



SAVE FOR HEALTH UGANDA (SHU)

"Community solidarity for quality health"

ANNUAL REPOR 2010

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List of abbreviations

ANC	Antenatal care
BOD	Board of directors
CBO	Community based organization
CIDR	Centre international de développement et de recherché
CORDAID	Catholic Organization for Relief and Development Aid
EED	Evangelische Entwicklungs Dienst
HC	Health center
HCF	Healthcare facility
IPD	In patients department
MCH	Maternal and child health
NGO	Non -governmental organization
NHIS	National health insurance scheme
OPD	Out patients department
PNC	Postnatal care
SHU	Save for health Uganda
UCBHFA	Uganda community based health financing association
UGX ¹	Uganda shilling
USD	United states dollar

¹ USD 1 = UGX 2000

Introduction

Save for health Uganda (SHU) is a local Ugandan non-governmental organization (NGO) registered in 2003. SHU implements activities in five Ugandan districts located in the central and western regions.

Mission

To improve the quality of health of Ugandans using the community health financing approach in the target Districts

Strategic objectives:

1. Improve people's financial access to quality and affordable healthcare services. Many Ugandans especially the rural poor are excluded from healthcare services due to financial constraints. The direct out of pocket expenditures are unaffordable and sometimes if paid are catastrophic
2. Rationalize healthcare seeking behaviours of the target population. There are many acts of self medication among people. This habit is not only ineffective in curing diseases, it is also very expensive. Other people delay to seek the right care from the right services providers due to cultural beliefs. Delays result into expensive care when finally presented to the right places; to many rural poor, payment for such expensive care is not possible leading to runaway cases
3. Strengthen the civil society in Uganda by supporting and empowering communities create self-managed community based organisations through which they can support each other improve their wellbeing. Ideally, healthcare providers should offer services which respond to their target populations' felt needs. This however is rarely the case. Whereas it may be very difficult for individual patients to influence a healthcare provider decisions, it is easier with groups. Groups such as patient groups that guarantee payment for medical bills have a strong voice if empowered and well organised

4. Support women to take their place and play more roles in the development initiatives in Uganda. The status of women in Uganda has been steadily improving. Many women are now educated and are playing key roles in development. In the rural communities however, the speed at which women are actively involved in decision making both at family and community levels is slower than in urban places. Concerning family health, women in Uganda take the lead and yet they rarely participate in decisions on how to improve the health status of their family members and the communities in general

Principle activity of the SHU programme:

Efforts are concentrated on sensitising and building the target communities capacities to create new schemes, and use the running self-managed community-based healthcare financing schemes as a way to improve access to quality healthcare services and minimize the consequences of irrational healthcare seeking behaviours.

Methodology employed:

SHU works with selected communities in its target districts to create self managed, self financed and community owned health micro-prepayment schemes which then became a channel for implementing all activities and for accessing benefits

Projects being implemented:

For the period July 2009 to June 2012, two projects are being implemented. They are:

1. Reducing barriers to quality healthcare services of the rural poor in Luwero, Nakaseke, Nakasongola, and Bushenyi districts of Uganda. It is a project funded by Evangelische Entwicklungs Dienst (EED) which aims to improve the target populations' financial access to quality healthcare services.
2. Reducing delays to maternal and infant healthcare services in Bushenyi district of Uganda. It is a project funded by the catholic organisation for relief and development aid (Cordaid) aiming to improve maternal and neonatal health indicators through improved utilization of maternal and neonatal healthcare services.

Context up - date

The national health policy

The Government of Uganda still implements a free healthcare policy in Government health facilities. Without changing the policy, the government is introducing a national health insurance scheme to cover all Ugandans. Whereas a lot has been done, the scheme is still at design stage and its actual start date remains unknown.

General elections

The year has been full of political activities as each political party prepares for the up-coming general elections scheduled to take place between February and April 2011. Whereas the ruling party has been consolidating its achievements and trying very hard to fulfill its promises, the opposition parties have concentrated on demanding for free and fair elections in 2011. Specifically, the opposition has been demonstrating against the current electoral commission which they say is not independent. In the communities where SHU intervenes, there is no much fears among the population arising from the up-coming elections.

New districts

The Government continued to split some old districts into new and smaller districts. Bushenyi district one the districts where SHU has worked since 2006 was split into five districts during the year. The new districts² created out of Bushenyi district are: Sheema district (201,000 people); Bushenyi district (242,300 people); Mitooma district (181,400 people); Rubirizi district (124,500 people); and Nsiika district (108,300 people). As a consequence of this development, the districts where SHU implements activities in the area have now increased to two and are: Sheema and Bushenyi districts.

