



SAVE FOR HEALTH UGANDA (SHU)

“Community solidarity for quality health”

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Head office
Plot 580, SekabakaKintu
Road, MengoRubaga
P. O. Box 8228 Kampala-
Uganda Tel: +256
414271841
Fax: +256414271841
Email: shu@shu.org.ug

Luwero Area Office
Kasoma zone in Luwero
Town council off the
Kampala- Gulu highway;
P.O.Box123 Luwero
Tel: +256414610187
Email: shu-luwero@shu.org.ug

Wobulenzi Satellite Office
Kampala - Gulu Highway,
Wobulenzi Town Council
P.O.Box 123 Luwero
Tel: +256 783 668 393
Email: Shu-wobulenzi@Shu.org.ug

Bushenyi Area Office
Bugomora Cell, Katungu
zone in Ishaka town
council off the Bushenyi-
Kasese highway
P.O. Box 277 Bushenyi
Tel: +256485433005;
Email: shu-bushenyi@shu.org.ug

Masaka Office
Twin Tower Building
opposite Stanbic Bank,
Masaka Town
P.O.Box 16 Masaka
Tel: +256414695182;
Email: shu-masaka@shu.org.ug

Mubende Office
Ssaza Road in Central
Zone, Mityana
Municipality
P.O.Box 285, Mityana
Tel: +256414696308
Email: shu-mubende@shu.org.ug

Website: www.shu.org.ug



SAVE FOR HEALTH UGANDA (SHU)

“Community solidarity for quality health”

Vision

Healthier families with simplified access to quality health care.

Mission

To improve the quality of health of Ugandans through community health financing (CHF) approaches.

Goal

To contribute to the reduction of the disease burden in the targeted districts through viable, affordable and sustainable community health financing approaches.

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LIST OF ACRONYMS

ANC	Antenatal Care
BftW	Bread for the World
CHF	Community Health Financing
CHI	Community Health Insurance
CRA	Customer Relations Assistant
IPC	In-patient care
MBUSO	Munno mu Bulwadde Union of Schemes Organization
MSCOM	Munno mu Bulwadde Mubende Schemes Cooperation Mechanism
NHIS	National Health Insurance Scheme
OPC	Out-patient care
PACE	Program for Accessible communication and Education
PCC	Patient-centred care
PNC	Post-natal care
PNFP	Private-not-for-Profit
PSI	Population Services International
SHU	Save for Health Uganda
UCMB	Uganda Catholic Medical Bureau
UGX	Uganda Shilling
UPMB	Uganda Protestant Medical Bureau
VHSLA	Village Health Saving and Loan Associations
WATSA	Western Ankore Tweragurize Schemes Association



**Mr. Zakaria Kasirye
Muwanga**

MESSAGE FROM THE BOARD OF DIRECTORS



**Mr Fredrick
Makaïre**

It is our pleasure, once again, to share with you this report about Save for Health Uganda's work and achievements during the year 2016. We are happy to note that 2016 was such a fruitful year for SHU with remarkable successes registered in the various areas of our work.

This year, membership in the community health financing (CHF) schemes increased with a corresponding increase in the number of schemes. There were 31,869(14,385 males and 17,484 females) members in 93 schemes compared to 24,445 in 91 schemes in 2015. We expanded coverage to more areas and created 27 new schemes in Luwero, Sheema and Mitooma districts. Activities to promote CHF in Kampala and Wakiso also started. Schemes were served by 15 healthcare providers and promptly paid a total of UGX 275,237,064 in members' medical bills for 7,369 outpatient and 1,587 inpatient cases. The health care providers contracted by schemes made efforts to improve the quality of services by institutionalizing customer relations desks, improving drug stocks and recruiting more staff. SHU trained 25 health workers and 182 scheme leaders in patient rights and responsibilities.

We equipped 793 (226 males and 567 females) scheme members with vocational skills to enable them undertake activities for improving their household income, and linked them to micro finance institutions for low-interest loans. Up to 1,276 scheme members accessed loans for agriculture and working capital.

Our advocacy for introduction of an all-inclusive National Health Insurance Scheme (NHIS) increased. We used various platforms including the mass media and meetings to share information with the general public. The climax of our advocacy work in 2016 came in December when we hosted the first national CHF conference in Kampala, which attracted 109 key stakeholders and policy makers. We also oriented 268 of all newly elected leaders in six of SHU's target districts about CHF and shared with them our position on the draft NHIS bill.

We launched a new strategic for plan 2016/2017 – 2020/2021 to guide our work over the next five years. We plan to continue working with communities to ease financial access to quality healthcare services and advocate for a national health insurance scheme that caters for the healthcare needs of low-income families and vulnerable members of the population.

We wish to appreciate our funding partners, Bread for the World (BftW) and Population Services International, whose support made the work you are going to read about possible. We are also very grateful to other partners including local and central government agencies, civil society organisations and health care facilities who supported SHU financially and technically in the different activities undertaken.

We are once again grateful for your support. Thank you.

**Zakaria Kasirye Muwanga
Board Chairperson**

**Fredrick Makaïre
Executive Director**

ABOUT SAVE FOR HEALTH UGANDA

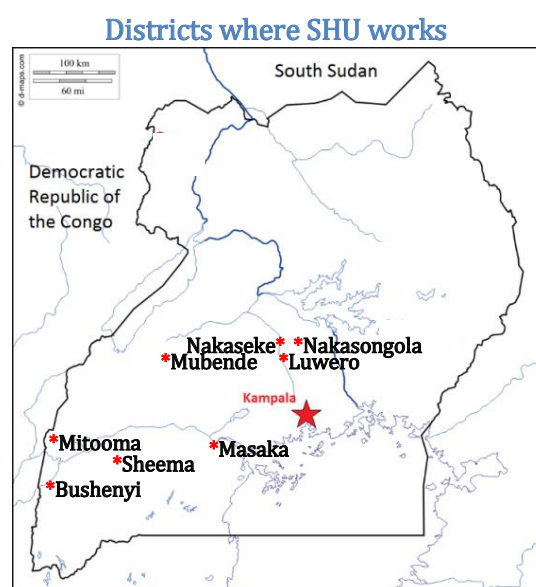
Save for Health Uganda (SHU) is a Ugandan non-governmental organization (NGO) formed in 2002 to improve people's financial access to quality and affordable healthcare services. SHU has five core areas of work: 1) Community health financing (CHF); 2) Women empowerment for health; 3) Livelihood improvement; 4) Quality healthcare services delivery; and 5) SHU Institutional development. SHU works with low-income families to enable them overcome financial barriers to accessing healthcare; empowers women to participate in decision making pertaining to healthcare; advocates for delivery of quality healthcare services; and improves household incomes by skilling people and linking families to income generating opportunities.

SHU currently works in 10 districts namely: Luwero, Nakaseke, Nakasongola, Kampala, Wakiso, Mubende, Masaka, Bushenyi, Sheema and Mitooma. The head office located in Rubaga Division, Kampala city, coordinates all activities while field offices in the districts of Luwero, Mityana, Masaka and Bushenyi serve as centres for community mobilisation.

There are 93 running CHF schemes formed by SHU at parish level in the districts of operation. Each scheme has leaders at village and parish level. To increase their sustainability and bargaining power, SHU supported the schemes to form networks at regional level which are directly responsible for contracting health care providers, purchasing health care, issuing identification cards, and managing scheme funds. The networks have so far contracted 15 healthcare providers to offer services to scheme members.

At national level, SHU is advocating for introduction of a National Health Insurance Scheme (NHIS) to protect citizens from impoverishment due to paying medical bills. SHU envisages an all-inclusive NHIS as a passage for Uganda to achieve Universal Health Coverage (UHC). It also advocates for improved healthcare services and increased budget allocation to the health sector.

The SHU team in 2016 comprised of 28 staff members and a board of directors. The board members were: Mr. Zakaria Kasirye Muwanga–Chairperson; Mr. Fredrick Makaire– Secretary; Mr. Ernest Kaddu – Treasurer; Mr. Paul Michael Waigolo – Member; and Ms Leticia Nakimuli – member. The senior management team members were: Mr. Makaire Fredrick – Executive Director; Mrs. Juliet Nazibanja Kibirige– Programs Officer; Ms. Asio E. Veronica – Finance and Administration Officer; Mr. Eria Mugisa Kumaraki– Monitoring and Evaluation Officer; and Ms. Proscovia Nnamulondo– Communication and Advocacy Officer.



