



SAVE FOR HEALTH UGANDA

Community solidarity for quality health

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Head office

Nansana- Kyebando Road,
Nansana West Ward
Nansana Municipality
P. O. Box 8228 Kampala
Tel: +256 414271841
Fax: +256414271841
Email: shu@shu.org.ug

Luwero Area Office

Kasoma zone
Luwero Town council
Kiwoko Road
P.O.Box 123 Luwero
Tel: +256 778578677
+256 706680466
Email: shu-luwero@shu.org.ug

Bushenyi Area Office

Bugomora Cell,
Katungu zone,
Ishaka-Kagamba Road
Bushenyi Ishaka
Municipality
P.O. Box 277 Bushenyi
Tel: +256 779717761;
Email: shu-bushenyi@shu.org.ug

Mityana Area Office

Mityana Community
Centre Building,
Thoban Road Central
Zone, Mityana Municipality
P.O.Box 285, Mityana
Tel: 0414 271 841
Email: shu@shu.org.ug

Iganga Area Office

Lubasi Road
Nkono 1 Cell
Northern Division
Iganga Municipality
P.O.Box 8228 Kampala
Tel: 0414 271 841
Email: shu@shu.org.ug

Website: www.shu.org.ug



SAVE FOR HEALTH UGANDA

Community solidarity for quality health

Vision: Healthier families with simplified access to quality health care.

Mission: To enhance the quality of health of Ugandans through community health financing schemes.

Our values:

- Team Work
- Client-focused
- Integrity
- Professionalism
- Ownership
- Trust in God
- Being economically oriented
- Respect

Thematic areas of work:

- Community Health Financing
- Household livelihood improvement
- Quality Healthcare delivery

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ACRONYMS

BftW	Bread for the World
BURATS	Busoga Region Association of Tweidhandhabe Schemes
CRUMBS-L	Central Region Urban Munno Mu Bulwadde Scheme
HC	Health Centre
CHF	Community Health Financing
CHI	Community Health Insurance
CRA	Customer Relations Assistant
CRD	Customer Relations Desk
FDGN	Forum for Development of Greater Nebbi
HCP	Healthcare provider
IPC	In-patient care
MBUSO	Munno mu Bulwadde Union of Schemes Organization
MFI	Microfinance Institution
MGLSD	Ministry of Gender, Labour and Social Development
MOH	Ministry of Health
MSCOM	Munno Mu Bulwadde Schemes Cooperation Mechanism
NHIS	National Health Insurance Scheme
OOP	Out of pocket
OPC	Out-patient care
SHU	Save for Health Uganda
SHUF	SHU Finance Limited
T/C	Town Council
UGX	Uganda Shillings
WATSA	Western Ankole Tweragurize Schemes Association

ABOUT US

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. Our work focuses on three core thematic areas: 1) Community health financing (CHF); 2) Livelihood improvement; and 3) Quality healthcare services delivery.

1. Community Health Financing: SHU is currently working with communities in 12 districts to create and manage community health insurance (CHI) schemes. The 12 districts are: Luwero, Nakaseke, Nakasongola, Bushenyi, Sheema, Mitooma, Kassanda, Mityana, Masaka, Iganga, Bugweri, Mayuge. There are five main schemes which bring together sub-schemes formed at parish level. 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.

They include:

- i. Munno mu Bulwadde Union of Schemes Organisation (MBUSO) for Luwero, Nakaseke and Nakasongola district.
- ii. Munno mu Bulwadde Schemes Cooperation Mechanism (MSCOM) for Mityana and Kassanda district.
- iii. Western Ankole Tweragurize Schemes Association (WATSA) for Mitooma, Bushenyi and Sheema district.
- iv. Central Region Urban Munno Mu Bulwadde Scheme for Luwero area and Masaka district.
- v. Busoga Region Association of Tweidhandhabe Schemes (BURATS) for Iganga, Mayuge and Bugweri.



Generic logo of CHI schemes supported by SHU.

In addition, SHU is providing technical support to Forum for Development of Greater Nebbi (FDGN) for establishment of CHF schemes in West Nile area in the three districts of Nebbi, Pakwach and Zombo.

To augment the community-level CHF work, we engage policy makers at national and local government levels to advocate for laws and policies that should enable all people in Uganda to access quality healthcare services without facing financial hardships. At national level, we specifically focus on advocacy for a national health insurance law that covers every citizen with a single pool of funds, recognises CHI, and guarantees enrolment of indigents. At local government level, we engage leaders to provide a legal framework and support CHI schemes to grow and be more sustainable.

2. Livelihood improvement: We enhance community capacity to generate income for family welfare and access to health care. We do this through training community members in vocational skills, business management and finance literacy. We also link them to our partner microfinance institutions to access low-interest credit facilities.

3. Quality healthcare services delivery: To enable members of CHI schemes to access quality healthcare services, we work closely with healthcare providers at different levels to improve client experience and satisfaction. We advocate for improved infrastructure, reliable supply of drugs and inputs, and adherence to professional standards. We facilitate patient centred care training for health workers and create feedback mechanisms between the healthcare providers contracted by schemes and members of CHI schemes. This creates a cordial and mutually beneficial relationship between healthcare providers and the communities they serve.

MESSAGE OF THE CHAIRPERSON BOARD OF DIRECTORS

Our dear partners and friends, I take the pleasure to share with you this report for the year 2022. It was yet another year characterised by uncertainties particularly in health and economic sectors. The second wave of COVID-19 hit the country as we were rising from the impact of the first one. The outbreak of Ebola virus in Kassanda and other districts further muddled up many of our plans for the year. The follow-on sharp increase in the cost of living hit hard the incomes of the families SHU targets in its work, hence posting a mixed bag of results. Nonetheless, I am thankful to God for everything accomplished during the year and I believe we shall see better times going forward.



*Leticia Nakimuli Irumba (Phd)
Board Chairperson*

I am grateful to all partners that supported us at various levels. The financial partners made it possible for SHU to remain vibrant and deliver on its mandate. I also recognize the different organizations that worked with us in organising various activities and delivering services to our target population.

This was the second year of SHU's strategic plan for 2021-2026 which focuses on three thematic areas: Community Health Financing (CHF), Livelihood improvement and Delivery of quality healthcare services. I am glad that the technical team is on course in all the three areas. Key milestones registered in CHF include expansion of geographical coverage, the signing of a memorandum of understanding among schemes to create a joint national level pool of funds and allow portability of benefits across regions. In livelihood improvement, SHU maintained partnership with microfinance institutions to extend low-interest credit facilities to community members and equipped hundreds with vocational skills for income generation. In the area of healthcare services delivery, the functional referral system with feedback mechanisms is in place and many of the partner healthcare providers have improved the quality of services offered.

Regarding SHU governance, I wish to recognise Mr. Paul Micheal Waigolo who retired from the Board of Directors in May after eight years of service. Mr. Waigolo made various contributions to SHU's growth. In the same vein, I warmly welcome Mr. Sekyanzi David Kitakule who joined the Board as a community Representative. Mr. Senkyanzi, a retired teacher, was the chairman of the Board of Directors for the scheme in Luwero area. I am confident that our team will support SHU to grow from strength to strength.

I once again thank you all for being a part of SHU's journey in promoting and advocating for CHF and the National Health Insurance Scheme. I have faith that SHU is making a mark on Uganda's quest for universal health coverage.

I wish you a fruitful 2023. God bless you!

OTHER MEMBERS OF THE BOARD OF DIRECTORS



*Mr. Douglas Opio
(Treasurer)*



*Dr. Martin Ruhweza
(Member)*



*Mr. David Sekyanzi Kitakule
(Member)*



*Mr. Fredrick Makaire
(Secretary)*

MESSAGE OF THE EXECUTIVE DIRECTOR

This was the second year of implementing our strategic plan 2021-2026 and the three-year project titled 'enabling vulnerable families in Uganda to equitably access healthcare services of quality'. This is a tripartite funded project among Bread for the World, SHU and CHI schemes. I greatly appreciate the partners for all the support that made it possible for us to continue working at various levels.