² Population is according to the Bushenyi district population office as reported in the New vision

BOD chairpersons' overview



Dr. Lorna B. Muhirwe
BOD Chairperson



Sr. Ernestine Akulu
BOD Vice
Chairperson



Dr. Joseph Baguma
BOD Treasurer

It is still necessary to support the poor in Uganda to access quality healthcare services. Private healthcare facilities in Uganda are perceived to offer better quality care than the government ones and many Ugandans prefer to access private services. The costs of transport and services however limit many.

To improve this financial challenge, SHU is mobilizing and helping rural communities organize themselves into self managed health micro-prepayment schemes. Through these schemes, families are able to pool resources and support each other to access quality services. Though challenging, at SHU we have been able to support 28 communities create schemes. By 30th June 2010, a total of 15,306 individuals had made contributions into the schemes and were covered.

To have enough capacity to support more communities in the near future, efforts have been put in strengthening the SHU institution this year; a head office was opened up in Kampala to improve coordination, an independent board of directors (shown on the left) was instituted and has since met four times, a finance and administration officer was recruited to guarantee accountability and timely reporting and a technical partnership agreement between Centre international de développement et de recherché (CIDR) and SHU renewed. A finance policy has been drawn while a human resource policy will be finalized soon.

SHU continued to be an active member of a national umbrella



Mr. Fredrick
Makaire
Executive
director/BOD
Secretary



Mr. Clement
Bagatuzayo
BOD Member



Ms. Rachel
Kisakye
BOD Member

association -UCBHFA- for all community health financing initiatives in Uganda. Several other partners are working together with SHU to make her activities possible. EED who have funded the project since the beginning still provide support and the current contract expires at the end of June 2011. Since July 2009, a new partnership with Cordaid started. Cordaid is committed to a three-year support to SHU ending June 2012. The other partners with whom we worked during the year include: Healthcare providers to the schemes (Kiwoko hospital; Ishaka Adventist hospital, Kitagata hospital and Bishop C. Asili health center), the Local authorities in the districts of operation, and the community members who have enrolled into the schemes. In December 2009, the second annual partners' workshop was held in Kampala. At the workshop, SHU's results and activities for the year 2010 / 2011 were shared and a representative of the ministry of health gave participants an up-date about the national health insurance scheme (NHIS) being designed. SHU together with UCBHFA have been actively lobbying the task force responsible for designing the NHIS to enrol the informal sector sooner than the 15 years after take-off as planned. SHU will continue to reach out to its partners to continue advocating and to lobby for the poor's involvement in the scheme as well as for government to subsidise their premiums to make the scheme affordable. *SHU is grateful to all partners for their contributions*

Dr. Lorna B. Muhirwe
BOD Chairperson

Programme up - date

I. Activities carried out during the year

During the period July 2009 to June 2010, several of the planned activities were done. The main activities done include:

a) Sensitization

As an important part of the SHU methodology, sensitization meetings were held in all communities selected for creating new schemes. In these communities, the sensitizations were targeting two categories of residents: First were the local administrative and health authorities who have to give SHU a go ahead to introduce its programme in the communities. After they accept the programme, the authorities help in the mobilization of the community members to be sensitized;

Second are the households. the General assembly for a scheme.

Hundreds of meetings were held during the year. Sensitizing households was done at different levels: At household level through an activity we refer to as “door-to-door sensitization”; at village level through village meetings; at zonal level where three to four villages meet at a single venue; and at parish level an activity we call



General assembly in Kibose scheme - Nakaseke district

In each target parish, these sensitization meetings were done to give families and authorities all the information they needed to appreciate the problem to be or being addressed and to support / be part of the solution proposed.

b) Promotion

The saving culture for healthcare in rural Uganda is still new. To succeed in creating schemes, enrolling members, and maintaining the old members takes much of our resources. During the ended year, several promotion activities and tools were done and used respectively to ensure the old schemes continued to run, while new communities accepted the principles

and enrolled into the health micro-prepayment schemes. The activities carried out included among others the scheme days where a full day was dedicated in a scheme kicking it off with road shows to mobilize the members and ending with a meeting at a central place where members perform plays, and win gifts after answering questions correctly.



