



SAVE FOR HEALTH UGANDA (SHU)

Community solidarity for quality health

ANNUAL REPORT 2011

SHU/2011/N°2

May 2012

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ANC	Antenatal Care
CHF	Community Healthcare Financing
CIDR	International Center for Development and Research
CORDAID	Catholic Organization for Relief and Development Aid
DPT	Diphtheria, Pertussis, and Tetanus
EED	Evangelischer Entwicklungs Dienst
HCP	Healthcare Provider
HMCS	Health Micro Credit Schemes
HMIS	Health Micro Insurance Schemes
HMMS	Health Micro Mixed Schemes
HMPS	Health micro prepayment scheme
ITN	Insecticide treated Net
MBUSO	Munno Mu Bulwadde Union of Schemes' Organization
MOH	Ministry of health
NGO	Non Governmental Organization
NHIS	National Health Insurance Scheme
OPV	Oral Polio Vaccine
PNC	Postnatal Care
SHU	Save for Health Uganda
TTC	Text to Change
UCBHFA	Uganda Community Based Health Financing Association
UNHCO	Uganda National Health Consumers' Organization
WATA	West Ankole Tweragurize Association



MESSAGE FROM THE CHAIRPERSON BOARD OF DIRECTORS

Welcome! This is, Save for Health Uganda's annual report for the year 2011. In it, you will read about the work we have done during the year, our achievements, the challenges we face, our aspirations and the highlights of our revised strategic plan.

Formed in 2002, Save for Health Uganda (SHU) is a local nongovernmental organization (NGO) operating in five districts in Uganda namely: Luwero, Nakaseke, Nakasongola, Bushenyi and Sheema. Our mission is to improve the quality of health of Ugandans through self managed health financing approaches. For two and half years now, we have been implementing a revised strategy envisioning healthier families with simplified access to quality health care. The goal is to contribute to: the reduction of the disease burden in Uganda; and the achievement of Uganda's millennium development goals (MDG) 4 and 5 commitments.

The year 2011 has been a busy and fruitful year. We engaged with our clients, with our partners, and had internal reflections on various issues. With the clients (community), we engaged on: a) access (financial and geographical) to quality healthcare services; b) safe motherhood; c) newborn survival; d) the active role of women in health and leadership; and e) households incomes. With the partners, it has been on: a) provision of quality healthcare services; b) the recognition and inclusion of community health financing (CHF) schemes in the planned national health insurance scheme (NHIS). Within SHU, it has been on: a) reviewing and updating the strategic plan; and b) developing new and improving our accountability systems.

We have been able to do so much in 2011 thanks to a dynamic SHU team and the support we received from our various partners and stakeholders. Evangelischer Entwicklungsdienst (EED) and the Catholic Organization for Relief and Development Aid (Cordaid) gave both financial and technical support. The CHF schemes beneficiaries actively participated in the activities and funded most of their medical care benefits. The authorities in the districts of Luwero, Bushenyi, Sheema, Nakasongola, Nakaseke and at the Ministry of Health (MOH) headquarters in Kampala have been very supportive especially at building the confidence of the target population in the pre-payment schemes. The partner health facilities (Kiwoko hospital, Bishop C. Asili health center, Ishaka Adventist hospital, Kitagata hospital, Laura health center, Hope medical center, and Franciscan health center) have not only provided medical services to beneficiaries, they have been promoting the CHF schemes as well. The SHU board that I chair has provided strategic leadership to the organization.

The Board met four times during the year and was able to achieve the following:

- i. Embarked on a strategic planning process
- ii. Addressed cross cutting capacity building needs of the directors
- iii. Approved and shared accountability reports with stakeholders

The year itself has not been without challenges which we have shared in the body of this report. However, knowing our challenges has only energized us. We are determined to continue implementing all the 5 programs of our revised strategic plan over the next years until 2016. We intend to consolidate the current activities within the current 5 Districts, and at the same time introduce new ones that are not currently funded. We intend also to extend our activities to the Northern and Eastern parts of the country. We wish to inform the readers therefore that none of the programs is fully supported and hence any support will be warmly received. Soon, SHU will embark on the process of registering and becoming a national NGO to allow for easy implementation of the strategic plan. We pledge to continue working professionally in our joint effort with partners to serve humanity.

Please take the time to visit our internet based sites for more information on SHU and opportunities for collaboration: www.shu.org.ug; www.facebook.com/saveforhealthuganda; and on www.linkedin.com/company/save-for-health-uganda

Once again I thank the development partners, other partners and well wishers whose support was vital to the achievements that were registered this year. I would like to appreciate the commitment displayed by the Board of Directors, the staff of SHU, health service providers and the CHF scheme beneficiaries.

Thank you



Lorna Muhirwe

This year, our engagements with clients and partners, as well as the internal reflections have covered all the 5 program areas of the SHU's revised strategic plan. The programs are: i) community health financing (CHF); ii) women's health and empowerment; iii) livelihood; iv) healthcare service delivery; and v) SHU institutional development. The actions have been through implementing three projects: (a) Reducing barriers to quality healthcare services of the rural poor in Luwero, Nakaseke, Nakasongola and Bushenyi districts. This project ended in June 2011; (b) Reducing delays to maternal and infant healthcare in Sheema district; and (c) Reducing Barriers to quality health care services of the Rural Poor in Luwero, Nakasongola, Nakaseke and Bushenyi Districts of Uganda. This project started in July 2011.

On the CHF program, our actions were on: promoting health micro-prepayment schemes (HMPS), creating new schemes, enrolling schemes members, supporting running schemes to contract service providers, capacity building for self management of the schemes, risk monitoring and management, and advocating for the inclusion of CHF in the proposed National health insurance scheme (NHIS). On the women's health and empowerment program: we did health education, promoted and created HMPS covering maternal and neonatal health risks including transport, did disease prevention, and promoted women's active participation in leadership. On the livelihood program: we identified organizations in the field of income generating activities (IGA) and attracted them to the schemes but also promoted their IGAs, we started preparations to micro finance IGAs. On the healthcare service delivery program: we supported schemes and healthcare providers to enter into contractual arrangements, sensitised consumers on patient rights and opened communication channels between schemes and healthcare providers (HCP), and engaged local health authorities to support supervise the healthcare facilities. On the Institutional development program we worked on: the strategic plan, the capacities of the team, setting up a website, and improving on the monitoring and evaluation framework.

A number of results and achievements have been realised and are visible: (1) concerning the access to quality healthcare services, in 2011 alone, we supported communities to create 17 new health micro-prepayment schemes. Now in total, there are 53 running schemes covering a total of 26,566 individual beneficiaries. All schemes cover both out-patient and in-patient care services. To improve geographical access, one new health facility (Franciscan health center IV) located in Kakooge sub county in

Nakasongola district came on board. In total, the schemes are now contracting 7 healthcare facilities. Three of these 7 facilities are offering services to schemes beneficiaries in a referral arrangement. In total 4,690 healthcare claims were covered by the schemes in 2011. Of these, outpatient consultations were 3,730 cases (including 381 antenatal and 48 postnatal care cases) while the inpatient cases were 960 cases (including deliveries); (2) concerning safe motherhood, lots of health related knowledge has been given to the target families in Sheema district. 83 institutional deliveries (79% of the expected) were recorded. Each of the expecting women was given a free insecticide treated mosquito net (ITN). No maternal death was reported during the year among the covered population; (3) about newborn survival, all (100%) of the babies born at the contracted health care facilities received the Oral Polio Vaccine (OPV). The Diptheria, Pertussis, and Tetanus (DPT) immunization attendance was not monitored as the schemes covered babies for one month after birth, and for lack of a village-based monitoring system. Each new born baby received a free ITN. Knowledge about child survival strategies was given to families during the year. Since 2010, two neonatal death (born in community) and two pre-matures deaths born at provider have been recorded; (4) concerning the active role of women in health and leadership, we took the affirmative action approach and successfully lobbied all schemes (new and old) and their networks to provide for women's representation at all levels of schemes' leadership. Today, about 45% of all leadership positions in the schemes and their two networks are occupied by women. For the position of treasurer at all levels, women occupy it at 82%; (5) on household incomes, the opportunity study on micro financing of income generating activities proposed by schemes beneficiaries was finalised. The opportunity exists and supporting families in this area will start mid 2012. At the same time and through our partnership with Bishop C. Asili health center, 15 schemes have been linked to a livelihood project being implemented by Heifer international and just-like-my-child foundation. The project is to provide hybrid goats to vulnerable scheme member households who will be required to pass on a young goat to another family later on. The distribution of goats will start early 2012; (6) about the provision of quality healthcare services, all the 53 schemes have service contracts with their specific health care providers (HCP). The contracts provide for a monthly direct communication meeting between schemes leaders and HCP. Issues of concern are discussed and answers to previous issues are given during these meetings; (7) about the recognition of CHF schemes in the proposed NHIS, We feel satisfied with the design, the proposed regulation and service provider accreditation provisions in the draft bill. Though still a draft, it is now agreed that the NHIS scheme will be made up of a social health insurance scheme, a community health insurance scheme, a private

commercial health insurance scheme, and a third party managed health insurance scheme; (8) on the SHU side, the review and up-dating of the strategic plan continued. The website was designed and is available at www.shu.org.ug. A monitoring and evaluation department was created and is now operational.