In this report, we are posting mixed results compared to our performance for the previous years due to disruptions in our work occasioned by the COVID-19 pandemic, Ebola outbreak and escalation of prices of essential commodities which were not foreseen. We made good progress in some areas but suffered setbacks in others.



Mr. Fredrick Makaire

We continued to support community health insurance (CHI) schemes in 12 districts which include Masaka, Luwero, Nakaseke, Nakasongola, Bushenyi, Sheema, Mitooma, Mityana, Kassanda, Iganga, Bugweri and Mayuge. We provided technical support to Forum for Development of Greater Nebbi (FDGN) to start a CHI scheme in Nebbi, Zombo and Pakwach district. Our advocacy for a National Health Insurance Scheme (NHIS) and Luwero District CHI scheme also continued at national and district level.

The newly created CHI scheme in the eastern region named Busoga Region Association of Tweidhandhabe Schemes (BURATS) was fully constituted while the urban scheme formerly known as SHU- managed CHI (SHUMCHIS) evolved into Central Region Urban Munno Mu Bulwadde Scheme (CRUMBS) and officially registered as community based organizations (CBO) in their respective districts.

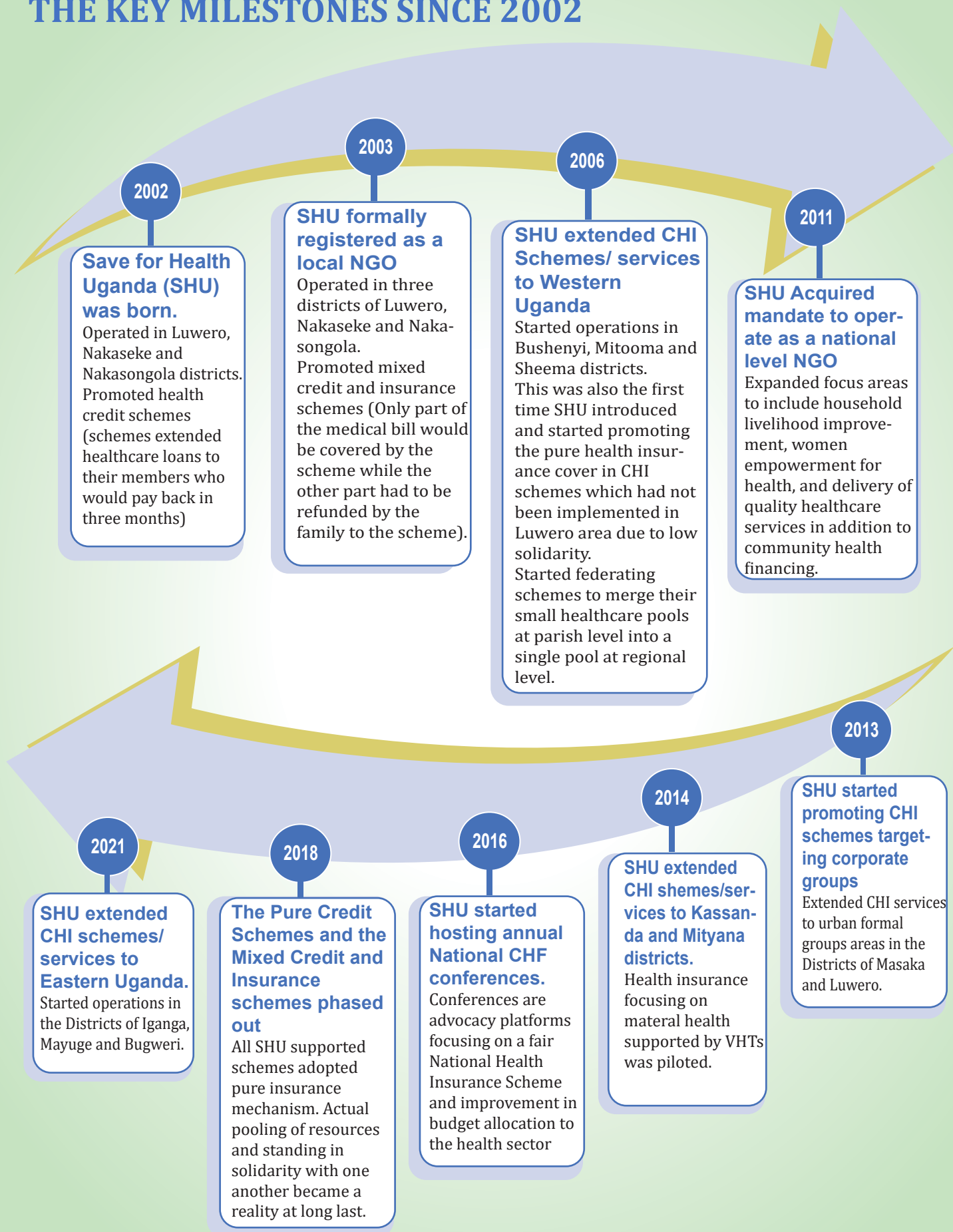
The five federal CHI schemes, Munno mu Bulwadde Union of Schemes Organisation (MBUSO), Munno mu Bulwadde Schemes Cooperation Mechanism (MSCOM), Western Ankole Tweragurize Schemes Association (WATSA), Central Region Urban Munno Mu Bulwadde Scheme (CRUMBS), and Busoga Region Association of Tweidhandhabe Schemes (BURATS) coordinated 94 sub-schemes which covered 18,984 individuals (8,588 male and 10,396 female) from 3,274 households. They mobilized ugx369,815,644 in premiums. Our partner microfinance institutions extended credit facilities to 365 individuals and enabled their families to enroll into schemes. The schemes contracted 31 health facilities and fully paid medical bills worth ugx293,239,724 for a total of 6,263 cases (4,715 outpatient and 1,548 inpatient). The most common illnesses were malaria, peptic ulcer disease, respiratory tract infections, urinary tract infections and hypertension. The schemes provided 73% protection to their members although majority experienced overconsumption of healthcare budgets.

Our key milestones for the year include the signing of a memorandum of understanding to establish a national level joint healthcare pool and make benefits portable across the schemes. Secondly, schemes migrated from the paper system to an electronic information management system.

I wish to thank all local and international partners including government agencies, CSOs and private companies that supported our activities during the year. I look forward to more fruitful relations.

WE ARE CELEBRATING 20 YEARS OF EXISTENCE

THE KEY MILESTONES SINCE 2002



NEW DEVELOPMENT

We rolled out a new electronic information management system for CHI schemes

Towards the end of 2021, SHU embarked on developing an electronic information management system (IMS) for managing data for the community health financing (CHF) program. The digital platform was built to manage information from beneficiaries, contracted healthcare providers and other implementing partners and to facilitate decision making through real-time reports generated by the system. The system was rolled out in schemes and contracted healthcare providers under the domain shumicroinsurancemanager.org.ug. It can be accessed on web and computer devices through both android and iphone operating systems. It is hosted on the cloud and available in both online and offline modes. During offline mode, data is input and saved on the device locally and synched to the server once the user has access to internet. The system is built with various key end user profiles whose rights are controlled and managed by the designated administrators of the platform. It is usable at SHU offices, contracted healthcare facilities and community level using computers and smart phones. The system is specifically used to register and manage the status of families and individual beneficiaries, issue bills for premiums and healthcare services, identify beneficiaries and produce real-time reports. It is possible to capture photographs and generate a quick response (QR) code for each fully paid up family member and chose preferred healthcare providers. The family QR codes are scanned with mobile devices and code readers to retrieve information about a scheme member before accessing healthcare services and issuing bills. SHU supported Holy Family Naluggi HCII with a new computer to enable the facility to join the new system.



SHU Team Leader for Mityana Area, Isaac Jjuuko (second left), Training staff of Naluggi HCII on how to use the computer SHU donated to the facility in preparation for rolling out the new IMS.



A team at Kitovu hospital tries out the QR code scanner.



