has generated, applied, and institutionalized lessons learned during project implementation to improve programme quality, responsiveness, and effectiveness.
5. To identify innovations and emerging opportunities. Document existing innovations developed through the project and identify strategic opportunities for expansion, partnership, policy influence, and future programming.
6. To provide strategic direction for the next phase of programming. Generate evidence-based recommendations to inform the design, prioritization, and implementation of the subsequent project phase and strengthen its potential for impact and sustainability.

5.3. METHODOLOGY

The evaluation adopted a predominantly secondary data review and analysis approach, complemented by targeted primary data collection to validate findings and generate insights for the next phase of programming. The assessment covered project implementation from January 2024 to May 2026, focusing on project performance, achievement of intended results, sustainability of outcomes, institutional capacity, organizational learning, innovation, and strategic opportunities for the next phase.

The document review included an analysis of key project records and routinely generated monitoring data, including the project proposal, annual and semi-annual progress reports, monitoring and evaluation reports, financial



and administrative records, Community Health Insurance (CHI) scheme reports, and data extracted from the electronic CHI Information Management System (IMS). Performance was assessed by comparing planned targets against actual achievements and examining implementation trends over the evaluation period.

To complement the documentary review, qualitative primary data were collected through Key Informant Interviews (KIIs) and selected Focus Group Discussions (FGDs) involving Scheme Managers, Sub-scheme Agents, Community Health Insurance members, managers of contracted healthcare facilities, SHU field officers, and SHU Board of Directors. These consultations were primarily intended to validate evidence obtained from secondary sources, provide contextual explanations for observed performance, capture stakeholder perspectives on sustainability, and inform strategic recommendations for the next project phase.

Data from both secondary and primary sources were triangulated to enhance the credibility and reliability of the evaluation findings and conclusions.

6. EVALUATION FINDINGS.

6.1. ASSESSMENT OF PROJECT PERFORMANCE AND ACHIEVEMENT OF RESULTS

This section presents the evaluation findings organized around the evaluation objectives and key assessment areas. It examines the project's overall performance, effectiveness, and achievement of intended objectives and results, including contributions to improved healthcare access, financial protection, Community Health Insurance (CHI) strengthening, and health financing policy development.

The section further assesses the sustainability of project results beyond the period of donor support, identifies the institutional strengths, capacities, and competitive advantages that position Save for Health Uganda (SHU) to deliver effective and sustainable interventions, and examines how the organization has adapted to changing community needs and developments within the health financing sector. It also highlights key innovations, lessons learned, strategic partnerships, and emerging opportunities that can inform SHU's future programming and contribution to Community Health Financing and Universal Health Coverage in Uganda.

6.1.1. Project Performance and Results

6.1.1.1. Assessment of Progress Towards Objective 1

Indicator 1: The proportion of clients satisfied with the quality of services provided by contracted healthcare facilities.

The evaluation found that client satisfaction exceeded the end-of-project target. Satisfaction levels increased from 94% in 2023 (baseline) to 96% in 2025, surpassing the target of 95% and representing an achievement rate of 101%.

The positive performance is attributable to a combination of interventions implemented by SHU and the Community Health Insurance (CHI) schemes. These included regular dialogue meetings between CHI schemes and contracted healthcare providers, establishment and operationalization of Client Relations Desks (CRDs), continuous sensitization of CHI members on benefit packages and service procedures, and periodic client satisfaction surveys whose findings were used by health facilities to strengthen service delivery.

Evidence gathered during the evaluation indicates that the CRDs played a particularly important role in improving communication between clients and providers, facilitating feedback management, and guiding clients through service delivery processes, thereby contributing to enhanced client experience and overall satisfaction.

"Before the Client Relations Desk was established, we struggled to collect and respond to patient feedback systematically, and unresolved complaints often affected the hospital's image within the community. Today, we have a structured mechanism for receiving and addressing client concerns, which has improved client satisfaction, strengthened accountability, and enhanced trust between the hospital and the communities we serve. The impact has been so significant that we are institutionalizing the initiative through a fully-fledged Client Relations Department."

- Mr. Andrew Lubega, CHI coordinator, Kiwoko Hospital

Indicator 2: The CHI networks pay all (100%) of the schemes' medical bills on time to the contracted healthcare providers.

The evaluation found that the CHI networks consistently met the target of paying 100% of eligible medical bills in full and within the agreed contractual timelines to contracted healthcare providers. Between January 2024 and April 2026, the schemes financed a total of 3,961 healthcare cases, comprising 3,257 outpatient visits and 704 inpatient admissions, with cumulative payments amounting to UGX 222,334,825.

The sustained, timely settlement of medical claims was enabled by several sound financial and operational practices, including periodic product reviews and premium adjustments to match changing healthcare costs, the establishment of reserve funds, the pooling of member premiums into centralized scheme funds, and the deployment of a digital Community Health Insurance Information Management System (IMS). In addition, the introduction of an online medical bill payment mechanism streamlined claims processing and reduced payment delays.

The evaluation further established that the digital IMS significantly enhanced beneficiary identification, claims verification, invoice reconciliation, and payment processing, thereby improving operational efficiency, financial accountability, and trust between CHI schemes and contracted healthcare providers.

"One of the reasons we have maintained our partnership with the CHI schemes for nearly 18 years is their reliability. Medical bills are paid on time, which enables us to provide services to members with confidence and without financial uncertainty. The schemes are well organized, and their leadership structures make communication and community mobilization much easier. This has created a strong and mutually beneficial partnership between the hospital and the communities we serve."

- Sr. Ernestine Akullu, Hospital Administrator, Bishop C. Asili Hospital

Indicator 3: The proportion of contracted healthcare facility managers satisfied with the performance of CHI schemes in their catchment areas.

The evaluation found that satisfaction among managers of contracted healthcare facilities increased from 79.9% in 2024 to 90% in 2025, thereby achieving the project target.

Evidence from document reviews and stakeholder consultations indicates that this improvement was driven by strengthened collaboration between CHI schemes and healthcare providers, enhanced awareness among CHI members regarding their entitlements and procedures for accessing care, and the consistent payment of medical bills in full and on time. The introduction of the digital Information Management System also improved beneficiary identification and reduced administrative challenges during service delivery.

"Before the Information Management System, our staff spent a lot of time manually recording patient details, which often led to long waiting times for CHI members. Today, member verification and service recording are much faster, reducing delays for patients and easing the workload of our staff. The system has greatly improved efficiency and service delivery at our facility."

- Mr. Andrew Lubega, CHI Coordinator, Kiwoko Hospital

Healthcare providers reported that timely reimbursement of medical bills improved cash flow and financial predictability, enabling them to procure medicines and medical supplies, meet operational obligations such as staff remuneration, and invest in essential equipment. Collectively, these improvements contributed to better service delivery and strengthened confidence in the Community Health Insurance schemes among partner health facilities.

Unintended outcome 1: Establishment of CHI schemes by institutions beyond the project's direct sphere of implementation.

Kiwoko Hospital, one of the contracted healthcare providers, established its own CHI scheme after leveraging more than two decades of experience gained through collaboration with SHU-supported schemes. Stakeholder consultations indicated that the hospital's decision was influenced by the demonstrated effectiveness of the scheme, particularly its reliable claims reimbursement mechanisms and contribution to financial stability. Similarly, Mushanga SACCO introduced a CHI scheme under the leadership of former members and leaders of the Western Ankore Tweragurize Schemes Association (WATSA), who applied the knowledge and practical experience acquired through the project. These developments underscore the project's wider systemic impact, illustrating how sustained investments in capacity building, institutional learning, and community ownership have catalysed the independent adoption and scaling of CHI approaches, thereby extending access to community-based health financing beyond the project's intended beneficiaries and geographical scope.

6.1.1.2. Assessment of progress towards objective 2.

Indicator 4: The number of Members of Parliament who recognize CHI and support its inclusion in the NHIS law and/or implementation regulations.

The evaluation found substantial progress towards strengthening policy support for the inclusion of CHI within the National Health Insurance framework. The number of Members of Parliament (MPs) who recognized CHI and expressed support for its inclusion in the National Health Insurance Scheme (NHIS) law and/or implementation regulations increased from 28 in 2023 (baseline) to 48 in 2026, representing a 96% achievement against the target of 50 MPs.

The supportive MPs comprised four Cabinet Ministers, twenty-five members of the Parliamentary Health Committee, eight former members of the Committee, and eleven MPs representing SHU's areas of operation. This progress is attributable to sustained advocacy and engagement efforts, including stakeholder dialogue meetings, annual national Community Health Financing conferences, policy presentations, and targeted one-on-one interactions with policymakers.

The evaluation also found evidence of increased national awareness and acceptance of CHI as a practical mechanism for expanding healthcare

access among vulnerable populations and workers in the informal sector. However, some policymakers continued to demonstrate a limited understanding of CHI, partly because its implementation remains concentrated in selected districts. Some expressed concerns regarding the compatibility of CHI with the government's policy on free healthcare services in all public healthcare facilities.

Overall, the findings indicate that the project made significant contributions to elevating CHI within national policy discussions and strengthening stakeholder appreciation of its potential role in advancing the National Health Insurance Scheme in Uganda.

Unintended Outcome 2: Enhanced Recognition of SHU as a Centre of Excellence in Community Health Insurance/ Financing.

Beyond the planned advocacy outcomes, the evaluation found that SHU has increasingly been recognized as a national knowledge hub for the design, promotion, and management of third-party and member-managed Community Health Insurance schemes. Throughout the project period, several Members of Parliament, government institutions, civil society organizations, and the Luwero District Local Government engaged SHU for technical assistance, experience sharing, and guidance on the design, development, and implementation of various Community Health Insurance (CHI) scheme models.

This enhanced institutional recognition can be attributed to SHU's sustained investment in knowledge dissemination through annual national Community Health Financing conferences, joint stakeholder forums, policy engagement processes, and community sensitization initiatives. The evaluation considers this growing reputation a strategic institutional asset that positions SHU to play an expanded role in policy influence, technical assistance, and scaling up Community Health Insurance initiatives in Uganda.

Unintended Outcome 3: Revival of the proposed Luwero District Community Health Financing Scheme.

An important unintended outcome of the project was the revival of the proposed Luwero District Community Health Financing Scheme (LDCHFS), which had remained inactive since 2019. Although the Luwero District Council had passed an ordinance to establish the scheme in 2018, the process stalled after the Solicitor General advised that the proposed National Health Insurance Bill would establish a national framework for health insurance, making a district ordinance unnecessary.

During the project period, however, the Luwero District Local Government renewed its commitment to the initiative and, with technical support from SHU, resumed the process of developing the scheme. SHU supported the review and updating of the scheme design, preparation of an implementation roadmap and budget, and establishment of a steering committee to oversee implementation.

The revival of the scheme demonstrates the project's broader influence beyond its planned interventions and highlights SHU's growing recognition as a trusted technical partner in the development and implementation of Community Health Financing initiatives. It also represents an important opportunity to institutionalize sustainable healthcare financing at the district level and generate lessons for replication in other districts.

6.1.1.3. Assessment of progress towards project outputs.

Output 1: Recruitment and Facilitation of 180 Sub-scheme Agents

The evaluation found that 113 Sub-scheme Agents had been contracted and facilitated to undertake the day-to-day operational management of Community Health Insurance (CHI) sub-schemes by May 2026, representing 63% achievement against the target of 180 agents. Of those recruited, 93 were deployed within the four established CHI schemes, while 20 served the newly established scheme in Eastern Uganda.

