



SAVE FOR HEALTH UGANDA (SHU)

“Community solidarity for quality health”

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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 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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BftW	Bread for the World
CBC	Complete Blood Count
CH	Health Centre
CHF	Community Health Financing
CHI	Community Health Insurance
CRA	Customer Relations Assistant
CRD	Client Relations Desk
HPU	HealthPartners Uganda
IPD	In-patient Department
MBUSO	Munno mu Bulwadde Union of Schemes Organization
MSCOM	Mubende Munno Mu Bulwadde Schemes Cooperation Mechanism
NHIS	National Health Insurance Scheme
OPD	Out-patient Department
SHU	Save for Health Uganda
T/C	Town Council
UCBHFA	Uganda Community Based Health Financing Association
UGX	Uganda Shillings
UPMB	Uganda Protestant Medical Bureau
USAID	United States Agency for International Development
WATSA	Western Ankore Tweragurize Schemes Association

MESSAGE OF THE CHAIRPERSON, SHU BOARD OF DIRECTORS

Leticia Nakimuli Irumba (Mrs)



Dear partners and readers, I am glad to share with you the first annual report of Save for Health Uganda (SHU) during my term as Chairperson of the Board of Directors. I thank the Board of Trustees for giving me the opportunity to contribute to the strategic direction and growth of SHU. I also appreciate the immediate past Chairperson, Mr. Zakariah Kasirye Muwanga, and other Board members for the services rendered to the organisation over the past years.

The year 2019 presented a mixed bag of opportunities and challenges for SHU. To begin with, I am happy that our mandate as a **NATIONAL** non-governmental organisation was renewed by the National Bureau for Non-Governmental Organisations. This is important because it legally guarantees continuity of our work wherever we may wish to intervene across the country.

SHU continued to support efforts to expand community health insurance (CHI) initiatives through giving technical support to organisations and individuals that sought to learn about how they could implement CHI in their respective areas. We also shared experiences through meetings and printed materials to encourage stakeholders to embrace CHI for the good of all citizens.

SHU's work involves a high degree of community participation in activities and decision making at all levels. Therefore, during the year, we supported the CHI schemes to review and strengthen their leadership structures for efficiency and sustainability of our work. This is expected to ease mobilisation of communities for different activities.

I wish to thank the Executive Director and the entire technical team for the work done. We were able to attract more partners to support our activities and events, particularly the annual national community health financing conference, which is a major advocacy platform for CHI. In addition, I congratulate the Ministry of Health for tabling the National Health Insurance Scheme (NHIS) Bill in Parliament, and commit, on behalf of SHU, to continue supporting this process until the law is passed and implemented.

It is important to note that we would be celebrating many more achievements especially with regard to the number of people enrolled in the CHI schemes if: CHI in Uganda was formally regulated and supported by the authorities at national and sub national levels; household incomes were significantly improving to enable households meet basic needs and also pay for health insurance; and the distances to the health care service providers of quality contracted were much shorter.

Thank you all for your support.

OTHER MEMBERS OF SHU BOARD OF DIRECTORS



Mr. Opio Douglas
Treasurer



Mr. Paul Waigolo
Member



Dr. Martin Ruhweza
Member



Mr. Makaire Fredrick
Secretary

Greetings and thank you for sparing time to read our 2019 report! Since our founding in 2002, we dream of “healthier families with simplified access to quality health care” and we have dedicated all efforts in the past years to empowering families and communities to establish and operate community health insurance (CHI) schemes that are viable and responsive to people’s needs as the vehicle to help get there. We did realise along the way that promoting CHI schemes alone was not sufficient, so we have over the years introduced additional interventions to: boost household incomes; improve the quality of health care provided to consumers; empower women for health and making health related decisions for themselves and their families; advocate for the regulation and promotion of CHI, as well as its integration in the proposed universal national health insurance scheme (NHIS) for Uganda.



Building on previous efforts, we carried out numerous activities in 2019 that have yielded tremendous progress towards our ambitions. The major activities included: health insurance education in communities; training of schemes and sub-schemes leaders to perform their roles; accrediting health care service providers in the target areas and recommending those for contracting to the four CHI schemes; supporting the four schemes to contract 23 service providers, and pay healthcare bills worth UGX 292,945,008 million for the 7,227 cases in 2019 alone; linking families to livelihood programmes particularly the low-cost microfinance services, and through the public-private-partnership, we received 2,000 hand hoes and distributed them to farmers in Luwero district; organizing and participating in advocacy dialogue meetings at national level, one such meeting being the 4th National CHF conference all focusing on the quick introduction of a fair and universal NHIS and the extension of other social protection initiatives to the informal sector; educating the general public about CHI using articles in newsletters and public media; and supporting organizations and individuals trying to establish and operate CHI schemes in various parts of the country.

Progress was made in 2019 that clearly showed some light at the end of the tunnel. Among the key milestones are: the Ministry of Health finally tabling the long awaited NHIS bill 2019 - with a clause making the scheme mandatory and universal- before parliament for debate and passing into law; the four SHU-supported long-running federated CHI schemes continuing to consolidate, ably coordinating 107 sub-schemes covering 22,763 individuals and operating more autonomously than ever before; more women occupying the top positions of leadership in the CHI schemes and being more autonomous in making decisions at home about seeking health care; partner (contracted) health care providers continuing for the 19th year in a row to recover 100% their treatment costs from CHI scheme members. We also saw a significant increase in the interest in CHI as a viable and alternative health care financing approach from communities, civil society organizations and the media. A significant number of stories about CHI were run in print, social and mass media platforms rightly presenting CHI as a solution currently enabling thousands in the rural informal sector to access quality health care services, and as a potential solution to the on-going catastrophic healthcare financing challenge that many families cope with by selling assets. CHI has also been discussed in several formal and informal platforms as potentially a necessary tool and first step -as it were the case in Ghana and Rwanda-in introducing a universal NHIS but also in getting the informal sector families into the scheme.

I extend our sincere appreciation to partners including our donors, government ministries and departments, members of Parliament, local government leaders and civil society actors who supported us during the year. Thank you very much.

Makaire Fredrick
Executive Director

Save for Health Uganda (SHU) is a national non-governmental organisation (NGO) established in 2002 to rationalize health seeking behaviours; protect families from vulnerability resulting from catastrophic health spending; and improve the quality of health care services provided. SHU's goal is to contribute to the reduction of the disease burden in the target districts through viable, affordable and sustainable community health financing approaches.

SHU's work focuses on five core program areas: 1) Community health financing (CHF); 2) Women empowerment for health; 3) Livelihood improvement; 4) Quality healthcare services delivery; and 5) Institutional development. SHU currently operates in the districts of: Luwero, Nakaseke, Nakasongola, Bushenyi, Sheema, Mitooma, Mubende/Kassanda, Mityana, Masaka and Kampala. The head office is located in Kampala with field offices in Luwero, Wobulenzi, Mityana and Bushenyi.

1. Community Health Financing Program: SHU formed and supports four community health insurance (CHI) schemes which bring together and coordinate 107 CHI sub-schemes created at parish level in nine districts. The schemes manage funds collected by sub-schemes, contract healthcare providers, pay medical bills, and perform other technical roles for and on behalf of the sub-schemes. A scheme brings together a number of sub-schemes to increase risk protection and resource pooling to enable members access a bigger package of quality health care services while keeping premiums affordable. A scheme has a leadership structure which includes a general assembly constituted by representatives of sub-schemes, a board elected by the general assembly, and a secretariat which handles technical roles on behalf of the board. Each scheme is registered as a community based organisation. The four schemes are:



1. Munno mu Bulwade Union of Schemes Organisation (MBUSO): it was formed in 2006 and coordinates all CHI sub-schemes created by SHU in Luweero, Nakaseke and Nakasongola districts. Its office is located in Luwero Town Council. In 2019, it had a membership of 74 running sub-schemes covering 18,017 individuals.



2. Mubende Munno mu Bulwade Schemes Cooperation Mechanism (MSCOM): it was formed and registered with Mubende District Local Government in 2016. It brings together 11 sub-schemes in Mityana and Kassanda district, which was formerly part of Mubende district. Its office is located in Mityana Municipality. In 2019, MSCOM covered 1,988 individuals.



3. Western Ankole Tweragurize Schemes Association (WATSA): it was established in 2011 and coordinates all CHI sub-schemes SHU formed in the districts of Bushenyi, Sheema and Mitooma. Its office is located in Ishaka Municipality. In 2019, it coordinated 18 schemes covering 2,291 individuals.