Scheme:	Luwero Town Council Semi Urban
Family:	Kagumba Fred Shadrach
Name:	Fred Shadrach Kagumba
Gender:	Male
Member No:	CRUMBS/1/8/1
Expires On:	Dec. 31, 2023



An image of a QR code with beneficiary profile

THE WORK WE DID IN 2022

THEMATIC AREA 1: PROMOTING AND MANAGING COMMUNITY HEALTH FINANCING SCHEMES

1. COMMUNITY HEALTH INSURANCE SCHEMES

A) Key activities

A.1 Health insurance education and CHI schemes sensitization of new communities

Every year, SHU targets to reach more people with community health insurance (CHI) education and interest them in forming CHI sub-schemes to benefit from financial protection against impoverishing out-of-pocket health care expenditures. During the year, four schemes, Munno mu Bulwaddde Schemes Cooperation Mechanism (MSCOM), Western Ankole Tweragurize Schemes Association (WATSA), Busoga Region Association of Tweidhandhabe Schemes (BURATS) and Central Region Urban Munno Mu Bulwaddde Scheme (CRUMBS) ventured into new areas to expand coverage and introduce CHI to previously unreached communities. Community members were sensitized on the formation, operations and functioning of CHI schemes. This was done through village, parish level and small group meetings that involved residents and community leaders at various levels from political, religious, cultural and other categories. A total of 1,654 people living in 35 parishes in 11 districts were reached. These included Iganga, Bugweri, Mayuge, Bushenyi, Sheema, Mitooma, Luwero, Nakaseke, Nakasongola, Kassanda and Mityana.



The Projects Marketing and Promotions Officer, Mr. Waiswa Kenneth, addresses a CHI sensitization meeting for church leaders in Central Busoga Diocese.

A.2 Mobilization of families in old CHI schemes to pay premiums for the year 2022

The growth of CHI sub-schemes in areas where they already exist depends a lot on continuous community engagements to sensitize more people and encourage them to enroll. SHU supported the schemes to mobilise revenue through setting premiums, developing and reviewing products and providing data to guide decision making. Schemes were also advised on working in partnership with microfinance institutions, negotiating for discounts and flat rates at health facilities, conducting general fundraising activities and generating interest from funds collected. Schemes in Bushenyi area worked with village-based savings groups to encourage them to incorporate premium savings in

their plans. During the year, the old schemes contracted and supervised 111 (79 male and 32 female) scheme agents, who were then trained by SHU on their roles and responsibilities. They were facilitated with airtime, transport, and sensitized on new products. The scheme agents played a pivotal role in bridging the gap between the schemes and sub-schemes where they coordinated collecting premiums, supervised village coordinators, took photographs for healthcare access cards and issued them. During the total lock down due to COVID-19, field officers also supported the scheme agents through phone calls and sending out text messages to family heads. As the restrictions were eased, schemes held small decentralized meetings. The meetings focused on the functioning of schemes and the products they offer with the objective of enrolling more members and encouraging old ones to renew membership for the year. A total of 5,639 individuals were reached in the areas where schemes were already operating.



Mr. Swaibu Ndinabo, the agent for Busheregyenyi Scheme in Mitooma district sensitizing community members about operations of the scheme.

A.3 Training of scheme leaders for effective operations

SHU senior managers conducted support missions to boost the secretariats of schemes to perform their roles effectively especially handling feedback from members, developing products and planning for major activities. In addition, a total of 545 (263 male and 282 female) sub-scheme leaders from MBUSO and WATSA were trained on the use of the CHI sensitization guide developed by SHU in 2021. They gained knowledge on using the guide to educate community members about CHI. In West Nile, SHU trained staff of Forum for Development of Greater Nebbi (FDGN) to enable them start and promote a CHI scheme. In addition, SHU supported FDGN with a printer and a computer to facilitate registration of families and printing of identification cards for the enrolled members. Management teams at Angal hospital in Nebbi district and Nyapea hospital in Zombo district were oriented on CHI and accepted to introduce and manage the CHI program with support from FDGN and SHU.

A.4 Facilitating old schemes to strengthen them as institutions

SHU supported the five CHI schemes to grow stronger as independent institutions. They fully constituted governance boards and held mandatory meetings including annual general meetings to report to their members and account for resources. SHU trained new board members of MSCOM, BURATS, WATSA and CRUMBS on their roles and responsibilities. MSCOM developed and launched its five-year strategic plan. The SHU-managed scheme (SHUMCHIS) officially evolved into Central Region Urban Munno Mu Bulwade Scheme (CRUMBS-L) and was registered with Luweero



Members of the Board of CRUMBS after being trained on their roles and responsibilities.

district as a community based organization (CBO). Schemes conducted quarterly sub-scheme management and mid-year meetings for planning and approving sub-scheme invoices for the secretariat to pay facility medical bills. The meetings were also used to communicate new products



The chairperson Busheregyenyi sub-scheme and WATSA Board Treasurer participating in a discussion during one of the leaders' assessment meetings.

and assess the leaders on the targets set for them in recruiting and sensitizing members as well as launch re-contributions for the subsequent year. A total of 191 sub-scheme management and 94 midyear meetings were held at parish level. One scheme audit exercise was conducted in MBUSO, WATSA, MSCOM and CRUMBS to assess their financial and technical performance.

A.5 Sensitizing and facilitating discussions in the 4 old schemes for cooperation on portability of benefits and a joint national referral arrangement

SHU facilitated the five schemes to hold consultative meetings with members of CHI schemes to introduce the idea of making healthcare benefits portable across regions and starting a joint pool. Consequently, leaders of the schemes signed a memorandum of understanding to allow all beneficiaries of CHI schemes supported by SHU to access healthcare services at any of the 31 contracted health facilities across the regions starting in January 2023. In addition, three schemes, MBUSO, WATSA and CRUMBS, signed a memorandum of understanding to establish a joint healthcare pool for members to access services at a national level referral health facility. Members of the CHI schemes had always demanded for a national level referral facility to handle some of the complicated cases which the locally contracted service providers could not handle. SHU assessed Nsambya hospital and accredited it for contracting as the national level referral hospital. Representatives of contracted hospitals in different districts were trained on how to refer scheme patients to Nsambya

hospital. The national level referral facility will provide scheme members with services which are not available at other contracted health care providers.



Left – right: Mr. Mangasi Moses, Mr. Leonard Mwijukye and Mr. Mayanja Moses, leaders of CRUMBS, WATSA and MBUSO respectively, after signing a memorandum of understanding for a joint national level pool.

A.6 Contracting and purchasing healthcare services

SHU assessed several new health facilities which scheme members in different areas identified as potential service providers. Meetings were held with the management of the respective health facilities to introduce the CHI program, understand the operations of the facility and collect information that guided the assessment. The assessment was based on two aspects: the technical capacity of the health facility to provide the required health care services and their willingness to enter into collaboration with CHI schemes. A total of 15 health facilities were accredited for possible contracting by schemes in future. In addition, schemes obtained medical bills from the already contracted health facilities, verified them at various levels and made timely payments.



ST. JOSEPH'S HOSPITAL KITOVU

Our History

Kitovu Hospital was established by the Diocese of Masaka, 58 years ago in Masaka District, central Uganda. It is a private-not-for-profit (PNFP) hospital with 248 bed capacity. It shares the role of referral hospital with Masaka Regional Referral Hospital. It operates under the umbrella organization of the Uganda Catholic Medical Bureau (UCMB).

Our Mission

To continue the Healing Ministry of Jesus, by proclaiming the Sacredness of life, providing services which foster the health and well-being of the people, and caring in a special way for women, children and the poor.

Our services

- Out patient and in patient services
- A community Based / Primary Health Care Programme
- A Nutrition Education/Rehabilitation Unit
- A Psychosocial and Counseling Unit
- A Regional Blood Bank
- Laboratory services
- Laboratory Assistant Training School
- Theatre Assistant Training School

A training centre for Doctors and Nurses for vesicovaginal fistula (VVF) repair and caring for VVF sufferers since 2004 as a semi-autonomous unit.