A. THE WORK WE DID DURING THE YEAR

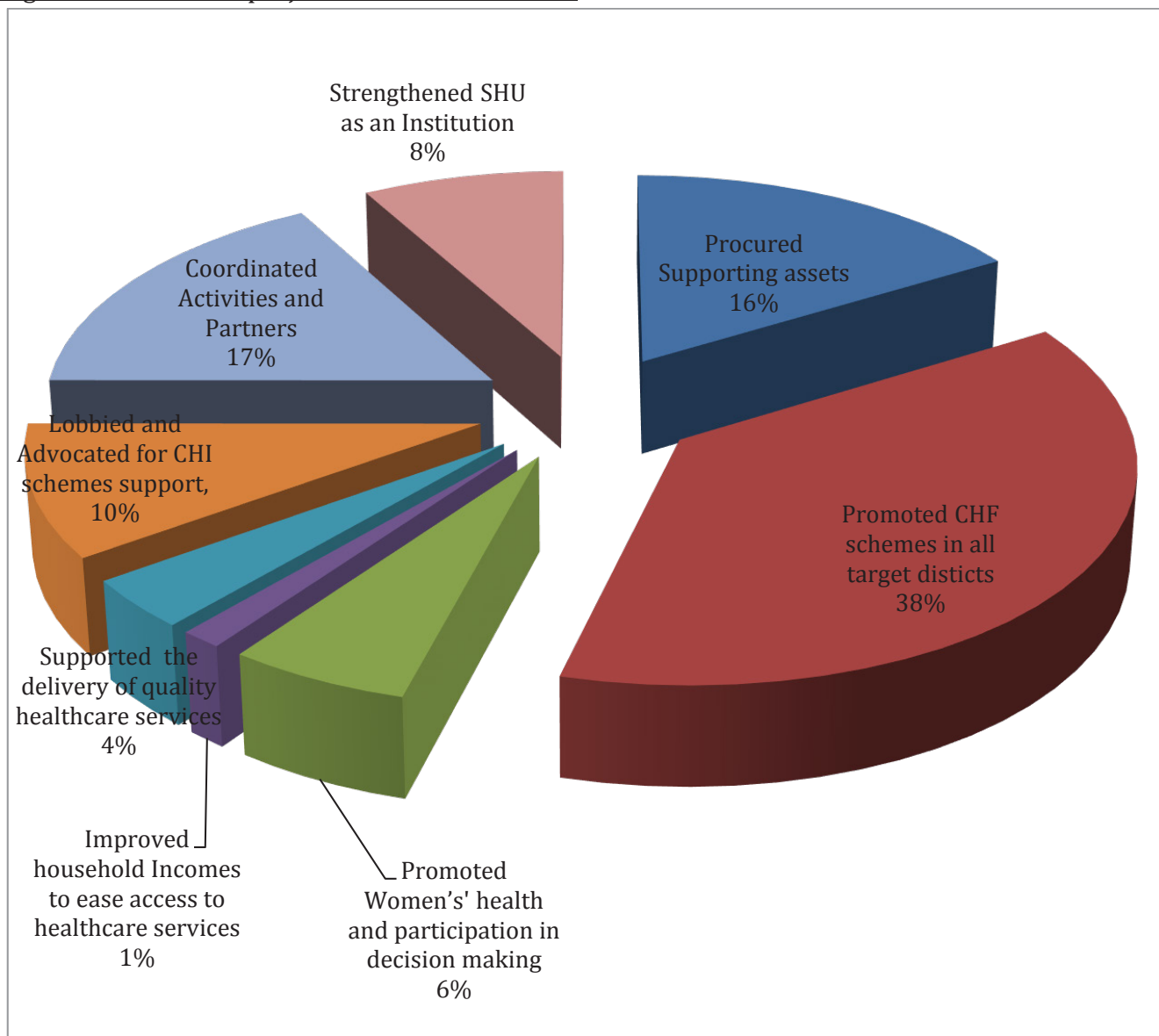
1. DEVELOPED PROJECTS, FUNDRAISED AND MADE ACCOUNTABILITIES

In the table below, we show details of the two projects implemented in 2016. After the table, the figure shows how the project funds were utilized.

Table N°1: Details of the two projects implemented in 2016

Project	What the project was about
1. Reducing barriers to utilizing quality health care services by the rural and urban poor in Uganda. The project is implemented in 9 Districts: 1. Luwero 2. Nakasongola 3. Nakaseke 4. Masaka 5. Bushenyi 6. Mitooma 7. Sheema 8. Kampala 9. Wakiso The total grant amount was Ugx 681,942,950. The funding partner is Bread for the World.	It is about simplifying access to quality health care services and supporting Government to develop a National Health Insurance Scheme (NHIS) that foresees universal health coverage. Specifically, the project focused on: 1. Promoting community health financing (CHF) schemes. 2. Advocating for a fair (including indigents and informal families + subsidies) and all-inclusive NHIS. 3. Advocating for an increase in the proportion of the national budget allocated to the health sector in order to improve the quality of health care services delivered. 4. Empowering communities to support women participate in decision making. 5. Supporting families to improve their livelihoods through vocational skills and micro-financing facilities.
2. Interventions to improve maternal health in Mubende District through community health prepayment schemes. The total grant amount was Ugx 157,458,000. The funding partner is Population Services International (PSI/ PACE).	It was about improving maternal health in Mubende District. Specifically, the project focused on: 1. Promoting community health financing (CHF) schemes 2. Health and obstetrics care education 3. ANC completion and institutional delivery 4. Family planning

Figure N°1: How the projects funds were utilized



2. PROMOTED AND SUPPORTED COMMUNITY HEALTH FINANCING SCHEMES

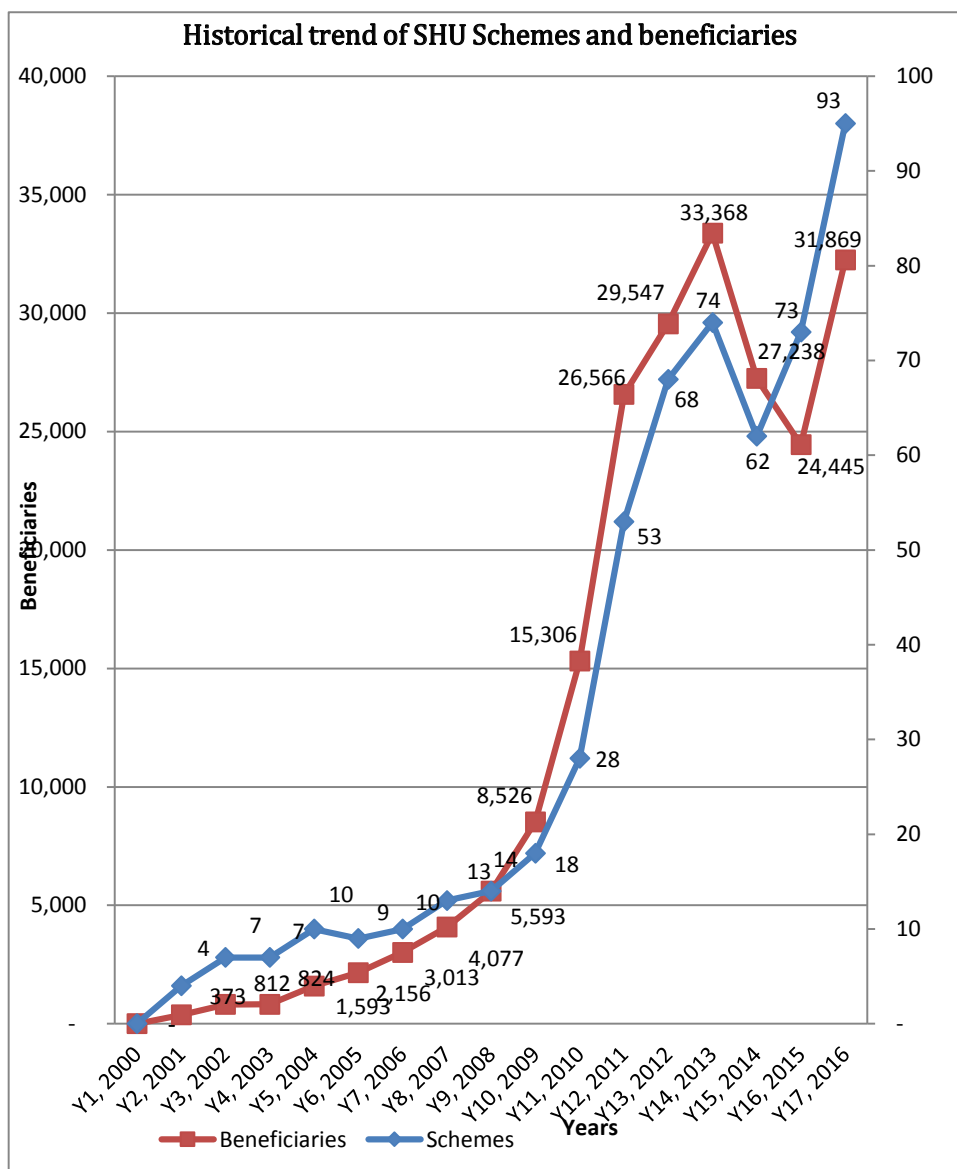
For our CHF program, we wanted to grow the number of CHF schemes and individual beneficiaries from 73 schemes with 24,445 beneficiaries in January 2016 to 102 schemes with 36,290 beneficiaries by December 2016. In order to succeed: (1) we supported with resources, and trainings, the four CHF schemes networks that support the individual schemes in a region by managing their premiums, pooling the premiums, and thus allowing for cross subsidization, contracting healthcare services for the schemes, purchasing the healthcare services, managing member identification and handling conflicts among schemes and with healthcare providers, so that they deliver successfully on those mandates; (2) we created new schemes in new sub-counties; (3) we introduced a savings mechanism to enable families with lower capacities to pay for insurance and save for their future health care needs; and (4) we accredited new healthcare providers and recommended them to networks for contracting to further ease access.