4. SHU-CHI: formed in 2013, it brings together sub-schemes in urban communities and corporate groups in Luwero, Nakaseke, Nakasongola and Masaka districts. It is directly managed by SHU because members in urban areas and corporate groups cannot commit time to manage the schemes due to their busy schedules. SHU gives them regular updates about the status of their funds and consumption of healthcare services. In 2019, the scheme covered 467 individuals.

A significant part of SHU's work under the CHF program focuses on policy advocacy aimed at contributing to efforts towards reaching universal health coverage, where all Ugandans have access to quality health care regardless of their incomes. Over the years, advocacy engagements with decision makers at community, district and national levels have centred around three issues namely: 1)Enactment and implementation of the National Health Insurance Scheme Bill; 2)Policy and regulations on community health insurance; and 3)Improved quality and delivery of health services for rural communities. SHU has succeeded in contributing to shaping the debate on healthcare financing to include health insurance for particularly the informal sector which was previously left out of the initial designs of the NHIS. In addition, district leaders and civil society organisations have expressed interest and supported initiatives to expand CHI to different parts of the country.

2. Women empowerment for health: SHU prioritises issues that make women and girls unable to access quality healthcare services at the time of need. These include lack of voice in decision making and low incomes. Therefore, SHU's work focuses on enhancing women's and girls' capacity in leadership so that they participate in decision making regarding their access to healthcare. SHU deliberately enrolls entire families into CHI schemes to prevent discrimination of some family members especially females who could otherwise be left out. As a result, more than 50 percent of members of CHI schemes are usually females and their annual utilization of healthcare services is quite higher than that of males. In terms of leadership, at least 47.3 percent of leadership positions in CHI schemes are occupied by women each year.

3. Household livelihood improvement: SHU works with families to enhance their capacity to improve incomes as a prerequisite for good family welfare and access to health care. Families with higher incomes are able to meet their basic needs and pay health insurance premiums to join CHI schemes. SHU conducts skills training in business management and financial literacy to enable community members engage in appropriate income generating activities. Further, SHU has built partnerships with microfinance institutions which extend low interest credit facilities to families to boost their businesses and meet urgent needs.

4. Quality healthcare services delivery: SHU's objective in the CHF program is to enable families to access quality healthcare services. As such, SHU supports the CHI schemes to accredit and contract healthcare providers of quality in the different areas of operation. SHU also works with healthcare providers to establish patient centred care (PCC) facilities and practices and improve client relations. The contracted healthcare providers are organised into a referral network for scheme members to access different levels of care depending on need. CHI schemes and healthcare providers enter into formal contracts through which feedback channels are established between the two parties. On several occasions, SHU has supported healthcare providers to acquire medical equipment to enhance the range and quality of services offered. Thus, families in CHI schemes are satisfied with the health care services offered while contracted health care providers fully recover costs of offering services to scheme members.

1. National Health Insurance Scheme Bill tabled in Parliament

On 24th August 2019, the Minister of Health presented the National Health Insurance Scheme (NHIS) Bill, 2019 in Parliament. Subsequently, the Health Committee of Parliament started scrutinising the Bill and receiving views of stakeholders and the general public. This was a great milestone on Uganda's journey to establish the NHIS. The key provisions of the Bill include:

- (a) Every resident in Uganda including indigents shall belong to the NHIS;
- (b) Every resident in Uganda who has attained the age of 18 years shall make a contribution to the NHIS depending on the total income of the person;
- (c) Indigents are exempted from paying contributions to the scheme;
- (d) All government hospitals and health centres shall be healthcare providers under the Act;
- (e) Privately owned and nongovernmental health facilities will be subjected to an accreditation criteria to qualify to provide services to the scheme;

Since 2012, SHU's Executive Director has represented the CHI fraternity on the NHIS taskforce. In addition, our advocacy for the NHIS over the years has focused on establishing a scheme that covers every citizen particularly those in the informal sector who are the majority, earn low incomes, and are vulnerable to shocks from ill health. Before the Bill was presented in Parliament, SHU supported efforts of the chairperson of the Health Committee, Dr. Michael Bukenya, to develop a private member's bill on NHIS. On 9th July 2019, SHU coordinated a visit of seven Members of Parliament led by Dr. Bukenya to Luwero and Nakaseke districts to learn about operations of CHI schemes to inform the process of drafting the private member's bill. However, a critical analysis of the Bill presented in Parliament showed that it does not explicitly provide for CHI, the source of premium for indigents, portability of benefits, and selection of most board members; it does not subject government facilities to the accreditation process; and prescribes lenient penalties for misappropriation of funds.



Hon. Dr. Michael Bukenya addressing members of Kakinzi CHI sub-scheme in Butuntumula, Luwero district during a visit by the Health Committee of Parliament.

2. Piloted the capitation mode of payment for healthcare

MBUSO, the umbrella scheme for all CHI sub-schemes in Luwero, Nakaseke and Nakasongola districts piloted the capitation mode of paying healthcare bills for its members at St. Mary's HCIII Kasaala in Butuntumula sub-county, Luwero district. The capitation method piloted was implemented as follows: MBUSO compiled a list of all its members who selected the facility as their provider for the year and computed their annual cost of care depending on their premiums, the benefit package, and the price list of the facility. The amount computed and terms of payment were agreed upon with the healthcare provider in a contract. The money was transferred to the facility in instalments on a quarterly basis. A total of 1,131 scheme members were attached to the facility for the year 2019. By the end of the year, the facility had used 64.5 percent of the capitation amount and made a surplus of 35.5 percent to invest in improving the quality of services or start building a strong capitation

reserve fund, which can subsequently be used to make good for the years it may incur a deficit. Both the health facility management and members of schemes appreciated the capitation arrangement and agreed to continue implementing it in subsequent years.



The Technical Manager of MBUSO, Mr. Samuel Kitenda, speaking during a meeting between scheme leaders and the management of St. Mary's Kasaala HCIII to negotiate and sign a service contract

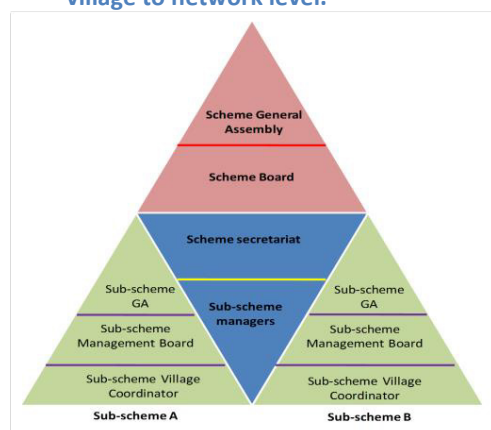


Leaders of CHI sub-schemes inspecting the ambulance of St. Mary's HCIII Kasaala on the day of signing a service contract with the facility.

3. Reviewed and overhauled leadership structures in CHI sub-schemes

During the year, SHU and the four schemes reviewed and overhauled the leadership structure in CHI sub-schemes to enhance the capacity of leaders as well as motivate them to effectively perform their roles. The exercise started with a three-day centralised workshop for SHU management, heads of field offices, scheme leaders and representatives of scheme members. Participants resolved to revise the leadership structure and provide for coordinators at village level as well as empower chairpersons to represent their sub-schemes in the scheme general assembly. Previously, representatives of sub-schemes in the general assembly did not have any other leadership role and were presumed not to be abreast with the day-to-day operations of their sub-schemes. The four schemes later organised general elections in all CHI sub-schemes to fill up the new leadership structure which includes a coordinator for each village in a sub-scheme, an executive committee comprising the chairperson, secretary and treasurer, and a scheme manager who is responsible for routine operations of the sub-scheme. Newly elected leaders were oriented on their roles and responsibilities, and facilitated with the tools required to execute their work. The chairperson of each sub-scheme represents it in the scheme/network general assembly which also has two representatives of CHI promoters and one representative of the contracted healthcare providers. The general assembly elects two representatives of sub-schemes to constitute the scheme board together with the two representatives of the CHI promoters and one representative of the healthcare providers.

The structure of leadership in CHI sub-schemes and schemes from village to network level.



4. SHU got a new Board Chairperson

SHU's top leadership changed during the year following the expiry of the term of office of Mr. Zacharia Kasirye Muwanga, who was the Chairperson of the Board of Directors. Mr. Kasirye joined the board in 2012 and served as treasurer for three years before becoming the chairperson in 2015. During his tenure, he used his expertise in civil society and development work to broaden SHU's strategic direction from focusing only on CHI to embrace policy advocacy. The annual CHF conferences held since 2016 and engagement meetings with leaders at district and national level were his brain child. Mr. Kasirye was recognised for the steadfast leadership he exhibited during his term of office. Mrs. Leticia Nakimuli Irumba, an academican, was appointed the new Board Chairperson. She joined the board in 2018.