- AIDS Care & Treatment Program (ACT)

- Intern Doctors Training Programme (Makerere – linked) Neo natal Unit
- Palliative care and Chemo therapy
- Radiology (X-ray & Ultra scan services)
- Cervical Cancer screening
- Obs/Gynae services
- Surgical Services
- Paediatric Services
- Medical services
- Safe Male circumcision
- Laboratory Services

***School of Nursing and Midwifery opening very soon in July 2023**



Neonatal intensive care unit



Happy mothers delivered at the hospital



Our fully-equipped dental unit.



VVF patients while at the hospital learn Craft work for re-integration.

B. Key results

B.1 Scheme revenues increased by 34.8 percent

B.1.1. Premiums collected from families: The five schemes mobilized ugx 369,815,644 in direct premium payments and loans by families, discounts on healthcare bills and general fundraising initiatives. There was a significant increase in premiums collected by 34.8 percent compared to ugx274,281,093 realized in 2021. The increase was attributed to the launch of schemes in eastern Uganda under BURATS and revival of three schemes under MSCOM which did not run in 2021.

Table 1: Funds mobilized by schemes in premium

Scheme	Premium collected in 2022 (ugx)	Premium collected in 2021 (ugx)
MBUSO	199,903,874	174,742,751
WATSA	67,028,200	55,362,416
CRUMBS-L	27,705,403	44,175,926
MSCOM	20,824,000	0
BURATS	54,354,167	0
Total	369,815,644	274,281,093

B.1.2. Other revenues collected by schemes: Some schemes raised revenue from other sources. MBUSO and CRUMBS realized ugx 6,218,450 and ugx 538,670 respectively from discounts offered by contracted healthcare providers on medical bills. In addition, MBUSO raised ugx377,500 from contributions by individuals towards premiums for needy persons.

B.2 Membership reduced by 16.3 percent

The five schemes kept 94 sub-schemes running and together covered 18,984 members (8,588 male and 10,396 female) from 3,274 households in 12 districts. However, there was a decline in the number of sub-schemes and members covered from 111 and 22,693 respectively in 2021. This reflected a 16.3 percent reduction in membership in schemes. This performance could be attributed to the countrywide lockdown imposed midyear due to COVID-19 outbreak which was followed by another in Kassanda district towards the end of the year because of Ebola disease. Many activities were suspended or reduced in scale and the economic impact of the two episodes greatly affected people's incomes, hence making it difficult for many families to pay premiums into schemes.

Table 1: Coverage of CHI schemes supported by SHU in 2022

Scheme	District	Sub-counties	sub-schemes	Families	Total beneficiaries	Male	Female
MBUSO	Luwero	8	33	933	6,179	2,758	3,421
	Nakaseke	8	18	470	3,236	1502	1734
	Nakasongola	2	7	188	1,281	561	720
MSCOM	Mityana	1	1	74	406	146	260
	Kasanda	2	2	122	630	285	345
CRUMBS	Masaka	1	1	2	57	54	3
	Luwero	1	2	263	373	261	112
WATSA	Bushenyi	4	5	157	872	380	492
	Sheema	4	7	187	981	432	549
	Mitooma	3	4	166	892	445	447
BURATS	Iganga	3	8	410	2,392	1,030	1,362
	Bugweri	2	3	119	617	270	347
	Mayuge	1	3	183	1,068	464	604
Total		40	94	3,274	18,984	8,588	10,396

B.3 Utilization of medical services increased by 22.4 while bills rose by 15 percent

All the five schemes fully paid their bills to 30 contracted healthcare providers within the time stipulated in the service contracts. Only one facility, Nakaseke hospital, did not register any case of a scheme member. The providers registered a total of 6,263 cases (4,715 outpatients and 1,548 inpatients) with medical bills amounting to Ugx 295,775,167. The average cost of care was ugx53,811 for out patients and ugx118,516 for inpatients. Up to 65 percent of the cases handled were presented by female members. There was a 22.4 percent increase in cases handled compared to 5,116 in 2021 while bills paid rose by 15 percent from ugx257,235,260. This was due to an increase in the cases handled by contracted facilities and new members brought on board in Iganga area. Consequently, schemes experienced over consumption of the health care funds up to 120 percent.

The most common illnesses presented by scheme members at the contracted healthcare facilities were malaria (19%), peptic ulcer disease (9%), hypertension (8%), respiratory tract infections (6%) and gastritis (4%).

B.4 Protection rate increased from 63 to 73 percent

Averagely, the schemes covered 73% of the total patients’ bills which was higher than 63 percent for 2021. This was so far the highest protection rate recorded over the past four years and it shows that schemes significantly reduced the burden of paying healthcare bills on families. This may be attributed to the increase in premiums which meant that more funds were available for healthcare. The different modes of bills payment at health facilities especially capitation and flat fees also helped to avoid escalation of bills.

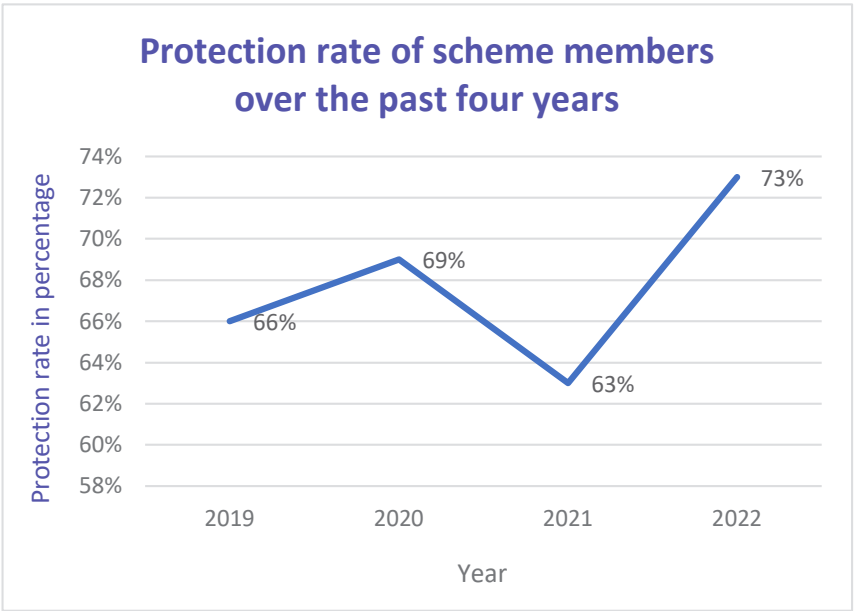


Table 3: Healthcare bills paid by schemes to each contracted health facility and cases handled