The Sub-scheme Agents, as contracted by the five CHI schemes, are presented in the table below.

CHI Scheme	Status at project start	Target	Actual (May 2026)
1. Munno mu Bulwadde Union of Schemes Organization (MBUSO)	Existing	108	66
2. Western Ankore Tweragurize Schemes Association (WATSA)	Existing	24	17
3. Munno mu Bulwadde Union Schemes Cooperation Mechanism (MSCOM)	Existing	12	6
4. Central Region Urban Munno mu Bulwadde Union Scheme - Luwero (CRUMBS-L)	Existing	6	4
5. Busoga Region Association of Tweidhandhabe Schemes (BURATS)	New	30	20
Total		180	113

The evaluation established that the recruitment process benefited from well-defined Terms of Reference and transparent selection procedures, which generated substantial interest among prospective applicants. However, stakeholder consultations revealed that the level of facilitation offered to Sub-scheme Agents was perceived by some candidates as insufficient relative to the workload and responsibilities associated with the role. This constrained recruitment, motivation, and retention in some schemes.

The evaluation found that while the contracted agents have improved the operational capacity of the CHI schemes, many still need ongoing technical mentorship, supportive supervision, and capacity building. These measures are essential for them to manage scheme operations independently and effectively and contribute to long-term sustainability.

Output 2: Establishment and Operationalization of the Eastern Uganda Community Health Insurance Scheme/Network.

The evaluation found that the Busoga Region Association of Tweidhandhabe Schemes (BURATS) was operating with seven sub-schemes, comprising two newly established and five existing sub-schemes, representing 23% achievement against the target of 30 sub-schemes (15 new and 15 existing).

Evidence from the evaluation indicates that the slower-than-anticipated expansion was largely attributable to the complexities of replicating the Community Health Insurance (CHI) model in a new geographical and socio-cultural context. Although the model had proven successful in the Luwero region, implementing it in Eastern Uganda required significant adaptations to fit the local context. This included building community trust, forming partnerships with Microfinance Institutions (MFIs) to enhance household incomes and facilitate premium collection, and developing governance structures that were appropriate for the local environment.

The evaluation further established that the project's strategy of transferring management responsibility for newly established sub-schemes to Sub-scheme Agents (SSAs) shortly after launch required a longer transition period than originally anticipated. Although communities expressed confidence in SHU as the implementing organization, they were initially hesitant to entrust premium collection and pooled fund management to newly recruited SSAs. This

challenge was compounded by the relatively low levels of formal education and management experience among some SSAs, necessitating more intensive mentoring and capacity development before they could independently manage scheme operations.

In addition, stakeholder consultations revealed that while SSAs received financial facilitation, some volunteer scheme leaders perceived inequities in incentives and recognition. In several instances, this contributed to reduced engagement by non-remunerated leaders and weakened the functionality of governance structures within the affected sub-schemes.

Overall, the findings suggest that successful replication of the member-managed CHI model requires not only technical implementation but also sustained investment in community confidence-building, leadership development, governance strengthening, and equitable incentive structures.

Output 3: Development and Roll-out of a Customized Community Health Insurance Schemes' Information Management System.

The evaluation found that the customized Community Health Insurance Schemes' Information Management System (IMS) was successfully developed and deployed across all five CHI schemes and 33 contracted healthcare facilities, representing approximately 83% achievement against the planned target.

The system supports key operational functions, including real-time member registration, beneficiary verification, claims management, invoice generation, and reporting, and has substantially improved the efficiency, transparency, and accuracy of scheme administration. However, the evaluation identified the need for further enhancement of the platform through integration of a comprehensive financial management module to strengthen financial reporting, fund management, and accountability across CHI schemes.

The evaluation also found that active user involvement throughout the system design and implementation process contributed significantly to stakeholder ownership and adoption. Among the 33 partner healthcare facilities where the system was introduced, 19 facilities invested their own resources to provide personnel, computers, and internet connectivity to operationalize the platform. The remaining 14 facilities faced financial constraints that limited their ability to

procure the necessary equipment and reliable internet services, thereby affecting the full utilization of the system.

Overall, the IMS represents a significant institutional innovation that has modernized the CHI scheme's operations and established a strong foundation for the digital transformation of community-based health financing. Nevertheless, continued investment in system enhancement and infrastructure support will be necessary to maximize its long-term effectiveness and sustainability.

Unintended outcome 4: Digital Transformation of Community Health Insurance Scheme Financial Management.

An important unintended outcome identified by the evaluation was the transition of MSCOM, WATSA, and MBUSO from manual banking processes to online banking systems. This organizational change was influenced by the positive experience and operational efficiencies realized through the adoption of the digital CHI Information Management System.

The shift to online banking has improved the efficiency of financial transactions, including the settlement of medical claims and other operational payments, while strengthening transparency, accountability, and financial management practices within the participating schemes. This outcome illustrates the project's broader catalytic effect in accelerating digital innovation beyond its originally intended scope.

Output 4: Operationalization of Client Relations Desks in Contracted Healthcare Facilities.

The evaluation found that 33 of the targeted 40 contracted healthcare facilities had operationalized Client Relations Desks (CRDs) by the end of the assessment period, representing 83% achievement against the target. Of these, 22 facilities institutionalized existing CRDs, while 11 established new CRDs for the first time.

The evaluation indicates that this achievement was facilitated by sustained technical engagement between SHU and partner healthcare providers, including annual experience-sharing meetings and the presentation of evidence (viability reports) demonstrating the value of CRDs in improving client satisfaction, communication, and service quality. These engagements strengthened management commitment and contributed to the institutionalization of CRDs in the 22 facilities.

However, progress was constrained in the remaining seven facilities. Some healthcare managers had not fully embraced the CRD concept, while

others faced financial and operational limitations that hindered the establishment and long-term maintenance of the desks. These findings suggest that continued advocacy and targeted institutional support will be necessary to achieve universal adoption across all contracted healthcare service providers.

Output 5: Recruitment and Facilitation of Scheme Managers.

The evaluation found that seven Scheme Managers were contracted and facilitated to provide technical and operational leadership across the four established Community Health Insurance (CHI) schemes, representing 87.5% achievement against the target of eight managers. The recruited personnel comprised two managers each for MBUSO, MSCOM, and CRUMBS, and one manager for WATSA.

Evidence from the evaluation indicates that recruitment performance improved significantly following revisions of the Terms of Reference and selection criteria after the first year of implementation. Initial recruitment efforts attracted few suitable candidates due to restrictive eligibility requirements. The revised recruitment strategy broadened the pool of qualified applicants and enabled the identification of individuals with the competencies required to support scheme

management and operations.

The findings demonstrate the importance of adaptive management in strengthening human resource recruitment processes and ensuring that technical positions are filled with appropriately qualified personnel.

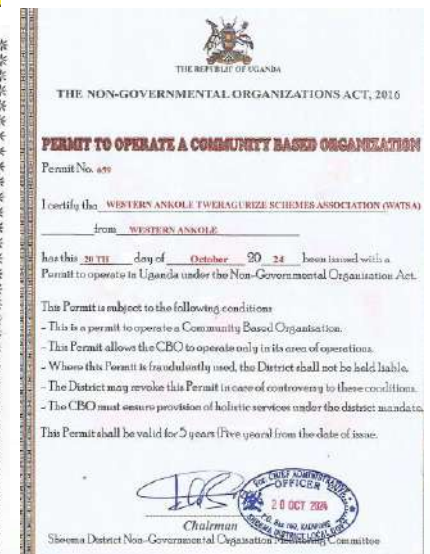
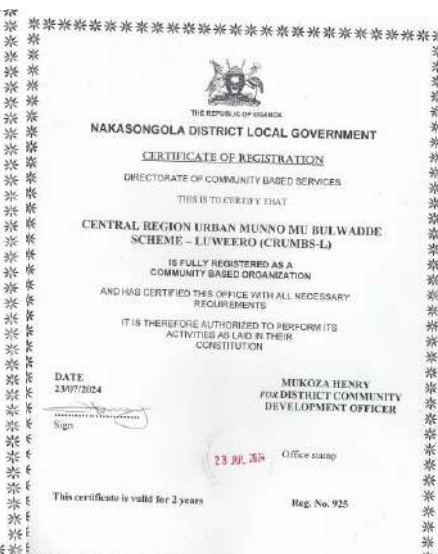
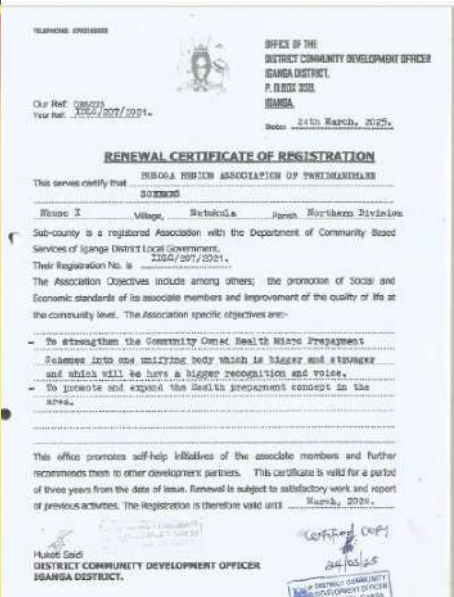


One of WATSA's scheme managers meets with members in one of the sub-schemes

Output 6: Maintenance of Valid Operational Permits for CHI Schemes.

The evaluation found that all five Community Health Insurance schemes maintained valid operational permits throughout the project period, meeting 100% of the planned target.

This outcome reflects sustained technical support from SHU to strengthen institutional governance and



regulatory compliance within the schemes. Support included preparing, reviewing, and updating essential operational documents, such as governance instruments, internal guidelines, annual work plans, and budgets, which are critical for registration and renewal of operational permits.

The continuous compliance of all schemes with regulatory requirements demonstrates strengthened institutional capacity and provides a solid foundation for their long-term legitimacy and sustainability.

Output 7: Commitment by Members of Parliament to Support Inclusion of CHI in the NHIS Framework.

The evaluation found that 39 Members of Parliament (MPs) had expressed commitment to support the inclusion of Community Health Insurance (CHI) within the National Health Insurance Scheme (NHIS) law and/or its implementing regulations, representing 78% achievement against the target of 50 MPs. Those expressing support included four Cabinet Ministers, twenty-five members of the Parliamentary Health Committee, eight former members of the Committee, and two MPs from Northern Uganda.

The observed progress was driven by sustained policy advocacy and stakeholder engagement, including targeted sensitization during annual National Community Health Financing conferences, presentation of evidence through policy briefs, and direct engagement with policymakers at both national and district levels. These initiatives raised awareness and appreciation of CHI's role in advancing Universal Health Insurance Coverage, especially for vulnerable populations and those in the informal sector.

Despite these gains, the evaluation identified persistent knowledge gaps among some policymakers.

Limited exposure to CHI implementation outside a few districts constrained understanding of the

model, while some stakeholders expressed concerns that formal recognition of CHI could be perceived as inconsistent with the Government's policy of providing free public healthcare services. These findings highlight the need for continued advocacy and dissemination of evidence demonstrating the complementary role that CHI can play within Uganda's broader health financing architecture.