With tools; calendars, t-shirts, posters, and bicycles fully labeled with scheme logos and names were used

➡ *Scheme members in Bushenyi dressed in scheme t-shirts, caps with a scheme bicycle*

c) Training/ capacity building

The health micro-prepayment schemes SHU promotes are community based and self managed. For this reason, efforts are made to build the capacities of the scheme managers who in this case are community members themselves. Because communities have had bad experiences with other NGOs in the past, scheme leadership is based on trust as opposed to capacity and ability to learn. This has created a real challenge for SHU in its efforts to transfer knowledge to manage the schemes at some reasonable level of professionalism. Several trainings in basic book keeping, minutes recording, cards filling, bills analysis and payment authorization, effective communication, meetings management, etc have been organized and leaders trained, but same trainings have to be re-done many times if leaders must become operational. Leadership in schemes changes and this too keep the trainings ongoing as the retiring leaders can hardly pass on skills to the new ones. Training new and old leaders has therefore been a major activity during the year. Workshops, coaching and exchange of experiences visits were the methods used. The new leaders from new schemes in Bushenyi visited the older schemes in Luwero. In addition to building confidence in the system, elderly leaders appreciated the visits because they learnt more than during workshops

d) Advocacy

Our advocacy activities have ranged from community-level advocacy to the national level. Two issues formed our agenda for the ended year. Several activities were performed on the two issues which are: 1) More women involvement in senior schemes leadership. This has been done at community level. The activity involved holding meetings with schemes members which resulted into amending the constitutions for the schemes and the union of schemes organization which is the umbrella body for all the schemes in the Luwero area; 2) Involving the informal sector (especially the existing health micro-prepayment schemes in Uganda) earlier than proposed in the national health insurance scheme. SHU through UCBHFA has played an active role in this campaign. The latest NHIS design incorporates most of the UCBHFA demands including government subsidies to the people in the informal sector who will enroll into the scheme. The poorest of the poor are proposed to be fully subsidized.

e) Disease prevention

Whereas SHU aims at increasing utilization of medical and obstetric services at facilities that offer quality, efforts are done to prevent diseases that can be prevented. SHU took on this activity for two main reasons: First as a risk management measure. The community schemes rely on meager community resources pooled among the poor. The resources are not enough if no disease prevention interventions are done; secondly, it was for improving attractiveness of the



An adult scheme member receives a bed net from an SHU official

schemes. One of the frequently asked questions has been and has remained “what if I do not fall sick?” people had and some still refer to schemes as being for the sick as opposed to schemes that aim at pooling

risks.



Young scheme members receive a bed net each from an SHU official

With the disease prevention activities we have done -health education and availing mosquito

bed nets- therefore, the perceptions have not only been improving, but also the schemes have been able to control overutilization of the funds. A total of 1500 bed nets were distributed this ended year. A stock of 500 nets from last phase with EED support, and during the year, 1,000 nets distributed to pregnant women and families contributing premiums to support women prepare and deliver babies safely.

f) Institutional building support to local scheme structures

To be self sustaining, SHU is supporting the schemes to create structures that will strengthen governance and continuous technical roles performance. During the year therefore, the team supported the Luwero area union of schemes organization legally registered as “munno mu bulwade union of schemes organization (MBUSO)”to build its governance capacities by reviewing the constitution, and training leaders to perform their roles. The executive team was also trained.

With SHU support and guidance, the individual schemes transferred some of their activities to the union secretariat. The agreements between individual schemes and healthcare providers were reviewed and the arrangement changed. Since January 2010, each healthcare provider enters into an agreement with the union which represents all the schemes. The bills payment arrangement too has since changed.



Official opening of the MBUSO office in 2008

The union pays medical bills on behalf of each scheme even if

each scheme must verify the bill before payment is effected.

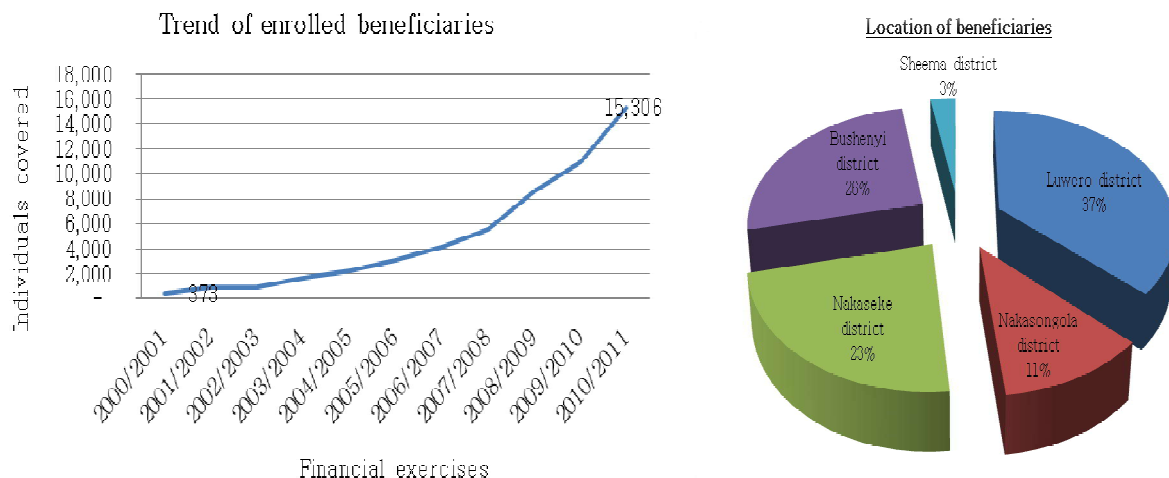
The Bushenyi area schemes have been supported to discuss the possibility to form a union. Having agreed to form one, the schemes are now drafting the union constitution and policies. Next year, the union in Bushenyi will start to function.