	Health Facility	OPC			IPC			TOTAL		
		Total cases	Total bill	Scheme bill	Total cases	Total bill	Scheme bill	Total case	Total bill	Scheme bill
1	Kiwanyi HC	81	3,186,000	2,376,000	93	4,445,000	3,435,000	174	7,631,000	5,811,000
2	Ibulanku Comm. HC	64	2,271,000	1,461,000	36	2,886,000	2,396,000	100	5,157,000	3,857,000
3	Naluko Women's Hospital	200	12,197,600	10,132,100	46	6,716,100	6,215,600	246	18,913,700	16,347,700
4	St Francis Buluba Hospital	767	48,309,290	39,249,290	26	3,387,200	3,107,200	793	51,696,490	42,356,490
5	St Francis Comm. HC	24	2,312,000	1,988,000	2	700,000	380,000	26	3,012,000	2,368,000
6	Kitokolo HC	186	3,184,000	2,657,000	34	1,578,000	1,091,000	220	4,762,000	3,748,000
7	Naluggi HC	180	3,068,000	2,039,000	86	3,805,000	2,527,000	266	6,873,000	4,566,000
8	St Gabriel Mirembe Maria HC	19	466,000	285,000	38	2,312,000	1,140,000	57	2,778,000	1,425,000
9	Bitooma HC	234	5,892,600	2,536,000	310	17,152,000	11,412,000	544	23,044,600	13,948,000
10	Mushanga HC	534	17,699,000	12,229,000	142	11,933,000	9,043,000	676	29,632,000	21,272,000
11	Hope Medical Centre	13	378,000	70,000	4	231,000	75,000	17	609,000	145,000
12	Nyakatsiro HC	225	4,993,600	3,529,500	126	8,928,800	6,184,300	351	13,922,400	9,713,800
13	Ishaka Adventist Hospital	418	30,886,600	15,208,000	54	12,755,700	3,832,400	472	43,642,300	19,040,400
14	Kitagata Hospital	36	1,266,200	675,000	3	250,000	120,000	39	1,516,200	795,000
15	Bishop C. Asili Hospital	445	33,243,900	22,687,700	73	14,350,700	9,702,700	518	47,594,600	32,390,400
16	Franciscan HC	162	11,659,000	7,433,000	57	7,486,000	4,947,000	219	19,145,000	12,380,000
17	Kaludo Pharmacy	180	4,395,200	4,273,600	-	-	-	180	4,395,200	4,273,600
18	Kitovu Hopital	122	5,666,446	5,604,377	-	-	-	122	5,666,446	5,604,377
19	Kiwoko Hospital	520	44,999,400	29,632,000	246	64,120,300	38,398,100	766	109,119,700	68,030,100
20	Our Lady of Lourdes HC	13	734,000	545,000	2	275,000	180,000	15	1,009,000	725,000
21	St Matia Mulajje HC	3	131000	101000	4	276000	231000	7	407000	332000
22	Good Samaritan HC	9	547,200	337,200	10	1,142,000	725,000	19	1,689,200	1,062,200
23	Holy Cross HC	116	5,912,300	4,466,800	72	9,232,200	6,696,500	188	15,144,500	11,163,300
24	St Francis Kijaguzo HC	3	279,300	189,300	-	-	-	3	279,300	189,300
25	St Jerome Cove HC	41	3,413,500	1,843,500	15	1,555,900	876,500	56	4,969,400	2,720,000
26	St Kizito Nattyooole HC	33	1,488,000	1,248,000	1	53,000	48,000	34	1,541,000	1,296,000
27	St Luke Namaliga HC	7	519,500	459,500	-	-	-	7	519,500	459,500
28	St Mary Mother of Jesus HC	59	3,491,000	2,848,000	39	4,892,000	4,352,000	98	8,383,000	7,200,000
29	St Mary Kasaala HC	17	996,000	476,000	29	3,000,000	1,948,000	46	3,996,000	2,424,000
30	Yaffe Pharmacy	4	132,000	132,000	-	-	-	4	132,000	132,000
	GRAND TOTAL	4,715	253,717,636	176,711,867	1,548	183,462,900	119,063,300	6,263	437,180,536	295,775,167

B.5 The three new schemes were recognized and registered as community based organisations

The newly created CHI scheme in the eastern region called Busoga Region Association of Tweidhandhabe Schemes (BURATS) was fully constituted. The CHI urban scheme evolved into Central Region Urban Munno mu Bulwadde schemes (CRUMBS). Both schemes were registered as community based organisations (CBOs) in their respective districts of operation. On the other hand, SHUMCHIS evolved into a CBO called CRUMBS-L which was registered with Luwero district. In West Nile, a CHI network called Greater Nebbi community health insurance (GNCHI) scheme was designed and formally registered. This enabled the registered schemes to stand as recognized independent entities that are able to enter into service contracts with healthcare providers and other partners without being accompanied by SHU.

2. POLICY ADVOCACY FOR COMMUNITY HEALTH INSURANCE AND A FAIR NATIONAL HEALTH INSURANCE SCHEME

One of the key components of our work is policy advocacy aimed to reduced financial hardships people face in accessing healthcare. During the year, our advocacy efforts focused mainly on two issues: 1) inclusion of CHI in the National Health Insurance Scheme (NHIS) and 2) establishment of a universal Luweero District Community Health Insurance Scheme.

2.1. Inclusion of CHI in the National Health Insurance Scheme (NHIS)

A) Key activities

A.1 Educating Members of Parliament about Community Health Insurance Schemes

SHU together with Luweero District Local Government hosted nine members of the Health Committee of the Parliament of Uganda. The main objective of the visit was to orient MPs on the status and operations of CHI schemes so as to build support for recognition of CHI in national level health financing policies and legislation. The MPs led by the Deputy Chairperson of the committee, Hon. Joel Ssebikaali, visited Kireku CHI sub-scheme in Kikyusa sub-county, Bishop Caesar Asili Hospital and Luweero Hospital. The MPs pledged to push for the reintroduction of the NHIS bill in parliament and expressed interest to initiate CHI in their respective constituencies.



Members of the Health Committee of Parliament led by Hon. Joel Ssebikaali (seated left), SHU ED (seated centre) and members of Kikyusa CHI scheme during the visit of the MPs to Luweero.

A.2 Sensitizing and dialoguing with policy makers, government officials, advocates and the general public on the proposed NHIS and role CHI schemes will play

The 6th National Community Health Financing (CHF) conference was held on 24th and 25th November, 2022 at Golf Course Hotel, Kampala. The objective was to enhance support for fast-tracking the establishment of an inclusive National Health Insurance Scheme for Uganda. A total of 144 participants from 15 districts attended the conference physically while others followed through online live streaming. Participants included six members of parliament (MPs) led by the Deputy Chairperson of the Health Committee Hon. Joel Ssebikaali and the shadow Health Minister Hon. Timothy Batuwa. Others were representatives of government ministries and agencies, international agencies, local government leaders, civil society actors, private sector players, representatives of healthcare providers, leaders of CBHI schemes, and members of the press. The conference was officially opened by Dr. Charles Olaro, Director Clinical Services, Ministry of Health (MOH) on behalf of the Minister of Health and closed by Mr. Prosper Muhumuza, Commissioner for Elderly and Disability Affairs, in the Ministry of Gender, Labour and Social Development (MGLSD) on behalf of the Permanent Secretary. The keynote address was delivered by Dr. Marios Obwona for the Chairperson of the National Planning Authority. At the end, the following resolutions were adopted:

- (i) Explore the option of the Ministry of Health issuing guidelines / regulations to guide operations of Community Based Health Insurance Schemes due to the delay to introduce the NHIS.
- (ii) The Ministry of Health should fast-track the process of reintroducing the NHIS bill in parliament and start preparations for its implementation.
- (iii) The Insurance Regulatory Authority of Uganda working together with CBHI promoters and other stakeholders including Ministry of Health should develop and issue appropriate regulations for micro health insurance to facilitate their growth and sustainability.
- (iv) CBHI schemes should be recognized in the proposed NHIS to play the roles of promotion, distribution, marketing and collection agents for the NHIS.
- (v) Luwero District Local Government to resubmit its Community Health Insurance Scheme Ordinance to the Attorney General through the Ministry of Local Government.
- (vi) Private Commercial Health Insurance Schemes to address negative perceptions about their services through raising awareness on health insurance.
- (vii) The Ministry of Health should harmonize concerns of various stakeholders and invest in reducing disparities in the distribution and quality of health care services across the country in preparation for equitable access to services under a universal NHIS.
- (viii) ICT providers to share evidence on their coverage of the informal sector on various platforms to guide the roll out of a universal NHIS covering even hard-to-reach population categories.



A group photo of some of the conference participants after the opening ceremony.

A.3 Pushing the CHI agenda in national level fora on NHIS and Social protection

We participated in various engagement meetings with policy makers and civil society organizations to advocate for the NHIS and recognition of CHI. In June, SHU shared about the 'place and lessons from CHI in Uganda' at a meeting organized by CSOs to orient MPs for greater appreciation of the need for adequate financing for health care through innovative financing mechanisms, wield their support as well as lay strategies to contribute to expediting the re-tabling of the NHIS bill in Parliament and its successful implementation. We held meetings online with representatives of CHI promoters and other private sector health insurance players to discuss implications of the NHIS bill to CHI. SHU continued to participate in quarterly meetings of the Social Insurance Thematic Committee and the Social Protection Technical Working Group under the Ministry of Gender, Labour and Social Development. We used the platforms to share periodic updates about CHI as a social protection mechanism and highlight to policy makers the operational and regulatory challenges CHI schemes face.