Some of the participants at the 8th National CHF conference, together with the chief guest, the Director General of Health Services

Output 8: Development and Submission of Policy Briefs and Position Papers.

The evaluation found that this output was partially achieved, with an estimated 60% completion against the planned target. During the project period, SHU prepared and submitted a policy brief to the Minister of Health and the Director General of Health Services advocating for the development of Community-Based Health Financing (CBHF) Guidelines as an interim policy measure while awaiting the re-



SHU board Chairperson, Executive Director, DHO Luwero, and others, after meeting the Minister of State for Primary Healthcare (Center) for a policy brief at the MOH headquarters in Kampala



Advocacy coalition team led by SHU after submitting the draft CBHF guidelines to the Director General of Health Services at the MOH headquarters in Kampala

tabling of the revised National Health Insurance Scheme Bill.

Subsequent engagements contributed to the development and submission of draft CBHF Guidelines to the Ministry of Health for further review and approval, representing an important policy milestone despite the original position paper not being formally submitted to Parliament as initially envisaged.

The evaluation attributes this progress to sustained multi-stakeholder engagement with senior officials from the Ministry of Health and the Ministry of Gender, Labour

and Social Development, Members of Parliament, and other key actors, through the annual National Community Health Financing conferences and targeted policy dialogues. In particular, resolutions emerging from the Seventh National Community Health Financing Conference underscored the need for CBHF Guidelines and helped shape subsequent advocacy efforts. Direct consultations with senior Ministry officials further strengthened the visibility and consideration of SHU's policy recommendations.

Overall, the findings indicate that although the planned output was only partially achieved, the advocacy process generated meaningful policy engagement and laid important groundwork for future integration of Community Health Insurance within Uganda's evolving health financing framework.

6.2. ASSESSMENT OF THE SUSTAINABILITY OF PROJECT OUTCOMES

6.2.1 Results which are likely to continue in the absence of donor support and actions to sustain them

This section presents the evaluation's assessment of the sustainability of project outcomes beyond the period of donor support. It examines the results that are likely to continue and those that may not be sustained without additional support, together with the actions required to strengthen their sustainability. The section also assesses the extent to which project-supported structures, systems, and community mechanisms are functioning independently, identifies those requiring further support to become self-sustaining, and highlights the approaches, methodologies, and partnerships that have produced the strongest and most sustainable results. Based on these findings, the evaluation proposes strategic actions to consolidate achievements and enhance the long-term sustainability of the project's outcomes.

6.2.1. Results which are likely to continue in the absence of donor support and actions to be taken to enhance and sustain them

Result	Actions to sustain the results
1. Clients' satisfaction with the quality of services provided by the contracted health care providers is likely to be sustained through the institutionalized Client Relations Desks (CRDs) in the 22 healthcare facilities, some of which have operated for more than 10 years.	1. Following up with partner healthcare providers on Client Relations Desks through periodic visits. 2. Sharing experiences on CRDs through a formally established bi-annual physical or virtual platform.
2. The timely and full payment of medical bills to the contracted healthcare providers and the satisfaction of the healthcare providers with this payment is also likely to be sustained, particularly under the CRUMBS-L scheme (Third-Party Managed), which targets corporate groups making indirect premium payment through employers, and the MSCOM scheme (Member-Managed), which partners with an MFI (Butaba Co. Ltd) making indirect premium payment through the MFI. In addition, CRUMBS-L has built financial reserves, maintains appropriate premium levels, and has established a partnership with an MFI (SHU Finance Ltd) to collect premiums. These schemes have consistently settled medical bills fully and on time over the past seven years, demonstrating	1. Schemes to hold regular physical and virtual engagements with managers of the corporate groups for updates about the scheme, sharing performance reports, getting their feedback, their input on benefits, and premium payment. 2. Support partner MFIs with low-interest loans and motorbikes to facilitate their outreach to distant clients 3. Schemes to train managers and staff of partner MFIs and corporate groups about the functioning of the CHI schemes annually.

Result	Actions to sustain the results
reliable premium collection arrangements.	
4. The increased recognition of CHI as a strategy for healthcare financing is also likely to continue due to its increasing integration into national plans, policies, and strategies. The key national frameworks, including Vision 2040, the fourth National Development Plan (NDPIV), the National Social Protection Policy 2015, and the National Social Protection Strategy 2024-2029, all emphasize Universal Health Coverage and affordable health financing mechanisms. At the sub-national level, Luwero District Local Government, with support from SHU, has initiated the establishment of a district-wide CHF Scheme. Furthermore, the Government of Uganda, with support from SHU, is in the process of developing CBHF implementation guidelines.	1. Provide information on CHI through annual CHF conferences, participating in government strategy and policy formulation and review meetings, and publications. 2. Provide technical support to the Luwero District Local Government to implement the district-wide CHF scheme
4. The transition from manual to electronic and digital information management systems in the 5 CHI schemes, and the 33 partner health facilities, is likely to be sustained since they successfully migrated to and operationalized the systems in 2024. Sustainability is further reinforced by the scheme's financial contributions to system maintenance, with the scheme	1. Upgrade the CHI schemes' information management system to integrate a comprehensive financial management module and synchronise with the emerging CHI operational needs and digital data collection tools

Result	Actions to sustain the results
currently meeting 60% of the annual maintenance cost and expected to increase member contributions to system support in 2026.	2. Schemes to charge a fee to cover the annual system maintenance costs fully
5. The adoption of the Client Relations Desks concept by the partner health facilities is expected to continue based on the increasing number of facilities institutionalizing the model, which grew from 13 in 2023 to 22 in 2026. In addition, the remaining 11 healthcare facilities expressed commitment to institutionalizing CRDs within the next 3 years, reflecting growing appreciation of their contribution to service quality improvement and client satisfaction.	1. Document viability reports from the 22 health facilities that institutionalized the CRDs and share them with the 11 health facilities that committed to institutionalizing the desks. 2. Follow up on the 11 healthcare facilities on the progress with institutionalizing the CRDs 3. Hold bi-annual CRD experience sharing meetings with the healthcare facilities.
6. The recognition of CHI schemes in the districts of Luwero, Nakaseke, Nakasongola, Bushenyi, Sheema, Mitooma, Kassanda, and Iganga is likely to continue. The five CHI schemes are formally registered as CBOs and have consistently maintained valid operational permits within their respective districts. The schemes have also established governance and operational structures that support continued compliance with the districts' registration requirements. In addition,	1. CHI schemes to share quarterly and annual reports with their respective districts 2. CHI schemes to support and participate in events and activities organised by their respective districts 3. CHI schemes to invite the district NGO monitoring committee to their activities at least twice a year

Result	Actions to sustain the results
WATSA's participation in the Western Ankore Civil Society Forum and the NGO monitoring committee in Ishaka Division has strengthened institutional visibility and local recognition.	4. CHI schemes to comply with the requirements for renewing operational permits in their target 10 districts annually.
7. The awareness and understanding of CHI among key stakeholders, including members of parliament, the Ministry of Health, the Ministry of Gender, Labour and Social Development, and the Luwero District Local Government, is likely to continue. SHU has continuously promoted awareness and knowledge sharing on CHI through annual national CHF conferences, exchange learning visits, stakeholder engagements, annual report publications, quarterly newsletters, newspaper articles, and the organization's website. SHU's participation in national structures such as the National Health Insurance Scheme task force, the Federation of Uganda Employers, and the Uganda National NGO Forum further strengthens its visibility and policy influence.	1. Collaborate with universities and training institutions to research and publish CHI, and to integrate CHI concepts into public health and health financing curricula. 2. Establish an online CHI knowledge and resource centre. 3. Engage with the media regularly to share CHI's successes and lessons learned. 4. Continue hosting national CHF conferences
8. The first draft of the Community-Based Health Financing guidelines, developed and submitted to the Ministry of Health for review and approval, is likely to contribute to long-term policy and regulatory reforms in the health financing	1. Support the Ministry of Health to finalise, approve, and disseminate the CBHF guidelines. 2. Establish a multi-stakeholder technical committee to update the newly appointed state

Result	Actions to sustain the results
sector. The process was initiated by the state minister of health in charge of primary health care and the director general of health services, demonstrating government ownership and commitment. The Ministry of Health formally received the draft guidelines, and the review process has already commenced under the Health Policy Advisory Committee (HPAC).	Minister of Health in charge of primary health care about CHI schemes' operations, and follow up on the process of approving the CBHF guidelines.
9. The implementation of the Luwero District Community Health financing scheme is likely to continue following the establishment of the steering committee and the development of an implementation roadmap to guide the operationalization of the scheme. The district intends to utilize existing MBUSO scheme structures to support the scheme management, while the ongoing resource mobilization efforts by the District Health Officer and the continued technical support from SHU further strengthen prospects for sustainability. The involvement of key ministries, including Ministries of Health, Local Government, and Gender, Labour and Social Development, also demonstrates institutional support for the initiative.	1. Work with the Ministry of Health and other stakeholders to build the technical capacity of the Luwero District Local Government to establish and manage the LDCHF scheme. 2. Formalise the collaboration between MBUSO and Luwero District Local Government in the management of the LDCHF scheme. 3. Support the Luwero district Local government with the information management system to manage the LDCHF scheme. 4. Sensitise the population about CHI to facilitate enrolment into the scheme. 5. Advocate for budget allocation to the LDCHF scheme from the Luwero District Council.

Result	Actions to sustain the results
10. The premium collection partnerships established between MSCOM, CRUMBS-L, and the two partner MFIs are likely to continue because of the formal partnership arrangements between the parties.	1. Formalise and sign long-term partnership agreements between schemes (CRUMBS-L and MSCOM) and all the institutions they are working with. 2. Expand partnerships to additional MFIs, SACCOs, cooperatives, employers, and other formal organizations/ groups/ institutions for indirect premium collection and payment. 3. Periodically assess partner performance and member satisfaction. 4. Develop risk-sharing arrangements that protect schemes and the partner MFIs.
11. The Third-Party managed CHI scheme model is likely to be sustained because of the indirect premium collection mechanisms, particularly among organized groups and corporate clients	1. Expand the third-party-managed CHI scheme model to SHU program areas where volunteer (sub-scheme agents, scheme managers, and scheme leaders) management is difficult. 2. Document the good practices and lessons from CRUMBS-L. 3. Develop operational standards for the third-party scheme management. 4. Support the third-party managed CHI scheme to build and invest its reserves.

6.2.2. Results that are not likely to continue in the absence of donor support and actions to strengthen the weak areas to sustain results.

Result	Actions to sustain the results
1. The CHI scheme managers' capacity to effectively perform management roles and responsibilities within the schemes is unlikely to be sustained without continued support. There has been a significant decline in membership within schemes that have been handed over to scheme managers, with membership reducing by approximately 60% from 14,072 in 2023 to 5,636 members in 2026. This decline indicates that although scheme managers acquired management skills and experience during the project period, many schemes continued to face challenges relating to member mobilization, retention, and scheme administration in the absence of continuous technical guidance and institutional support from SHU. Similarly, the management capacity of CHI sub-scheme agents to perform operational roles within the schemes is also unlikely to be sustained without external support. Only 42% of the sub-schemes (38 out of 90) handed over to sub scheme agents in 2024, remained	1. Transform MSCOM, WATSA and BURATS into third-party schemes managed by SHU and employing the indirect premium collection approach through partnerships with MFIs, SACCOs, Organized groups, and corporate organizations. 2. CRUMBS-L to take over MBUSO scheme operations under the SHU third-party managed scheme. 3. Seek schemes approval to transform the four member-managed CHI schemes into third-party managed schemes managed by SHU. 4. Support MBUSO, MSCOM, WATSA and BURATS to establish SACCOs. This will formalize and qualify them to benefit from the third-party schemes managed by SHU. 5. Build capacity of the SACCO leaders and managers to effectively manage the operations of the SACCOs. 6. Popularize the SACCOs to the target communities to attract members 7. Formalize partnerships between the schemes and SACCOs to facilitate effective collaborations.