g) Capacity improvement for the SHU team

To ensure the SHU team performs to keep the organisation ahead in all it does, several capacity enhancement activities were carried out during the year. Quarterly joint team meetings were held, one technical support mission from CIDR done, several short courses organised and attended to, and an external exchange of experience visit to Mbozi Tanzania done. The team members who joined SHU at the beginning of the year were inducted for one month at SHU's head office before starting the on-job continuous training from the field offices.

II. Programme results at the end of the year

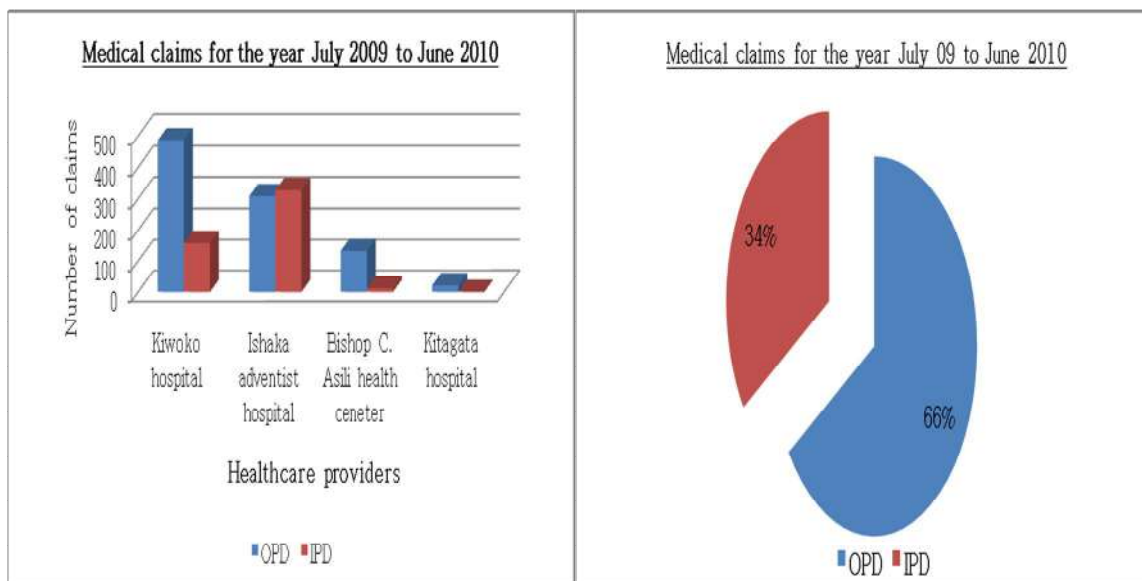
a) Increased number of people protected



All the schemes in Luwero and Nakasongola districts (9 and 3 respectively) are pure health micro-credit schemes. Of the 7 schemes in Nakaseke district, 6 are health micro-mixed schemes (partly credit and partly insurance), while one is a credit scheme. All the schemes in Bushenyi and Sheema districts (8 and 1 respectively) are pure health

micro-insurance schemes. The scheme in Sheems district is a unique scheme as it focuses on improving utilization of obstetric services.