A.4 providing updates to the public and key stakeholders on the SHU promoted CHI schemes, and the proposed NHIS

SHU published a two-page supplement in the Daily Monitor newspaper calling for universal coverage of the population and recognition of the role of CHI in the NHIS. It featured views on the proposed NHIS bill and success stories of CHI beneficiaries. In addition, we produced and shared two versions of the SHU newsletter.

2.2. Establishing Luwero District CHI scheme

A) Key activities

A.1 Engaging Luwero District leaders

The visit of MPs in Luwero district provided an opportunity for discussions with the district leadership and SHU team regarding approval and implementation of Luwero District CHI Scheme ordinance. At a meeting held at Luwero Diocese Guest House, matters regarding the ordinance which was rejected by the Solicitor General in anticipation of the NHIS were discussed. The MPs advised the district leadership to seek legal counsel on the available options under existing laws which the district could use to implement the CHI scheme without using the ordinance.

A.2 Supporting Luwero District leaders to develop a community health financing framework

SHU engaged a legal consultant to support Luwero district leaders to identify mechanisms for implementing the ordinance within the existing legal framework. The lawyer held consultative meetings with the district leadership focusing on alternative approaches to implementing the objectives of the ordinance. The meetings were intended to obtain views of district leaders on the possibility of developing a District Community Health Financing mechanism. A framework was agreed upon to guide discussions on the next steps for establishing the district scheme.



Members of Luwero District Health Committee in a consultative meeting with a legal consultant on the District CHI Scheme ordinance.

B) Key result

B.1 Minimal progress registered on the NHIS and Luwero District Scheme

In spite of the various engagements held over plans to introduce the NHIS, it remain uncertain when this could materialize. By the end of the year, there was no substantive NHIS bill. Similarly, Luwero district leaders were yet to take a final decision on establishing a district CHI scheme. Some leaders continued to cite low understanding of health insurance and high poverty levels as reasons for their delay to make the decision to introduce the scheme.

THEMATIC AREA 2: HEALTHCARE SERVICES DELIVERY

2.1 Improving the quality of healthcare services provided to scheme members

A) Key activities

A.1 Sharing feedback between schemes and contracted healthcare providers

Feedback meetings were held at contracted facilities between managers of the healthcare providers and scheme leaders. During the meetings, discussions focused on the quality of services provided by the contracted facilities and the behaviors of scheme members who utilize the services. Resolutions reached at the meetings included increasing the number of staff during night shifts, orienting new staff about CHI, improving diagnosis and billing system, among others. Special review meetings were held at facilities where complaints about medical bills were common. This helped to safeguard scheme funds from abuse.



Scheme leaders and managers of Bishop Caesar Asili hospital in Luwero District after a successful feedback meeting.

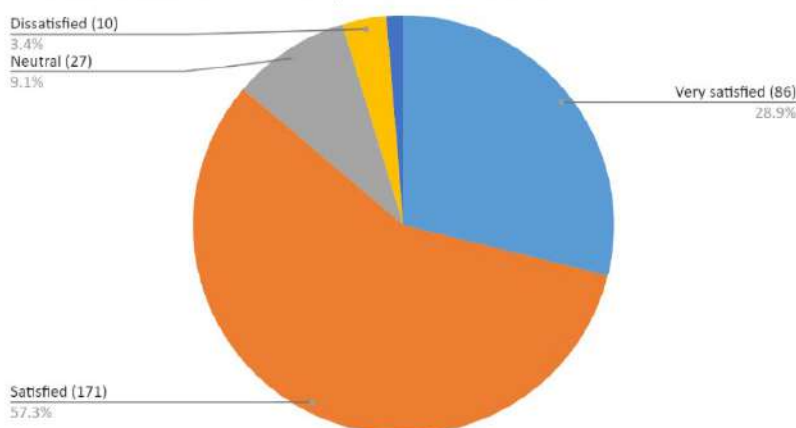


A feedback meeting between key scheme leaders and managers of Bitooma HCIII in Bushenyi District.

A.2 Assessing satisfaction of scheme members with the quality of healthcare services

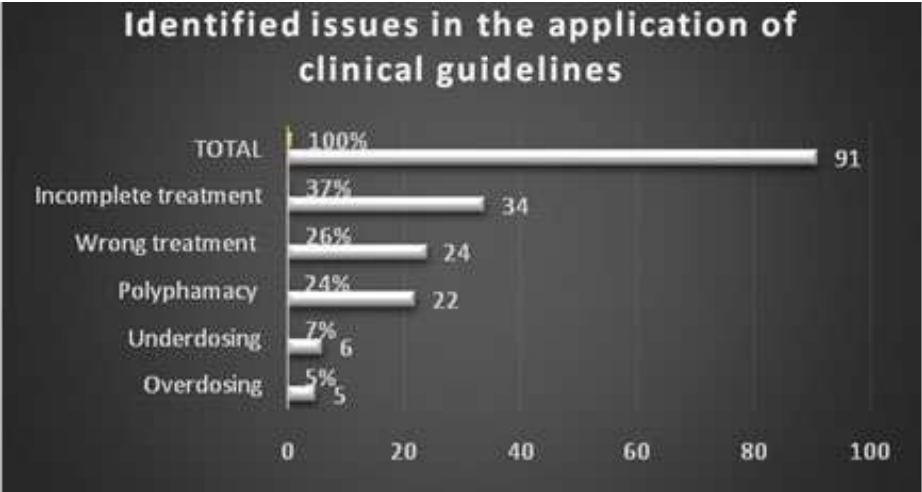
In October, SHU engaged a consultant to carry out a satisfaction survey regarding the quality of healthcare services provided at 31 facilities contracted to serve CHI schemes members. The facilities included 27 that had been contracted by the end of 2020 and 4 that were contracted in 2021. The survey focused on three main dimensions of quality of health care service delivery, that is, reception, access to services, and capacity of the facility to provide services. The three dimensions were assessed using thirteen indicators. The indicators for reception were waiting time, attitude of staff, attributes of staff, knowledge of staff at reception to address patients' needs, comfort provided to patients, access to patients information service and responsiveness of staff. Access to services was measured focusing on clients' knowledge on available services, availability of information on services and time taken to receive the service. Satisfaction with capacity to provide services considered staffing levels, infrastructure and lifesaving equipment, and availability of drugs. A cross sectional survey design was adopted. A total of 62 key informant interviews, facility-based observations and 379 client exit interviews were conducted.

Overall satisfaction with reception at the facilities



A.3 Assessing adherence to professional standards at contracted health care facilities

SHU conducted a medical audit at 26 partner health care facilities to assess the quality of health care services provided to CHI schemes beneficiaries during the period between July 2021 and June 2022. The objective was to establish whether schemes and non-scheme members get the same treatment and are managed the same way for the same conditions in terms of reception, investigation, prescription, admission and billing. The assessment criteria was based on the treatment guidelines provided by the Ministry of Health with specific focus on how patients were received, the number and type of investigations done, type and quantity of drugs prescribed, average number of days for admissions, and the practices that may escalate the cost of services. The health facilities covered included 6 hospitals, 3 HCIVs, 13 HCIIIs and 4 HCIIIs all in 12 districts. A total



sample of 668 patients’ medical records with an equal number for members and nonmembers of schemes with corresponding conditions for the period July 2021 until June 2022 were considered. Findings revealed that both scheme and none scheme patients were treated in the same way for the same conditions presented. The medical audit, however, identified that clinical guidelines were not met in managing 14 percent of cases which led to situations where unnecessary drugs and drugs of the same class were given (polypharmacy), wrong treatment, incomplete treatment (under dosing) and overdosing. Cases of incomplete information and some patients’ records missing in the registers were common. It was recommended that health facilities should work towards centralizing patients’ information and records to ease access as well as adhere to standard clinical guidelines in all cases.