Result	Actions to sustain the results
operational by May 2026. Most Sub Scheme agents were unable or unwilling to effectively manage scheme operations under conditions of limited supervision and facilitation from SHU. This demonstrated continued dependence on external technical oversight, operational support, supervision, and facilitation to sustain routine scheme operations and functionality.	8. Register the SHU third-party schemes in target districts.

6.2.3. Structures, systems, and community mechanisms functioning independently and actions to sustain them.

Structures, systems, and community mechanisms	Actions to sustain them
1. The online banking systems adopted by MBUSO, MSCOM, WATSA, and CRUMBS are functioning independently and have significantly strengthened the efficiency and accountability of scheme operations. Partner banks, including Stanbic Bank, Centenary Bank, and DFCU Bank, have already provided and operationalized the online banking platforms required by the schemes. Through these systems, the schemes have consistently managed medical bill payments and other financial transactions since 2022. The continued utilization of these platforms demonstrates the schemes' capacity to independently manage financial processes in a transparent and efficient manner.	1. Conduct regular financial audits to ensure that there are no errors or mismanagement of scheme funds 2. Establish succession arrangements for account signatories to ensure the continuous smooth running of scheme operations. 3. Train system users (scheme managers and signatories) on online banking operations

Structures, systems, and community mechanisms	Actions to sustain them
2. The Client Relations Desks (CRDs) institutionalized within the 22 partner health facilities are also operating independently and have become an integral part of service delivery within the health facilities. Most of the CRDs have been functional for over 5 years, reflecting strong institutional ownership and sustainability. In four (4) healthcare facilities (Kiwoko Hospital, Bishop Ceaser Asili Hospital, Ishaka Adventist Hospital, and Holy Cross HC), the CRDs have evolved into fully operational reception and customer care units. On average, approximately 51,000 clients utilize CRDs annually, demonstrating their continued relevance and effectiveness in enhancing client support and coordination within the health facility.	1. Promote experience sharing and learning among the healthcare providers on CRD viability 2. Develop the standard operating procedures for the CRD functions 3. Train CRD staff on patient-centered care and communication skills. 4. Document and publish success stories on the sustained CRDs
3. The Third-Party managed scheme, CRUMBS-Luero, is a mechanism that is functioning independently. The scheme has remained operational since 2013 and continues to fully cover beneficiaries' medical bills as intended. The scheme demonstrates operational stability and effective management under the third-party arrangement. In addition, the scheme's reserve level currently stands at 241% of the annual healthcare budget compared to the internally recommended benchmark of 300%, indicating progress towards long-term financial sustainability and resilience.	1. Expand membership and diversify the client base 2. Document and disseminate success stories and lessons learned from the model to facilitate replication. 3. Develop standard operating procedures for the third-party managed scheme

6.2.4. Actions for structures, systems, and mechanisms requiring additional support to function independently

Structures, systems, and mechanisms requiring additional support	Actions
1. The indirect premium payment mechanism is already operational under the CRUMBS-L and MSCOM schemes through partnerships with two MFIs, enabling scheme members to access financial support for payment of healthcare insurance premiums. While the mechanism has demonstrated potential in improving affordability and access to scheme services, it still requires additional technical, financial, and institutional support to operate fully and independently. The two schemes require enhanced technical capacity to determine and periodically review appropriate premiums for members, while the partner MFIs require additional financial resources to expand loan services to the underserved target communities currently not covered. In addition, the partnership and coordination mechanism between the schemes and the MFIs needs to be further strengthened through improved operational frameworks, communication, accountability, and joint planning to ensure long-term sustainability and effective independent functioning of the mechanism.	1. Build the capacity of the scheme managers to periodically review and adjust premiums 2. Mobilize additional financial resources for the partner MFIs to enable them to expand their loan services to underserved populations 3. Support the third-party schemes to expand partnerships with additional MFIs, SACCOs, corporate bodies, and others. 4. Support the third-party schemes to establish regular coordination and planning meetings between the schemes and MFIs

Structures, systems, and mechanisms requiring additional support	Actions
2. The CHI scheme electronic/digital information management system also requires additional support to enhance its functionality and operate independently. Further investment is needed in digital infrastructure (including computers, Quick response (QR) code readers and smart phones), system expansion to include a financial management module, system integration and synchronization, user training, and maintenance, which is currently funded at 60% level, to ensure effective data collection, management, and utilization for informed and timely decision making and scheme administration.	1. Upgrade the CHI scheme information system to integrate a comprehensive financial management module and respond to the emerging systems operational needs 2. Develop the system operation manual and train system users on the functionality and adaptation of the system. 3. Periodically review the performance of the system. 4. Provide system infrastructure, including computers, QR code readers, and smartphones, to the CHI scheme and partner healthcare providers that have demonstrated limited financial capacity. 5. Schemes to charge a fee to fully cover annual system maintenance costs.
3. The Luwero District Community Health Financing Scheme (LDCHFS) also requires additional technical and financial support to be fully established, become operational, and be independently managed by the Luwero District Local Government. The technical support required includes developing the scheme design, CHI products and tools, promoting and creating awareness about the schemes, adapting and integrating the current CHI schemes into the	1. Provide technical support to Luwero district local government on developing the scheme design, governance structures, and operational procedures (CHI products and tools). 2. Train Luwero District leaders, healthcare providers, and implementers to manage the scheme.

Structures, systems, and mechanisms requiring additional support	Actions
district-wide scheme, monitoring the Scheme performance, adopting the CHI schemes information management system, and training the scheme implementers. The financial support is required for conducting a feasibility study, engaging Actuaries to develop appropriate products, sensitizing the current CHI scheme leaders and members, community members, and healthcare providers to prepare them for the district scheme, and organizing training and mentorships for scheme leaders and staff of potential healthcare providers.	3. Sensitize the general public to create awareness about the scheme 4. Upgrade the current CHI schemes' information management system for adaptation and integration by the district-wide scheme. 5. Mobilize additional financial support to conduct a feasibility study and actuarial study to develop appropriate products for the scheme. 6. Adapting and integrating the current CHI schemes into the district-wide scheme.
4. The CBHF implementation guidelines approval, dissemination, and popularization require additional support to the Ministry of Health. The required support is in terms of providing technical information and making presentations to refine the draft guidelines. Once fully approved and adopted, SHU will provide finances to hold stakeholder engagements to sensitize and disseminate the guidelines.	1. Provide technical support to the Ministry of Health to finalize and approve the draft CBHF guidelines 2. Hold stakeholders' dissemination and sensitization meetings on the CBHF guidelines.

6.2.5. Approaches, methodologies, and partnerships that have produced the strongest and most sustainable results and actions to sustain them.

Approaches, methodologies, and partnerships.	Actions
1. The partnerships established with MFIs (Butaba Co. Ltd, SHUF Ltd) to facilitate indirect premium collection from non-formal community groups were effective. Through this arrangement, partner MFIs collected premiums on behalf of the CHI schemes enabling members to access healthcare services without the burden of the immediate Out of Pocket payments. In the year 2025 for example, 86% of all the members under CRUMBS-L and MSCOM enrolled through the two partner MFIs. This approach contributed significantly to the availability of funds required for timely and full payment of medical bills, at the contracted healthcare facilities, thereby strengthening trust among the communities, healthcare providers and scheme managers. The partnership also demonstrated the viability of integrating micro finance services with community health financing mechanisms to improve affordability and enrollment among low-income populations.	1. Mobilise funds to boost the partner MFIs' capital to give loans to more CHI member families. 2. Introduce IGAs to boost family income enabling them pay premiums effectively. 3. Support CHI schemes and partner MFIs to formalise their collaboration. 4. Promote partner MFIs products to the CHI schemes target communities to increase their clientele. 5. Support partner MFIs with motorcycles to facilitate reach out to more CHI schemes target communities.
2. The strategy of working in partnership with key stakeholders and engaging them in advocacy for improved health services, and the inclusion of CHI within the proposed NHIS also generated strong and sustainable results. This approach involved collaborating with health care providers, CHF promoters,	1. Continue producing policy briefs, newsletters, and position papers to demonstrate CHI contribution to NHIS and UHC 2. Establish a structured national CHI advocacy

CSOs, district Local Governments, MOH through the NHIS task force, and Technical Working Group meetings, and the MoGLSD through the social protection committee. As a result, there was an increased recognition of CHI as an important healthcare financing strategy, and improved awareness and understanding of CHI among key stakeholders, including members of parliament, officials from the Ministry of health, and the Ministry of Gender, Labour and Social Development, and officials from Luwero District Local Government. The advocacy engagements also contributed to increased adoption and institutionalization of Client Relations Desks within the Partner healthcare facilities.	coalition comprising of healthcare providers, civil society organizations, Local governments, academic institutions, and community representatives. 3. Strengthen engagements with the Ministry of Health, MoGLSD, MoLG, Parliament, Luwero District Local Government, and development partners.
3. The promotion of CRDs through presenting viability reports, experience sharing during joint partners' meetings, and training of Client Relations Assistants proved to be another highly effective methodology. Out of the 40 healthcare facilities where the CRD concept was promoted, 33 adopted it, while 22 of the 33 institutionalised the desks. These interventions strengthened the capacity of healthcare facilities to manage client relations, coordinate healthcare access, and address beneficiaries' concerns on time. Consequently, client satisfaction with the quality of services improved significantly, while healthcare providers demonstrated increased commitment to maintaining the CRDs as part of the routine service delivery structures.	1. Develop CRD operational standards, guidelines, and performance indicators 2. Include the CRD training in the Continuous Medical Education sessions. 3. Train all facility staff in Customer care 4. Establish an experience-sharing and learning platform where successful facilities mentor the new adopters of the CRDs 5. Strengthen monitoring of the CRD performance, client satisfaction,

	and utilization of CRDs for quality improvement.
4. High-level engagement and continuous follow-up meetings with the Minister in charge of primary healthcare and the Director General of health services yielded important policy results. These engagements focused on following up on the resolutions of several national CHF conferences and advocating for policy support for CHI schemes. As a result, the first-ever Community-Based Health Financing guidelines were drafted and submitted to the Ministry of Health for review and approval, marking a significant milestone towards the formal recognition and regulation of CHI initiatives in Uganda.	1. Follow up on the approval, dissemination, and implementation of the CBHF guidelines. 2. Generate and share evidence on the performance of CHI schemes to support policy decisions. 3. Develop a structured policy engagement strategy with clear milestones and responsibilities.
5. Sensitising the Luwero District Council and the provision of technical and financial support were a successful approach that enhanced their ownership and participation in the process of developing the Luwero District CHF scheme. The sensitization meetings significantly increased understanding and commitment among district leaders, which led to the commencement of the implementation process for the scheme. This included vital steps such as the formation of the steering committee and the development of an implementation roadmap. Complementing this effort, the provision of technical and financial support to the Luwero District Council and the District Health Team further strengthened institutional capacity, ensuring effective coordination and	1. Formalise the partnership between SHU and Luwero District Local Government on the LDCHF scheme 2. Document and share information about the existing CHI schemes in the district, and their performance. 3. Mobilise resources to support the district to conduct a feasibility and actuarial study, and finalise the scheme design. 4. Support the district in holding multi-stakeholder meetings to