Mr. Kasirye Muwanga handing over the office of SHU board chairperson to Ms. Leticia Nakimuli Irumba at a ceremony held at SHU Head Office in Kampala.

MAJOR ACTIVITIES AND ACHIEVEMENTS PER PROGRAM AREA

1. COMMUNITY HEALTH FINANCING

A. Activities implemented

1. We reached 4,122 people with community health insurance education

During the year, SHU reached more areas with health insurance education to enable community members to appreciate the principles, operations and benefits of CHI. The approaches used included village and parish level community meetings, house-to-house visits, radio talk shows, road shows and distribution of health insurance educational materials. Separate meetings were held for local leaders at different levels to orient them on the program and empower them to participate in mobilization of residents to enrol in CHI schemes. In some areas, community awareness activities were conducted in partnership with the healthcare providers serving schemes, local and district leaders.



A resident asks a question during a community meeting held at Kagogo in Makulubita Sub-county, Luwero district.

Table 1: Areas and number of people reached with health insurance education through community meetings in 2019

District	Sub-counties / Town Councils	Parishes	Number of people
Luwero	Katikamu, Makulubita, Kalagala, Luwero Town Council, Wobulenzi	Tweyanze, Waluleeta, Kabulanaka, Busiika, Wobulenzi central, Wobulenzi East, Wobulenzi West, Bukalasa	1,588
Nakaseke	Semuto, Kapeeka	Kirema, Kikandwa, Kikyusa, Bugambakimu, Naluvule, Kisimula, Kapeeka, Kalagala, Namusaale	1,395
Mityana	Kalangaalo	Bujaayu, Busembi, Kalangaalo, Kyamusisi, Kalama	409
Bushenyi	Rwentuha Town council, Bitooma Town Council, Nyabubare, Kakanju	Rutooma, Nyarugote, Bitooma, Kitojo	209
Mitooma	Rutookye Town Council, Bitereko, Mitooma, Nyakizinga	Nyakatsiro, Nyakashojwa, Kibaare, Kigarama, Nkinga, Nyakizinga	521
Total			4,122

2. We supported new communities to form 10 CHI sub-schemes

The direct outcome of health insurance education in communities is the formation of new CHI sub-schemes at parish level. SHU supported residents in 10 parishes to form sub-schemes by electing their leaders and enrolling families. A total of 1,816 individuals from 291 households were enrolled. All the newly elected leaders were trained in their roles and responsibilities and how to use scheme management tools such as cash books, family registration forms, registers, and bank deposit slips. Leaders were trained to build their confidence and competence in enrolling members, managing funds, and verifying healthcare bills, among other roles.

Table 2: Location of New CHI sub-schemes formed in 2019 and their membership

Scheme	District	Sub-county	Sub-scheme	Households	Beneficiaries		
					Male	Female	Total
MBUSO	Luwero	Makulubita	Kagoggo	40	128	141	269
			Kangave	27	89	101	190
			Mawale	28	76	100	176
		Katikamu	Katikamu	32	91	107	198
		Kikyusa	Kibengo	30	93	108	201
			Wabusaana	34	97	118	215
		Ziobwe	Nakigoza	24	63	85	148
		Nyimbwa	Sambwe	24	67	89	156
SHU - CHI	Luwero	Luwero Town Council	Luwero T/C B	27	91	41	132
WATSA	Sheema	Kagango Division	Ngoma	25	52	79	131
TOTAL			10	291	847	969	1,816

3. CHI schemes coordinated 107 sub-schemes

During the year, the four schemes supported 107 sub-schemes across the nine districts to enrol members, collect premiums, verify medical bills and perform other technical roles. They also organised training sessions for leaders to enhance their capacity to manage the sub-schemes. In addition, the schemes organised midyear meetings in all sub-schemes to review their performance in utilization of services and collect feedback on the quality of services scheme members received at the contracted health facilities.



WATSA staff and scheme leaders in Bitereko Sub-county Mitooma district after their training in CHI scheme functioning and their roles in marketing CHI.

4. Schemes contracted one more healthcare provider

The demand for more healthcare providers serving CHI scheme members grows with the expansion of operations to more areas. During the year, SHU assessed two healthcare providers in Ziobwe and Nyimbwa sub-counties in Luwero district. The facilities which met minimum requirements were recommended to schemes for contracting next year. In Bushenyi area, WATSA contracted Nyakatsiro HCIII in Mitooma district. The 20-bed facility is affiliated to Uganda Catholic Medical Bureau. This increased the number of healthcare providers serving CHI schemes to 23, which include 6 hospitals, 3 HCIVs, 12 HCIIIs and 2 HCIIIs. Two out of the six hospitals are public facilities owned by government while the rest are private not for profit facilities.



L-R: Sr. Nakanwagi Christine, in-charge Nyakatsiro HC III, Mr. Muhumuza Stephen, WATSA board chairman, and Sr. Maria Gorret, in-charge Maternity ward, after signing the service contract.

B. Key achievements

1. CHI schemes mobilised UGX 383,153,885 from families and partners

Sustaining CHI schemes largely depends on the amount of money schemes collect from families in annual premium to cover health care and other operational costs. During the year, schemes mobilised a total of UGX 383,153,885 from different sources including family premiums, bank interest, discounts, membership, subsidies and other payments. The amount mobilized was lower than Ugx 401,620,459 collected in 2018 due to a lower number of people enrolled for the year.

Table 3: Funds mobilized by schemes networks in 2019 and 2018

	Amount of Premium collected 2019 (UGX)	Amount of Premium collected 2018 (UGX)	Increase / (Drop) in Scheme funds	Percentage Increase / Decrease
WATSA	51,529,117	38,017,200	13,511,917	36%
MBUSO	225,995,350	268,212,825	(42,217,475)	-16%
MSCOM	66,024,918	58,581,267	7,443,651	13%
SHU -CHI	39,604,500	36,809,167	2,795,333	8%
TOTAL	383,153,885	401,620,459	(18,466,574)	

2. 107 sub-schemes ran covering 22,763 individuals

The four schemes coordinated 107 sub-schemes which ran during the year covering 22,763 individuals (10,001 male and 12,762 female) in nine districts. Out of the 107 sub schemes, 10 were new while 97 were old. However, there was a decline in the number of sub schemes and individuals covered during the year compared to 111 and 31,723 respectively reached in 2018. The drastic decrease could be attributed to strict conditions introduced on access to healthcare services particularly in Luwero area during the year. The restrictions were prompted by a high influx of scheme members to contracted health facilities especially in the areas to which SHU had just extended operations. Many new scheme members who had acquired healthcare access cards for the first time flocked to contracted health facilities to experiment if they could actually get services without paying cash while others had illnesses which they had failed to treat for a long time because they could not afford the cost. To avert depletion of scheme funds before the end of the year, conditions for accessing healthcare services were tightened in some areas which subsequently affected enrolment in the schemes.

Table 4: CHI sub-schemes which ran in 2019 in each district and the people covered

Scheme	District	Sub-schemes	Households	Members/beneficiaries		
				Total	Male	Female
MBUSO	Luwero	50	1,614	11,622	5,146	6,476
	Nakaseke	16	562	4,306	1,937	2,369
	Nakasongola	8	281	2,089	916	1,173
	Total	74	2,457	18,017	7,999	10,018
WATSA	Bushenyi	4	85	460	199	261
	Sheema	9	205	1,097	462	635
	Mitooma	5	138	734	338	396
	Total	18	428	2,291	999	1,292
SHU-CHI	Luwero	1	44	161	68	93
	Nakasongola	1	22	22	7	15
	Nakaseke	1	59	183	80	103
	Masaka	1	13	101	51	50
	Total	4	138	467	206	261
MSCOM	Mubende	1	481	1813	733	1080
	Mityana	10	169	175	64	111
	Total	11	650	1,988	797	1,191
Grand total		107	3,673	22,763	10,001	12,762

3. The schemes fully cleared the medical bills and funds consumption started to improve

During the year, the four schemes purchased healthcare services from 23 contracted healthcare providers in nine districts worth UGX 292,945,008 (representing 66.1 percent of the total cost incurred by families for