2.1. Achievements

1. Positive growth in the number of people covered by the CHF schemes

The total number of CHF schemes that covered people during the year grew to 93 from 73 in 2015. This indicates a growth of 27.4% from last year and a performance of 91% against the annual target.

For the first time in four years, the number of CHI schemes increased with a corresponding increase in the number of beneficiaries. The number of beneficiaries increased to 31,869 (14,385 males and 17,484 females) from 24,445 households compared to 24,445 from 3,953 households in 2015.



2. Extended coverage of CHF schemes in the target areas

2.1. Sub-counties and parishes covered by December 2016

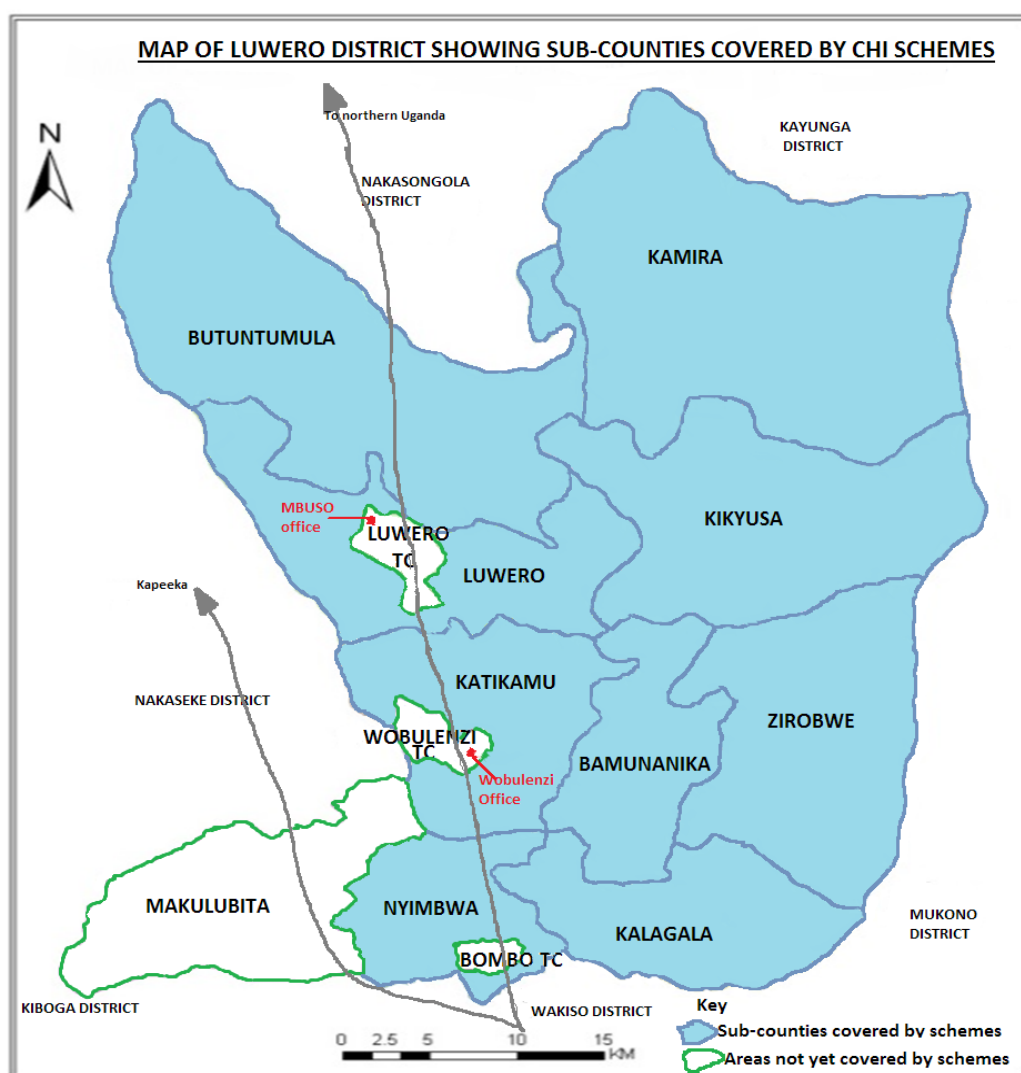
The number of districts where we work increased from eight to 10 when we extended operations to Wakiso and Kampala districts. We introduced the CHI concept to potential service providers and 25 organised groups in the two districts. In the other Districts, we extended coverage to new sub-counties and parishes. The table below shows all the areas covered by the schemes and whether they are newly reached or old.

Table N°2: Districts and sub-counties where we worked in 2016

District	Name of sub-county of operation	Year when operations started	Number of parishes covered	Number of schemes	Number of people covered
Luwero	1. Butuntumula	2016	6	6	3,333
	2. Luwero	2001	10	10	4,559
	3. Katikamu	2006	3	3	623
	4. Kamira	2016	4	4	1,385
	5. Bamunaanika	2016	3	3	1,130
	6. Nyimbwa	2016	1	1	158
Nakaseke	1. Kikamulo	2003	8	8	4,057
	2. Kito	2012	2	2	624
	3. Wakyato	2000	2	2	971
	4. Nakaseke	2011	2	2	1,042
	5. Kasangombe	2011	2	2	602
Nakasongola	1. Kakooge	2001	6	6	3,224
Mubende	1. Kassanda	2014	7	7	2,840
	2. Bukuya	2014	3	3	609
Masaka	1. Masaka Municipality	2013	1	1	163
Bushenyi	1. Kakanju	2013	2	2	202
	2. Nyabubare	2012	5	5	724
	3. Bumbaire	2008	1	1	202
	4. Central Division	2009	1	1	295
	5. Kyeizooba	2011	2	2	203
	6. Ibaare	2007	1	1	229
Mitooma	1. Kabira	2015	4	4	903
	2. Mutara	2015	5	5	616
	3. Katenga	2013	1	1	350
Sheema	1. Kitagata	2010	3	3	808
	2. Kasaana	2010	3	3	880
	3. Bugongi Town Council	2011	2	2	479
	4. Kashozi	2014	1	1	202
	5. Sheema Division	2015	1	1	353
	6. Mutara	2015	1	1	103
Total			93	93	31,869

2.2. Luwero District to be fully covered by June 2018

We have covered 9 out of the 13 lower local governments (10 sub-counties and 3 town councils) of Luwero District. Work in all three remaining town councils and one sub-county is planned for 2017 and the first half of 2018.



3. Improved capacities of CHF schemes and networks to perform their mandates

The CHF schemes networks are: (1) Munno Mu Bulwadde Union of Schemes Organisation (MBUSO); (2) Western Ankore Tweragurize Schemes Association (WATSA); (3) Munno mu Bulwadde Mubende schemes Cooperation Mechanism (MSCOM); and (4) SHU-CHI.

The networks enrolled more members, extended the risks and financial pooling to all schemes in each network, and mobilized more funds from member schemes to implement network activities. Altogether, the networks managed a total of 93 schemes. The schemes contributed Ugx 26,033,122 towards the operations of these networks.

Table N°3: The CHF schemes networks and their sizes

Network	MBUSO	WATSA	MSCOM	SHU-CHI
Districts of operation	Luwero, Nakaseke and Nakasongola	Bushenyi, Sheema and Mitooma	Mubende	Luwero and Masaka
Number of member schemes	48	33	10	2



All four networks are legally recognized as community based organizations (CBOs) with valid registration certificates. MSCOM, the youngest network amended its constitution and strengthened its governance structure. The new network board now has representatives of the schemes, the health care service providers and SHU. All networks board members and their technical managers (16 people in

total) were trained in governance and management to further strengthen the capacity of schemes and their networks for managing funds, records, mobilisation and other operations. The training was intended to enable office bearers understand their roles and perform them effectively, as well as address issues of conflict between board members and the secretariat teams. All leaders at scheme level were trained by the networks staff and have continued to improve in the way they communicate, market and promote the schemes, and fill scheme management tools.



Mr. Arinaitwe Evarist, a Field Officer, training village scheme leaders at Nyabubare parish headquarters in Kabira sub-county Mitooma district.

4. Improved geographical/ physical access to healthcare services

The number of health care facilities contracted to provide services to schemes members increased from 15 in 2015, to 18 in 2016. The increase, which was a result of an accreditation exercise, ensured that services were further brought closer to the scheme members in the Districts of Luwero, Nakaseke and Nakasongola. The new health care facilities are: St. Luke Namaliga, St. Matia Mulumba Mulajje HC IV and Holly Cross HC III. The table below shows the 18 contracted health care facilities and the year each facility first joined the partnership.