During the year 2011, we have had to deal with serious challenges many of which had significant impact on our work. Inflation peaked up to 30% leading to price increases thus significantly reducing further the target households' capacities to pay into the schemes. In the old CHF schemes, 39% of the last year beneficiaries dropped out, while two of the safe motherhood schemes had to freeze for some time. The increases in drug prices also affected 6 schemes as their insurance funds had a 17% deficit. The other major challenges have been: (a) irrational cultural beliefs and practices that are still common and often encountered. A number of families for example still use traditional birth attendants even where the schemes are covering all costs including transport; (b) the unfavourable distribution of quality (private not for profit) and affordable health care facilities for our CHF program. The Government health care facilities that are better distributed are implementing the free healthcare policy with low quality services; (c) low willingness to offer voluntary services to the schemes by the members of the CHF schemes that are by design community based and self managed. Out of all the elected schemes leaders, 52% have actively carried out schemes activities.

During the coming year, we will aim to significantly progress on the implementation of the five programs. In addition, work will be done to up-date the feasibility studies of 1998 and in 2005 with the aim to provide new and up-to-date realities useful to improve the relevance of the programs. Emphasis will be as well be put to developing the network of schemes that have been formed. These networks aim to supplement the individual schemes by performing the technical functions that individual scheme-based leaders find very difficult and also expensive to perform.

At the East African level, Uganda continues to promote the economic and political federation of East Africa. A number of protocols to facilitate this process have been signed for example the customs union, and are now working on a common market.

At the national level, Uganda still implements a free healthcare policy in Government health care facilities. This policy which is believed to have increased the outpatient attendance to over 90% however suffers from high levels of drugs stock outs, and a non motivated workforce, in most government facilities. The ministry of health (MOH) in an effort to improve access to services and financing of the sector is working on a national health insurance scheme (NHIS). The draft bill for the scheme was finalized and committed to the 1st parliamentary council for scrutiny.

The country experienced one of the highest inflationary conditions since the early 1990's. After the 2011 presidential, parliamentary and local government elections, the country started experiencing a general increase in price of essential commodities from 10% in March 2011 to 30% in October, and later on eased slightly to 27% by the end of the year 2011. The community targeted by SHU has been affected in two ways; the amount contributed by the schemes for healthcare was rendered insufficient, and the premium for the new schemes had to be increased. Still on the economy, in western Ankore and part of Buganda regions, families' bananas and coffee crops were destroyed by a bacterial banana disease and the coffee weevil thus further affecting peoples' livelihood.

Socially, the government continues to implement a free and universal primary and secondary education policy. According to the UNICEF-Uganda literacy statistics, the average adult literacy rate by 2010 was 73% and 74.6 % at end of December 2011. The country has a total population of about 33 million people structured as follows: above 60 years 4.4%; age between 18 to 60 years 40.1%; age between 5 to 18 years 36%; and age below 5 years 19.3%.

Telecommunication technologies have continued to improve to the benefit of SHU's activities. In 2011, according to the media council, there are over 244 fm radio stations at a rate of slightly over two stations per district, while mobile phones ownership and access at 38%. This has led to emergency of mobile money transfer services, increasing on the level and volume of electronic communication, including access to internet. 13% of the total population can access internet.

We carried out activities in all our five strategic program areas hence enabling us to progress on the implementation of our strategic plan. Below are the details of the activities under each program area:

Program Area 1: Community health financing (CHF)

a) Promotion of health micro-prepayment schemes (HMPS)

Promotion and marketing of HMPS was done in 17 new communities (parishes) and in the 36 old parish-level schemes. The promotion was done by SHU, the partner healthcare facilities, the existing schemes and the schemes'



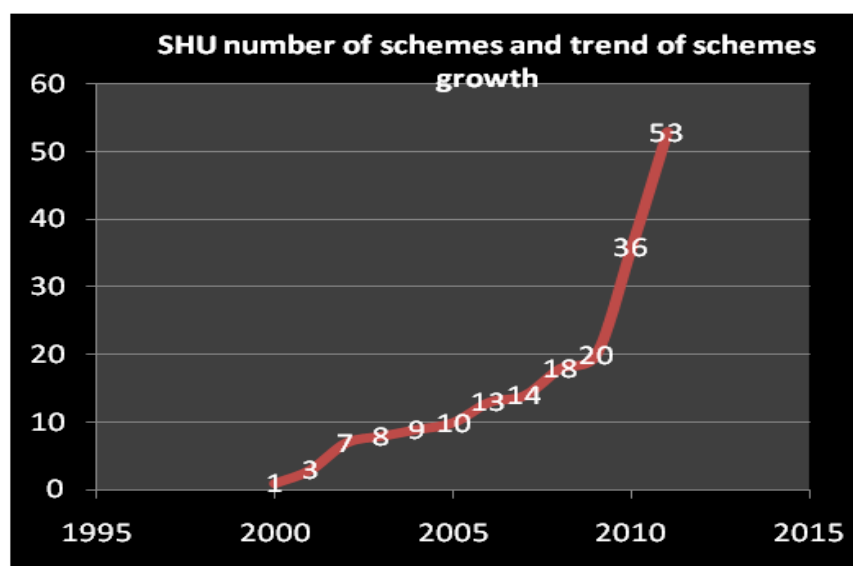
One of the typical village sensitisation meetings conducted by one of the SHU team members in Luwero area, while promoting the CHI concept for the 1st time in a new area.

networks.

The activity has been done using tools such as T-shirts, posters, murals, bicycle logos and calendars. Radio talk shows, talks with patients at the healthcare facilities, community meetings and discounts to schemes member bills are the other ways we have promoted the schemes. All the approached 17 communities welcomed the schemes.

b) Creation of Health micro-prepayment schemes

This activity involves mobilization of the community leaders and members, sensitization and marketing of the products. 17 new schemes have been created as a result and are functioning. The schemes are of two types: Those covering general health care conditions, and those covering only maternal and neonatal health care conditions.



The trend of scheme creation and growth

c) Enrolment of beneficiaries into the schemes

In total, the 53 schemes are covering 25,566 beneficiaries. The location of the beneficiaries is as follows:

- × Luwero district: 16 schemes with 9,079 beneficiaries
- × Nakaseke District: 15 schemes with 6,154 beneficiaries
- × Bushenyi district: 11 schemes with 5,338 beneficiaries
- × Nakasongola district: 6 schemes with 3,198 beneficiaries
- × Sheema district: 5 schemes with 2,797 beneficiaries.

d) Supporting schemes to contract healthcare service providers

One additional healthcare facility (Franciscan) was contracted during the year. The number of contracted healthcare facilities is now 7. The facilities that are of different grades are distributed in all the 5 target districts as shown in the table.

Table N°4: Details of contracted healthcare facilities

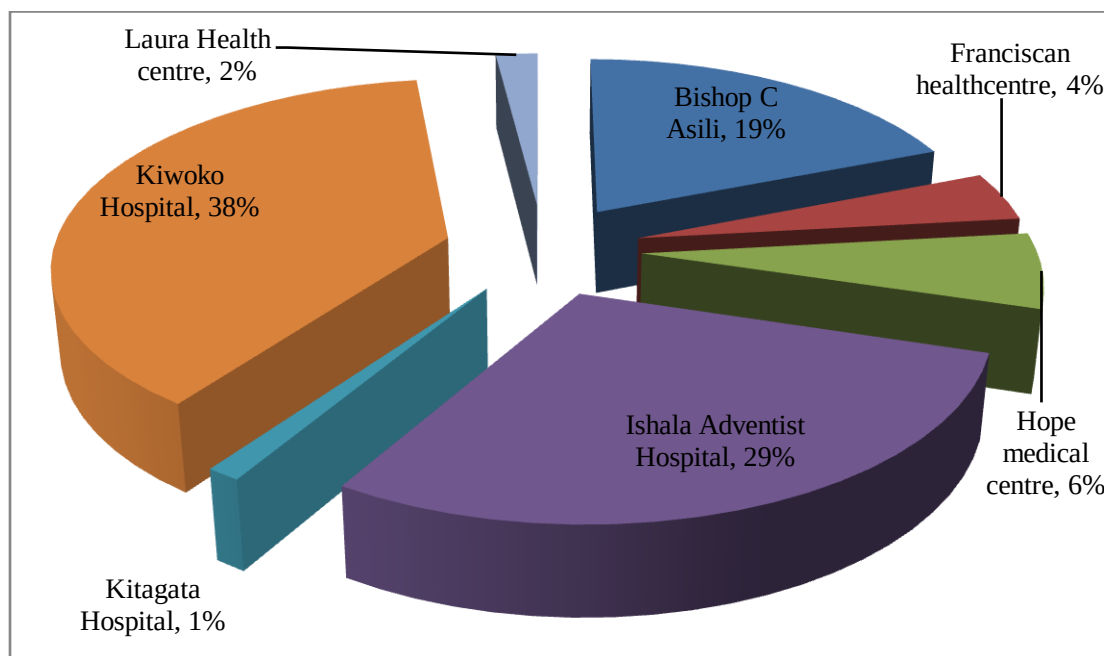
District	Grade			
	Hospital	Health center (HC) IV	HC III	HC II
Luwero		Bishop C. Asili (catholic church owned)		
Nakaseke	Kiwoko (Anglican church owned)			
Nakasongola		Franciscan (catholic church owned)		