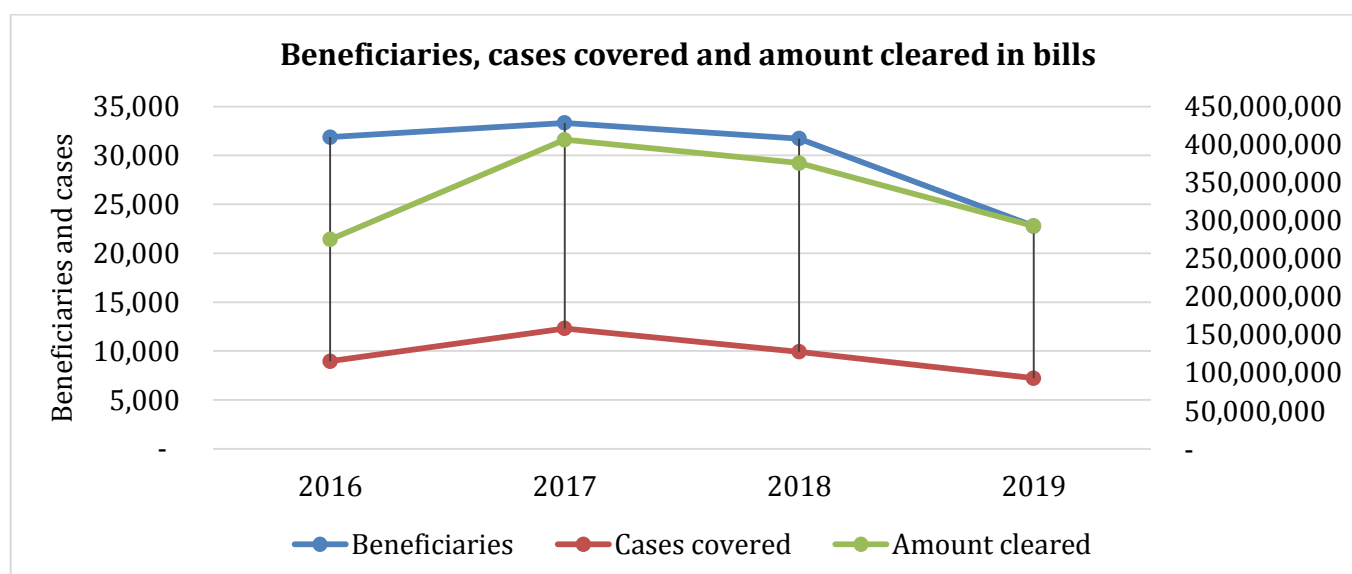
medication) for 7,227 (5,328 OPD and 1,899 IPD) member cases. The balance was directly paid out of pocket by members as co-payment or amount in excess of the scheme ceiling.

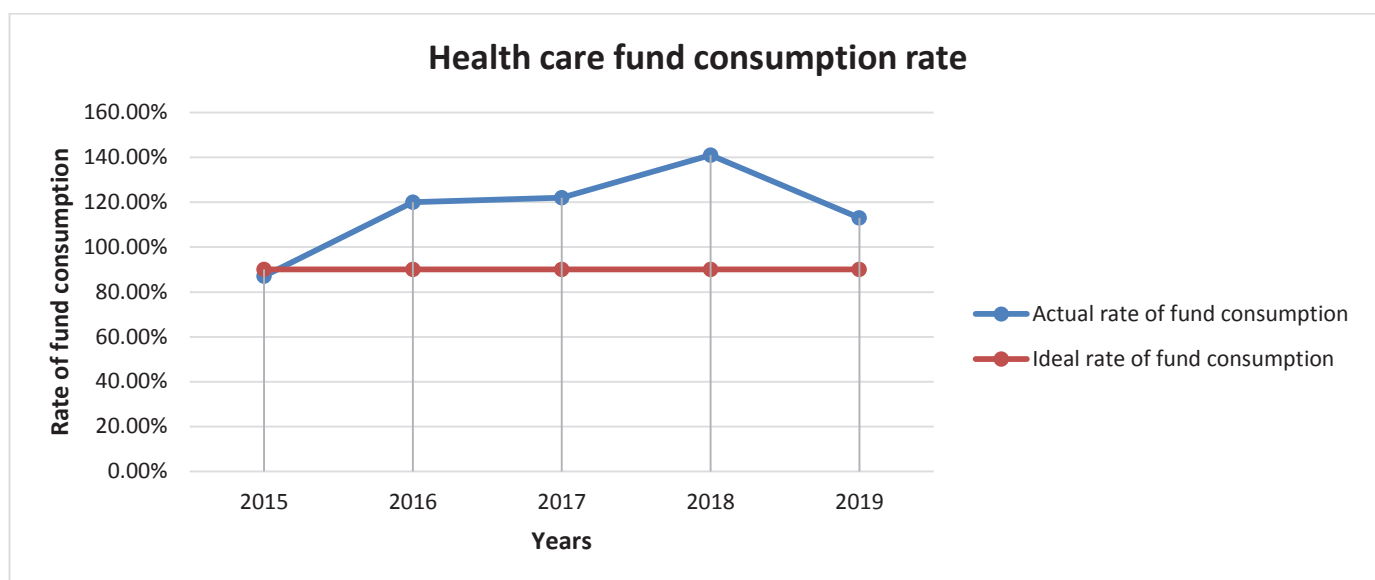
Table 5: Medical bills of scheme members paid by schemes to each contracted health care provider in 2019

No	Health Facility	OPD		IPD		Total	
		Cases	Scheme bill	Cases	Scheme bill	Cases	Scheme bill
1	Kiwoko Hospital	753	31,896,900	629	80,925,340	1,382	112,822,240
2	Bishop Caesar Asili Hospital	734	32,682,300	156	18,696,900	890	51,379,200
3	Franciscan HCIV Kakooge	127	4,390,000	78	6,385,000	205	10,775,000
4	Nakaseke Hospital	6	94,000	3	100,000	9	194,000
5	St. Matia Mulumba Mulajje HCIII	4	75,000	13	367,000	17	442,000
6	Holy cross Kikyusa HCIII	119	2,076,300	104	6,005,000	223	8,081,300
7	St Luke Namaliga	42	1,561,500	6	449,000	48	2,010,500
8	St. Kizito Nattyoole HCIII	4	93,000	0	0	4	93,000
9	Our Lady of Lourdes	1	8,000	4	169,300	5	177,300
10	St. Francis Kijaguzo	41	1,068,500	7	361,000	48	1,429,500
11	St. Mary's Kasaala	48	1,000,000	25	1,360,000	73	2,360,000
12	Good Samaritan	72	1,842,600	23	2,018,000	95	3,860,600
13	St. Francis Community HCIV	166	12,338,300	18	2,597,900	184	14,936,200
14	St. Gabriel Mirembe Maria HCIII	811	9,108,000	401	15,142,000	1212	24,250,000
15	Holy Family Naluggi HCIII	650	7,721,000	190	5,887,000	840	13,608,000
16	Kitokolo HCII	62	307,000	13	422,500	75	729,500
17	Kitovu Hospital	234	10,623,838	4	404,330	238	11,028,168
18	Ishaka Adventist Hospital	256	5,469,000	51	2,901,000	307	8,370,000
19	Kitagata Hospital	724	13,695,000	2	95,000	726	13,790,000
20	Mushanga HC III	298	4,601,000	46	2,138,000	344	6,739,000
21	Hope Medical Centre	71	759,000	1	30,000	72	789,000
22	Bitooma HC III	60	615,000	90	2,235,000	150	2,850,000
23	Nyakatsiro HCIII	45	729,000	35	1,501,500	80	2,230,500
	Total	5,328	142,754,238	1,899	150,190,770	7,227	292,945,008

This year, the number of cases and bills paid were lower compared to 9,927 (7,802 OPD and 2,125 IPD) recorded at UGX375,743,821 in 2018. The reduction is largely due to the measurers introduced to control over consumption of the health care funds and strengthen the schemes to become more financially viable. As a result, the fund consumption dropped from 141% in 2018 to 113% in 2019 as shown in the figure below.

Figure showing the trend of cases covered between 2016 and 2019





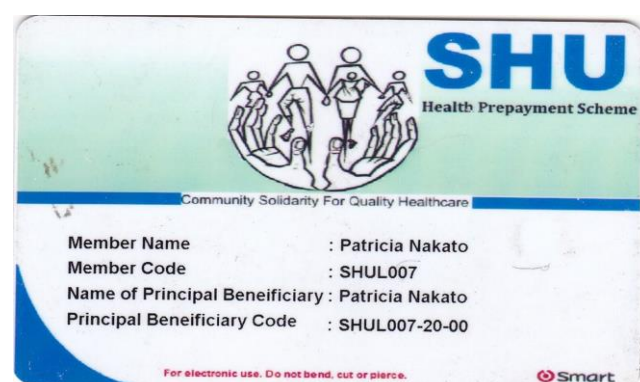
Among the measures introduced was the requirement for a family to pre-select two health care service providers of their choice and a strict gate-keeping policy where families visit a second (higher level) facility only on referral or else they pay a penalty. To cover the 13% fund deficit, schemes used part of their reserve fund. Malaria remained the most prevalent disease among the scheme members. But as shown in the table below, chronic diseases were common among the scheme target groups. Pooling resources by scheme members alone to cover all illnesses including the now common chronic diseases is the next challenge in the struggle to make the schemes financially viable. In the coming year, specific measures to expand pooling among the members and with external supporters will be developed and implemented.