B) Key results

A.1 Client satisfaction with quality of healthcare services increased by 0.4 percent

Findings of the satisfaction survey showed that overall satisfaction with quality of healthcare across the three dimensions at the 27 facilities that existed by the end of 2020 was 86.9 percent while it was 87.56 percent at 4 facilities contracted in 2021. This showed an improvement from 86.5 percent recorded in 2020. Overall, clients’ satisfaction with the reception and access to healthcare services remained unchanged at 86.3 percent and 93.1 percent respectively while satisfaction with capacity of the healthcare providers reduced to 81.22 percent from 86.3 in 2020. Satisfaction levels were at 96.1 percent, 86 percent and 85.1 percent for reception, access to services and capacity of the facilities respectively at the four newly contracted facilities. Respondents recommended improving hygiene, training staff in customer care and improving staffing levels to achieve higher client satisfaction.

B.2 Renewed service contracts with 31 healthcare providers

The schemes were able to renew service contracts with 31 healthcare providers. These included six hospitals, four HCIVs, 15 HCIIIs, four HCIIIs and two pharmacies. Out of the 31 facilities, 30 handled cases of scheme members during the year and were fully reimbursed for their services, hence maintaining a good working relationship.



Naluko Women's Hospital Administrators, Ms. Shadiilo Hearts (third right) and Mr. Kenneth Kikonyogo (third left) sign a service contract with Mr. Ahmed Nabola, the Chairman of BURATS (right), other leaders and SHU representative.

2.2 Promoting client relations initiative at contracted healthcare facilities

A) Key activity

The main activity has been advocating for establishment of Client Relations Desks at the 12 health facilities. For the past ten years, SHU has been promoting the client relations desk (CRD) initiative in all healthcare providers contracted by CHI schemes. The main objective of the initiative is to improve client reception at the health facilities and make the environment conducive for patients as well as encourage utilization of services. Under the program, healthcare providers are persuaded to include a position of a client relations assistant (CRA) on the human resource structure and payroll, formally appoint personnel to serve in the position, set up a desk in a strategic location accessible to patients, supervise the staff in the position and act on reports from the desk. During the year, SHU directly promoted the CRD initiative at 12 contracted healthcare providers through holding meetings with management and sharing viability reports.

B) Key result

Overall, the number of healthcare facilities with CRDs increased from 20 to 25 out of which 13 had their desks fully institutionalized. Among the 12 health facilities where the concept was promoted for the first time, five (including Holy Cross Kikyusa HC, St. Jerome COVE HC, KALUDO pharmacy, Kitokolo HC, and Naluko Hospital) adopted it. The facilities dedicated staff to work as client Relations Assistants, and set up the desks. Kaludo pharmacy assigned responsibility to one of their staff to play the roles of the client relations assistant.



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Some members of our dedicated team of health workers.



A side view of the health centre complex



Sharing is caring: we show our Christian values by supporting vulnerable families with some basic household items.



We conduct community level meetings to provide basic health education to residents.

THEMATIC AREA 3: HOUSEHOLD LIVELIHOOD IMPROVEMENT

A) Key activities

A.1 Linking scheme members to low-interest credit facilities

SHU maintained partnership with microfinance institutions (MFI) in Luwero and Mityana district to extend low-interest credit facilities to community members. This was done through meetings, community outreaches and recommendations for those who needed the services. The MFIs extended loans to community members for home improvement, school fees, working capital, agricultural projects and CHI premiums.

A.2 Equipping community members with financial literacy skills

SHU partnered with St. Lawrence University to train 88 community members in Mityana and Kassanda district in financial literacy. The main objective of the training was to empower community members to improve financial management in their livelihood projects. It was conducted in Kizibaawo and Lusaba parishes in Kassanda district and Bujaayo parish in Kalangaalo sub-county, Mityana district. The beneficiaries, who included 48 males and 40 females, acquired skills in book keeping, business relations, marketing and customer care. They were awarded certificates at a ceremony held on 3rd February, 2022 at St. Lawrence University in Kampala.



Some of the community members who were trained in financial literacy in a group photo with Dr. Nakimuli Irumba, SHU Board Chairperson and lecturer at St. Lawrence University.

A.3 Promoting group savings for premiums and other family needs

In Bushenyi area, scheme leaders conducted meetings at village level to encourage families to incorporate saving for CHI premiums into their village savings groups. This was done in ten villages in the districts of Mitooma and Sheema. By the end of the year, three sub-schemes had members who were able to join through premium savings in small groups.

B) Key results

B.1 Loan beneficiaries increased from 334 to 365

The number of loan beneficiaries increased from 334 individuals who were reached in 2021 to 365 (182 male and 183 female) individuals in 2022. This reflects a modest recovery from the hard times occasioned by COVID-19 over the two previous years. At least 90 families with 530 members enrolled into the scheme using microloans from partner MFIs. The table below details the types of loans accessed by members in 2022.

Table 2: Beneficiaries of the different types of loans provided by partner MFIs in 2022.

Loan product	Female	Male	Total
Agri-business	95	79	174
Working Capital	66	76	142
Home Improvement	16	18	34
School Fees	6	9	15
Total	183	182	365

B.2 77 families joined schemes through premium savings groups

A total of 77 families with 404 beneficiaries enrolled into WATSA using the money saved for premiums in village savings groups.

Table 3: Families and beneficiaries that enrolled in schemes using premium savings

Sub-Scheme	Location	Families	Beneficiaries
Kalimbiro	Mitooma	26	139
Busheregyenyi	Mitooma	34	179
Rushozi	Sheema	17	86
Total		77	404

B.3 Three schemes which did not run in 2021 were revived

During the year, three sub-schemes which did not run in 2021 were revived with 1,036 individuals from 196 families. At least 40 families among the beneficiaries of the financial literacy training were able to pay premium and enrol into MSCOM scheme. This was a result of their improved financial management skills and the desire to safeguard their finances against out-of-pocket payments for healthcare. In addition, some beneficiaries expanded their income generating projects.

Ms. Maria Nakyambadde a resident of Bujjaayo in Kalangaalo sub-county, Mityana District ventured into commercial maize growing after participating in the financial literacy training.





St. Lawrence University

Tel: +256751820151
+256774174171
+256756949551

Website: www.slau.ac.ug
Email: info@slau.ac.ug



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Diploma of Education (DEP) - In-service

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Bachelor of Science in Computer Engineering (BSCE)
Bachelor of Science in Computer Science (BCS)
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Diploma in Public Administration and Management (DPA)

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Diploma in Social Works and Social Administration (DSW)

THEMATIC AREA 4: INSTITUTIONAL CAPACITY STRENGTHENING

A) Key activities

A.1 Giving strategic support to CHI schemes for program and institutional growth

Members of SHU board visited schemes and contracted healthcare providers in Luwero area. The objectives of the visit were: To receive updates from the two schemes secretariats (MBUSO and CRUMBS-L), discuss results and provide recommendations for improvement; to explore new modes of medical bills payment and working with private pharmacies; to share experiences with the partner microfinance; and examine the leadership challenges in schemes. They held meetings with members of CHI schemes and administrators of the contracted healthcare providers.



Members of SHU Board of Directors with staff of KALUDO pharmacy after holding a meeting on the experiences of the pharmacy in serving scheme members.

A.2 Upholding good governance in SHU

SHU bade farewell to one of its long-serving Board members, Mr. Paul Micheal Waigolo. Mr. Waigolo, a professional banker, joined the Board in 2014 and served on various committees. He variously contributed to the steady growth of SHU.

Later, one new member joined the Board as a community Representative. Mr. Sekyanzi David Kitaakule had previously served as the chairman of MBUSO Board of Directors.



Mr. Paul Michael Waigolo (Left) receives a plaque from Mr. Ssebombo Edward, a member of SHU's Board of Trustees, in recognition of his services upon retirement from the Board of Directors.