Table N°4: The accredited and contracted healthcare providers by the end of 2016

Health facility	District of location	Type	Ownership/ Affiliation	Year of partnership	Bed capacity
1. Kiwoko hospital	Nakaseke	PNFP	UPMB	2000	250
2. Ishaka Adventist Hospital	Bushenyi	PNFP	UPMB	2006	110
3. Bishop C. Asili Hospital	Luwero	PNFP	UCMB	2007	100
4. Kitagata Hospital	Sheema	Public	Government	2009	100
5. Hope Medical Centre	Sheema	PNFP	NGO (Apostolic Ministries for the gospel)	2009	13
6. Bitooma Health Centre III	Bushenyi	PNFP	UCMB	2011	40
7. Franciscan HCIV- Kakooge	Nakasongola	PNFP	UCMB	2011	25
8. Bangi Maternity Home	Mubende	PFP	Individual	2013	4
9. Kitovu Hospital	Masaka	PNFP	UCMB	2013	248
10. St. Francis community health Centre IV	Mityana	PNFP	UCMB	2013	37
11. St. Gabriel Mirembe Maria HC III	Mubende	PNFP	UCMB	2013	26
12. Nakaseke hospital	Nakaseke	Public	Government	2014	150
13. Naluggi community Health centre III	Mityana	PNFP	UCMB	2014	16
14. Mushanga Health Centre III	Sheema	PNFP	UCMB	2014	29
15. Kitokolo Health Center III	Mubende	PNFP	UPMB	2016	8
16. St. Luke Namaliga HCIV	Luwero	PNFP	UCMB	2016	37
17. Matia Mulumba Mulajje HC III	Luwero	PNFP	UCMB	2016	15
18. Holly Cross HC III	Luwero	PNFP	UCMB	2016	25

5. Members utilized medical services and networks cleared bills

CHF schemes in each region now pool their healthcare funds. The pooled funds in each network (see table below) enabled each member to access healthcare worth UGX200,000 per episode of illness compared to UGX 80,000, which was previously the maximum amount covered by individual schemes.

Table N°5: The total amount collected as premiums in 2016

Networks' size in 2016				Size of the health care funds	
Name of Network	Number of running schemes	Number of people covered	Total contributed by members (UGX)	Amount allocated to the insurance fund	Total accumulated credit fund
MBUSO	48	21,504	191,026,639	61,529,371	86,470,036
WATSA	33	6,549	57,338,739	48,917,600	0
MSCOM	10	3,449	14,754,958	11,803,966	0
SHU -CHI	2	367	28,794,349	20,156,044	0
TOTAL	93	31,869	291,914,685	142,406,981	86,470,036

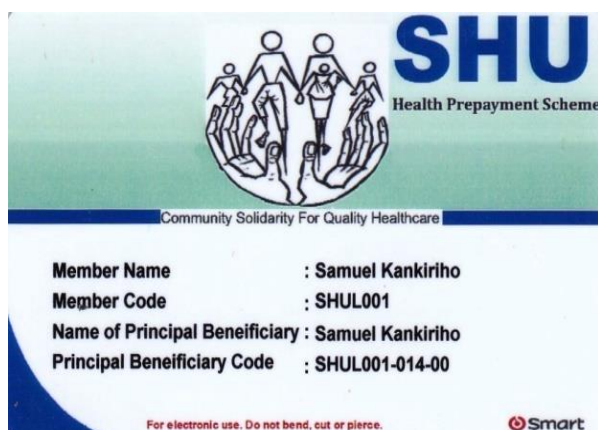
Table N°6: Medical claims in 2016

Name of Network	Insurance fund	Credit fund	Number of OPD cases	Number of IPD cases	Total schemes bill and amount cleared (UGX)	Network performance (fund consumption)
MBUSO	61,529,371	86,470,036	1,748	705	143,534,100	97%
WATSA	43,582,991	-	2,745	289	64,265,500	147%
MSCOM	33,577,844	-	2,417	560	47,364,070	141%
SHU -CHI	20,156,044	-	459	33	19,123,964	95%
TOTAL	158,846,250	86,470,036	7,369	1,587	274,287,634	

The deficit in WATSA was covered by reserves built over the years previously belonging to each individual scheme but pooled during the year. MSCOM's deficit was partly covered by reserves, diversion of management funds to the insurance fund and a loan from SHU.

6. Introduced the biometric identification system in the urban CHF scheme

The biometric system was introduced to gradually phase out the manual health care access cards used by scheme members. It was promoted among SHU-CHI members who belong to organised groups and corporate bodies. The SHU-CHI team and key staff at Kiwoko Hospital, Bishop Caesar Asili Hospital and Franciscan HCIV were trained to use the equipment. Members of the SHU-CHI scheme in Luwero were also trained in using the new cards and 73 families were able to use them to access services. Biometric cards will be used by members of the urban scheme until rural schemes can afford them.



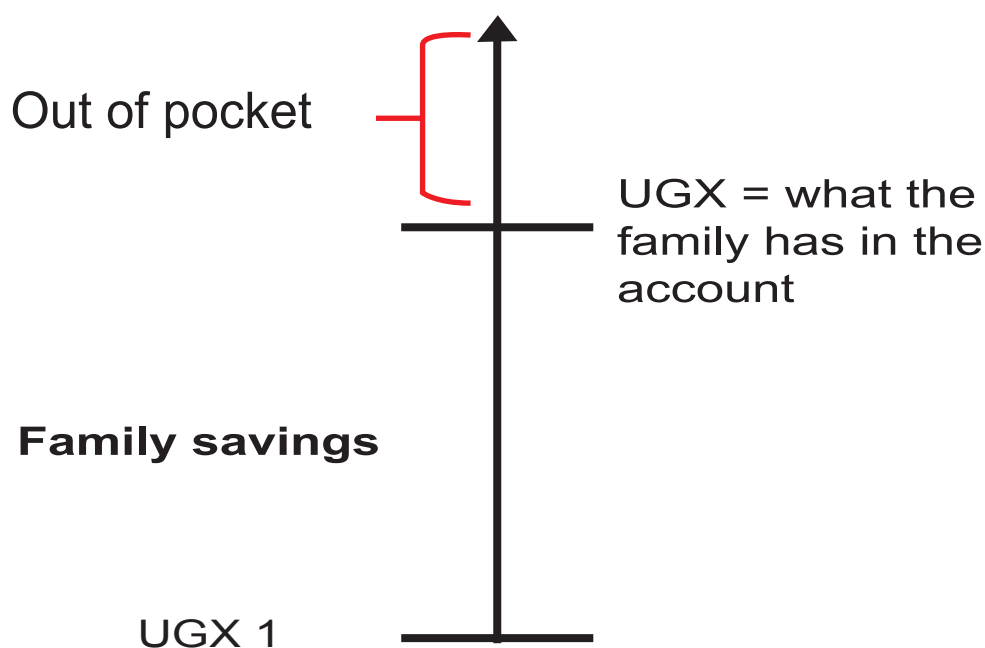
The biometric healthcare access card introduced for SHU- CHI schemes members in 2016



A scheme member in Luwero registers to receive a biometric card.

7. Introduced a new mechanism / scheme for communities with very low solidarity levels

During the year, we developed and introduced the Family Savings for Health care mechanism. This mechanism introduced to communities in Bukuya Sub-county of Mubende district does not involve risk pooling with other community members but rather allows families to open up individual family healthcare accounts with MSCOM which is the network of CHF schemes in the area.



The network set a uniform minimum family account balance before a family account becomes active. Once active, a family that needs to access medical services receives an authorization slip from the network to be presented to the health care facility. If the patient's bill is less than the savings, the network clears the bill in full on behalf of the family at the end of the month. However, if the bill exceeded the funds on the family account, the patient pays cash out-of-pocket equivalent to the amount above the balance on the account. Once the account balance drops below the minimum balance, the account is frozen until the family tops up.

This family savings mechanism increased the number of CHF mechanisms promoted by SHU to four. The other three are: (1) pure credit mechanism where families make a one-time contribution into a credit fund from which health care loans are issued and refunded by patients after discharge; (2) pure insurance mechanism where premiums are paid and pooled annually. The patient's bills are cleared from the pooled insurance fund; (3) mixed credit and insurance mechanism where families make two contributions once in a credit fund and annually into an insurance fund. Medical bills are cleared from both funds with the portion drawn from the credit fund being a loan to the family.

The most popular mechanisms were two in 2016; the pure insurance mechanism and the mixed credit and insurance mechanism.