Table 6: Most common illnesses presented by scheme members at contracted healthcare providers

Illness	Cases	Illness	Cases
Malaria	1,751	Deliveries	57
Hypertension and diabetes	880	Typhoid fever	57
Peptic ulcer disease	451	Arthritis	45
Upper Respiratory tract infections	445	Anaemia	39
Respiratory Tract Infections	178	Allergy	28
Enteric fever	174	Bacteria	23
Urinary tract infection	125	Pelvic inflammatory disease	19
Gastritis	117	Pneumonia	8
Caesarean section	92	Wounds	4
Antenatal care	59	Others	2,675
Total			7,227

4. Schemes increased use of technology in operations

The schemes adopted more efficient modes of operation to reduce costs and reach community and scheme members faster. These included extending the biometric health insurance cards to rural areas, communicating to families via telephone (short text messages, Whatsapp, calls), online payment of healthcare bills and encouraging payment of premiums via mobile money. A total of 167 families in both urban and rural areas used biometric cards to access healthcare services. The plan for next year is to further expand use of modern technology to reduce operational costs on items such as transport to make schemes more sustainable.



The biometric health insurance card scheme members use

2. POLICY ADVOCACY

A. Activities implemented

1. A position paper on the NHIS was presented in Parliament

On 5th November, 2019, SHU's Executive Director led a team of six people to Parliament to present a position paper on the NHIS Bill, 2019 before the Health Committee. The position paper was developed in collaboration with four other CHI promoters that included Uganda Community Based Health Financing Association (UCBHFA), HealthPartners Uganda (HPU), Uganda Protestant Medical Bureau (UPMB) and Bwindi Hospital. Other CHI promoters provided information from their projects to give a comprehensive picture of the status of CHI in the country. The position paper called for recognition of CHI as an agent of the NHIS for purposes of enrolling families in the informal sector. The key issues raised in the paper on the NHIS are summarised below:



The Chairperson of the Health Committee of Parliament, Dr. Michael Bukenya (third right) with SHU Executive Director, Mr. Makaire Fredrick (centre) and other members of the team after presenting the position paper before the Health Committee of Parliament.

1. The NHIS is long overdue and we pray that it is passed quickly and implemented.
2. Community health insurance schemes should be recognized and promoted as an important component of the NHIS that will enrol beneficiaries and collect contributions from the informal sector.
3. The NHIS should manage a single pool of funds for all contributors to provide a comprehensive benefit package and guarantee equity in accessing the benefits.
4. Contributions to be made to the Scheme should depend on a contributor's capacity to pay; contributions for the poor should be subsidised by government, donors or the wealthy while contributions for indigents should be fully paid by the Government.
5. Members of the Board of the Scheme who are not representing Ministries should be identified through a fair process by a public advertisement and interviewed by the Public Service Commission.
6. To guarantee quality of care and accountability, all healthcare providers including government owned should be subjected to the same accreditation process and criteria before they are contracted by the Scheme.
7. To improve access being one of the main objectives of the Scheme, all benefits of the Scheme should be accessible and portable across the country.

2. SHU Organised the 4th National Community Health Financing Conference

From 13th to 15th November, 2019, SHU, in partnership with Ministry of Health, Ministry of Gender, Labour and Social Development and eight other organisations, hosted the fourth national CHF conference at Imperial Royale Hotel, Kampala. The theme of the conference was 'Community Health Financing Initiatives: Moving towards Universal Health Coverage', and the aim was 'to mobilise leaders and other actors to embrace and support CHF initiatives and the NHIS for universal health insurance coverage'. The number of participants grew from 186 from 28 districts in 2018 to 225 from 36 districts in 2019. A special guest from Ghana shared about his country's experiences in implementing a national health insurance scheme. A lot of progress had been made on resolutions from the previous conference such as expanding CHI to reach more parts of the country with the number of districts where CHI schemes exist growing from 21 in 2018 to 32 in 2019. Five resolutions were agreed upon by participants for implementation before the next conference.

Table 7: Resolutions made by participants at the 4th National CHF conference

- | | |
|---|---|
| 1. Conference participants and CHI promoters will continue to support the process of enacting the NHIS law by participating in debates and making proposals. | |
| 2. Continue to advocate for CHI schemes to play the role of linking the informal sector to the NHIS as:
a. Marketing distribution channels for the NHIS
b. Collection agents for the NHIS | 3. Maintain existing CHI schemes/programs and expand beyond the 32 districts currently covered by:
a. Building resilient systems for sustainability e.g. adoption of technology
b. Linking CHI to livelihood/ economic programs |
| 4. Advocate for implementation of a multi-sectoral approach with all relevant sectors (finance, gender, labour and social development, etc.) playing their respective roles to ensure a healthy population. | 5. Mobilize leaders and advocate/demand for their involvement in promoting CHI and supporting the implementation of NHIS. |



A group photo of some of the conference participants and key speakers with the Chief Guest, State Minister for Health in charge of General Duties, Hon Sarah Opendi, after the official opening of the 4th CHF conference.

3. We documented and shared knowledge about CHI

SHU and the CHI schemes it supports continued to serve as a learning hub on CHI implementation in Uganda and shared experiences with stakeholders and the general public at local and national levels. In June, MBUSO, hosted a team of seven proprietors and staff of private health facilities from Sironko, Oyam and Apac districts who wanted to learn about sustainable management of CHI schemes. Their facilities were supported by USAID/Uganda Voucher Plus Activity to start up a CHI program in 2018 but they faced challenges along the way including low participation of community members in the initiative, high levels of consumption of the healthcare fund, inadequate premiums charged, among others. USAID/Uganda Voucher Plus Activity facilitated their visit to Luwero to learn how to manage the CHI program as a way to sustain benefits of the maternal voucher project they were implementing.

In August, SHU's Executive Director made a presentation at the Universal Health Coverage (UHC) Symposium titled "Partnerships for Health Improvements across Governments and Societies at Local, National and Global Levels", organised by Makerere University School of Public Health. His presentation focused on experiences of community health insurance program in five districts of Uganda in leveraging community partnerships for

efficiency and sustainability. He shared with participants about how partnerships at various levels had enabled CHI schemes to thrive. In addition, SHU produced information, education and communication (IEC) materials to share updates as well as educate communities about CHI. A total of 10,000 copies of a CHI sensitization leaflet were produced in Luganda, English and Runyankore and distributed in communities to provide answers for the frequently asked questions. A leaflet on the status of CHI in Uganda was also produced and disseminated at different events. Other materials produced included newsletters, reports and advertorials in newspapers and magazines. These became key resources for people in government, civil society and the media who were seeking information about CHI.



SHU's Communication and Advocacy Officer and the Assistant Program Officer for M&E explain how CHI works to the Health Minister, Dr. Jane Ruth Aceng, at World Health Day 2019 event at Kira in Wakiso district.



Visitors from Sironko, Apac and Oyam districts with leaders of Kasaala sub-scheme in Luwero district during their learning visit.

4. We participated in technical working groups of government ministries

SHU staff continued to participate in meetings of the Inter Ministerial Committee on Universal Health Coverage as one of the three CSO representatives. In addition, SHU continued to actively participate in meetings of the social insurance and the social protection thematic committees hosted by the Ministry of Gender, Labour and Social Development. In these fora, SHU focused on advocating for expanding social protection to the informal sector and low income earners particularly against impoverishing out-of-pocket payments for healthcare.

5. We engaged the media on CHI and NHIS

Numerous media engagements were done to publicize CHI and SHU's position on the proposed NHIS. The activities included two media cafes (one in Luwero and one in Kampala), interviews with journalists and sponsored publications. Some of the activities were sponsored by USAID/Uganda Voucher Plus Activity. As a result, dozens of stories were published in print, broadcast and online media about SHU's work. This increased visibility of CHI especially in the media, civil society and government agencies. Below are links to some of the stories published in the media on CHI and NHIS.