fundraising for the scheme development process.	discuss the proposed scheme and popularise it among the population.
6. Registering CHI schemes as Community-Based Organizations (CBOs) was a successful strategy. It increased their formal recognition and legitimacy within the districts of Luwero, Nakaseke, Nakasongola, Bushenyi, Sheema, Mitooma, Kassanda, and Iganga, thereby improving collaboration with healthcare providers, district authorities, and other stakeholders.	1. Document and share quarterly and annual reports with stakeholders. 2. Participate in the formally organized meetings by the District Community Development Office. 3. Renew the schemes' operational permits and comply with all the licensing requirements.
7. The partnerships established with 10 corporate groups to facilitate indirect premium collection from formal corporate groups were effective. Through this arrangement, partner corporate groups paid premiums for their members, enabling them to access healthcare services without the burden of out-of-pocket payments. Through this arrangement, CRUMBS-L registered 100% retention of members for the years 2023, 2024, and 2025. This approach contributed significantly to the availability of funds required for timely and full payment of medical bills at the contracted healthcare facilities, thereby strengthening trust among the groups, healthcare providers, and scheme managers. The partnership also demonstrated the viability of integrating formal corporate groups with	1. Share performance reports with the corporate groups 2. Carry out satisfaction surveys and share the findings with the groups 3. Seek referrals and recommendations from the existing corporate groups

community health financing mechanisms to improve enrollment of the vulnerable and the low-income earners in formal employment.	
8. Managing a CHI scheme by a hired third-party manager on behalf of the members in urban and formal settings proved to be one of the most effective approaches for implementing CHI schemes in contexts where members have limited time to volunteer to manage the scheme. Through this approach, the full-time third-party manager registers members, manages the fund, and contracts services providers. CRUMBS-L demonstrated the capacity to pay medical bills fully and on time over the past 5 years, built its reserve fund to the current reserve level of 241% against the internally recommended benchmark of 300%, and increased membership by 38% since 2021. As a result, there was increased satisfaction among healthcare provider managers with full and timely medical bill payment.	1. Develop standard operating procedures and performance benchmarks for the scheme managers. 2. Strengthen governance oversight to ensure performance and accountability. 3. Build reserve funds to reach and exceed the recommended benchmark.
9. Engaging a developer and involving users in the process of designing a customised CHI scheme Information Management System proved to be an effective strategy. The developer designed the system while adopting the needs of the system users, following intensive consultations and continuous feedback from the CHI schemes and the partner healthcare providers to facilitate improvement. The system developer has provided continuous support and possible system upgrades whenever required. Consequently, there was a transition from manual to electronic and digital information management systems in the 5 CHI schemes and the 33 partner healthcare providers in 2024.	1. Engage the system developer to enhance the system based on the existing gaps, user feedback, and emerging needs 2. Train system users on the new developments 3. Monitor the system performance 4. Mobilize funds to pay for the system upgrade and maintenance 5. Develop the system operating manual.

6.3. KEY SUCCESS FACTORS, INNOVATIONS, AND LESSONS LEARNED

6.3.1. Success factors

The evaluation identified several interrelated factors that contributed to the successful implementation of the project and the achievement of most of its intended results. These factors strengthened project effectiveness, stakeholder ownership, sustainability, and the overall impact of project interventions.

1. Strong technical knowledge and experience in community health insurance.

One of the key success factors was SHU's extensive experience and technical expertise in Community Health Insurance (CHI) development and management. Over the years, SHU has built strong institutional knowledge, implementation systems, stakeholder relationships, and practical experience in supporting community-based health financing initiatives. This experience enabled the organization to provide effective technical support to the 5 CHI schemes, healthcare providers, CSOs, Luwero district leaders, technical staff in the Ministry of Health, the Ministry of Gender, Labour and Social Development, and policymakers, while adapting implementation approaches to emerging opportunities and challenges.

2. Strong Community Ownership and Participation

The project benefited from active participation and ownership by CHI scheme members, scheme leaders, and healthcare providers. Existing governance structures, particularly Scheme Boards and Management Committees, played an important role in providing oversight, mobilizing communities, promoting enrolment, monitoring healthcare service delivery, and supporting implementation of project activities. Community ownership was therefore an important factor in sustaining member engagement and strengthening the relevance of the schemes within the communities they serve.

3. Strategic Partnerships and Stakeholder Engagement

The project successfully leveraged partnerships with healthcare facilities, Microfinance Institutions (MFIs), district local governments, Members of Parliament, the Ministry of Health, and other development actors. These partnerships enhanced resource mobilization,

facilitated policy engagement, improved healthcare service delivery, and expanded opportunities for financial inclusion. Collaboration with healthcare providers strengthened service quality and responsiveness, while partnerships with MFIs supported innovative premium payment mechanisms that improved affordability and membership retention.

4. Introduction of Innovative premiums financing and scheme management models

The introduction and expansion of indirect premium payment mechanisms through MFIs and VSLAs, online banking systems, the CHI schemes Information Management System, Client Relations Desks, and the Third-Party Managed CHI model significantly contributed to project success. These innovations improved operational efficiency, accountability, transparency, healthcare quality, and financial sustainability in the third-party managed scheme while addressing several longstanding challenges affecting Community Health Insurance schemes.

5. Effective digital transformation of scheme operations

The development and deployment of the customized CHI Information Management System across schemes and contracted healthcare facilities improved member registration, beneficiary verification, claims management, reporting, and decision-making. The system reduced administrative inefficiencies, strengthened accountability, improved data quality, and enhanced confidence among both healthcare providers and scheme members. The adoption of online banking systems further strengthened financial management and transparency.

6. Full and timely payment of medical bills

The CHI schemes' ability to ensure full and timely payment of healthcare claims strengthened confidence among healthcare providers and scheme members. Healthcare facilities remained committed to serving CHI beneficiaries because of the reliability of payment arrangements, while members gained confidence that their healthcare costs would be covered when needed. This contributed significantly to improved client satisfaction, provider satisfaction, and continuity of healthcare services.

7. Continuous policy engagement and advocacy

SHU's sustained engagement with policymakers, Members of Parliament, Luwero district leaders, officials of the Ministry of Gender, Labour and Social Development, and the Ministry of Health played an important

role in increasing recognition of Community Health Insurance within national health financing discussions. Regular advocacy, evidence sharing, stakeholder dialogues, and policy engagement activities contributed to increased parliamentary support for CHI and facilitated the development of the draft Community-Based Health Financing Guidelines.

8. Strong monitoring, learning, and adaptive management

The project demonstrated a strong culture of monitoring, learning, and adaptive management. Routine monitoring data, stakeholder feedback, and periodic reviews enabled SHU and project partners to identify implementation challenges and make timely adjustments. This flexibility allowed the project to respond effectively to emerging needs, strengthen interventions that were performing well, and introduce innovations that enhanced project outcomes.

9. Commitment of healthcare providers and leaders in the third-party-managed CHI scheme.

The commitment demonstrated by healthcare providers, Scheme Managers, Boards, Management Committees, and other local leaders contributed significantly to project achievements. Their willingness to embrace new systems, participate in capacity-building activities, and support implementation of project interventions strengthened service delivery, governance, and accountability across the supported schemes.

6.3.2. Innovations

The evaluation identified several innovations that significantly enhanced the effectiveness, efficiency, and sustainability of the project. SHU introduced these innovations to address key operational, financial, governance, and service delivery challenges affecting Community Health Insurance (CHI) schemes. They improved the affordability of premiums, strengthened financial management and accountability, enhanced member identification and claims processing, promoted patient-centered care, reduced operational costs, and increased the resilience of CHI schemes. The innovations are:

- a) Introduction of indirect premium payments through partnerships with MFIs that collect premiums on loans. The innovation addressed the problem of families being unable to pay premiums directly out of pocket because premiums are high and seasonal.
- b) Contracting pharmacies to provide drugs not given to scheme members using free government services. The innovation addressed the problem

of overconsumption of CHI scheme funds due to high costs at contracted healthcare facilities.

- c) Promotion of Client Relations Desks through partnerships with CHI healthcare providers. The innovation addressed the problem of high dropout from the schemes due to perceived poor quality of services and low client satisfaction.
- d) Introduction of the digital CHI schemes Information Management System that registers members, identifies scheme patients, invoices schemes, and provides reports. The innovation targeted fraud by healthcare providers arising from manual member identification and billing practices.
- e) Introduction of mobile money transfer services for receiving premiums from scheme leaders and members, and for paying scheme managers and agents. The innovation addressed the problem of mismanagement of scheme funds by scheme leaders and the high transport costs for banking premiums.
- f) Adoption of online banking services for paying healthcare and other service providers and statutory bodies. This innovation solved the issues of high transaction costs, cash theft, and delays in completing over-the-counter transactions.
- g) Merging the individual sub-scheme pools into a single pool for cross-subsidization and effective management of the scheme funds. This innovation addressed the issue of high management costs for individual, fragmented sub-scheme funds and the suspension of sub-schemes due to fund depletion.

6.3.3. Lessons learned from implementing the project.

The evaluation identified several important lessons from the implementation of the project and the evolving Community Health Financing landscape in Uganda. These lessons highlight emerging trends in health financing, changing community priorities and behaviours, and the importance of organizational adaptability and innovation. They provide valuable insights to guide SHU, its partners, and other stakeholders in strengthening the design, implementation, and sustainability of future interventions. The key lessons identified by the evaluation are presented below:

1. Health financing patterns should inform the design of CHI schemes' interventions:

SHU's experience during the project implementation found that health financing patterns differ considerably between the formal and informal sectors, with important implications for the design of Community Health Insurance (CHI) schemes. Experience shows that households in the informal sector rely largely on tax-funded public health services,

supplemented by out-of-pocket payments and borrowing to meet healthcare costs, reflecting limited financial protection and high vulnerability to health-related financial shocks. In contrast, individuals in the formal sector largely rely on health insurance, although out-of-pocket expenditure remains a significant source of healthcare financing. Project experience further demonstrated that, despite the Government's policy of free healthcare in public facilities, frequent medicine stock-outs often forced households to purchase medicines from private pharmacies or seek care from private providers. This emphasizes the necessity for Community Health Insurance Schemes to be customized to meet the distinct needs of both the formal and informal sectors. It is also important to complement public health services to address gaps in drug availability, thereby enhancing financial protection and improving continuity of care.

2. Community priorities influence demand for CHI:

Experience from project implementation showed that healthcare financing competes with many other immediate household needs. Throughout the project period, interactions with scheme members and community leaders revealed that households often prioritized basic needs such as food and communication over health insurance, with healthcare receiving greater attention only when illness occurred. This experience demonstrated that successful Community Health Financing interventions should not only promote the benefits of health insurance but also respond to households' economic realities. Integrating Community Health Financing with livelihood improvement, financial inclusion, and social protection interventions can strengthen enrolment, improve member retention, and enhance the sustainability of CHI schemes.