Bushenyi	Ishaka Adventist (Seventh day Adventist church owned)			Laura (cathol ic church owned)
Sheema	Kitagata (Government owned)		Hope medical center (Advancing the Ministry of the Gospel organization)	

All the 7 service providers are serving under a contract that is reviewed annually. For the schemes in the districts of Luwero, Nakasongola and Nakaseke, a single contract is signed per provider. Their network- the Munno Mu Bulwadde Union of Schemes Organization (MBUSO) negotiates and contracts on each individual scheme's behalf.

All the contracted facilities have been visited by the beneficiaries during the year. The hospitals though quite a distance are still the most visited facilities as the figure below shows.

Figure N°: proportion of schemes patients treated by each provider during the year



e) Facilitating utilization of healthcare services

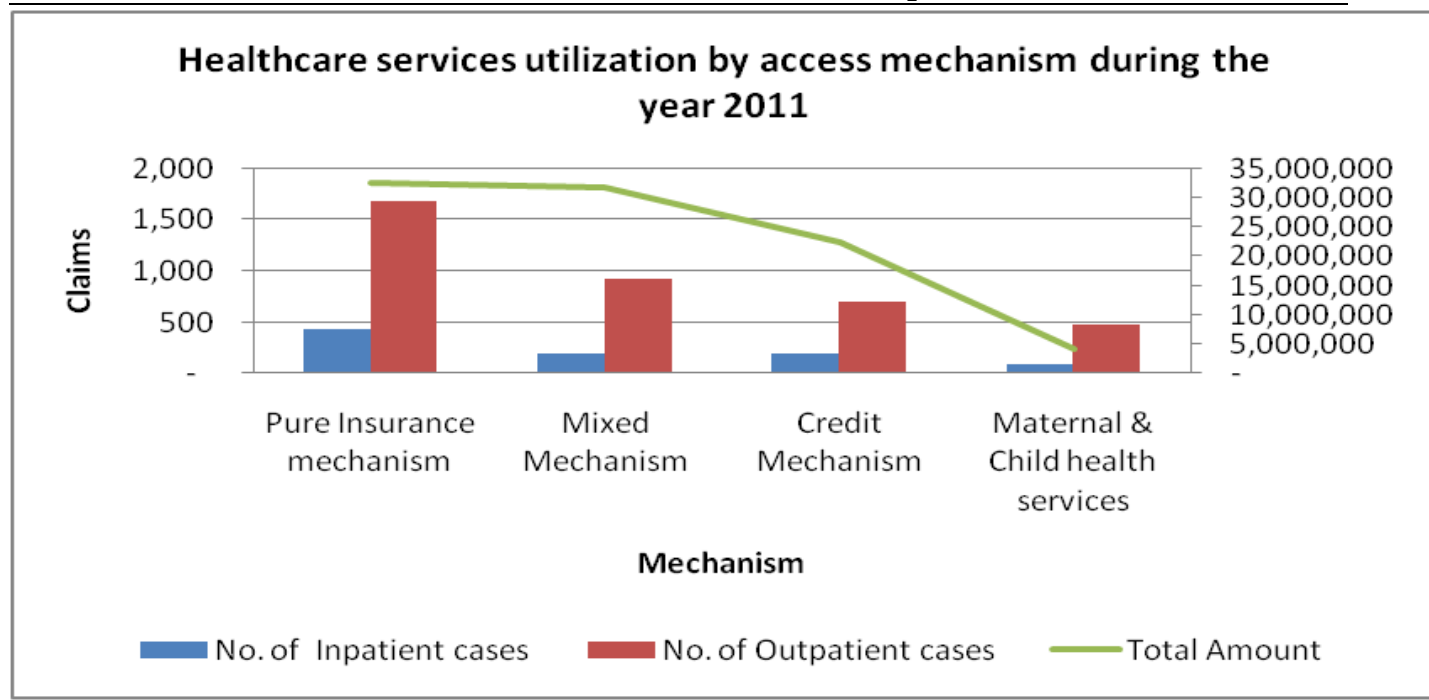
In order to satisfy the interests of the different communities, the way beneficiaries access medical care services vary. The schemes during the year have been of four types and their details are shown in the table below

Table N°5: Details of schemes

District	Type of scheme			
	1. Pure insurance		2. Pure credit	3. Mixed insurance and credit
	<i>Benefits to voluntarily paid up individuals</i>	<i>Benefits to pregnant women and new born babies resident in the parish¹</i>	<i>Benefits to voluntarily paid up individuals</i>	<i>Benefits to voluntarily paid up individuals</i>
Luwero	1	0	10	5
Nakaseke	1	0	3	11
Nakasongola	0	0	3	3
Bushenyi	11	0	0	0
Sheema	2	3	0	0
Totals	15	3	16	19

In terms of healthcare utilization, in total 4,690 medical claims were covered by the schemes in 2011. Of these, outpatient consultations were 3,730 cases (including antenatal and postnatal care) while the inpatient cases were 960 cases (including deliveries). Utilization according to scheme type was:

Table N°6: Utilization of healthcare services by schemes beneficiaries



Of the 480 outpatient consultations in the maternal and neonatal schemes, 381 of these consultations were at the antenatal care (ANC) clinic, 48 at

¹ Parish is made up of about 7 – 10 villages

the postnatal care (PNC) clinic, 24 at the medical OPD, while 27 were immunizations for new born babies. For the 91 admission cases in the same schemes, 83 of them were deliveries constituting 79% of the expected deliveries (105) among the pregnant women who showed up at the facilities for ANC during the year. The same utilization levels but classified according to districts is shown in the figure below

Figure N°: Utilization of healthcare services by District

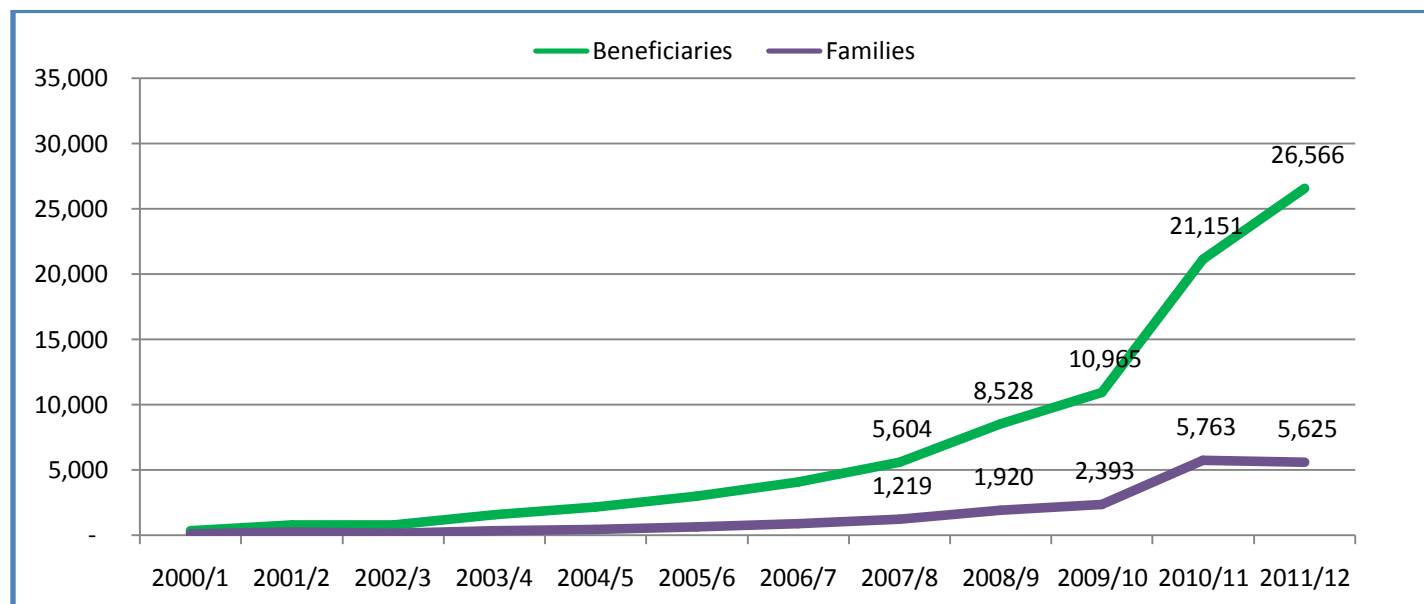
District	Outpatient cases	Admission cases
Bushenyi	1,422	400
Luwero	945	246
Nakaseke	675	159
Nakasongola	208	64
Sheema	480	91
<i>Total</i>	<i>3,730</i>	<i>960</i>

f) Risk monitoring and management

f.1). Schemes' growth

During the year, membership in schemes grew by 29.4% (from 20,504, with external growth of 39.2% and internal decline of 10.4%). The beneficiary trend is summarized in the figure below