- ⇒ <https://www.monitor.co.ug/News/National/Local-health-insurance-scheme-brings-smile--Kamira-Kikondere/688334-4901300-12x1yxiz/index.html>
- ⇒ https://ugandaradionetwork.com/story/26000-residents-embrace-community-health-insurance-in-greater-luweero-#disqus_thread
- ⇒ <https://www.monitor.co.ug/OpEd/Commentary/Why-proposed-government-health-insurance-scheme-faces-resistance/689364-5183946-22730dz/index.html>
- ⇒ https://www.newvision.co.ug/new_vision/news/1496694/-400-people-enroll-health-insurance
- ⇒ <http://www.thecommunityagenda.com/index.php/health2/item/200-community-health-financing-a-gateway-to-universal-health-coverage/200-community-health-financing-a-gateway-to-universal-health-coverage>
- ⇒ <http://www.thecommunityagenda.com/index.php/health2/others/item/208-nhis-bill-s-silence-on-community-health-financing-worries-experts>
- ⇒ <http://www.thecommunityagenda.com/index.php/health2/item/201-government-commits-to-support-community-health-insurance>

B. Key achievements

1. Increased demand for technical support to implement CHI

As a result of our work, a number of organisations and individuals approached SHU for technical support to start implementing CHI in their respective areas. In November 2019, SHU provided technical support to the Forum for Development of Greater Nebbi (FDGN) in the northern region. This included carrying out a feasibility study for implementation of CHI and educating over 90 local leaders in the three districts of Nebbi, Pakwach and Zombo about CHI.



SHU Executive Director, Mr. Makaire Fredrick (2nd left, front row) and Programs Officer, Ms. Juliet Nazibanja (left on second row) with local government leaders in Nebbi after a training on CHI.

2. Increased visibility of CHI

Publicity around CHI increased its visibility especially at national level among development partners, the civil society and government agencies. Several local and international researchers conducted studies on CHI as a form of social protection and sought information from SHU. In addition, government entities working on social protection interventions severally cited CHI as one of the ongoing social protection interventions in the country.

3. Universal health insurance under NHIS

For many years, SHU's advocacy for the NHIS focused on convincing policy makers to design a scheme that would benefit every citizen regardless of their social economic status. We believe that our efforts contributed to the changes in the NHIS Bill presented in Parliament from a social insurance scheme for formal sector workers to a universal scheme that targets every resident in Uganda.

3. PROVISION OF QUALITY HEALTHCARE SERVICES

A. Activities implemented

1. Promoted establishment of client relations desks at partner healthcare facilities

SHU promotes customer relations desks (CRDs) at contracted healthcare facilities to improve reception of patients and provide a direct avenue for them to seek assistance while at the facility. The number of contracted healthcare facilities that have CRD increased from 12 in 2018 to 14 in 2019. This followed the establishment of CRDs at Bitooma HCIII in Bushenyi district and St. Mary's Kasaala HCIII in Luwero district. During the year, a total of 61,242 people sought assistance at the CRDs at 10 health facilities.

Table 8: Number of people received at customer relations desks at 10 contracted healthcare facilities in 2019

District	Healthcare facility	Number of people
Bushenyi	1. Ishaka Adventist Hospital	23,210
	2. Bitooma HC	2,406
Sheema	3. Mushanga HC	6,845
	4. Hope Medical Centre	2,653
	5. Kitagata hospital	5,280
Luwero	6. Good Samaritan HC	4,948
	7. Bishop Asili hospital	10,467
Nakaseke	8. Kiwoko hospital	467
	9. Nakaseke hospital	565
Mubende /Kassanda	10. St. Gabriel Mirembe Maria	4,401
	Total	61,242

2. Facilitated and strengthened communication platforms for healthcare users and providers

One of the benefits communities reap from CHI is the formal and mutual accountability relationship they establish with healthcare providers. The four CHI schemes, with support from SHU, coordinate and facilitate dialogue meetings between leaders of CHI sub-schemes and decision makers in health facilities to share feedback on the quality of services, the behaviour of patients, and compliance to terms of service contracts by the parties involved. During the year, at least one feedback meeting was held at each contracted health facility between the facility administrators and scheme leaders. In April, SHU organised a centralised meeting for decision makers in contracted health facilities and representatives of CHI schemes which attracted 62 participants. At the end of the meeting, representatives of contracted health facilities committed to further improve services by increasing staffing



Dr. Johnson Kabwishwa, Medical Superintendent at Kitagata Hospital, addressing scheme representatives during a feedback meeting at the hospital. On his right are Mr. Friday Moses, Union technical Manager-WATSA and Mr. Muhumuza Stephen, WATSA board chairman.

levels, improving reception facilities and signage, orienting new staff about CHI and conducting mobile clinics in rural areas to take services closer to the people.

3. Supported a healthcare provider to acquire a complete blood count machine

SHU endeavours to support health facilities contracted by schemes to improve the quality and range of services they offer. During the year, we supported St. Kizito Nattyoole HCIII to acquire a complete blood count (CBC) machine. The machine is used in the laboratory to evaluate the overall health of an individual and detect disorders such as anaemia, dehydration, inflammation and infections. St. Kizito Nattyoole HCIII is located in Ziobwe Sub-county, Luwero district, and serves CHI scheme members mainly from Ziobwe and Kalagala sub-counties.



A laboratory technician at St. Kizito Nattyoole HCIII using the CBC machine acquired with support from SHU.

B. Key achievement

1. Schemes provided 66 percent protection to their members

During the year, the 23 health care facilities contracted by schemes received 7,227 cases (5,328 OPD and 1,899 IPD) of scheme members which cost a total of UGX 442,860,765. Schemes paid UGX 292,945,008 out of the total bill, hence providing 66 percent protection of scheme members from out of pocket healthcare expenditures. The remaining 44 percent of medical bills was paid by scheme members either in copayments or top up cash for bills above the maximum ceiling offered by schemes.

Table 9: Level of protection provided to CHI scheme members against out of pocket payment of healthcare bills

Scheme	Total bills	Scheme bills	Level of protection
MBUSO	286,920,600	184,322,200	64.2
WATSA	60,951,400	34,768,500	57.0
MSCOM	69,953,700	53,523,700	76.5
SHU-CHI	25,035,065	20,330,608	81.2

4. HOUSEHOLD LIVELIHOOD IMPROVEMENT

A. Activities implemented

1. Enabled families to access credit facilities through partnerships

SHU works in partnership with microfinance institutions to extend livelihood programs to the target communities. During the year, two microfinance institutions, SHUF and Butaba Company Limited, extended loan facilities to community members for premium and other family needs. In Luwero, Nakaseke and Nakasongola districts, SHUF gave out 506 loans while Butaba reached 269 families in Mityana and Kassanda districts with loans. The two institutions also extended premium loans to individuals to join CHI schemes.



Mr. Kasajja Joseph, a resident of Katakala Ward in Central Division, Mityana Municipality, in front of his house which he completed with a home improvement loan from Butaba Company Limited.

Table 10: Families that accessed loans from partners

Partner MFI	Districts of operation	Home Improvement		Agri-Business		School Fees		Working Capital		Total No. of Loans		Total loans
		Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	
Butaba Company Limited	Mityana and Kassanda/Mubende	4	3	0	0	2	4	109	147	115	154	269
SHUF	Luwero, Nakaseke and Nakasongola	2	0	106	36	3	2	225	132	336	170	506

2. We supported families with farm implements through public-private partnerships

A large majority of the people in communities where SHU works are predominantly small scale farmers who use ordinary farm implements on their farms. However, many still find the farm implements unaffordable given the competing priorities for the small family incomes. To enable them increase their farm production, SHU, with support from partners distributed 2,500 hand hoes to households in Luwero district.



SHU Executive Director, Mr. Makaire Fredrick (with microphone) hands over hoes to community members in Luwero.

B. Key achievement

1. More than 7,000 individuals joined CHI schemes through microfinance institutions

A total of 7,483 individuals in the five districts of Luwero, Nakaseke, Nakasongola, Mityana and Kassanda enrolled into CHI schemes through the two partner microfinance institutions SHU works with. These constituted 32.9 percent of the number of people schemes covered during the year. The microfinance institutions, Butaba Company Limited and SHUF, collected a total of UGX 104,610,800 in premium for the CHI schemes, which was 27.9 percent of the all premiums collected.