3. Technological trends should be taken into account to improve the effectiveness of CHI schemes:

Experience from project implementation showed that institutional adaptability to changing operational and technological contexts is essential for enhancing the effectiveness, efficiency, and sustainability of CHI schemes. Throughout the project period, SHU adopted virtual communication platforms, online banking systems, mobile money premium payment mechanisms, and electronic CHI information management systems to support scheme operations and coordination. This experience demonstrated that the timely adoption of appropriate digital technologies and flexible operational approaches significantly improved communication, operational efficiency, accessibility, financial management, and service delivery. It further showed that strengthening digital systems within CHI operations enhances the satisfaction of scheme members and partner healthcare service providers.

6.4. SWOT ANALYSIS: INSTITUTIONAL STRENGTHS AND COMPETITIVE ADVANTAGES.

This section evaluates SHU's institutional strengths and competitive advantages that enable the organization to design, implement, and sustain high-impact interventions. It focuses on SHU's internal capabilities, technical expertise, organizational systems, partnerships, and innovations that set it apart in Uganda's health financing sector. Additionally, the analysis identifies internal limitations and external factors that may affect the organization's future performance. The findings are presented using a SWOT framework to guide strategic planning and enhance SHU's long-term effectiveness and sustainability.

6.4.1.1. Expanded SWOT analysis

SWOT Element	Key Finding	Evidence / Justification from the Evaluation	Strategic Implication	Recommended Strategic Action	Priority	Timeframe
Strengths	1. National technical leadership in Community Health Insurance (CHI) and health financing	SHU has over 20 years of experience in CHI design, benefit package development, premium calculation, feasibility studies, scheme management, and policy advocacy. It supported five CHI schemes, designed the Luwero District Community Health Financing Scheme, contributed to the draft Community-Based Health Financing Guidelines, and provided technical support to organizations such as ENABEL, One World Health, SAJIDA Foundation, UPMB, UCBHFA, FDGN, and HuysLink.	Positions SHU as a national centre of excellence and a trusted technical resource for health financing reforms.	Expand consultancy services, technical assistance, research, and advisory support for NHIS implementation and district health financing initiatives.	High	Short- to Medium-term
	2. Proven and sustainable CHI	SHU has successfully promoted both Member-Managed and Third-Party	Provides scalable models for	Scale up successful CHI models	High	Medium-term

SWOT Element	Key Finding	Evidence / Justification from the Evaluation	Strategic Implication	Recommended Strategic Action	Priority	Timeframe
	implementation models	Managed CHI models for more than 15 years. Partnerships with Microfinance Institutions and Third-Party Managed CHI demonstrated strong sustainability potential and operational effectiveness.	expanding financial protection and Universal Health Coverage.	nationally and document lessons for replication.		
	3. Strong community mobilization and grassroots institutional structures	Long-standing community structures such as WATSA, MBUSO, MSCOM, CRUMBS-L, and BURATS have remained operational since 2006, supporting mobilization, governance, awareness creation, premium collection, and local ownership.	Enhances programme sustainability, trust, and community participation beyond project cycles.	Strengthen and replicate community-led governance and mobilization structures in future programmes.	High	Ongoing
	4. Strong policy advocacy, partnership, and sector leadership	Parliamentary support for CHI increased from 28 to 48 Members of Parliament. SHU has organized eight National Community Health Financing Conferences and coordinates five CHI	Strengthens SHU's influence on policy, sector coordination, knowledge sharing, and	Sustain policy engagement, strengthen partnerships, and position SHU as the leading national	High	Ongoing

SWOT Element	Key Finding	Evidence / Justification from the Evaluation	Strategic Implication	Recommended Strategic Action	Priority	Timeframe
Strengths		schemes, over 105 sub-schemes, 33 healthcare providers, and nine CHI promoters supporting approximately 57 schemes in 37 districts.	strategic partnerships.	coordination platform for CHI.		
	5. Innovative digital systems and quality improvement mechanisms	The CHI Information Management System was rolled out across five CHI schemes and 33 healthcare facilities, while Client Relations Desks contributed to client satisfaction increasing from 94% to 96%. Provider satisfaction also increased to 90% following the timely reimbursement of UGX 222.3 million for 3,961 healthcare cases.	Demonstrates SHU's capacity to improve efficiency, accountability, transparency, and service quality through innovation.	Continue investing in digital transformation, interoperability, and institutionalization of Client Relations Desks.	High	Medium-term
	1. Heavy dependence on donor funding	Most programme activities remain externally financed, creating vulnerability to	May constrain long-term institutional sustainability	Develop a social enterprise, establish and expand	High	Short- to Medium-term

SWOT Element	Key Finding	Evidence / Justification from the Evaluation	Strategic Implication	Recommended Strategic Action	Priority	Timeframe
		fluctuations in donor priorities and funding availability.	and programme continuity.	consultancy services, and diversify funding sources and unrestricted income streams.		
	2. Limited research dissemination and knowledge management	Although SHU generates valuable implementation experience and evidence, research outputs, publications, and documentation, and institutional learning remain underdeveloped.	Reduces organizational visibility, thought leadership, and evidence-informed advocacy.	Develop and implement a comprehensive research, documentation, and publication, and knowledge management strategy.	High	Short-term
	3. Capacity gaps among local implementers and emerging technical areas	Some Scheme Managers and Sub-Scheme Agents require continued mentorship and institutional strengthening. Capacity in advanced data analytics and digital innovation also requires enhancement.	May affect programme quality, scalability, and SHU's competitiveness in an evolving development landscape.	Strengthen technical assistance, staff development, digital capabilities, and local capacity-building systems.	Medium	Medium-term

SWOT Element	Key Finding	Evidence / Justification from the Evaluation	Strategic Implication	Recommended Strategic Action	Priority	Timeframe
Opportunities	1. National Health Insurance Scheme (NHIS) and district health financing reforms		Positions SHU to play a leading implementation, advisory, and capacity-building role in national health financing reforms.	Establish SHU as a strategic partner for NHIS implementation, district health financing schemes, and policy support.	High	Short- to Medium-term
	2. Expansion of consultancy, social enterprise, and Third-Party Managed CHI models	SHU possesses marketable expertise in health financing, CHI, research, training, and capacity building, while evaluation findings confirm the effectiveness of Third-Party Managed CHI.	Offers opportunities to diversify revenue, strengthen sustainability, and expand national impact.	Develop a social enterprise strategy and business plan while scaling up consultancy services and proven CHI models.	High	Short- to Medium-term
	3. Strategic partnerships and integrated programming	Opportunities exist to collaborate on livelihoods, maternal and reproductive health, climate resilience, environmental protection,	Broadens SHU's portfolio, attracts diversified funding, and enhances the	Conduct stakeholder mapping and develop joint programmes and funding	Medium	Medium- to Long-term

SWOT Element	Key Finding	Evidence / Justification from the Evaluation	Strategic Implication	Recommended Strategic Action	Priority	Timeframe
Threats		research, and social protection through joint programming and resource mobilization.	resilience of vulnerable communities.	proposals with strategic partners.		
	1. Increasing competition for donor funding and resource constraints	The external funding environment is becoming increasingly competitive, potentially limiting available resources for health programmes.	Could reduce programme expansion and institutional sustainability .	Strengthen fundraising systems, diversify financing sources, increase organizational visibility, and expand unrestricted income generation.	High	Short-term
	2. Policy uncertainty and delays in health financing reforms	Changes in government priorities or delays in NHIS implementation could affect opportunities for scaling Community Health Insurance.	May slow policy gains and programme expansion.	Maintain proactive advocacy, strengthen stakeholder alliances, and adopt adaptive programme	Medium	Ongoing

SWOT Element	Key Finding	Evidence / Justification from the Evaluation	Strategic Implication	Recommended Strategic Action	Priority	Timeframe
				planning approaches.		
	3. Economic vulnerability, climate shocks, and public health emergencies	Household financial constraints may reduce premium payments, while climate-related events and disease outbreaks can increase healthcare needs and disrupt livelihoods.	Could undermine CHI enrolment, financial sustainability, and community resilience.	Expand flexible premium payment mechanisms, strengthen Microfinance Institution partnerships, and integrate climate resilience and social protection into programme design.	Medium	Medium- to Long-term

6.4.2. Key findings and strategic implications

The SWOT analysis demonstrates that Save for Health Uganda (SHU) has built a strong institutional foundation for delivering effective and sustainable interventions. The organization's specialized expertise in Community Health Insurance and health financing, coupled with its strong partnerships, innovative programme models, and policy engagement, positions it as a leading technical resource in Uganda's health financing landscape.

The analysis also highlights several opportunities that SHU can leverage to enhance its impact and long-term sustainability. These include supporting the implementation of the National Health Insurance Scheme and the Luwero District-wide Community-Based Health Financing Scheme, expanding Third-Party Managed Community Health Insurance models, strengthening partnerships with government and Microfinance Institutions, healthcare facilities, and other development actors, establishing a social enterprise, and developing joint programmes in health financing, livelihoods, climate resilience, maternal and reproductive health, and research.

At the same time, the evaluation identifies strategic areas requiring further investment. These include strengthening resource mobilization, research and knowledge management, digital technologies, and staff capacity in emerging technical areas. Addressing these gaps will improve organizational resilience, enhance competitiveness, and position SHU to respond effectively to changing development priorities and funding environments.

Overall, the findings indicate that SHU is well-positioned to build on its existing strengths while proactively addressing internal weaknesses and external risks. Continued investment in institutional development, innovation, and strategic partnerships will be critical to sustaining its leadership role and maximizing its contribution to equitable healthcare access and social protection in Uganda.

6.5. RELEVANCE OF SAVE FOR HEALTH UGANDA'S INITIATIVES IN ENHANCING COMMUNITY HEALTH FINANCING AND ACCESS TO HEALTHCARE

6.5.1. Stakeholder demand for SHU's initiatives

The evaluation found strong demand for SHU's Community Health Financing initiatives, demonstrating their continued relevance in strengthening financial protection and improving access to healthcare. Stakeholders

consistently recognized the value of SHU's Community Health Insurance (CHI) implementation models, technical assistance, capacity strengthening, policy engagement, and community-based financing approaches in addressing health financing challenges.

Community Health Insurance schemes and healthcare providers expressed interest in sustaining and expanding interventions that strengthen scheme governance, management capacity, financial sustainability, healthcare financing, and service quality. Particular value was placed on initiatives such as Client Relations Desks, timely reimbursement of medical bills, and community mobilization to increase CHI enrolment and utilization of healthcare services.

Government institutions, including the Ministry of Health, the Ministry of Gender, Labour and Social Development, and the Luwero District Local Government, identified SHU's Community Health Financing approaches as relevant for supporting Community-Based Health Financing implementation and informing national health financing reforms. Similarly, Microfinance Institutions recognized the value of indirect premium payment mechanisms in improving the affordability of health insurance while promoting financial inclusion among vulnerable households.

The evaluation further found growing interest from research and academic institutions in SHU's implementation experience as a source of evidence for Community Health Financing. Community members and local leaders continued to value SHU's initiatives for improving financial protection and access to healthcare, while digital technology providers expressed interest in supporting the expansion of digital solutions to strengthen CHI scheme management and service delivery.