Figure N°: Schemes membership and beneficiary's growth



The drop out of members in the old schemes has been attributed to the inadequate capacity in the MBUSO network which transferred the technical management of the schemes to SHU recently. The worsening families' economic situation too has been another cause. In the maternal and

neonatal health insurance schemes, the benefits not being enjoyed by the other members of the community was an even more serious issue.

f.2). Schemes' financial performance

1. Maternal and Neonatal Health Insurance Schemes

Balance sheet as at 31st of December 2011

ASSETS	Amount
FIXED ASSETS	
<i>Schemes bicycles</i>	750,000
CURRENT ASSETS	
<i>Cash at Bank- (Centenary)</i>	11,674,150
<i>Cash at (Village bank a/c)</i>	3,302,915
<i>Cash at hand</i>	1,720,000
Total Assets	17,447,065
EQUITY AND LIABILITIES	
<i>Guarantee Fund</i>	4,000,000
<i>Prepaid premiums</i>	2,467,000
<i>Direct donations (By shu for Bicycles)</i>	920,000
<i>Outstanding (bicycle acquisition fees)</i>	200,000
EXCESS INCOME OVER EXPENDITURE	
<i>Healthcare fund</i>	6,237,654
<i>Transport fund</i>	1,965,098
<i>Outstanding Union membership fees</i>	500,000
<i>Other management costs fund balances</i>	885,463
<i>Outstanding healthcare bills</i>	271,850
TOTAL EQUITY & LIABILITIES	17,447,065

Income and Expenditure for the period up to 31st December 2011

INCOMES		Amount	%age to total income
1	Premiums		
	<i>Members contribution</i>	11,802,950	63.8%
	<i>SHU co financing</i>	4,568,000	24.7%
	<i>Donations</i>	1,870,250	10.1%
	<i>Leaders contributions</i>	135,500	0.7%
2	Interest from Bank	82,935	0.4%
3	Discount from AMG	48,930	0.3%
	Total income	18,508,565	100.0%
EXPENDITURE		Amount	%age to total exp.
1			
1	<i>Medical bills</i>	2,091,200	24.2%
2	<i>Transport to HCP</i>	4,512,900	52.2%
3	<i>Management costs</i>	2,044,400	23.6%
	Total expenditure	8,648,500	100.0%
Excess of income over expenditure		9,860,065	53%

2. Health Micro-insurance schemes in Bushenyi

Balance sheet as at 31st of December 2011

ASSETS	Amount
<i>Schemes bicycles</i>	1,650,000
CURRENT ASSETS	
<i>Cash at Bank-(Centenary)</i>	12,102,706
<i>Cash at WATA account</i>	4,989,466
<i>Cash at Hand</i>	1,212,000
<i>Debtors</i>	71,000
Total Assets	<u>20,025,172</u>
EQUITY AND LIABILITIES	
<i>BF Reserves</i>	3,616,857
<i>Loan from SHU</i>	4,061,000
<i>Frozen fund</i>	859,500
<i>Creditors</i>	-
<i>Provider bills</i>	1,827,849
<i>Union contribution</i>	800,000
<i>Prepaid Premiums</i>	3,757,600
Excess income over exp.	
<i>Healthcare fund</i>	3,265,042
<i>Management fund</i>	3,665,173
TOTAL EQUITY & LIABILITIES	<u>20,025,172</u>

Income and expenditure for the period up to 31st of July 2011

INCOMES	Amount	%age of total
Premiums		
Members contribution	35,764,600	86.3%
SHU launching subsidy	1,000,000	2.4%
Other donations from launching	1,760,000	4.2%
Membership fees	1,039,000	2.5%
Interest from Bank	268,234	0.6%
Discount from AMG	1,594,031	3.8%
Total income	<u>41,425,865</u>	100.0%
EXPENDITURE		
Medical bills	29,875,650	72.1%
Management costs	4,620,000	11.2%
Total expenditure	<u>34,495,650</u>	83.3%
Excess of Income over expenditure	6,930,215	17%

3. HMPP schemes in Luwero, Nakaseke and Nakasongola districts

Balance sheet as at 31st of December 2011

ASSETS	Amounts (UGX)
<i>Cash at Bank-Schemes</i>	71,071,124
<i>Guarantee Fund (Kiwoko)</i>	5,000,000
<i>Guarantee Fund (Bishop C. Asili)</i>	1,000,000
<i>Loans to members</i>	38,299,950
Total Assets	115,371,074
EQUITY AND LIABILITIES	
<i>Accumulated fund balance</i>	31,587,382
<i>Surplus for the period</i>	24,983,430
Sub total	56,570,812
CURRENT LIABILITIES	
Creditors	
<i>Kiwoko Hospital</i>	5,917,680
<i>Bishop C. Asili</i>	1,950,700
<i>Franciscan Health Centre</i>	1,200,500
<i>Insurance above ceiling Fund</i>	5,559,030
<i>Union Guarantee Fund</i>	4,018,019
<i>Loan Insurance Fund</i>	3,166,000
<i>Frozen Fund</i>	15,490,350
<i>Revolving Fund</i>	8,609,870
<i>Schemes reserves</i>	12,888,113
Total Current Liabilities	58,800,262
TOTAL EQUITY & LIABILITIES	115,371,074

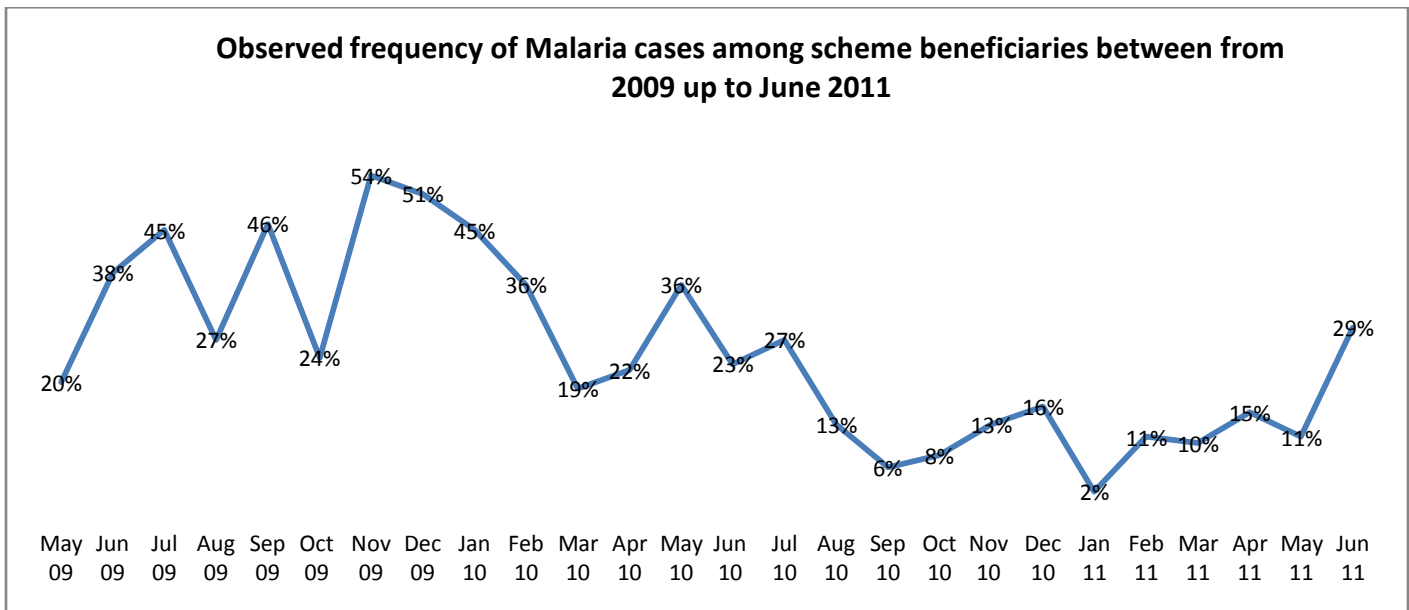
Income and expenditure for the period up to 31st of December 2011