Table 11: Individuals who enrolled in CHI through microfinance institutions in 2018 and 2019

Scheme	Districts	2018		2019	
		Individuals	Amount (UGX)	Individuals	Amount (UGX)
MBUSO	Luwero, Nakaseke and Nakasongola	5,495	45,772,550	5,495	48,129,500
MSCOM	Mityana and Kassanda	2,276	58,581,267	1,988	56,481,300
Total		7,771	104,353,817	7,483	104,610,800

5. WOMEN EMPOWERMENT FOR HEALTH

A. Activities implemented

1. Promoted family registration for CHI scheme membership

In all SHU's areas of operation, the family is the basic unit of enrolment into the scheme. Heads of households are targeted with awareness messages to appreciate CHI as an intervention that brings maximum benefits to entire families rather than individuals. Therefore, when a family head makes a decision to enrol, all members of the household are registered without discrimination. This helps to ensure that men and women, boys and girls in a household get the opportunity to benefit from the scheme. During the year, 12,762 (56 percent) of the members in schemes were females while 10,001 (44 percent) were males. The percentage of female members was maintained from last year despite the reduction in absolute number which stood at 17,675 females and 14,048 males in 2018.

2. Sensitized members about the role of women in leadership

SHU strives to enable women to actively participate in decision making regarding healthcare services delivery both at family and community level in addition to taking up leadership positions in schemes and at other levels. In the year 2019, a total of 818 leaders were elected in all the CHI sub-schemes and trained in their roles. Out of the 818 positions, 47.3 percent were occupied by women compared to 42.8% in 2018. This shows that there was an increase in women's participation in leadership in schemes. The leaders, both male and female, serve as volunteers in the schemes but benefit from trainings in financial and records management, patient rights, negotiation and community mobilisation skills.

Table 12: Gender distribution of leaders in CHI schemes

Scheme	Male	Female	Total
MBUSO	322	302	624
MSCOM	35	23	58
WATSA	74	62	136
Total	431	387	818



Ms. Odillah Ahimbisibwe, a leader from Buharambo sub-scheme demonstrating how to fill scheme tools during a hands-on session in the leaders training at Kitagata Hospital

B. Achievements

1. We linked 324 women to credit facilities

During the year, SHU in partnership with two microfinance institutions enabled 324 women to access low interest loans for school fees, working capital, agri-business, home improvement and other purposes. A total of 154 women in Kassanda and Mityana districts accessed loans from Butaba Company Limited while 170 in Luwero, Nakaseke and Nakasongola districts got credit from SHUF. The two microfinance institutions work with SHU to provide credit facilities to members of CHI schemes.



Ms. Namande Margaret of Buvuma in Nyimbwa sub-county, Luwero district accessed a working capital loan for her poultry business.



Ms. Nakitende Prossy of Kiziba in Kikyusa Sub-county, Luwero district got a loan and started building rental houses.

2. Enabled women to access quality healthcare services with ease

Schemes enabled more female than male members to access healthcare services. Up to 66 percent of all cases of illness handled at the contracted healthcare providers were presented by female scheme members. The schemes are, therefore, helping women who ordinarily have little control over family resources to access timely and quality healthcare services because they do not need cash at the point of access.

Table13: Gender distribution of cases of illness presented at contracted facilities by scheme members in 2019

Scheme	OPD		IPD		Total cases	
	Male	Female	Male	Female	Male	Female
MBUSO	567	1,196	272	762	839	1,958
MSCOM	544	1,141	236	390	780	1,531
WATSA	567	887	80	145	647	1,032
SHU-CHI	201	225	5	9	206	234
Total	1,879	3,449	593	1,306	2,472	4,755

6. ORGANIZATIONAL DEVELOPMENT

1. SHU secured a new licence and operational permit from the national NGO Bureau

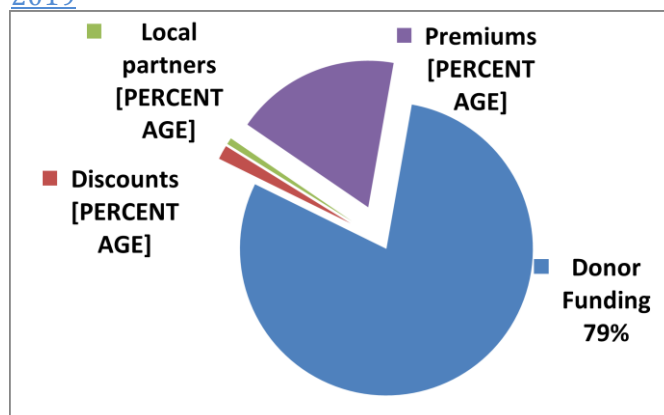
During the year, our mandate as a national non-governmental organisation was renewed by the National Bureau for Non-Governmental Organisations. This is important because it legally guarantees continuity of our work across the country. The new permit was received after satisfying all requirements of the NGO Bureau.

2. Mobilized partners for support towards our work

During the year, we reached out to different organisations to support our work. We mobilised a total of UGX 2,101,257,708 from families, local and international partners. In addition to funds received from Bread for the World, our major donor, we mobilised UGX 24,200,000 in local contributions towards the 4th national CHF conference, UGX 12,660,120 in discounts on medical bills and UGX 383,153,885 from families as premiums.

The mobilized funds were utilized as follows: 10% for Promoting, forming and supporting CHI schemes; 4% for supporting the delivery of quality healthcare services; 16% for advocating for universal health care coverage policies and insurance schemes; 46% for coordinating activities and partners; 4% for strengthening SHU as an institution; and 20% for managing CHI schemes and paying medical bills.

[The percentage share of sources of funds mobilised in 2019](#)



Besides financial contributions, there was in-kind support offered to scheme members by partners. A total of 355 scheme members received free healthcare services offered by Kiwoko hospital and St. Mary's Kasaala HCIII during a health camp held at the launch of the new scheme year at Butuntumula sub-county in Luwero district. These included 180 screened for diabetes and high blood pressure, 80 for malaria, 70 for HIV/AIDS and 18 for dental services.

4. The Board of Directors fully executed its functions

During the year, the Board of Directors performed all its functions as required. The Board held four full board meetings and two finance committee meetings. Members received periodic reports from the technical team, scrutinised and approved audit reports for onward submission to donors and other partners.

5. Strengthened technical capacity of the team

We organised two centralised training sessions for staff who expressed their capacity needs during an assessment exercise conducted during the year. Ten members of the technical team from five offices benefited from training in social marketing, effective communication, report writing and photography. Another team of seven staff were trained in community health insurance and risk management. Two team leaders were supported to undertake a short course in financial management for non-financial managers. The management team also benefited from technical support in advocacy planning conducted by Development Links Consult with support from Bread for the World.

7. MAJOR CHALLENGES FACED

1. High dropout rate of scheme members

During the year, a sizable number of scheme members dropped out which resulted into failure of 14 sub-schemes to keep running. Only 97 out of 111 sub-schemes which ran in 2018 were maintained. In addition, membership in the sub-schemes that continued to run also reduced hence low total membership for the year. The high dropout rate may be attributed to long distances to health facilities and fluctuating incomes in families.

2. High prevalence of chronic illnesses

As indicated earlier in this report, most of the most common illnesses presented by scheme members at the 23 contracted healthcare providers were chronic except malaria. Chronic illnesses such as hypertension, diabetes and peptic ulcers require frequent medical attention because of the random symptoms they present. Some community members enrol into the scheme because they cannot afford the cost of treating such illnesses as individuals. This imposes a high burden on the scheme funds due to frequent visits to health facilities by such members. This partly explains the high consumption of healthcare funds above the budget for the year.

3. Long distances to quality healthcare service providers

In some of the remote areas where SHU created CHI sub-schemes, most nearby health facilities did not meet the minimum quality standards required for accreditation and contracting. This meant that scheme members had to travel long distances to access healthcare services yet transport costs in some areas were prohibitive. Such hardships in accessing services caused low satisfaction of members with the scheme.