Table N°7: Mechanisms used in 2016

Mechanism	Number of families	Number of people
Pure Insurance	2,473	13,710
Mixed Credit and Insurance	2,701	17,734
Family Savings	102	425
Pure Credit	0	0
TOTAL	5,276	31,869

2.2. Challenges

High cost of healthcare services: The cost of healthcare in some facilities increased due to price escalation of commodities on the open market. In addition, there was over utilization of services in some areas. This led to depletion of the healthcare fund in some scheme networks before the end of the year hence encroaching on reserves. MBUSO used up to 83.3% (Ugx25 million) of its reserves to clear healthcare bills.

Prolonged drought: Many areas where CHF schemes exist experienced a long dry spell which caused crop failure and death of livestock. This negatively affected family incomes. Many families failed to pay premium as they prioritized buying food.

Absence of a policy on CHF: Although a growing number of community members and leaders at different levels were appreciative of the potential of CHF to increase equitable access to healthcare, the absence of a national policy made it difficult for them to mobilise people to join schemes. Many of them felt that their hands were tied until there is a national policy/law on operations of CHF.

3. ADVOCATED AND SUPPORTED THE PROCESS OF DEVELOPING A FAIR NATIONAL HEALTH INSURANCE SCHEME FOR UGANDA

We wanted the proposed National Health Insurance Scheme (NHIS) as defined in the draft Bill of 2014 to be improved and consider enrolling all Ugandan residents regardless of their social-economic, and employment status through the three sub-schemes of Social Health Insurance Scheme (SHIS), Community Health Insurance Scheme (CHIS), and the Private Commercial Health Insurance Scheme (PCHIS). Within the NHIS Bill, we wanted a clause providing that there will be a minimum healthcare package to be accessed by all beneficiaries regardless of the sub-scheme through which they join the NHIS. Finally, we wanted the Bill to recognize the existing CHF schemes and commit to supporting them with subsidies and for them to start together with the groups that shall start first immediately the NHIS is launched, according to the phasing model that the Government shall choose. In order to succeed: (1) we sensitized the general public and the district authorities and leaders about CHF, its current contribution to financing healthcare and the justification for its inclusion as a sub-scheme in the proposed NHIS design; (2) We participated in several meetings with other organizations with whom we developed proposals and position papers and presented them to the officials responsible for developing the NHIS Bill; (3) we publicized our CHF schemes activities, results, and their impact on families, health care providers and the local communities through monthly newsletters that were sent out to ministries, organizations, and individuals interested in healthcare financing issues; and (4) We organized the first national conference on CHF which brought together stakeholders of CHF schemes and the NHIS. The theme of the conference was “advancing community health financing to achieve Universal Health Coverage in Uganda”.

3.1. Achievements

1. The graphical illustration of a fair NHIS for Uganda we made is being used by the NHIS secretariat to raise awareness about the NHIS.

The key principles in the illustration are: (1) Equity in contributing and accessing services; (2) A compulsory pool for the universal minimum package of services; (3) A voluntary pool for supplementary services; (4) Three sub-schemes through which people according to their social-economic categorization will pay for the compulsory package; and (5) purchaser- provider split with two funds managers: the NHIS to manage the NHI Fund for the compulsory minimum package, while the PCHIS and CHIS manage the PHI Funds for the voluntary supplementary package(s).



“National solidarity for equitable access to quality healthcare by all”

2. NHIS continued to attract the attention of the public and was occasionally discussed in the national media during the year

Some of the articles published by mass media on the proposed NHIS



SHU's Communication and Advocacy Officer, Proscovia Nnamulondo, making a presentation on Community Health Insurance during the orientation meeting of Bushenyi district local authorities.

3. The first national CHF conference hosted by SHU made important resolutions on CHF, the NHIS, and UHC for Uganda.



Some of the participants at the Conference after its official opening by the Germany Ambassador to Uganda, H.E Peter Blomeyer (3rd left on front row).

On 1st and 2nd December 2016, we hosted the first national CHF conference in Uganda held at Silver Springs Hotel, Kampala under the theme, 'advancing community health financing to achieve universal health coverage'. The conference organised in collaboration with the Ministry of Health and Uganda Community Based Health Financing Association (UCBHFA), brought together 109 major players in the health sector including government ministries, parliament, five donor agencies, academic institutions, civil society organisations, healthcare providers, local government leaders and healthcare financing experts. The conference was officially opened by the Germany Ambassador to Uganda, Dr. Peter Blomeyer, and closed by the Commissioner for Equity and Rights in the Ministry of Gender, Labour and Social Development Mr. Bernard Mujuni-Makuba. The Chairperson of the Parliamentary Committee on Health Hon. Dr. Michael Bukenya pledged to press for tabling of the NHIS Bill in Parliament. CHF implementers from the East African region shared experiences on how other countries in Africa have integrated CHF in national health financing programs. At the end of the conference, participants made the following declarations for advancing CHF, NHIS and UHC in Uganda.

- a. Realizing that funding for health care has stagnated at about 8% of the national budget;
- b. We call upon Government to strengthen CHI as an integral part of the health care financing mechanism and provide financial support to the scheme; we urge the private sector, development partners and households to support funding of CHF schemes;
- c. Cognizant of the fact that the current health system is more skewed towards curative health care services;
- d. We urge government to clearly earmark a budget line for delivery of cost effective preventive health care services;
- e. Recognizing that the current free health care service delivery fostered by Government has serious limitations in addressing the health care needs of the population;
- f. We implore Government to introduce social marketing as one of the health care delivery models that serve different population segments with appropriate health care services; We

further urge the Government to make clear provisions for identification and enrolment of indigents into CHI schemes in order to have equitable health care services for the population;

- g. Cognizant of the lack of explicit legislation to regulate Community Health Financing and the inherent contextual socio-cultural and economic disparities in the diverse communities in Uganda;
- h. We implore Government to show its commitment by expediting the process of passing the NHI Bill into law in order to regulate CHI in the country while ensuring integration of other forms of health insurance; We further call upon Government to phase implementation of the NHI scheme within the premises of its financial implications;
- i. Recognizing that there is low awareness of communities and decision makers about the merits of Community Health Financing in reducing out-of-pocket expenditures thus mitigating catastrophic health expenditures among the poor communities;
- j. We call upon Government and CSOs to design and operationalize a health insurance education strategy to raise awareness of all stakeholders on CHF as a way of increasing buy in, participation and enrolment; We do call for combined efforts of the Government, bilateral and multilateral partners, civil society and the private sector to invest in action research on community health financing in order for the country, region and even beyond to understand what works, in what way and in what context.

3.2. Challenges

Low awareness levels on CHF and health insurance: A big proportion of policy makers at different levels and the general public do not appreciate the benefits of health insurance due to low awareness levels. Many perceive health insurance as a luxury for the rich while others believe that it is government's duty to provide for all their healthcare needs without any direct contribution from citizens.

Lack of trust in government financial management system: There is a general fear among members of the public regarding the capacity of government to protect the health insurance fund from misappropriation if it is introduced. This has left many people sceptical about supporting efforts to introduce the NHIS.

4. EQUIPPED HOUSEHOLDS WITH VOCATIONAL SKILLS AND SUPPORTED THEM TO ACCESS LOW INTEREST MICRO- LOANS

Our livelihood program aims at improving household incomes to enable families meet their financial obligations and remain members in the CHF schemes to satisfy their healthcare and other needs.

For the year 2016, our target was to reach 1,000 individuals. The individuals were to benefit from our skills trainings, our partners' micro-loans and high breed dairy goats. They were also expected to form and benefit from the Voluntary Health Savings and Loans Associations (VHSLAs) that we promoted in Mubende District. To achieve this target, we organized skills training sessions for scheme members; we introduced SHU Finance Ltd (SHUF) and Butaba Co.

Ltd (BCL) to the schemes and linked families to both SHUF and BCL for microfinance opportunities. We also worked with the Asili livelihood project to extend high breed dairy goats beneficiaries who were due to pass on gifts to others, mobilized the recipients and followed up to ensure new beneficiaries received the gifts.

4.1. Achievements

1. A significant number of families enrolled into the CHF schemes thanks to the partnership with SHUF and VHSLAs.

Table N°8: Families that enrolled in the CHF schemes through SHUF and VHSLAs in 2016

MFI	Number of Families	Corresponding number of individuals	Total amount of premiums paid
SHUF	625	3,804	37,531,100
BCL	266	1,134	24,622,800
VHSLAs	814	2,763	20,297,958
TOTALS	1,705	7,701	82,451,858

2. Family businesses and homesteads have been improved using borrowed funds from SHUF, BCL and VHSLAs

Through partnerships with micro-finance institutions (MFIs) in Luwero and Mubende districts, we enabled scheme members to access low-interest loans to finance income generating activities, meet other family needs and pay premiums. A total of 744 scheme members in Luwero and 532 in Mubende accessed loans from SHU Finance limited and Butaba Company Limited respectively. The partners were linked to scheme members through networks of schemes. In addition, we continued to promote village health savings and loan associations (VHSLA) in Mubende district to enable the target communities save and easily access small loans within their groups at low interest rates. By the end of the year, 14 groups with 183 savers had completed their first cycle and shared savings amounting to Ugx 17, 323,200. The VHSLA concept enabled us to promote the saving culture for healthcare and other among community members.