Item	Amount	Percentage share
INCOMES		
• Healthcare	62,208,550	69%
• Management	16,114,595	18%
• Membership	2,483,600	3%
• Union	7,385,319	8%
• Interest	2,063,109	2%
Total (A)	90,255,173	100%
EXPENDITURES		
• Schemes management costs	7,799,413	11.95%
• Revolving fund bills	42,104,150	64.51%
• Insurance fund bills	297,500	0.46%
• Frozen fund refunds	11,743,580	17.99%
• Reserve fund expenses	3,316,900	5.08%
• Income fund withdraws	10,200	0.02%
Total (B)	65,271,743	
Net Income (A - B)	24,983,430	

g) Malaria prevention

Malaria being the main cause of morbidity and mortality, SHU together with our partners EED, just like my child foundation (JLMCF) and Bishop C Asili Health centre availed subsidised bed nets to the schemes members starting 2009. In total, over 3,000 nets have been distributed to the schemes members between 2009 and 2011. During the year 2011, about 300 nets have been distributed to members in the Luwero area at a subsidised amount of UGX 2,500. UGX 500 was facilitation to the community-based distributors. JLMC availed the nets to SHU at a fee of UGX 2,000 per net. As a consequence, the frequency of malaria cases presented to the contracted health facilities is dropping as shown in the figure below.

Figure N°: Schemes membership and beneficiary's growth



h) Building capacity for self management of the schemes and their networks

During 2011, it is worth mentioning that SHU transferred most of the technical management of the Luwero area schemes to the MBUSO network. For the schemes in Sheema and Bushenyi districts, the formulation of a network progressed significantly and the network "west ankore tweragurize association (WATA) was formed. WATA is now registered as a community based organization.



The ED giving a key note speech at the WATA inauguration ceremony

Leaders in both MBUSO and WATA have received training in governance and basic management. Today, MBUSO is estimated to be at 15% autonomy level, while WATA is below 5%.

At the individual schemes level, Scheme leaders were trained to increase their capacity to manage and carry out scheme activities. Specifically, scheme leaders were trained in basic book keeping, leadership skills and principles of health prepayment. Scheme beneficiaries from both networks were facilitated to exchange experiences and learn from each other.

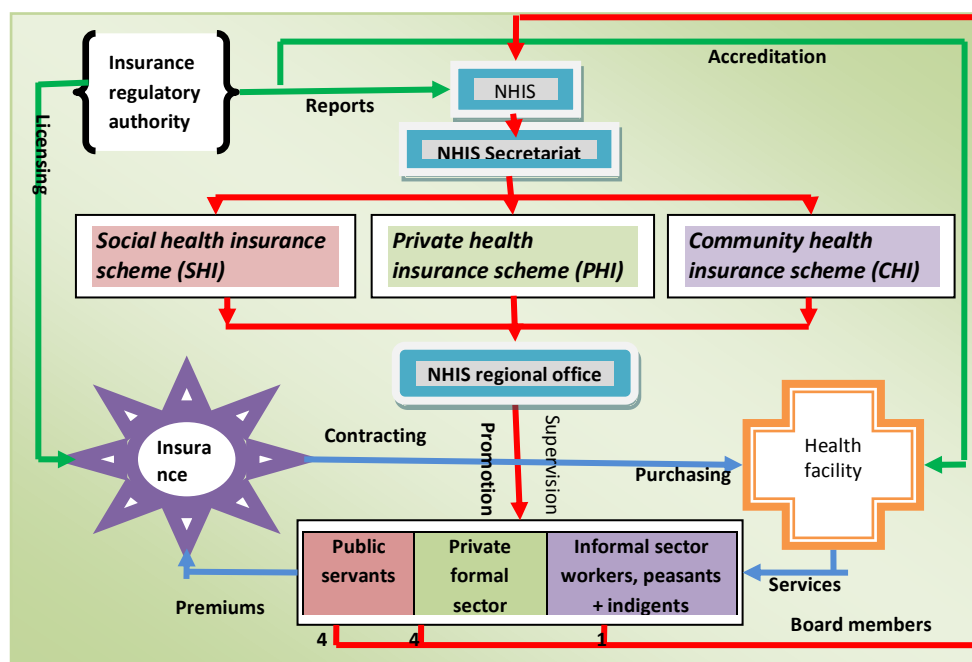


Scheme members from the Luwero area schemes being briefed at SHU head office on their way to visit the Bushenyi and Sheema schemes

i) Advocacy to include and recognise CHI in the proposed NHIS

The SHU executive Director seconded by the UCBHFA is a member of the National task force responsible for designing the NHIS for the country. He represents the community based prepayment schemes and informal sector. During the year, he participated in several task force meetings and took members of the task force on a learning visit to the schemes in Luwero and Bushenyi. CHI is now highly appreciated and all stakeholders have unanimously agreed to make it part of the NHIS right from the beginning. If the current momentum is maintained at the different stages of its development and introduction, the scheme may be launched in 2014. The NHIS design and proposed operations look like shown in the figure below.

Figure N^o: NHIS re-drawn design and proposed operation



Program area 2: Women's health and empowerment

a) Health education

Health education was conducted in Sheema and Bushenyi districts with a double aim: 1) To change attitude and behaviour about maternal and child health issues and appropriate services utilization; and 2) to promote the health micro-insurance schemes. The activity was done in community meetings, Radio talk shows and via telephone text messaging. The text messaging approach was done through a partnership with Text to Change (TTC). In the table below are the topics covered during the health education activities

Table N°: Topics covered in health education

Maternal health	Child health
▪ ANC ▪ Institutional deliveries ▪ PNC ▪ Obstetric risks/danger sign ▪ Malaria in pregnancy ▪ Curative medicine in pregnancy ▪ Family planning	▪ Immunization ▪ Breast feeding ▪ Danger signs

Because we do not have a comprehensive monitoring and evaluation system capturing information at community level and at non contracted healthcare facilities, we do not know with certainty the total impact of our health education on the target population. We have testimony however from people saying the messages are useful and in fact, some people are keeping the text messages on their phones for reference now and in future. The utilization of services too has improved among the insured population.

b) Maternal and neonatal health insurance schemes

Three products were promoted during the year. The products are summarized in the table below.

Table N°: Products promoted to cover maternal health issues

Package	beneficiaries	Product
1. Basic obstetrics services for pregnant mothers	Pregnant women	- 4 ANC visits - 1 Delivery (all outcomes) - 1 PNC visit - Transport for above services - Transport of dead body - Transport to referral facility - Medical cover during pregnancy, up to one month after delivery. This

Package	beneficiaries	Product
		applied to the newborn as well
2. Mixed package (automatic obstetrics & voluntary general healthcare)	Pregnant women	- 4 ANC visits - 1 Delivery (all outcomes) - 1 PNC visit - Transport for above services
	All village residents	- OPD services - IPD services - Emergency surgery
3. Universal coverage product	All village residents	- 4 ANC visits - 1 Delivery (all outcomes) - PNC visits - Transport for above services - OPD services - IPD services - Emergency surgery - Transport of dead body - Funeral support

Two of the running schemes are offering product 1 while the other 3 are using product 2.

c) Disease prevention

We worked with communities and women specifically to prevent diseases in families but more so among the pregnant women and new born babies. With text messages, we sent out reminders for people in the target areas to sleep under a bed net every night, and to keep and stay in a clean environment. Below are examples of the text messages.

1. Some diseases can be avoided if everybody drinks clean and safe water, uses a pit latrine, cleans utensils, and properly disposes waste in the homes. Promote this practice in your home.
2. Stay healthy! Wash your hands with soap before, serving food, before and after eating food, after visiting a latrine.
3. Malaria kills and is expensive to treat. Prevent it by sleeping under ITNs every night.

For the pregnant women specifically, we gave a free ITN to each on showing up at the healthcare facility for the first ANC clinic. A free ITN was

given also to each new born baby delivered at the contracted healthcare facility.

d) Promotion of women's active participation in leadership

For several years now, SHU continues to advocate at the grassroots for the appreciation of women's role in family health and for the recognition of their potential role in leadership. During the year, our advocacy message remained the same as in the previous year- That all health micro-prepayment schemes and their networks provide in their internal guidelines and policies for some female elected leaders at all levels in these organization structures-. We have also targeted women themselves through counselling and trainings. The aim was to change their attitude towards leadership as well as gain confidence to compete where necessary. Today, about 45% of all leadership positions in the schemes and their two networks are occupied by women. For the position of treasurer at all levels, women occupy it at 82%.