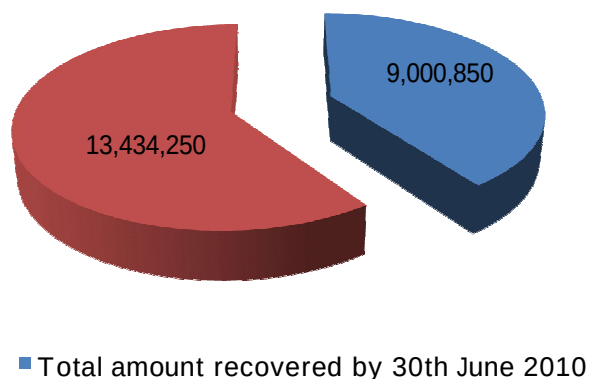
b) Increased utilization of medical services and improved rationality



A total of 1,444 claims were made during the year. 66% of them were out-patient consultations while 34% were hospitalisation cases. A total UGX 22,786,795 (USD 11,393.4) was paid to the healthcare providers by the schemes in settlement of the bills.

c) Health micro-loans recovery

Health micro-loans recovery results for the year



The total amount given out as health micro-credit during the year plus the amount of credit unrecovered from the previous years was UGX 22,435,100. Of this total amount, 40% had been recovered by the end of the year. This result shows no improvement from the previous year.

d) Other results (see tables in annex 1)

III. Programme challenges faced during the year

a) Health micro-loans recovery

The schemes in Luwero, Nakasongola, and Nakaseke districts use a credit arrangement to access medical services. Under this pure credit arrangement, at the point of service, the entire bill (up to the ceiling) is cleared by the scheme on behalf of the patient. The scheme then gives the patient up to three months to refund the exact amount (without interest) in instalments to the scheme. The mixed schemes on the other hand clear the bill (up to the ceiling) at the point of service and then ask the patient to refund up to a maximum of UGX 30,000 of the bill. Any amount that goes above the UGX 30,000 limit is covered by the scheme using the insurance fund. For bills below UGX 30,000, the patient refunds everything. Even here, the maximum period for refunding given to a family is three months.

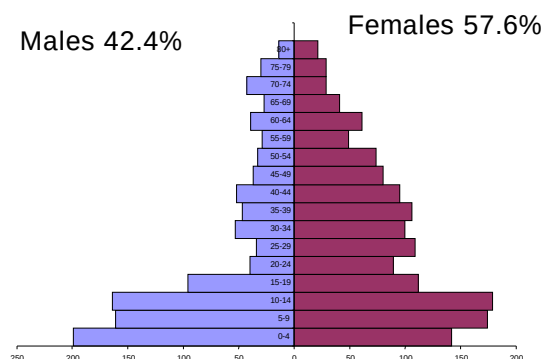
Prior to the start of the ended year (end of June 2009), an amount of UGX 10,956,100 was in debts. One year later (end of June 2010), an amount of UGX 4,450,950 (41%) was recovered. The 59% is not yet recovered is more than one year late. During the year, a total of UGX 11,479,000 was given out as new healthcare credits. By the end of the year, a total of UGX 4,549,900 (40%) had been recovered. The 60% of the new credits are not yet recovered.

Whereas scheme leaders remain hopeful that all the loans will be recovered, the current debt situation puts the members at a risk. The rate at which loans are granted is faster compared to the refunding rate. The schemes could become bankrupt any time. SHU has engaged the concerned schemes over the risk but all the concrete measures including asking for collateral, involving the law and social pressure are not welcome. Leaders are very afraid of making enemies with their fellow village mates as a result of aggressive recovery of the loans. SHU has again recently started discussions with the union of schemes leadership to see possibilities of transferring the technical and other complicated tasks in the schemes to SHU at a fee. If this solution is agreed upon, SHU will be contracted to perform the technical tasks at the union secretariat while the beneficiaries govern both the union and the individual schemes

b) Adverse selection

The pure insurance schemes in Bushenyi district except those focusing on maternal health alone, are still enrolling more people with a higher chance of becoming ill than the healthy ones (see figure on the right). This ended year, the scheme's claims ratio was 112% far above the target of keeping it below 80%. As a consequence, schemes are for now unable to build reserves as expected. This risk has been discussed with the schemes and a solution agreed upon. The mode of premium payment is to change from an individual payment to a range system.

Age and sex composition in the Bushenyi schemes



The planned range will be 1 to 4 paying a fixed premium, while the 5th person and others will each pay a premium equivalent to one person's premium

c) Getting the village premiums paid

To improve utilisation of maternal and neonatal healthcare services, SHU took an approach not only intended for pooling risks but also make safe motherhood a culture among the people in the target communities. The innovative approach adopted is; villages as individual units contributing a premium (village premium) which then guarantees all women in their reproductive ages and resident in those particular villages that complete paying, access to maternal and neonatal healthcare services including medical care during pregnancy and transport to and from the healthcare facilities. In all the villages where the scheme has been presented, community members have welcomed it and participation in building the schemes structures has been very good. In total, the scheme has been introduced to 46 villages during the year. By the end of the year however, only 9 villages had fully paid up their village premiums and had their resident adult women covered by the schemes. The other villages had started to pay but the process was very slow. Communities recognise that

after paying the village premium, the actual beneficiaries are few. This reality has made many of the village residents reluctant to contribute towards the village premium. Many have come up with new proposals for the schemes to extend services to other village residents who may not become pregnant during the year. Knowing that building a new culture takes and needs time, SHU without adjusting the efforts to make safe motherhood a culture, but being responsive to people's needs at the same time, has started discussions within and with the partners about how to improve the attractiveness of the current schemes without losing focus on improving maternal and neonatal health.