6.5.2. Institutional adaptation

The evaluation found that SHU has continuously adapted its strategies, partnerships, and implementation approaches in response to evolving community needs, technological advancements, and national health financing priorities. These adaptations have enabled its initiatives to remain relevant while expanding their contribution beyond traditional CHI implementation.

A key adaptation has been SHU's strategic repositioning from primarily supporting communities and healthcare providers to serving as a technical resource for government institutions, development partners, and Community Health Financing (CHF) promoters. In addition to implementing CHI schemes, SHU now provides technical assistance for the design, implementation, and management of Community Health Financing

initiatives and actively contributes to national health financing reforms, including the National Health Insurance Scheme (NHIS), the Luwero District Community Health Financing Scheme, and the Community-Based Health Financing Guidelines.

The evaluation also found that SHU has enhanced the relevance of its programmes through innovations in financing and implementation models. Partnerships with Microfinance Institutions introduced indirect premium payment mechanisms that improved the affordability of CHI premiums, contributing to increased enrolment and member retention. Similarly, the introduction of the Third-Party Managed CHI model enabled SHU to reach organized groups, employers, and corporate institutions while addressing governance and management challenges associated with volunteer-led member-managed schemes.

In addition, SHU has embraced digital transformation to improve the efficiency and accountability of CHI operations. The introduction of the Community Health Insurance Schemes Information Management System and online banking modernized member registration, beneficiary verification, claims processing, financial management, invoice generation, and reporting, resulting in more efficient scheme administration and improved service delivery.

Overall, these strategic, programmatic, and technological adaptations have enabled SHU's initiatives to remain responsive to changing stakeholder needs and policy priorities, while strengthening their effectiveness and contribution to sustainable healthcare financing in Uganda.

6.6. FUTURE STRATEGIC OPPORTUNITIES AND DIRECTION (2027 – 2029 AND BEYOND)

This section presents the strategic opportunities and future directions emerging from the evaluation to inform Save for Health Uganda's programming beyond the current project. It identifies priority areas that warrant continued investment and strategic attention to strengthen Community Health Financing and Community Health Insurance, address persistent implementation challenges, and consolidate the gains achieved.

6.6.1. Identified Problems, Issues, and Gaps from the evaluation that need further attention and intervention.

1. Absence of a legal (support/policy) framework for CHI. All proposed policy frameworks, including the NHIS, the CBHF guidelines, and the Luwero District CHF scheme, have not yet been finalized.
2. Limited access to quality health care services due to some families' inability to afford premiums, the existing CHI schemes' poor performance due to low capacity and willingness among scheme leaders to fulfill their roles, and the lack of nearby quality health care facilities that the schemes can contract with.
3. Inadequate knowledge about Community Health Insurance (CHI), including coverage, benefits, how it works and functions, how it improves quality and access to services and the health system, among policymakers (Members of Parliament, MoH, MoGLSD, MoLG), the target population, and the general public.
4. Inadequate knowledge and capacity (human resources, space, customer care knowledge, integrating the CRD into their structures, training CRAs, and computers) in some partner health care facilities to provide reception services to clients.
5. Limited access to financial institutions to provide capital to some households in the target communities for starting and sustaining IGAs, due to ignorance about available financial services, lack of loan collateral, unfavorable loan terms and conditions, lack of capacity to manage established local saving and credit initiatives, and limited skills to apply for loans.
6. Limited capacity (in business development skills and knowledge management skills) of SHU to mobilize adequate resources to implement and sustain its operations without external donor support.
7. Limited technical capacity (in fund management, risk identification and management, negotiation and contracting services, product development and premium setting, member management) of scheme leaders to manage and sustain scheme operations.
8. Limited technical capacity (on scheme design, product development and premium setting, management tools development, scheme management and governance policies, and stakeholder sensitization) of Luwero District Local Government to implement and manage the LDCHF scheme.
9. Limited data and real-time reports on: target population, beneficiaries, premiums collected, service utilization, satisfaction with the quality of services, CRD utilization, and scheme expenses.

The evaluation identified a number of strategic actions that SHU should prioritize during the next phase to address the gaps and challenges identified. These proposals build on the organization's implementation experience, lessons learned, and stakeholder feedback, and are intended to strengthen the effectiveness, sustainability, and scalability of SHU's Community Health Financing initiatives. They provide a practical roadmap for enhancing programme implementation, strengthening institutional capacity, and increasing SHU's contribution to equitable and sustainable access to healthcare.

Table showing proposed interventions, target groups, and implementation approaches.

Problem/Gap/Issue	What to do to address the problem?	Why do this to address the problem?	Where to do the intervention/target	How best to implement?
1. Absence of a legal support and policy framework for CHI. All the proposed policy frameworks, including the NHIS, the CBHF guidelines, and the Luwero District CHF scheme, have not yet	Support the finalization, approval, and operationalization of the Community-Based Health Financing (CBHF) Guidelines, the National Health Insurance Scheme (NHIS), and the Luwero District Community Health Financing (LDCHF) Scheme.	To provide legal recognition, regulatory guidance, and institutional support for CHI schemes, while creating an enabling environment for scale-up and sustainability.	Ministry of Health (Health Policy Advisory Committee, senior management, top management), Parliament (health committee, social protection committee, MPs representing the target communities, other MPs), Ministry of Gender, Labour and Social Development, Ministry of Local Government, Luwero District	Strengthen CHI, LDCHF Scheme, and NHIS policy advocacy: - Provide technical support to policy review committees; - Organize stakeholder dialogues on guidelines, CHI, LDCHFS, and NHIS; - Develop and present policy briefs; - Support dissemination of approved frameworks; - Establish a national CHI advocacy coalition - Conduct media engagements to increase policy

Problem/Gap/Issue	What to do to address the problem?	Why do this to address the problem?	Where to do the intervention/target	How best to implement?
been finalized.			Local Council, CHI promoters, healthcare providers, CSOs, and development partners.	support and public awareness.
2. Limited access to quality healthcare services due to unaffordable premiums, weak scheme performance, and inadequate healthcare provider coverage.	Strengthen healthcare financing mechanisms, improve scheme management, expand healthcare provider networks, and promote flexible premium payment approaches.	To reduce financial barriers to healthcare, improve the scheme's sustainability, and increase access to quality healthcare services for vulnerable households.	The 5 existing CHI schemes, the target communities, the target MFIs, SACCOs, employers, corporate groups, and the target healthcare providers.	- Promote indirect premium payment mechanisms through SACCOs, employers, and corporate groups, and MFIs; - Strengthen partnerships with microfinance institutions; - Support establishment of scheme-linked SACCOs; - Transform weak member-managed schemes into sustainable third-party-managed schemes where appropriate; and - Expand contracting of quality healthcare providers.

Problem/Gap/Issue	What to do to address the problem?	Why do this to address the problem?	Where to do the intervention/target	How best to implement?
3.	Implement a comprehensive CHI awareness, advocacy, and stakeholder engagement programme.	- To increase understanding of CHI benefits and operations, - To strengthen policy support, - To increase enrolment, - To promote informed participation on in health financing initiatives.	1. Policymakers, • Members of Parliament, • Ministry officials (MOH, MGLSD and MOLG), • Leaders in the target Districts, 2. Healthcare providers, 3. Employers, 4. Academic institutions, 5. Community leaders, and 6. The general public.	- Conduct district-level sensitization campaigns; - Organize annual CHF conferences; - Engage policymakers through policy dialogues; - Utilize mass media and digital platforms; - Develop and disseminate information materials; and - Collaborate with academic institutions to generate and disseminate evidence on CHI.
4. Inadequate capacity among healthcare facilities to provide effective reception and client support services	Strengthen and institutionalize Client Relations Desks and client-centred systems within partner healthcare facilities.	To improve client satisfaction, responsiveness to client concerns, quality of care, and utilization of healthcare services.	Partner healthcare facilities (Healthcare managers, Client Relations Assistants, and Healthcare workers).	- Conduct capacity assessments; - Conduct regular monitoring and support visits to enhance the performance of the CRDs. - Provide training and mentorship in

Problem/Gap/Issue	What to do to address the problem?	Why do this to address the problem?	Where to do the intervention/target	How best to implement?
through Client Relations Desks (CRDs) .				customer care and communication; - Develop and operationalize standard operating procedures for CRDs at the healthcare facilities; - Facilitate peer learning and experience-sharing through established platforms; - Equip CRDs with computers and the information management system; - Integrate CRDs into facility structures and budgets.
	Strengthen financial inclusion initiatives through: (1) partnerships between CHI schemes, SACCOS, and microfinance institutions;	To improve household incomes, increase financial resilience, and enhance the capacity of families to sustain premium	- Target communities, SACCOS, MFIs, CHI schemes.	- Support formation and strengthening of CHI scheme SACCOS; - Facilitate connections between partner MFIs and SACCOS with affordable financial service providers, such as the

Problem/Gap/Issue	What to do to address the problem?	Why do this to address the problem?	Where to do the intervention/target	How best to implement?
	and (2) CHI schemes establishing their own SACCOs	payments and meet other household needs.		Microfinance Support Center and others, to enhance their capital and enable them to expand their coverage; - Provide financial literacy, savings and enterprise development trainings; - Establish risk-sharing arrangements between schemes and financial institutions.
5. Limited institutional capacity of SHU to mobilize resources and sustain operations without donor support.	Strengthen SHU's resource mobilization, business development, knowledge management, and institutional sustainability systems.	To diversify funding sources, reduce donor dependence, and ensure long-term sustainability of SHU programs, including promotion and support services.	- SHU Board, management, and technical staff, - Development partners, - Academic institutions - Private-sector partners.	- Develop and implement a sustainability and resource mobilization strategy; - Build staff capacity in proposal development, business development, and knowledge management; - Establish an online CHI knowledge and resource centre; - Establish and strengthen consultancy services;

Problem/Gap/Issue	What to do to address the problem?	Why do this to address the problem?	Where to do the intervention/target	How best to implement?
				- Document and disseminate evidence and lessons learned; - Develop social enterprise initiatives.
6. Limited technical capacity of scheme leaders to manage and sustain scheme operations.	Expand third-party managed CHI scheme model to SHU program where areas scheme management by volunteers with limited technical capacity is difficult	To improve scheme performance, accountability, operational efficiency, and long-term sustainability in schemes where volunteer-led management structures have proven ineffective or unsustainable.	Existing member-managed CHI schemes (WATSA, MSCOM, BURATS, and MBUSO), • Scheme Boards • Annual General Meetings (AGMs) • Scheme members.	- Assess the suitability of existing schemes for transition to the third-party management model. - Obtain approval from scheme members, Boards, and AGMs to transition eligible schemes. - Transform selected member-managed schemes into third-party-managed schemes under SHU oversight. - Develop and operationalize standard operating procedures, governance structures, and

Problem/Gap/Issue	What to do to address the problem?	Why do this to address the problem?	Where to do the intervention/target	How best to implement?
				management tools for the third-party model. - Document and disseminate lessons, success stories, and good practices from CRUMBS-L to support replication and scale-up. - Provide technical support to newly transitioned schemes to ensure effective implementation and sustainability.
7.	Provide structured technical assistance to strengthen district capacity to establish, implement, and sustain the LDCHF Scheme.	To enable effective district ownership, oversight, management, and sustainability of the district community health financing scheme.	District Council, District Health Team, Chief Administrative Officer, District Community Development Officer, Chief Finance Officer, Steering Committee, healthcare providers, and	- Formalize collaboration between SHU and the district; - Support development of scheme design, governance structures, operational manuals, products, and management tools; - Conduct capacity-building and learning visits;

Problem/Gap/Issue	What to do to address the problem?	Why do this to address the problem?	Where to do the intervention/target	How best to implement?
			the public in Luwero District.	- Organize stakeholder engagements; - Support community sensitization and enrolment activities.
8. Limited data and real-time reporting on scheme performance and operations.	Strengthen digital information management, and monitoring, and reporting systems across CHI schemes and partner institutions.	To improve data quality, accountability, performance monitoring, evidence-based decision-making, and timely reporting.	SHU, CHI schemes, partner healthcare facilities, Luwero District CHF scheme members, and healthcare providers.	- Upgrade and scale the CHI Information Management System (IMS); - Provide ICT equipment where needed; - Train system users; - Strengthen data quality assurance mechanisms; - Conduct routine data reviews; - Promote regular generation and use of performance reports for decision-making.