Program area 3: Livelihood

a) IGA's promotion

Because of the hard economic times and the continuous proposal by the target communities to incorporate income generating activities into health micro-prepayment schemes' activities, SHU carried out two activities in an effort to promote IGAs in schemes member homes. First, we carried out a survey with the aim of understanding what IGAs are feasible in these communities. The findings are directing towards agribusiness related activities. Secondly, armed with the findings of the survey, we have now embarked on identifying organizations involved / specializing in supporting families start and manage IGAs to improve their livelihoods.

b) Micro financing of IGAs

In our interactions with the beneficiaries, the issue of easy access to affordable micro-loans keeps coming up. SHU with support from EED will now in addition to promoting IGAs and linking schemes to other organizations, also avail small and cheap loans to schemes member families with clear plans. The purpose is to boost the families' incomes for meeting the household needs including paying the scheme premiums and or fees. Since October, an SHU team has developed products and operational procedures. Starting mid next year, the first loans will be given to the schemes beneficiaries.

Program area 4: Healthcare service delivery

a) Supported schemes and healthcare providers to enter into contractual arrangements

To somehow guarantee continuous quality services delivery and recovering the treatment costs on the side of the partner healthcare facilities, SHU facilitated both parties to review and renew the contracts for old schemes, while the new schemes signed the contracts for the first time. As a result of the contracting, 100% (UGX 95,321,000 or about USD 38,000) of the healthcare provider bills have been paid during the year. On the side of delivery of quality services, all contracted facilities continued to operate well except Kitagata (Government) hospital which frequently runs out of drugs.

b) Community participation in management and delivery of services

Through the health micro-prepayment schemes, we empower communities to influence the type and quality of services their contracted service providers offer. In their service and collaboration contracts, both parties commit to opening up new formal communication channels. At each partner healthcare facility, a senior staff is made responsible to oversee the schemes and their partnership with the facility, while another junior staff is appointed to coordinate activities and issues with the schemes. Issues of dissatisfaction and services needed are presented to the coordinator (prepayment cashier) who then forwards such issues to the manager overseeing the partnership who subsequently ensures that the issues get to the facility management team for attention. In these contracts, challenges on the community side have been recognised and as such, the monthly meetings between the prepayment cashier and the individual schemes executive committee members take place in the schemes. One direct result of the community influence during the year has been the



**The
customer
care desk at
IAH**

introduction of a customer care desk at Ishaka Adventist hospital.

c) Patient rights awareness and communication channels

Through our partnership with the Uganda health consumers' organization (UNHCO), we mobilised schemes members in Sheema district to be trained by UNHCO in consumer rights. Similar sensitization meetings were held with staff and management members of Hope medical center, Kitagata hospital and Ishaka Adventist hospital. As a result of these sensitizations and dialogue meetings, the three healthcare providers (HCPs) agreed in principle to work with community committees that were selected to complement the schemes executive committees in collecting and presenting issues for consideration by the facilities. In addition, all facilities agreed to use suggestion boxes at their premises to improve service delivery.

d) Engaging local health authorities

On a routine basis, we engage the authorities at district level on mainly two issues: First, for them to participate in SHU work since we have seen from the past that when the district health officials visit the schemes and talk with the members, the confidence increases and in such schemes enrolment and retention of members is good. Every six months, we have met these officials about this issue and gave them progress reports; second, for them to carry out the support supervision to the contracted healthcare facilities especially Kitagata hospital which suffers frequent drug stock outs and staff absenteeism.

Program area 5: SHU institutional development

a) Strategic plan review

The process of reviewing and finalising the strategic plan has started and will continue into the next financial year. This very involving process has seen us hold consultations and discussions with the beneficiaries, our partners and SHU team and board. At this moment, the strategic direction has been agreed upon and adopted to guide operations.

Shared direction	
Vision	<i>Healthier families with simplified access to quality healthcare</i>
Mission	<i>To improve the quality of health of Ugandans through self managed community health financing approaches</i>
Goal/ overall objective	<i>To contribute to the reduction of the disease burden in Uganda</i>
Values	<i>1. Team work: We willingly do what must be done to assist and care for each other. 2. Client focused: We deliver services and answers that</i>

	<i>closely match our clients' needs and expectations.</i> 3. Integrity: We are honest, fair, accountable and transparent in all our activities and take responsibility for our actions. 4. Professionalism: We continuously create, seek and share knowledge and information on our work, and base our decisions on evidence. 5. Ownership: We share and collectively own opportunities, responsibilities and challenges of the organization. 6. Trust in God: We trust in God and respect the different religions and expressions. 7. Economically oriented: We are not wasteful and our actions are efficient and highly productive 8. Respect: We conduct ourselves with dignity and give credit where credit is due.	
Strategic focus	Focus	Desired state
	1. Clients	• Healthy families • Families with reliable incomes • Strong civic societies
	2. Partners	• Satisfied clients with services • Active in promoting the CHF schemes • Strong collaboration between schemes and healthcare providers • A regulatory framework for CHF • Government healthcare facilities offering quality healthcare services • Formal and strong relationship between schemes and the proposed NHIS
	3. SHU	• All decisions backed by evidence • A comprehensive MIS in operation • Having enough resources all the time

b) Capacity building

The Board together with senior management team was trained in finance management for non finance managers. Two staff members attended training in proposal writing which was organized by the EED Local support services, while four attended training on Action Research which was organized by UCBHFA. Other field staff members were trained in effective mobilization, microfinance project design, and community health insurance.

c) Partnerships identification and activities coordination

SHU is in partnership with text to change (TTC) and have worked together to educate communities about maternal and neo-natal health. Also in collaboration with Ugandan National Health consumers' association, communities were trained on patients' rights. SHU facilitated UNHCO to help communities in Sheema district select health committees responsible for monitoring healthcare services at the providers. The committees have been trained once.

d) Reports generation and sharing

Each semester SHU develops progress reports and shares them with stakeholders. In 2011, reports were shared with donors, district authorities and with other partners. Reports were also share on the organization's website. Two very important meetings (annual partners' meetings) are organised annually one at a national level, and two at local level. The picture below shows the local partners' meeting held in Bushenyi district early during the year.



***SHU
Partners in
Bushenyi
and
Sheema
districts at
this years'
local
partners'
meeting***

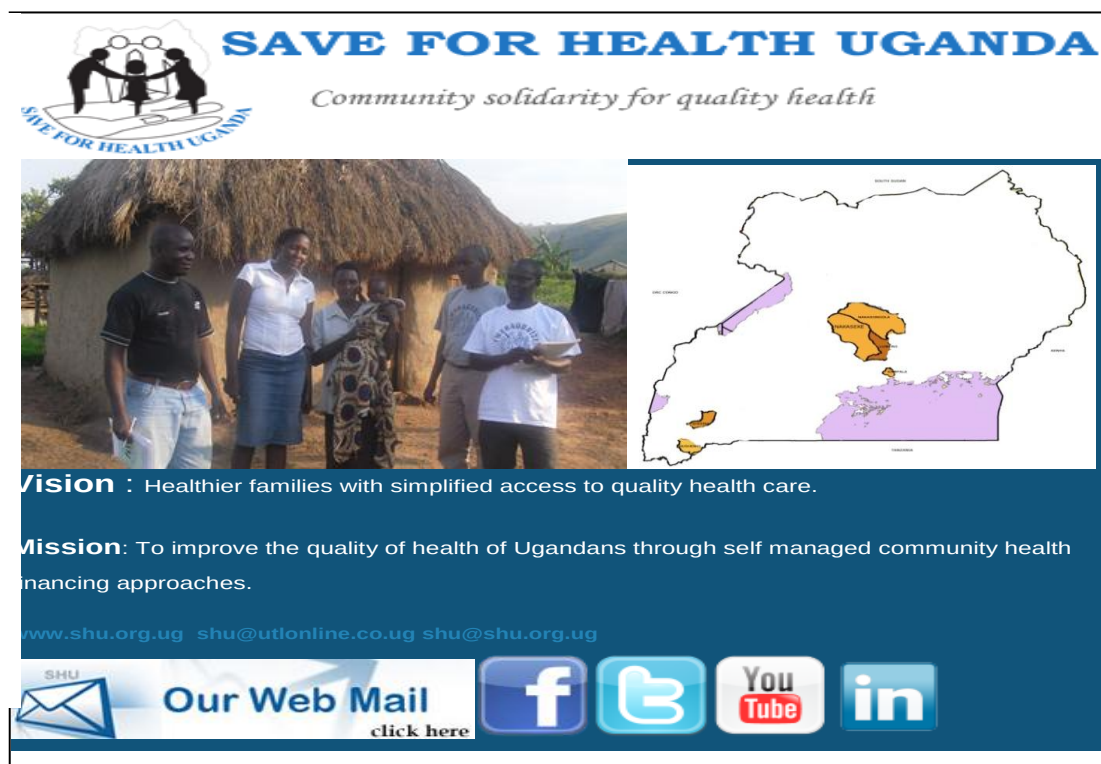
For this year, only local partners meetings were held. The national level partners' meeting will be held in November 2012.

e) Strategy review

A strategy review workshop was held in June 2011 to prepare for the new phase for the HMPS project and for the new financial exercise for the MNHIP project. This was done in a one week workshop where all team members were part. Project implementation strategies were reviewed and some new ones were adopted. The strategy guided the implementation of activities during the year.