IV. Key plans for next year

June 2010 will mark the end of the current contract for project support between EED and SHU. As a requirement, SHU will organize an end of the two year phase external evaluation expected to take place in January 2011. Soon after the evaluation report is presented, SHU will be seeking for support to continue with the project activities in the Luwero, Nakaseke, Nakasongola and Bushenyi districts for another phase.

The number of schemes and covered people will be increased significantly during the coming year. The June 2011 target is 33,000 (28,000 in the health micro-prepayment schemes, and 5,000 in the maternal and neonatal health schemes) individuals covered. Activities to sensitize communities promote the schemes and build the capacities of elected schemes leaders will be done during the year.

A referral system among the healthcare providers contracted by the schemes is expected to be functioning by the end of next year. SHU will design the system to suit the schemes context. The tools to be used in implementing the system will be designed as well. In response to people's demands and to make the referral system work for the patients, more (but which meet the minimum quality standards) lower level health care facilities will be brought on board.

At least 90% of the unrecovered loans by the end of the year will be recovered, and at least 95% of the new health micro-loans to be given during the coming year will also be recovered. SHU will undertake several

activities to ensure these outputs are realized. The activities will include: internal discussions to formulate workable solutions, other options and alternatives; studies and exchange visits to assess feasibility of the options; consultations with partners and negotiations with beneficiaries. The found workable solutions will be quickly implemented while the options and alternatives to the current schemes management and functioning will follow a longer process before adoption if that will be the way to go.

Conclusion

Despite having some challenges, the year July 2009 / June 2010 has been a successful year for SHU. The year started at a low pace having been the beginning of the phase and new team members joining soon after the year started. The second semester however saw much more activities carried out and has been much more productive. With the new team members now operational, next year will certainly be even more productive. The experiences from the past general elections have shown that schemes activities are not affected significantly when elections come. Hoping that the country's next general elections scheduled for February 2011 will be peaceful, the set targets for next year will be achieved.

Detailed year one results

Reducing barriers to quality healthcare services of the rural poor in Luwero, Nakasongola, Nakaseke and Bushenyi districts

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
1. Access to and quality of healthcare services have improved	1. To significantly increase the number of schemes and beneficiaries 2. To professionally manage the health micro-prepayment schemes	35 running health micro-prepayment schemes 28,000 individuals covered by the schemes 16% (12% in new schemes and 20% in old schemes) penetration rate - At most 70% claims ratio 95% loans recovery in the health micro-credit schemes	27 running health micro-prepayment schemes 20,809 individuals covered by the schemes 12.6% penetration rate - At most 70% claims ratio 80% loans recovery in health micro-credit schemes	27 running health micro-prepayment schemes 14,886 individuals covered by the schemes 12% (13% old schemes and 11% new schemes) penetration rate - Average is 69.1% - 112% in insurance schemes - 38% in mixed credit and insurance schemes	✓ There are still two major challenges to this objective: The large amount of bad debts and the adverse selection in the insurance schemes. The schemes leaders lack the capacity to recover the loans. Discussions are underway for the technical function in the schemes to be delegated to a more

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
		• 90% member retention rate • 0% fraud in schemes	• 90% member retention rate • 0% fraud in schemes	- 14.5% in credit schemes • 50% of outstanding loans had been recovered • Average is 81.5% retention rate - 74% in insurance schemes³ - 89% in credit & mixed schemes • 0% fraud	suited organization with enough capacities. Without this change, the schemes will run out of cash soon. ✓ Concerning adverse selection in the insurance schemes, a range system of premiums payment is to be enforced in all schemes ✓ The penetration figures are not very accurate. New districts continue to be created and as consequence, villages, parishes and other

³ The results are tentative. The schemes had just launched their new financial year with schemes still having a 2 weeks grace period. The rate will improve