Table N°9: Families that accessed loans from MFIs and VHSLAs in 2016

MFI	Number, type and amount of loans accessed by the target communities					
	Working capital loans		Agricultural loans		Total per MFI	
	Number	Amount	Number	Amount	Loans	Amount
SHUF	400	287,930,000	344	186,855,000	744	474,785,000
BCL	163	55,958,900	0	0	163	55,958,900
VHSLA	111	8,473,500	258	19,771,500	369	28,245,000
TOTAL	674	352,362,400	602	206,626,500	1,276	558,988,900

As a result of these loans, families have boosted their businesses, improved farming output and improved their homesteads.



A scheme member who used money from SHU Finance Limited to start trading in coffee is building a permanent residential house (on the right). On the left is her current home.

3. Family heads equipped with vocational skills to diversify the income sources

A total of 793 (226 males and 567 females) scheme members received training in processing vaseline, and bar and liquid soap as a way to empower them to initiate projects for improving household incomes. This was done through training sessions held at parish level in the districts of Luwero, Nakasongola, Sheema and Mitooma. Participants learnt both the theory and practical procedures for processing different products. They formed 55 (31 in Luwero and 24 in Sheema – Mitooma) self-help groups so as to work together to utilize the skills acquired.

4.2. Challenges

Absence of microfinance institutions willing to serve low income populations: The integration of microfinance activities into CHF activities proved to be working effectively but there were very few organizations in the target areas willing to extend low-interest credit services to our target communities. The few that were willing were overwhelmed by the high demand from the community.

High transport costs: The required raw materials to process soap were not locally available for the trained scheme members to practise the skills acquired. It was, therefore, expensive for members to transport materials from Kampala because it increased production costs. SHU appreciated the challenge and planned to support organised scheme members to access inputs without incurring high costs.

5. EMPOWERED WOMEN TO PARTICIPATE IN DECISION MAKING AND UTILIZE HEALTH CARE SERVICES WITH EASE.

Our objective in 2016 was to support new CHF schemes recognize the important role women play at home and in the communities regarding health care, and for all schemes to maintain in their constitutions clauses that guarantee women taking up leadership positions. To achieve this, and our ultimate goal of having equal representation of both men and women in leadership positions at scheme and network levels, we persuaded/ lobbied scheme members to make it

mandatory in their constitutions to reserve some leadership positions for women, trained elected women leaders in their roles and responsibilities and sensitized households especially household heads on family members' access to the family health care card, and its appropriate use to benefit with ease all household members especially women and children.

5.1. Achievements

1. The proportion of women leaders in the schemes and networks has remained high for 4 years now.

We sensitized members in new schemes to appreciate the need to include women in leadership structures. As a result, all schemes, both old and new, and their networks, maintained a clause in their constitutions requiring full participation of women in leadership with at least two positions on the five-member executive committees reserved for them. In MBUSO, 103 (44.2%) out of 233 leaders were female; in WATSA, 145 (47.5%) out of 305 leadership positions were occupied by women; in MSCOM, 3 out of 5 board members were women; and in SHU-CHI, 9 (56%) out of 16 group representatives were women.

2. The confidence levels among women scheme leaders have significantly increased and are doing a great job.

CHF schemes mobilise millions of shillings every year from families. The schemes also pay millions of shillings every year to the contracted healthcare providers. Thanks to the fact that 95% of all schemes treasurers are women, no cases of funds misappropriation or even non-payment of medical bills have ever been reported in the schemes for over 15 years of their existence.



These women leaders today have the capacity to address meetings, write and deliver reports, and to represent schemes at meetings organized by authorities and other development organizations both local and national.

Mrs. Harriet Mbaziira one of the many female scheme leaders delivering a report to members in a Kakoooge scheme meeting.

5.2. Challenge

Negative attitudes of some men: The major challenge is that some men do not want their spouses to take up leadership positions in schemes yet women leaders have proved to be very instrumental in running schemes. This is common especially in Nakasongola and Nakaseke districts. SHU will continue to advocate for equal participation of men and women in decision making on health matters at household level and in CHF schemes.

6. SUPPORTED CONTRACTED HEALTH CARE FACILITIES TO IMPROVE ON THE QUALITY OF THEIR SERVICES.

Promoting access to quality healthcare services for scheme members is a key tenet of our work. Our target for the year was to increase the number of contracted health facilities serving scheme members from 14 to 19 and support them to offer quality services to the communities. We, therefore, facilitated routine service review meetings between scheme leaders and healthcare providers; supported outreach activities; raised awareness on patient rights; advocated for institutionalization of customer relations desks at health facilities; and worked with district authorities during their routine support supervision missions to both private and public health care providers.

6.1. Achievements

1. Partner healthcare facilities adopted the idea of a customer relations desk and many have institutionalized it.

In 2013, we started negotiating with and supporting health care providers contracted by schemes to establish customer relations desks (CRD) to improve communication between providers and their clients including scheme members. In 2016, Kiwoko hospital in Nakaseke district and Mushanga HCIII in Sheema district established CRDs. This brought the number of CRDs at health facilities to seven, the others being at Kitagata hospital, Ishaka Adventist Hospital, Hope Medical Centre, Franciscan HCIV and Bishop Asili Hospital. Except Kitagata Hospital, all other facilities institutionalised CRDs and formally contracted the customer relations officers. The customer relations officers receive all patients at the facilities, answer their questions and guide them through the procedures of accessing healthcare services. They also collect complaints from the clients and present them to the administration for redress.



The customer Relations Officer at her desk at Mushanga Health Centre III

2. Partner healthcare facilities continued to serve scheme patients in an area referral arrangement.

We reviewed the referral system introduced among health facilities serving schemes to encourage scheme members to use first-line facilities for minor illnesses as well as facilitate quick referral for major cases. Out of the 15 health facilities contracted by schemes, 14 were organised in a referral arrangement. Referral tools were improved but customized to serve mainly scheme patients. During the year, 135 scheme members in Mubende and 17 in Bushenyi area benefitted from the referral arrangement.

Table N°10: Facilities Participating in the local referral network

Referral Network /Area of operation	First- line facilities	Next level facility(ies)	High level (Referral) facilities
MBUSO / Luwero area	Franciscan HC IV	Bishop Asili Hospital	- Kiwoko Hospital - Nakaseke Hospital
WATSA / Bushenyi area	- Hope Medical Centre - Mushanga HC III - Bitooma HC III	Kitagata Hospital	Ishaka Adventist Hospital
MSCOM / Mubende	- Bangi Maternity home - Naluggi HC II	St. Gabriel Mirembe Maria HC III	St. Francis community HC IV

3. Schemes members expressed high satisfaction with the quality of the health care services received from contracted providers.

The quality of health care especially the perceived quality has an important direct effect on the performance of the schemes especially with regards to the number of people enrolled. Thanks to the service contracts between schemes and health care service providers, the patients' rights awareness sessions held for both health workers and health care consumers, the community out-reaches and mobile clinics, and the established feedback mechanisms between the schemes and the service providers, no major issues emerged in 2016, and all other issues that were raised were resolved as they emerged.



A lawyer, Mr. Namanya Bernard, educating Mushanga HC III staff on patient rights and responsibilities.

6.2. Challenges

High cost of service delivery: During the year, all healthcare providers contracted by schemes made commitments to put in place patient-centred care facilities and continuously improve the quality of services offered. However, some providers failed to do so due to costs involved in establishing PCC facilities yet they had to keep prices low for communities to afford them. The cost of other medical supplies also increased due to inflation.

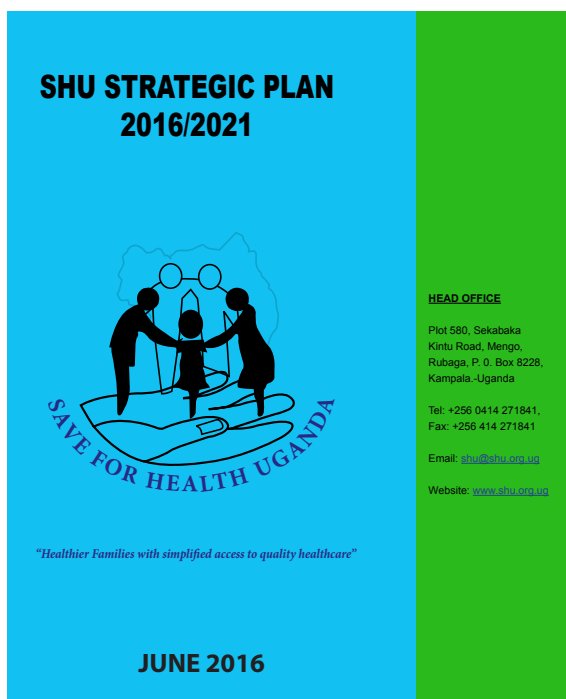
7. IMPROVED SHU'S CAPACITY AS AN INSTITUTION

To facilitate capacity development and growth of the organisation, we set four key targets for the year. We had to: (1) develop a new strategic plan for the period 2016/2017-2020/2021; (2) strengthen collaboration with civil society networks and partners; (3) hold 4 board meetings, 8 management meetings and 4 joint team meetings; and (4) facilitate team members to attend relevant external meetings, trainings, conferences and workshops. In order to achieve these targets, we engaged a consultant and stakeholders to develop the strategic plan; we fulfilled our obligations to networks; we looked around for relevant conferences, workshops and trainings to which staff would participate, and programmed for all internal meetings.