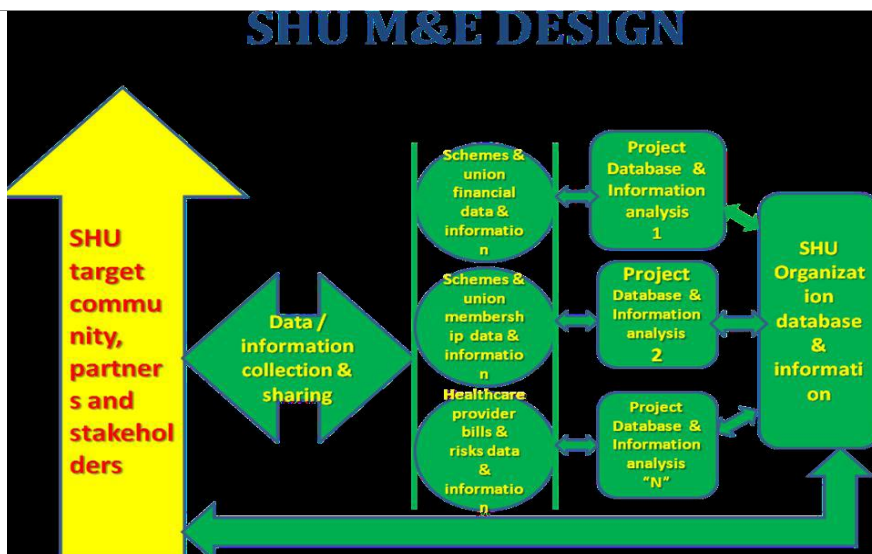
f) Designed an informative website

The organization developed website www.shu.org.ug and it is functioning. Most of the information about SHU has been uploaded and can be accessed.



g) Monitoring and Evaluation (M&E) framework development

To improve the reporting and information and data management, an M&E framework has been developed with relevant tools to collect, analyze and share the different organization projects data and information on the different performance indicators. On the right is the system that will be finalized next year



Achievements

For 10 years now, we have implemented projects professionally and received recognition as development partners in the districts where we intervene. Four projects have been successfully implemented since SHU's formation. The issues on which previous and current projects focus on (limited financial access to health care; unsafe motherhood; new born mortality; women exclusion from participation in leadership; low quality health care services; and irrational healthcare seeking behaviour) are considered priority issues by the authorities and the target communities. Unlike in the past, communities now invite SHU to extend her services to them. Further still, SHU's philosophies of: self ownership; self financing; and self management of the HMPS have earned us the much needed trust in the communities whose past experiences with NGOs was negative.

Our teams' capacities have continued to improve to the delight of the clients, partners and the general public. With the communities' participation, the team has innovatively designed schemes and products (shown in the table below) that cater for most families' interests.

Products	Membership	Schemes where it is sold
1. OPD + IPD + chronics cover	• <i>Voluntary</i>	• Health Micro-Insurance Schemes (HMIS) • Health Micro-Credit Schemes (HMCS)
2. OPD + IPD - chronics cover	• <i>Voluntary</i>	• HMIS • Health Micro-Mixed Schemes (HMMS)
3. Obstetrics services + OPD, IPD, transport, for pregnant women and new born babies	• <i>Automatic</i>	• HMIS
4. OPD + IPD + Chronics + Obstetrics services + Transport for pregnant women accessing obstetrics services	• <i>Universal</i>	• HMIS • HMMS
5. OPD + IPD + Chronics + Obstetrics services + Transport for pregnant women accessing obstetrics services	• <i>Automatic for women aged 14 - 49</i> • <i>Voluntary for others</i>	• HMMS

The level of satisfaction with the schemes by beneficiaries is better. The partner health care providers are satisfied with the program too! They actively promote the schemes to become more attractive and successful at

their own cost and motivation. Kiwoko hospital the oldest partner for example has been serving the schemes in a formal arrangement since the year 2000. All the 7 health care providers have staff (pre-payment cashiers) allocated to handle schemes' issues. The top leaders in these institutions participate in person to schemes activities both at the facility premises and in the communities.

Our capacities are also recognized by other parties outside our direct project operations. We have been consulted to carry out CHI related trainings and feasibility studies. At policy level, Fredrick our Executive Director is (Since 2010) serving on the National health Insurance Scheme (NHIS) Task Force. He is one of the two members of the committee appointed to represent the informal sector. Fredrick has also participated at different stages to the design of a new course - Advanced diploma in health insurance management - being developed by Uganda Martyrs University Nkozi. The course is scheduled to start late 2012. International Center for Development and Research (CIDR) has been consulting us and seeking for our input in their proposed Regional Resource Center (RCC) on micro financing planned to be based in Nairobi. The RCC will provide technical support to CHI schemes, CHI networks and micro finance institutions.

Significant steps and achievements have been made in the process of sustaining SHU activities. The health micro-prepayment schemes (HMPS) are attracting more members averaging 600 individuals and are surviving longer as seen in the table below.

Year of creation	Number created	Number still functioning today
2000/2001	4	1
2001/2002	3	2
2002/2003	4	4
2003/2004	1	1
2004/2005	1	1
2005/2006	1	1
2006/2007	3	3
2007/2008	1	1
2008/2009	4	4
2009/2010	2	2
2010/2011	16	16
2011/2012	17	17
Total	57	53

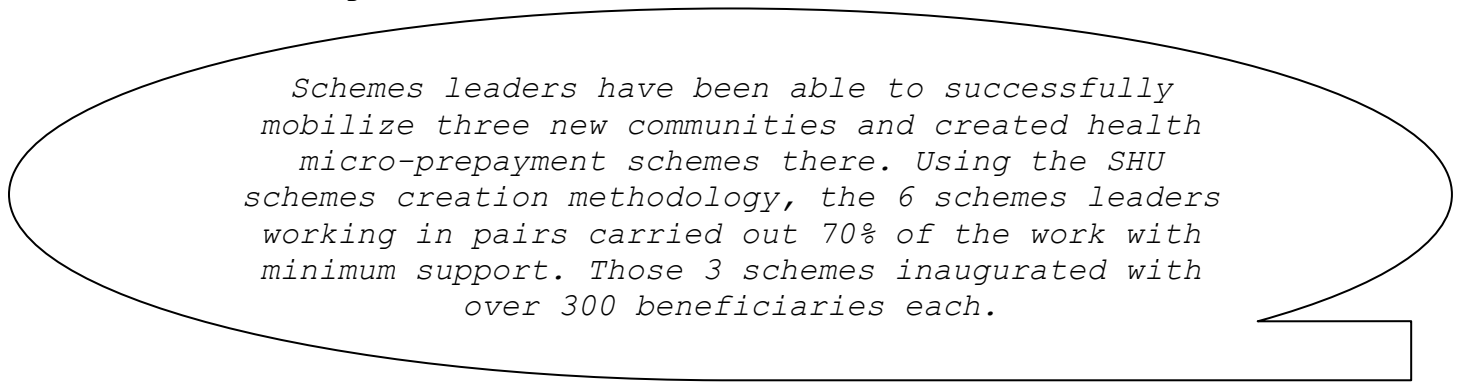
The 53 schemes are now organized into two networks WATA and MBUSO. The MBUSO network is today performing all the technical management functions of contracting service providers, purchasing care, managing and accounting for the centralized finances, making and issuing beneficiaries' identification cards, and training scheme-based leaders and pre-payment

cashiers. Although not fully self financed, the schemes this ended year covered 10% of the total MBUSO secretariat costs. In the MBOSO network still, all schemes management and health care access procedures and operations have been standardized. The schemes have the same financial year that starts on the 17th of March every year.

Success story

One major story stands out this year

1. Self management of CHF schemes



Schemes leaders have been able to successfully mobilize three new communities and created health micro-prepayment schemes there. Using the SHU schemes creation methodology, the 6 schemes leaders working in pairs carried out 70% of the work with minimum support. Those 3 schemes inaugurated with over 300 beneficiaries each.

Impact

Through the program interventions, new communication channels between HCP and communities have been created. Periodic dialogues between schemes representatives and HCP management committees are conducted in which the concerns of each party are discussed and rectified. This community recognition has reached the sub county levels. All the 5 sub-counties covered in the Luwero area offered free office space to the schemes which offices are now serving as coordination centers for schemes activities.