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
					administrative units are being split. Accurate information about the target population therefore needs some time.
2. Quality of the local healthcare system has improved	1. To strengthen the relationship between schemes and their healthcare providers 2. To strengthen the relationship between healthcare providers	- Timely and full payment of medical bills by schemes to healthcare services providers - Contracts between schemes and healthcare providers are respected to at least 95% level - A referral system is working among the healthcare providers serving	- All bills are presented to schemes on time; and schemes pay on time - All schemes have contracts with healthcare providers and they are respected - A referral system is working among the healthcare	- All (100%) bills are paid. Timeliness is estimated at 70% average. - All schemes have signed contracts with healthcare providers. A medical audit has not been done yet to measure the technical level of compliance with contracts. Subjectively, all parties respect the contracts	✓ Bills presentation to schemes in the Luwero area is facing challenges. The number of schemes has increased and the hospital is facing challenges to meet its obligation to present bills to each individual scheme at a community meeting of leaders. As a way to improve, the Luwero

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
	partnering with the schemes	the schemes	providers serving the schemes	No formal referral system yet.	schemes will delegate the bills management to their union secretariat. It will be the secretariat to verify the bills with the schemes before payments are authorised. ✓ A referral system will be worked on during this coming year. The issue has been discussed with the healthcare facilities and is awaiting formalising
3. Community based development initiatives	1. To improve the recognition of the health	7% of the healthcare provider decisions had their origin from the	7% of the healthcare provider decisions had their origin from	This indicator was not measured. In Bushenyi however, 5 decisions were made in relation to issues	✓ The coming together of the individual schemes to create an alliance and become one bigger

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
have strengthened the civil society	micro-prepayment schemes by their environment	partnership with schemes - The unions of schemes organizations participate in 30% of the activities about healthcare, organized by civil society in the area - The Luwero union of schemes organization is a member and participates to activities of the national umbrella body of all CHI initiatives	the partnership with schemes - The unions of schemes organizations participate in 30% of the activities about healthcare, organized by civil society in the area - The Luwero union of schemes organization is a member and participates to activities of the national umbrella body of all CHI initiatives	that were raised by schemes. - The schemes participate to many local health and other events in their respective sub-counties. At district level, the Luwero area union of schemes organization which is a registered CBO and a member of the Luwero NGO forum was invited to the Luwero NGO forum general assembly. - The union is a member of Uganda community based health financing association	voice is slowly but yielding results. The union secretariat is to perform the technical and other relations roles to help the schemes reach both technical and institutional sustainability

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
				(UCBHFA) and has participated to many UCBHFA events.	
4. Role and leadership of women in schemes are strengthened	1. To support women play an active role in governing the schemes to which they are much more interested than men	• Women occupy at least 30% of the top positions in schemes and their union organizations • All schemes' internal regulations / constitutions provide for at least one of the two scheme representatives to the union parliament to be female	• Women occupy at least 30% of the top positions in schemes and their union organizations • All schemes' internal regulations / constitutions provide for at least one of the two scheme representatives to the union parliament to be female	• 45% of the top schemes and Luwero union positions are occupied by females • The Luwero schemes and union internal regulations were reviewed and provide for a woman representative to the union parliament from each scheme	✓ Women are very active in the schemes but were mainly taking low level positions of leadership. A few years ago, few women were willing to compete for the top positions, but this is changing. Even if a clause has been included to elect at least one female representative to the union parliament, other women are competing with men

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
					for other senior scheme positions. Today, 30% of all schemes chairpersons for example are women who have presented themselves for election and were voted into these positions.

Reducing delays to maternal and infant health care in Bushenyi district – Uganda

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
1. To increase utilization of ANC and institutional delivery services by 30%	1. To empower families make good and timely decisions 2. To improve reception at healthcare facilities (HCFs) to enable pregnant women seek timely care 3. To improve financial capacities of families	- Timely care for enrolled pregnant women 80% of enrolled pregnant women complete all 4 ANC visits 80% of enrolled pregnant women deliver at HCFs - The solidarity approach to improved maternal health is appreciated and 80% of each village families contribute to the village funds for that purpose - Old schemes	- The enrolled women who are pregnant accessed care on time 30% of the enrolled pregnant women completed all 4 ANC visits 80% of the deliveries among members took place at HCFs 80% of the village families in each of the 3 target parishes where schemes have been	- One scheme (kasaana east) started functioning in June 2010. A total of 420 women are covered. Within one month of coverage, a total of 21 claims were covered 19 of them for ANC and 2 for medical care - The functioning scheme has covered women for only one month - By the end of month one, no delivery had been recorded 440 families out of the 609 families (72.2%) in Kasaana	✓ The other two schemes could not be launched on time. One (Muhiito) had collected 21% of the total premiums required, while the third parish of Kasaana west was still under sensitization. The two schemes will start next semester ✓ Scheme leaders have reported that the families that have not contributed are not satisfied with the scheme because it benefits only pregnant women.