**Table 13: COMMUNITY HEALTH INSURANCE SUB-SCHEMES WHICH RAN IN 2019
PER NETWORK AND THEIR MEMBERSHIP**

No	District	Sub-county	Scheme name	Year of creation	House holds	Beneficiaries	Male	Female
MUNNO MU BULWADDE UNION OF SCHEMES ORGANISATION								
1.	Luwero	Nyimbwa	Bajjo	2017	11	68	26	42
2.	Luwero	Makulubita	Kagoggo	2019	40	269	128	141
3.	Luwero	Butuntumula	Kakabala	2001	112	901	404	497
4.	Luwero	Zirobwe	Kakakala	2017	10	65	27	38
5.	Luwero	Butuntumula	Kakinzi	2002	77	716	316	400
6.	Luwero	Bamunanika	Kalwe	2016	10	61	31	30
7.	Luwero	Makulubita	Kangave	2019	27	190	89	101
8.	Luwero	Luwero	Kasaala	2010	77	630	287	343
9.	Luwero	Kamira	kaswa	2016	23	139	61	78
10.	Luwero	Kamira	Katagwe	2017	7	44	19	25
11.	Luwero	Katikamu	Katikamu	2019	32	198	91	107
12.	Luwero	Butuntumula	Bamugolodde	2010	45	354	153	201
13.	Luwero	Luwero	Katuugo	2010	29	261	104	157
14.	Luwero	Kalagala	Kayindu	2017	22	166	73	93
15.	Luwero	Kikyusa	Kibengo	2019	30	201	93	108
16.	Luwero	Bamunanika	Kibirizi	2017	12	82	38	44
17.	Luwero	Luwero	Kigombe	2005	11	70	34	36
18.	Luwero	Katikamu	Kikoma	2017	20	125	45	80
19.	Luwero	Luwero	Kikube	2010	44	328	144	184
20.	Luwero	Kikyusa	Kireku	2017	56	372	165	207
21.	Luwero	Bamunanika	Kiteme Bajjakakasa	2016	16	100	41	59
22.	Luwero	Nyimbwa	Kiyanda	2017	48	299	125	174
23.	Luwero	Zirobwe	Bubuubi	2018	10	61	26	35
24.	Luwero	Kikyusa	Kiziba	2017	35	249	111	138
25.	Luwero	Katikamu	Kyalugondo	2012	24	153	70	83
26.	Luwero	Bamunanika	Kyampisi	2017	7	45	20	25
27.	Luwero	Butuntumula	Kyawangabi	2006	41	342	137	205
28.	Luwero	Luwero	Kyesabukadde	2006	25	213	92	121
29.	Luwero	Kamira	Mabuye	2016	12	98	32	66
30.	Luwero	Makulubita	Mawale	2019	28	176	76	100
31.	Luwero	Kamira	Mazzi	2016	27	168	72	96
32.	Luwero	Katikamu	Migadde	2006	40	267	105	162
33.	Luwero	Butuntumula	Bukambagga	2010	25	188	81	107

No	District	Sub-county	Scheme name	Year of creation	House holds	Beneficiaries	Male	Female
34.	Luwero	Bamunanika	Mpologoma	2016	28	180	78	102
35.	Luwero	Katikamu	Musaale	2017	16	88	44	44
36.	Luwero	Zirobwe	Nakigoza	2019	24	148	63	85
37.	Luwero	Luwero	Nakikoota	2011	54	440	204	236
38.	Luwero	Kamira	Nambeere	2017	18	104	47	57
39.	Luwero	Butuntumula	Ngogolo	2002	19	165	78	87
40.	Luwero	Luwero	Nsabweteeka	2004	62	460	195	265
41.	Luwero	Katikamu	Bukolwa	2017	11	65	32	33
42.	Luwero	Nyimbwa	Buvuma	2016	8	45	23	22
43.	Luwero	Luwero	Bwaziba	2011	26	175	81	94
44.	Luwero	Bamunanika	Sekamuli	2016	11	84	33	51
45.	Luwero	Katikamu	SOS	2014	129	853	437	416
46.	Luwero	Nyimbwa	Ssambwe	2019	24	156	67	89
47.	Luwero	Kikyusa	Wabusana	2019	34	215	97	118
48.	Luwero	Kikyusa	Wankaanya	2016	60	408	164	244
49.	Luwero	Luwero	Kabakedi	2011	42	344	142	202
50.	Luwero	Kamira	Kabunyatta	2016	15	93	45	48
51.	Nakaseke	Kasangombe	Nakaseeta	2011	37	242	99	143
52.	Nakaseke	Kasangombe	Bukuuku	2013	40	244	118	126
53.	Nakaseke	Kikamulo	Kamuli	2003	22	244	111	133
54.	Nakaseke	Kikamulo	Kapeke	2010	62	554	238	316
55.	Nakaseke	Kikamulo	Kasana	2010	54	373	166	207
56.	Nakaseke	Kikamulo	Kibose	2010	46	286	152	134
57.	Nakaseke	Kikamulo	Kikamulo	2010	6	39	17	22
58.	Nakaseke	Kikamulo	Luteete	2011	23	207	102	105
59.	Nakaseke	Kikamulo	Magoma	2008	77	664	274	390
60.	Nakaseke	Kikamulo	Wakayamba	2010	12	74	37	37
61.	Nakaseke	Kito	Kito	2012	26	208	88	120
62.	Nakaseke	Kito	Kivumu	2012	31	211	95	116
63.	Nakaseke	Nakaseke	Kasambya	2011	25	193	92	101
64.	Nakaseke	Nakaseke	Kiggege	2011	38	240	116	124
65.	Nakaseke	Wakyato	Katooke	2008	29	209	89	120
66.	Nakaseke	Wakyato	Mijjumwa	2000	34	318	143	175
67.	Nakasongol	Kakooge	Kakooge	2001	56	397	155	242
68.	Nakasongol	Kakooge	Katuugo	2011	72	524	233	291
69.	Nakasongol	Kakooge	Kyabutaika	2002	21	141	63	78
70.	Nakasongol	Kakooge	Kyambogo	2011	34	266	123	143
71.	Nakasongol	Kakooge	Kyankonwa	2011	26	227	93	134

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72.	Nakasongol	Kakooge	Kyeyindula	2002	43	346	158	188
73.	Nakasongol	Wabinyonyi	Kamuniina	2017	18	118	58	60
74.	Nakasongol	Wabinyonyi	Sassira	2016	11	70	33	37
Sub - total					2,457	18,017	7,999	10,018
SHU - CHI								
75.	Luwero	Luwero T/C	Luwero T/C A	2018	13	56	16	40
76.	Luwero	Luwero T/C	Luwero T/C B	2019	27	91	41	50
77.	Luwero	Luwero T/C	Luwero Corporate	2013	85	219	98	121
78.	Masaka	Masaka Municipality	SHU-CHI Masaka	2013	13	101	51	50
Sub-total					138	467	261	206
MUNNO MU BULWADDE MUBENDE SCHEMES COOPERATION MECHANISM								
79.	Mubende	Kassanda	Kitongo	2014	69	257	98	159
80.	Mubende	Kassanda	Kamuli	2015	122	482	181	301
81.	Mubende	Kassanda	Namiringa	2014	51	184	69	115
82.	Mubende	Kassanda	Nabugondo	2015	32	126	59	67
83.	Mubende	Kassanda	Binikira	2015	27	108	44	64
84.	Mubende	Kassanda	Lwantale	2015	17	61	25	36
85.	Mubende	Kassanda	Lusaba	2015	58	205	88	117
86.	Mubende	Bukuya	Kizibawo	2014	57	210	93	117
87.	Mubende	Kassanda	Namabaale	2014	29	121	56	65
88.	Mubende	Nalutuntu	Ggambwa	2017	19	59	20	39
89.	Mityana	Mityana municipality	Mityana Urban	2017	169	175	64	111
Sub-total					650	1,988	797	1,191
WESTERN ANKOLE TWERAGURIZE SCHEMES ASSOCIATION								
90.	Bushenyi	Kakanju	Kakanju	2013	19	103	41	62
91.	Bushenyi	Nyabubare	Nkanga	2013	19	100	46	54
92.	Bushenyi	Ibaare	Ryeishe	2007	20	101	46	55
93.	Bushenyi	Kyamuhunga	Kibazi	2016	27	156	66	90
94.	Sheema	Kagango	Kihunda	2016	18	104	42	62
95.	Sheema	Sheema	Rushozi	2016	21	107	55	52
96.	Sheema	Sheema	Rwamujojo	2016	28	146	55	91
97.	Sheema	Kasaana	Kasaana West	2011	24	125	51	74
98.	Sheema	Bugongi	Kyamurali	2011	20	104	41	63
99.	Sheema	Kashozi	Karera South	2014	19	109	48	61
100.	Sheema	Kasaana	Kasaana East	2010	20	109	39	70

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101.	Sheema	Sheema Division	Nyarweshama	2015	30	162	79	83
102.	Sheema	Kagango Division	Kiziba	2018	25	131	52	79
103.	Mitooma	Kabira	Buharambo	2015	19	102	54	48
104.	Mitooma	Mutara	Mahwizi	2015	22	125	51	74
105.	Mitooma	Bitereko	Busheregyenyi	2016	32	164	71	93
106.	Mitooma	Katenga	Bitooma-Katenga	2013	43	227	110	117
107.	Mitooma	Bitereko	Kalimbiri	2018	22	116	52	64
Sub- total					428	2,291	999	1,292
GRAND TOTAL					107	22,763	10,001	12,762