The health seeking behavior among the target communities have improved. In the schemes, and over a number of years now, the utilization of healthcare services pattern shows more OPD claims than IPD claims. The average length of admission also keeps reducing each year. For maternal health, the institutional delivery ratio is 79% in the maternal health schemes.

Women scheme members are participating more in community development initiatives and community leadership. Several women have stood and won leadership positions in schemes but also for local political positions. Mrs Katende is one of such leader who is a councilor at the Luwero District council.

New social structures (schemes/associations) have been created and are being used by community members to advance several causes including health, funeral support, and other social events support. The associations are now accepted community social groups.

SHU donated two tents to Kitagata Hospital (Sheema District) and Bishop C. Asili Health Centre (Luweero District). The tents are being used by patients and their care takers.



SHU team members handing over a tent erected at the patients and care takers' waiting area of Bishop C Asili Health Centre IV. All HC patients now sit in this tent as they wait to be attended to.

During this year, SHU joined hands with the Government and the districts of Luwero and Bushenyi during the annual health campaigns. The specific events to which we have offered support include: the world AIDS day, safe motherhood day, mass immunization days, and Malaria days. The support we provided was both financial to support authorities with the organizations, but we did also provide material support in form of availing the organization vehicles and motor bikes during the mass immunization campaigns. We did also help with passing on information to our target communities to raise awareness about such activities. During such events especially the mass immunization days, we intentionally suspend our engagements with the communities to allow them time to participate in such important activities.

SHU supported many students with internship attachments and as research study centers. During the year, 4 under graduate students from local Universities completed their internship studies with us. One PHD student Dr. Robert Basaza also finalised his studies.



***Dr. Robert Basaza** handing over a copy of his PHD thesis to the SHU Executive Director*

Dr. Basaza's thesis title is Community health insurance in Uganda: status, obstacles and prospects

Low quality of healthcare in Government HC facilities

The public facilities are closer to the rural communities. However, the abolition of user fees in those facilities coupled with limited funding² has resulted into drug stock outs and none motivated staff. They are thus perceived to be of lower quality than the private facilities. The private facilities which are perceived to have quality healthcare are distant from the targeted population and sometimes perceived to be expensive. The low quality of healthcare has impacted on the enrollment of people into schemes.

Low voluntarism for self management

The SHU promoted schemes are self managed and as such the communities choose their leaders to take up scheme management. Their services are voluntary and many never desire to offer the service for long. They are ready to serve for a maximum of two years and yet in reality that is the period when it is hoped that one has started to master the CHI concept given their low literacy levels and the complexity of the different models developed. They demand to obtain other recognitions other than the social prestige.

No formal training institutions on CHI in Uganda

In Uganda, there are no formal training institutions in the field of CHI, despite the fact that this concept is complex and uncommon. The recruited staff thus cannot take up work fast; especially those involved in promoting the CHI concept. Many of them have to learn on job through inductions, experience, reading of CHF guides, exchange visits among others. This slows the level of extension and coverage within the target areas.

Limited funding of SHU

SHU heavily depends on donors and has not diversified her sources of funding. The schemes and their networks cannot mobilize enough funds to pay for the technical support provided by SHU. Presently, SHU has some projects that are not fully funded due to this.

Low participation in SHU activities by authorities

The methodology that SHU uses to approach any community inclusively involves the local authorities. Despite the fact that they are contacted first for permission and support, many of the local authorities however

² The Abuja commitment in 1998 was to raise the share of the global government budget directed to health services to 15% but its 10%.

pull out after understanding that their efforts are sought for but are to be voluntary. They however claim to have embraced the new development within their communities but are never activity in mobilizing their people to be part of the development initiative and sometimes, themselves are bystanders. Because behind them are a pool of supporters, many households hesitate joining schemes simply because their leaders have shunned away from them.

Low household incomes

During the year, the Ugandan shillings continued to lose value amongst all the international currencies. The cost of living was really high and inflation went up to 30%. Besides, during the year the whole country experienced unpredictable weather conditions yet 80% of the target population depend on agriculture. Bushenyi area was hit by the banana wilt a few years ago and the effect of this has been seen on food scarcity and reduction of incomes since bananas have also been a source of income for the rural households. This is evidenced in the many dying banana plantations within the region.



A cut down banana plantation in Bushenyi district; most once big plantations have been reduced to this type of plantation

The local authorities are doing what they can to sensitize the population on how to avoid/reduce the tragedy. The means include wiping out the affected plantations; but are being resisted by many farmers. The low household incomes led to high drop outs and low enrollment of new members into schemes. The photograph above shows one of the plantations that were hit with the wilt and those are now common within the region.

Save for Health Uganda (SHU) has the following plans for the year 2012.

Building a Management Information System (MIS)

The increase in the size and complexity of the organizations activities and operations, calls for a need to develop a Management Information system which will assemble, process, store, retrieve, evaluate and provide relevant information to facilitate planning and evidence based decision making.

The MIS is also intended to provide a way through which we will monitor our operations, evaluate and improve performance to make necessary changes in the organizational plans and procedures. The development of the MIS will not only ease the coordination within the different departments in the Organization but also serve as a link between managerial planning and control.

Building a resource Centre

Information has played an important part in the wider organizational learning process. One of the challenges that we have faced however is the limited information that is tailored to suit our local context. By building a resource center, we intend to support a wide range of learning activities by making information available and accessible to us and primary partners. This will play a valuable part in improving our and their performance.

Registering as a national NGO

SHU is currently mandated to operate in Luweero, Nakaseke, Nakasongola, Bushenyi and Sheema Districts. However this is now a limitation in the realization of our strategic plan. We will therefore register as a National NGO to create space for the organization to extend our services to the people in other parts of the country.

Diversifying SHU Activities

Since the beginning, SHU has been implementing activities in the field of Community Health financing (CHF). The plan to diversify activities is intended to create more areas of intervention in order to support SHU realize sustainability. In addition, the diversification plan intends to answer to the current beneficiaries continuously call to cater for their various needs other than health.

Extending SHU activities to new communities

Currently, SHU has managed to cover 53 parishes in 14 sub counties in the 5 districts where we work as indicated below;

Table showing the current sub counties and parishes where SHU has created schemes

District	Sub-counties where we operate	Number of parishes covered
Luweero	Luweero	9
	Butuntumula	6
	Katikamu	1
Nakaseke	Kikamulo	9
	Wakyato	3
	Nakaseke	3
	Kasangombe	1
Nakasongola	Kakooge	6
Bushenyi	Ibaare	3
	Bumbaire	4
	Kyeizooba	3
Sheema	Kitagata	1
	Kasana	3
	Bugongi	1
TOTAL	14	53

For the coming year, we plan to focus on covering more parishes in the current sub counties.

Updating the feasibility study

With the revised strategic direction, SHU will update the feasibility study during the coming year in order to provide up to date information and a baseline for the new projects that are being developed. As a learning organization, such realities from the feasibility studies/updates have always provided a basis for our decisions and actions.

Contracting additional Health care Providers

The schemes' beneficiaries are currently being covered by 7 HCPs as already listed,

As we plan to cover more parishes, more health facilities that are near to the beneficiaries will be identified and contracted.

Evaluating the Maternal and Child Health project and define its next activities.

The Maternal and Child Health project that is being funded by CORDAID is in the last semester of the pilot phase of its implementation. The results of this evaluation will be used to improve our organizational learning as far as the implementation of this project is concerned and provide an input of how the activities of the next phase of this project will be carried out.

The year 2011 has been a good year for SHU and for the communities it serves. Despite the several challenges faced, big strides have been registered and the organization is in a strong position to start the year 2012. We strongly acknowledge once again that whatever success and positive results we have, it has been because of the valuable support we have received from our partners and stakeholders. In a very special way, and once again, we would like to acknowledge the support given to SHU that has made our work easier and appreciated. The support that has done so much in making SHU's work successful is shown in the table below.

Table N°: SHU partners and stakeholders and the support they offered towards the program

Support	Given by
Discounts to schemes	1. Kiwoko Hospital UGX 4,872,000 2. IAH UGX 1,623,400 3. AMG Bugongi UGX 322,000
Offices space at sub-county level to MBUSO	1. Butuntumula sub-county 2. Luweero Sub-county 3. Wakyato Sub-county 4. Kikamulo Sub-county 5. Kakooge Sub-county
Technical support	1. CIDR 2. UCBHFA 3. DIS/EED 4. TTC 5. UNHCO
Financial support	1. EED 2. Cordaid
Community Mobilization	1. Local authorities
Schemes promotion	1. Kiwoko Hospital 2. Ishaka Adventist Hospital 3. Hope medical center 4. Bishop C Asili HC 5. Franciscan health Centre 6. Laura Health centre 7. Kitagata Hospital 8. Just Like My Child Foundation
Resources (Information)	MoH (planning unit)