7. CONCLUSION.

The evaluation concludes that the project was relevant, effective, and largely successful in achieving its intended objectives. The intervention responded to a critical need for affordable healthcare financing among vulnerable households and demonstrated that Community Health Insurance can significantly improve access to healthcare services while reducing financial barriers to care.

The project achieved notable improvements in client satisfaction, healthcare provider confidence, timely payment of medical bills, digitalization of scheme operations, and policy recognition of Community Health Insurance. Through strategic partnerships, innovation, advocacy, and capacity strengthening, SHU successfully enhanced the performance and credibility of Community Health Insurance schemes and contributed to national discussions on health financing reforms.

The evaluation further demonstrates that several project outcomes have strong sustainability prospects, particularly those linked to institutionalized systems, established partnerships, digital technologies, and the Third-Party Managed CHI model. However, sustainability challenges remain in areas requiring intensive local management capacity, particularly among some Scheme Managers and Sub-scheme Agents, highlighting the need for alternative management approaches and continued technical support.

Importantly, the project generated impacts beyond its original design. These include increased recognition of SHU as a national centre of excellence in Community Health Insurance, introduction of SHU CHI models by partner and other organizations, renewed efforts to establish the Luwero District Community Health Financing Scheme, and growing national interest in Community-Based Health Financing as a pathway towards Universal Health Insurance Coverage.

Overall, the project has laid a strong foundation for future expansion of Community Health Insurance, strengthened SHU's institutional position within Uganda's health financing sector, and created strategic opportunities for supporting national and sub-national health financing reforms. Building on these achievements will require continued innovation, stronger partnerships, investment in organizational capacity, and a deliberate focus on sustainable and scalable implementation models.

8. RECOMMENDATIONS

The evaluation findings demonstrate that SHU has made substantial contributions to expanding access to healthcare through Community Health Insurance, strengthening health financing systems, improving healthcare quality, and influencing policy development at both district and national levels. However, sustaining and scaling these achievements will require deliberate investments in policy engagement, institutional strengthening, financial sustainability, innovation, and strategic partnerships. The following recommendations are proposed to guide SHU's future programming and organizational development.

8.1. HIGH-PRIORITY RECOMMENDATIONS

1. Support National and District Health Financing Reforms

The evaluation found increasing recognition of community-based health financing as an important mechanism for advancing Universal Health Insurance Coverage in Uganda. SHU has played a significant role in generating evidence, piloting innovative financing approaches, and contributing to policy dialogue. Building on this foundation, SHU should strengthen its position as a technical partner to the Ministry of Health by supporting the finalization, dissemination, and operationalization of the Community-Based Health Financing Guidelines. This would provide a framework for standardizing and scaling community health financing approaches across the country.

At the sub-national level, SHU should provide technical support to the establishment and implementation of the proposed Luwero District Community Health Financing Scheme as a demonstration model for district-led health financing. In addition, sustained engagement with government institutions will be important to ensure that lessons and experiences from Community Health Insurance schemes inform the design and eventual implementation of the National Health Insurance Scheme. Such engagement will help position SHU as a strategic partner in Uganda's broader health financing reforms.

2. Scale Sustainable Community Health Insurance Models

The evaluation identified the Third-Party Managed CHI model as a promising innovation for addressing governance, accountability, and operational challenges that have affected some Member-managed schemes that rely primarily on volunteer leadership. While volunteer leadership remains valuable in promoting community ownership, several schemes

continue to experience difficulties in managing increasingly complex administrative and financial responsibilities.

SHU should therefore expand the Third-Party Managed model to areas where volunteer-led management has proven difficult or unsustainable. To ensure consistency and quality, the organization should develop clear operational standards, governance frameworks, performance benchmarks, and accountability mechanisms for such schemes. Systematic documentation and dissemination of lessons learned from the model will further support replication by other stakeholders and contribute to the national evidence base on sustainable community health financing.

3. Strengthen Premium Collection and Financial Sustainability

The long-term sustainability of Community Health Insurance schemes will depend on their ability to maintain adequate membership levels, improve premium collection efficiency, and strengthen financial resilience. The evaluation found that indirect premium payment arrangements involving Microfinance Institutions (MFIs), Village Savings and Loan Associations (VSLAs), and corporate organizations (employers) have improved affordability and increased enrolment among vulnerable populations.

SHU should therefore expand partnerships with microfinance institutions, SACCOs, cooperatives, employers, and community groups to facilitate premium collection and improve member retention. Further efforts should focus on strengthening reserve fund management, enhancing financial risk monitoring systems, and promoting financial literacy among scheme leaders and members. These measures will improve the capacity of schemes to withstand financial shocks while ensuring continuity of services for members.

4. Consolidate and Expand Digital Transformation

The digital systems established under the project have significantly improved scheme management, claims processing, reporting, and accountability. However, opportunities remain to enhance the functionality and long-term sustainability of these systems.

SHU should prioritize upgrading the Community Health Insurance Schemes' Information Management System to include a comprehensive financial management module capable of supporting budgeting, reserve fund tracking, claims analysis, and financial reporting. Additional investments should prioritize improving system integration, data analytics, reporting functionality, and decision-support capabilities. Continuous user training, infrastructure upgrades, and long-term maintenance arrangements will also be essential to maximize the value and sustainability of digital investments.

5. Institutionalize Healthcare Quality Improvement Mechanisms

The introduction of Client Relations Desks (CRDs) has improved communication between healthcare providers and clients while contributing to improved client satisfaction and accountability. Nevertheless, the effectiveness of CRDs varies across facilities, and there remains a need to institutionalize these structures within routine health service delivery systems.

SHU should work with healthcare providers and relevant stakeholders to fully institutionalize Client Relations Desks across all contracted facilities. This should include the development of standard operating procedures, performance indicators, reporting mechanisms, and quality assurance standards. Routine collection and utilization of client feedback should be strengthened to support continuous quality improvement and enhance responsiveness to patient needs.

6. Strengthen Sector Coordination and Collective Advocacy for Community Health Financing

SHU should leverage its growing influence to convene Community Health Financing promoters, researchers, policymakers, and practitioners through formal coordination and learning platforms. This will strengthen collective advocacy, facilitate knowledge exchange, promote harmonization of approaches, and advance policy and regulatory reforms for Community Health Financing in Uganda.

7. Strengthen SHU's Institutional Sustainability and Competitiveness

While SHU has established itself as a leading organization in Community Health Insurance and Community Health Financing, continued reliance on donor funding presents sustainability risks. The evaluation highlights the need for SHU to strengthen its financial sustainability and competitiveness to effectively support its long-term strategic objectives.

SHU should develop and implement a comprehensive resource mobilization strategy that expands engagement with development partners, government agencies, private sector actors, philanthropic organizations, and other potential funding sources. The organization should also explore sustainable income-generating opportunities, including consultancy services, technical assistance, training, management of Third-Party CHI schemes, and other social enterprise initiatives that align with its mandate and expertise. These efforts will strengthen SHU's financial resilience, reduce dependence on donor funding, and position the organization to sustain and expand its impact in Community Health Financing and Universal Health Coverage.

8.2. MEDIUM-PRIORITY RECOMMENDATIONS

8. Strengthen Organizational Capacity Development for Future Growth

The evaluation found that SHU's role is increasingly evolving from direct implementation of Community Health Insurance schemes to providing technical assistance, policy support, digital innovation, research, knowledge management, and support to Community Health Financing initiatives at district and national levels. Sustaining this expanded mandate will require continued investment in organizational capacity, leadership, and institutional systems.

SHU should strengthen its technical, managerial, and operational capacities to effectively respond to emerging opportunities and growing demand for its expertise. Priority investments should focus on staff development in health insurance and financing, policy analysis, digital systems management, monitoring and evaluation, data analytics, research, and strategic communication. These investments will position SHU to effectively fulfil its evolving role as a trusted technical partner and national leader in Community Health Financing and health financing reforms.

9. Invest in Research, Documentation, and Knowledge Management

The evaluation found that SHU has generated valuable evidence and practical experience that can inform national and regional health financing initiatives. However, much of this knowledge remains underutilized beyond project implementation areas.

SHU should strengthen its role as a national knowledge and learning centre for Community Health Insurance by investing in operational research, documentation, publication, and dissemination of evidence. Strategic partnerships with universities, research institutions, and professional associations should be pursued to enhance knowledge generation and facilitate broader learning. Strengthening knowledge management systems will also ensure that lessons learned are systematically captured and applied to future programming.

8.3. STRATEGIC GROWTH OPPORTUNITIES

1. Pursue integrated and multi-sectoral programming

SHU learned that improving healthcare access and financial protection requires addressing broader socioeconomic factors such as household income, livelihoods, social vulnerabilities, and resilience to shocks. This experience showed that future interventions should adopt more integrated and multisectoral approaches to address these barriers and increase participation in Community Health Insurance and Community Health Financing initiatives.

SHU should strategically link Community Health Financing interventions with household livelihood improvement, social protection, maternal, child, and reproductive health, climate resilience, environmental sustainability, and community empowerment programs. Such integration will strengthen household resilience, improve vulnerable families' ability to enroll in and sustain participation in health financing schemes, and contribute to more sustainable improvements in healthcare access and financial protection. This approach will also enable SHU to respond more effectively to evolving community needs while expanding opportunities for partnerships, resource mobilization, and program impact.

2. Strengthen Innovation and Adaptation to Emerging Health Financing Needs

The evaluation demonstrated that innovation has been a key driver of SHU's success in improving healthcare access, strengthening scheme sustainability, and responding to emerging challenges within Community Health Insurance. Innovations such as the Third-Party Managed CHI model, indirect premium payment mechanisms through Microfinance Institutions, digital information management systems, online banking platforms, and Client Relations Desks have improved accountability, affordability, service quality, and operational efficiency.

SHU should therefore continue to identify, test, refine, and scale innovative approaches that respond to evolving community needs and developments in the health financing sector. Particular attention should be given to expanding successful innovations, piloting new financing and service delivery models, and adapting implementation approaches based on emerging evidence and lessons learned. Continuous innovation and adaptation will enable SHU to remain responsive, enhance programme effectiveness, and strengthen its contribution to Community Health Financing and Universal Health Coverage in Uganda.