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
	to access care	accept the intervention and are able to mobilize more financial resources each year while external subsidies reduce as follows 40%, 30%, and 10% by June 2012	created did contribute to the village funds Each of the three created schemes has been able to collect a premium amount equivalent to 60% of its premium	east parish contributed to the scheme fund Kasaana had collected 38% of the total scheme premiums by the scheme launching	Next year, other products to benefit other community members will be developed ✓ Members of the Kasaana scheme pledged to collect the remaining 22% of the premiums during the first next semester
2. To improve child survival chances through timely access to neonatal care (reduce	1. To increase families' knowledge about MCH using community-based interventions	80% of enrolled pregnant women attend post-natal care (PNC) clinics 70% of children born to mothers enrolled in the schemes completed the 3 doses of DPT	80% of enrolled pregnant women attend post-natal care (PNC) clinics 70% of children born to mothers enrolled in the schemes completed the 3 doses of DPT	- No results yet. By the end of the year, no pregnant woman enrolled in the scheme had delivered, and no mother had attended PNC clinic in the one month of cover - No results yet concerning	✓ Since the running scheme had operated for only one month, there was not enough time to observe the reaction of families on this objective. While there were no deliveries during the month, mothers who

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
NMR by 30% and increase immunization coverage by 50%)				immunization	had recently delivered did not show up as well. But generally, utilisation of PNC services in the target community is low and among the planned activities for next year, is health education. With good education both at community level and at the ANC clinics, utilisation of PNC services could improve

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
3. To improve the quality of healthcare services at the participating healthcare facilities through improved decision making, improved reception and timely referrals	1. To improve the quality of services at health care facilities	- Positively perceived quality in all participating facilities - Respected services provision contracts between providers and schemes - Families participate in scheme activities	- Positively perceived quality in all participating facilities - Respected services provision contracts between providers and schemes - Families participate in scheme activities	- Two healthcare providers have been identified and contracted. One is Ishaka Adventist Hospital whose quality is perceived to be good by the users. The second provider is Kitagata government hospital. The hospital runs a private wing. It is services in the private wing that have been contracted. - The contracts have been respected in the short time they have come into force - The schemes creation process has	✓ SHU's is the first community health insurance promoter in Uganda to work with a Government facility. So far, the collaboration which has been well built is good and the hospital management is very positive and supportive of the initiative. Just as anticipated, challenges of drug stock outs are beginning to emerge. SHU is now negotiating with the hospital management to put in place a system that will guarantee schemes

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
				been longer than anticipated during this initial year. Families' participation therefore has been concentrated on schemes design and collecting contributions as opposed to discussing with services providers for improving quality	members services and drugs at the same point. Drug stocks for schemes, partnerships with private pharmacies, are some of the options to be discussed among others
4. Level of solidarity among community members has improved	1. To create community-based schemes 2. To increase families' participation through	• Twelve (12) functioning CHI parish-level schemes • Up to 80% of the target villages contribute to the scheme fund	• Three (3) functioning parish-level schemes • Up to 80% of the villages in the three parishes have contributed	• One (1) functioning parish-level scheme • All (100%) the 9 villages in the running scheme contributed towards the scheme fund	✓ The communities in general are very pleased with the schemes whose aim is to improve utilisation of maternal and neonatal healthcare services. The

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
	enrolling into the schemes		towards the scheme funds		willingness to contribute is however low. Families want products that will extend benefits to all instead of limiting benefits to pregnant women alone. Next year, other products will be developed to provide coverage for the other community members
5. Health management information system at the district has improved.	1. To have accurate information about MCH in target population 2. To share the information	100% captured MCH indicators 100% of reports shared with the health authorities in the district 90% of the information is used	- Developed tools to capture MCH indicators - Two SHU semester reports shared with the health authorities in the district	- Some tools to capture MCH have been developed with the support of CIDR - The SHU semester reports have been shared with the health authorities in the district	✓ Tracking MCH indicators for the catchment population (parishes not yet having schemes) is the challenge anticipated. A self reporting household

project objectives		Expected outputs		End of year 1 results	Comments
Overall	Specific	End of phase	End of year 1		
	with the local health authorities about MCH in the target population 3. To make the local health authorities use the MCH information provided		Negotiated system to track use of information	Negotiated about the system to track use of information have not been initiated yet	level system planned seems complex, expensive, and with uncertainties about whether families will fill the tools