7.1. Achievements

1. The SHU strategic plan for 2016/2017 – 2020/2021 was launched

The new strategic plan was launched in June 2016.



The Board Chairman Mr. Zakaria Kasirye Muwanga, and the Executive Director Mr. Fredrick Makaire signing the new five-year strategic plan. Behind them are Mr. Ernest Kaddu, the Treasurer and Mr. Paul Michael Waigolo, a board member.

Our work for the next five years will focus on five thematic areas indicated below:

Table N°11: Thematic areas in the new SHU strategic plan

Thematic area	Expected outcome
1. Community health financing	Low income earning families in the target communities organised in well-functioning CHI schemes and enjoying access to quality health care under the national health insurance scheme (NHIS).
2. Women empowerment for health	Women are actively participating in decision making in local health organizations; accessing sexual reproductive health (SRH) services especially maternal and child health services.
3. Livelihood improvement	Vulnerable and low income families in the target communities belong to local development initiatives to meet their health and other financing needs.
4. Quality health care delivery	The families in CHI schemes in the catchment areas are satisfied with the health care services offered by their contracted health care facilities.
5. Institutional development and organizational strengthening	SHU with capacity to plan and manage delivery of quality health care services to target communities and stakeholders.

2. Corporate strategies for 2016/2017 developed by SHU teams

Five strategies in total were developed by the SHU team to guide day-to-day operations during the year. These plans contributed greatly to the improvements and achievements registered in 2016. First was the SHU corporate strategy developed during a five-day retreat for all technical team members. This strategy reviewed SHU's performance during the previous year, identified challenges and came up with viable strategies to guide activity implementation in 2016/2017. The other strategies were specific network strategies developed at field office meetings and they are:

- a) MBUSO Corporate strategy for the period July 2016 – June 2017
- b) WATSA Corporate strategy for the period July 2016 – June 2017
- c) MSCOM Corporate strategy for the period July 2016 – June 2017
- d) SHU CHI Corporate strategy for the period July 2016 – June 2017

3. SHU's image and recognition as a key development partner improved

SHU board members interacted with SHU partners to learn about their experiences with SHU services and gather ideas on how to make SHU services responsive to the target communities' needs.



Members of SHU Board, WATSA Coordinator and the Medical Superintendent of Kitagata hospital Dr. Asiimwe Fiona



Board members interacting with the in-charge of Mushanga HCIII in Sheema district.

SHU received a number of invitations and participated in activities organised by the Ministries of Health and that of Gender, Labour and Social Development. SHU was also invited to participate in several meetings and activities organized by the Districts where SHU is operating. SHU also participated in a number of meetings and activities organized by CSO networks to which SHU belongs such as the Uganda National NGO Forum, the Civil Society Budget Advocacy Group, the Uganda Community Based Health Financing Association and the district CSO networks. We worked with other CSOs to advance our common advocacy agendas.

B. CONCLUSION

This report shows that all the plans we made and the efforts invested in implementing activities were not in vain. We ended the year with positive results in all the program areas evidenced by the increase in the number of CHF schemes and beneficiaries, and the number of contracted health care providers. The CHF conference and other advocacy activities prepared the ground for us to influence policy in favour of CHF as one of the avenues for achieving UHC.

C. ANNEXES

1. THE 2016 CHF SCHEMES AND THEIR DETAILS

Table N°12: Details of CHF schemes supported by SHU in 2016

Scheme name	Year of creation	Mechanism	District or area	Sub-county	Parish	Parish population	Households	Policy Holders at scheme level	Policy Holders at network level	Male	Female
1. Bamugolodde	2010	Mixed	Luwero	Butuntumul	Bamugolodd	7,444	51	361	361	178	183
2. Bukambagga	2010	Mixed	Luwero	Butuntumul	Bukambagga	3,702	51	309	309	112	197
3. Kakabala	2001	Mixed	Luwero	Butuntumul	Kakabala	7,810	207	1429	1429	694	735
4. Kakinzi	2002	Mixed	Luwero	Butuntumul	Kakinzi	4,917	76	522	522	250	272
5. Kasaala	2010	Mixed	Luwero	Luweero	Kasaala	3,489	98	673	673	321	352
6. KatuugoLuwu	2010	Mixed	Luwero	Luweero	KatuugoLuw	3,746	59	390	390	201	189
7. Kigombe	2005	Insurance	Luwero	Luweero	Kigombe	4,291	55	568	568	221	347
8. Kikube	2010	Mixed	Luwero	Luweero	Kikube	3,195	81	405	405	185	220
9. Kyawangabi	2006	Mixed	Luwero	Butuntumul	Kyawangabi	5,597	59	555	555	262	293
10. Kyesabukadde	2006	Mixed	Luwero	Luweero	Kagugo	3,983	54	418	418	186	232
11. Nakikoota	2011	Mixed	Luwero	Luweero	Nakikoota	3,871	127	324	324	153	171
12. Ngogolo	2002	Mixed	Luwero	Butuntumul	Ngogolo	6,533	42	850	850	401	449
13. Nsabweteka	2004	Mixed	Luwero	Luweero	Bweyeyo	3,911	105	294	294	140	154
14. Buyuki	2014	Mixed	Luwero	Katikamu	Buyuki	4,083	13	611	611	301	310
15. Bwaziba	2011	Insurance	Luwero	Luweero	Bwaziba	4,894	54	342	342	182	160
16. Kabakedi	2011	Mixed	Luwero	Luweero	Kabakedi	5,500	29	499	499	204	295
17. Migadde	2006	Mixed	Luwero	Katikamu	Migadde	7,800	72	815	815	386	429
18. Kyalugondo	2012	Mixed	Luwero	Katikamu	Kyalugondo	3,500	24	323	323	120	203
19. Kabunyatta	2016	Insurance	Luwero	Kamira	Kabunyata	4,790	68	553	553	230	323
20. Kalwe	2016	Insurance	Luwero	Bamunanika	Kalwe	4,214	70	417	417	151	266
21. kaswa	2016	Insurance	Luwero	Kamira	Kaswa	5,347	59	719	719	245	474

Scheme name	Year of creation	Mechanism	District or area	Sub-county	Parish	Parish population	Households	Policy Holders at scheme level	Policy Holders at network level	Male	Female
22. Mpologoma	2016	Insurance	Luwero	Bamunanika	Mpologoma	5,418	56	212	212	99	113
23. Mabuye	2016	Insurance	Luwero	Kamira	Mabuye	5,932	50	453	453	148	305
24. Mazzi	2016	Insurance	Luwero	Kamira	Mazzi	4,962	54	171	171	62	109
25. Sekamuli	2016	Insurance	Luwero	Bamunanika	Sekamuli	4,397	60	453	453	203	250
26. Nakatonya	2016	Insurance	Luwero	Nyimbwa		5,047	28	760	760	364	396
27. SHU -CHI	2013	Insurance	Luwero	Luweero	Kasana	1,700	38	616	616	299	317
28. Wakayamba	2010	Mixed	Nakaseke	Kikamulo	Wakayamba	3,400	63	518	518	180	338
29. Katooke	2008	Mixed	Nakaseke	Wakyato	Katooke	3,900	62	480	480	201	279
30. Nakaseeta	2011	Insurance	Nakaseke	Kasangomb	Nakaseeta	3,400	64	574	574	249	325
31. Bukuuku	2013	Mixed	Nakaseke	Kasangomb	Bukuuku	3,961	40	443	443	202	241
32. Kamuli	2003	Mixed	Nakaseke	Kikamulo	Kamuli	4,312	62	641	641	302	339
33. Kapeke	2010	Mixed	Nakaseke	Kikamulo	Kapeke	3,793	119	348	348	156	192
34. Kasambya	2011	Mixed	Nakaseke	Nakaseke	Kasambya	2,552	47	355	355	148	207
35. Kasana	2010	Mixed	Nakaseke	Kikamulo	Kasana	4,388	86	205	205	90	115
36. Kibose	2010	Mixed	Nakaseke	Kikamulo	Kibose	1,918	76	383	383	132	251
37. Kigege	2011	Mixed	Nakaseke	Nakaseke	Kigege	3,246	118	350	350	142	208
38. Kikamulo	2010	Mixed	Nakaseke	Kikamulo	Kikamulo	1,647	36	252	252	99	153
39. Kito	2012	Mixed	Nakaseke	Kito	Kito	3,023	70	88	88	35	53
40. Kivumu	2012	Mixed	Nakaseke	Kito	Kivumu	3,012	22	152	152	53	99
41. Luteete	2011	Mixed	Nakaseke	Kikamulo	Luteete	2,318	63	410	410	201	209
42. Magoma	2008	Mixed	Nakaseke	Kikamulo	Magoma	5,553	112	404	404	198	206
43. Mijumwa	2000	Mixed	Nakaseke	Wakyato	Mijumwa	2,209	109	355	355	190	165
44. Kakooge	2001	Mixed	Nakasong	Kakooge	Kakooge	5,609	80	353	353	189	164
45. Katuugo NSL	2011	Mixed	Nakasong	Kakooge	Katuugo NSL	4,091	88	299	299	147	152
46. Kyabutaika	2002	Mixed	Nakasong	Kakooge	Kyabutaika	3,870	74	321	321	198	123
47. Kyambogo	2011	Mixed	Nakasong	Kakooge	Kyambogo	4,884	82	373	373	201	172

Scheme name	Year of creation	Mechanism	District or area	Sub-county	Parish	Parish population	Households	Policy Holders at scheme level	Policy Holders at network level	Male	Female
48. Kyankonwa	2011	Mixed	Nakasong	Kakooge	Kyankonwa	3,125	60	158	158	78	80
49. Kyeyindula	2002	Mixed	Nakasong	Kakooge	Kyeyindula	3,627	91	204	204	89	115
50. SHU - CHI	2013	Insurance	Masaka	Masaka MC	Masaka	1,800	40	163	163	98	65
51. Katunga	2013	Insurance	Busheenyi	Kakanju	Katunga	4,904	20	100	0	38	62
52. Kakanju	2013	Insurance	Busheenyi	Kakanju	Kakanju	3,818	19	102	0	46	56
53. Kanyegetero	2013	Insurance	Busheenyi	Nyabubare	Kanyegetero	4,210	43	350	0	178	172
54. Kigoma	2012	Insurance	Busheenyi	Nyabubare	Kigoma	6,100	24	235	0	112	123
55. Kiyaga	2008	Insurance	Busheenyi	Bumbaire	Kiyaga	3,885	36	144	0	73	71
56. Ruharo	2009	Insurance	Busheenyi	Central	Ruharo	3,329	50	202	0	85	117
57. Rutooma	2012	Insurance	Busheenyi	Kyeizooba	Rutooma	4,815	19	295	0	126	169
58. Ryeishe	2007	Insurance	Busheenyi	Ibaare	Ryeishe	2,811	42	103	0	50	53
59. Kahungye	2013	Insurance	Busheenyi	Nyabubare	Kahungye	3,139	17	229	0	95	134
60. Nyabubare	2013	Insurance	Busheenyi	Nyabubare	Nyabubare	9,700	24	221	0	97	124
61. Kizinda	2012	Insurance	Busheenyi	Nyabubare	Kizinda	7,663	21	376	0	181	195
62. Buyanja	2011	Insurance	Busheenyi	Kyeizooba	Buyanja	4,316	20	337	0	160	177
63. Muhito	2010	Insurance	Sheema	Kitagata	Muhito	7,700	31	267	0	117	150
64. Kasaana East	2010	Insurance	Sheema	Kasana	Kasaana East	4,858	44	202	0	93	109
65. Kasaana west	2011	Insurance	Sheema	Kasaana	Kasaana	5,364	37	212	0	97	115
66. Nyarweshama	2015	Insurance	Sheema	Sheema	Nyarweshama	5,231	74	409	0	210	199
67. Kyarushakara	2015	Insurance	Sheema	Kitagata	Kyarushakara	3,719	35	208	0	102	106
68. Nyakatete	2015	Insurance	Sheema	Mutara	Nyakatete	5,468	17	182	0	86	96
69. Kashekuro	2012	Insurance	Sheema	Kitagata	Kashekuro	5,315	47	178	0	82	96
70. Kyeihara	2012	Insurance	Sheema	Kasaana	Kyeihara	1,581	22	104	0	46	58
71. Kyamulari	2011	Insurance	Sheema	Bugongi TC	Kyamulari	6,708	35	106	0	40	66
72. Kareera South	2014	Insurance	Sheema	Kashozi	Kareera	2,064	30	100	0	46	54
73. Isingiro	2014	Insurance	Sheema	Bugongi TC	Isingiro	3,795	28	104	0	50	54

Scheme name	Year of creation	Mechanism	District or area	Sub-county	Parish	Parish population	Households	Policy Holders at scheme level	Policy Holders at network level	Male	Female
74. Bitooma-	2013	Insurance	Mitooma	Katenga	Rutooma	4,711	61	123	0	60	63
75. Nyabubare_kab	2015	Insurance	Mitooma	Kabira	Nyabubare	5,500	52	105	0	43	62
76. Buharambo	2015	Insurance	Mitooma	Kabira	Buharambo	3,450	30	353	0	155	198
77. Rurehe North	2015	Insurance	Mitooma	Kabira	Rurehe	3,400	27	136	0	51	85
78. Kyeibare-	2015	Insurance	Mitooma	Mutara	Kyeibare	3,583	40	109	0	44	65
79. Nyakitita-	2015	Insurance	Mitooma	Mutara	Nyakhita	1,144	22	234	0	114	120
80. Bikungu	2015	Insurance	Mitooma	Mutara	Bikungu	2,834	25	103	0	46	57
81. Nyakatete	2015	Insurance	Mitooma	Kabira	Nyakatete	2,882	17	353	0	169	184
82. Mahwizi-	2015	Insurance	Mitooma	Mutara	Mahwizi	1,454	25	167	0	72	95
83. Furuma-Mutara	2015	Insurance	Mitooma	Mutara	Furuma	2,888	23	100	0	43	57
84. Namiringa	2014	Insurance	Mubende	Kasanda	Namiringa	4,161	125	450	0	196	254
85. Namiryango	2014	Insurance	Mubende	Bukuya	Namiryango	4,812	49	188	0	82	106
86. Namabale	2014	Insurance	Mubende	Kasanda	Namabale	5,244	90	390	0	170	220
87. Kitongo	2014	Insurance	Mubende	Kasanda	Kitongo	1,834	107	480	0	209	271
88. Kamuli	2015	Insurance	Mubende	Kasanda	Kamuli	2,097	125	450	0	196	254
89. Nabugondo	2015	Insurance	Mubende	Kasanda	Nabugondo	2,428	69	326	0	142	184
90. Kizibawo	2014	Insurance	Mubende	Bukuya	Kizibawo	4,265	66	296	0	129	167
91. Lwantale	2015	Insurance	Mubende	Kasanda	Lwantale	3,172	120	552	0	240	312
92. Binikira	2015	Insurance	Mubende	Kasanda	Binikira	1,593	32	192	0	84	108
93. Lusaba	2015	Insurance	Mubende	Bukuya	Lusaba	3,290	32	125	0	54	71
Total of running schemes						384,946	5,276	31,869	21,871	14,385	17,484

2. DETAILS OF MEDICAL SERVICES CONSUMED IN 2016

Table N°13: Number of cases covered by the schemes and cost in 2016

Health Facility	District	OPD		IPD		Total	
		Cases	Amount	Cases	Amount	Cases	Amount
1. Bishop C. Asili Hospital	Luwero	721	27,582,900	174	19,873,000	895	47,455,900
2. Franciscan HC IV	Nakasongola	195	8,090,000	53	5,217,000	248	13,307,000
3. Kiwoko Hospital	Nakaseke	1,016	34,172,240	474	54,885,780	1,490	89,058,020
4. Nakaseke hospital	Nakaseke	8	237,500	19	1,056,000	27	1,293,500
5. Kitovu Hospital	Masaka	267	9,956,454	18	1,587,190	285	11,543,644
6. Ishaka Adventist Hospital	Bushenyi	515	18,434,500	122	8,425,000	637	26,859,500
7. Kitagata Hospital	Sheema	1,603	20,937,000	17	218,000	1,620	21,155,000
8. Mushanga HCIII	Sheema	526	8,255,000	108	5,659,000	634	13,914,000
9. Hope Medical Centre	Sheema	65	715,000	0	0	65	715,000
10. Bitooma HCIII	Bushenyi	36	419,000	42	1,203,000	78	1,622,000
11. St. Gabriel Mirembe Maria HCIII	Mubende	1,630	18,842,000	470	15,794,000	2,100	34,636,000
12. St.Francis HC IV	Mityana	193	3,501,000	20	2,246,000	213	5,747,000
13. Bangi Maternity Home	Mubende	22	150,000	1	28,000	23	178,000
14. Naluggi HCII	Mubende	556	5,894,000	68	1,706,000	624	7,600,000
15. Kitokolo HCII	Mubende	16	122,500	1	30,000	17	152,500
TOTAL		7,369	157,309,094	1,587	117,927,970	8,956	275,237,064