A.3 Enhancing staff capacity in procurement and cost allocation

Two separate training sessions were held to orient the senior management team on cost allocation. This was necessitated by the fact that the current running project is co-funded by three partners, that is, Bread for the World, SHU and CHI schemes. The senior management team was also trained in procurement which led to setting up of procurement committees at the different offices and improved procurement practices. The training sessions were conducted by Development Links Company with funding from Bread for the World.

B) Key results

B.1 SHU's revenue declined by 22.4 percent

SHU received funds from three sources, that is, Bread for the World (BftW), our key financial partner, and local contributions particularly from CHI schemes and SHU sponsorships. A total of ugx 1,400,925,163 was raised against a budget of ugx 1,827,147,799 which was 76.7 percent. BftW contributed ugx 1,304,776,814 (93.1 percent) while local sources amounted to ugx 96,148,349 (6.9 percent) of the total income for the year. The total income declined by 22.4 percent from 1,806,436,637 realized in 2021. This could partly be attributed to low capacity of schemes to contribute towards co-funding due to low family incomes.

Table 4: Funds realized in 2022 against the budget

Source of funding	Actual for 2022	Budget for 2022
Bread for the World	1,304,776,814	1,733,347,799
Schemes and SHU generated income	96,148,349	93,800,000
Total income	1,400,925,163	1,827,147,799

B.2 SHU's mandate extended for five years with a new operational permit

SHU got a new operational permit for five years from the Uganda National Bureau for non-governmental organisations. The permit allows SHU to operate as an indigenous national NGO mandated to carry out activities in the field of improving access to quality healthcare facilities country wide in accordance with relevant laws of the country.

MAJOR CHALLENGES FACED DURING THE YEAR

The COVID-19 pandemic and its aftermath affected most activities

The country experienced a second wave of COVID-19 pandemic which was more severe than the first one, leading to a total lockdown of two months. This greatly affected our work and the welfare of the target communities. Because of these restrictions particularly on movement and gatherings, some of the activities were suspended while others were implemented differently through virtual connections. Families experienced financial hardships which resulted into high dropout from the CHI schemes because they could not afford the premium.

The Ebola outbreak in Kassanda district derailed scheme work

In September, the government of Uganda declared an outbreak of Ebola virus disease after confirmation of cases in Mubende and Kassanda districts. As a result, the two districts were placed under total lockdown for two months. This affected most of the scheme work in Kassanda since the district could not be accessed and meetings were banned. This further exacerbated the impact of COVID -19 on the communities in the affected areas.

High cost of essential commodities made families to postpone paying premiums

During the year, the country experienced an escalation of prices of most commodities following a sharp increase in fuel prices. The rapid hike in fuel prices increased transport costs for implementing field activities. This caused changes in planned activities whereby some were combined while others were held virtually. The increase in prices of food and other essential commodities affected families' ability to pay premiums to CHI schemes because they were spending more on basic household commodities. Unfortunately, this situation prolonged until end of year.

Low understanding of insurance caused delays in decision making

The low levels of appreciation of health insurance in Uganda prolongs the process of penetrating new communities and decision making on the part of leaders. This makes community mobilization and sensitization about CHI and the NHIS repetitive and expensive. In West Nile area, delays were experienced in introducing CHI due to low appreciation of the concept by both the leaders and community members. The

Scheme leaders misunderstood the role of scheme agents

We introduced the strategy of working with scheme agents to support routine operations of sub-schemes. However, while the strategy was welcomed in some areas, other scheme leaders gave up all their responsibilities, hence leaving the work to scheme agents. This made it difficult for agents to work effectively to traverse all villages under the sub-schemes. As a result, the number of people enrolled reduced in many schemes.

ANNEX**CHI SCHEMES WHICH RAN IN 2022 AND THEIR LOCATION****Western Ankole Tweragurize Schemes Association (WATSA)**

No.	Name of sub-scheme	District	Sub County	Year of establishment	No. Of families	Beneficiaries	Male	Female
1	Kashambya	Bushenyi	Bitooma T/C	2021	32	179	80	99
2	Kimuri	Bushenyi	Bitooma T/C	2021	36	200	98	102
3	Kitojo	Sheema	Sheema Div.	2015	33	167	72	95
4	Rwamujojo	Sheema	Sheema Div.	2016	33	179	71	108
5	Busheregyenyi	Mitooma	Biterekero	2016	41	218	98	120
6	Bitooma-Katenga	Mitooma	Katenga	2013	75	405	217	188
7	Kibazi	Bushenyi	Kyamuhunga	2016	44	255	102	153
8	Karimbiri	Mitooma	Biterekero	2017	35	186	95	91
9	Rushozi	Sheema	Sheema Div.	2016	38	196	85	111
10	Nyarweshama	Sheema	Sheema Div.	2015	34	185	81	104
11	Kakanju	Bushenyi	Kakanju	2013	17	95	38	57
12	Kanyeghero	Bushenyi	Nkanga	2013	28	143	62	81
13	Kyamulari	Sheema	Bugongi	2011	19	100	48	52
14	Karera South	Sheema	Kashozi Div	2014	15	79	39	40
15	Kasaana West	Sheema	Kasana	2011	15	75	36	39
16	Nyakashojwa	Mitooma	Rutookye T/C	2020	15	83	35	48
	TOTAL				510	2,745	1,257	1,488

Central Region Urban Munno mu Buleadde Schemes - CRUMBS

No.	Name of sub-scheme	District	Sub County	Year Formed	No. Of families	Beneficiaries	Male	Female
1	Luwero District Corporate	Luwero	Luwero TC	2013	238	256	215	41
2	Masaka district Corporate	Masaka	Masaka Mun.	2013	2	57	54	3
3	Luwero Town Council	Luwero	Luwero TC	2018	25	117	46	71
	TOTAL				265	430	315	115

Munno mu Bulwade Union of Schemes Organization - MBUSO

No.	Name of sub-scheme	District	Sub County	Year Formed	No. Of families	Beneficiaries	Male	Female
1	Kakinzi	Luwero	Butuntumula	2002	78	579	224	355
2	Kakabala	Luwero	Butuntumula	2001	74	511	230	281
3	Kalwanga	Luwero	Butuntumula	2017	17	114	55	59
4	Bubuubi	Luwero	Ziobwe	2018	10	67	29	38
5	Kyawangabi	Luwero	Butuntumula	2006	31	228	103	125
6	Bukuuku	Nakaseke	Kasangombe	2013	15	87	46	41
7	Kasaala	Luwero	Luwero	2010	61	406	185	221
8	Kabakedi	Luwero	Luwero	2011	37	235	105	130

9	Kabunyatta	Luwero	Kamira	2016	10	69	35	34
10	Ngogolo	Luwero	Butuntumula	2002	43	284	130	154
11	Bamugolodde	Luwero	Butuntumula	2010	31	208	95	113
12	Kakooge	Nakasongola	Kakooge	2001	41	259	109	150
13	Bukambagga	Luwero	Butuntumula	2010	16	121	57	64
14	Kamuli	Nakaseke	Kikamulo	2003	19	168	77	91
15	Kamuniina	Nakasongola	Wabinyonyi	2017	15	95	44	51
16	Kapeeka	Nakaseke	Kapeeka	2020	13	96	49	47
17	Kapeke	Nakaseke	Kikamulo	2010	59	413	174	239
18	Bwaziba	Luwero	Luwero	2011	10	62	28	34
19	Kasambya	Nakaseke	Nakaseke	2011	10	68	27	41
20	Kasana	Nakaseke	Kikamulo	2010	43	306	135	171
21	Kaswa	Luwero	Kamira	2016	10	60	24	36
22	Buyuki - SOS	Luwero	Katikamu	2014	93	492	244	248
23	Migadde	Luwero	Katikamu	2006	25	164	65	99
24	Katooke	Nakaseke	Wakyato	2008	35	221	112	109
25	Kagugo/ Kyesa Bukadde	Luwero	Luwero	2006	20	139	58	81
26	Katuugo nkl	Nakasongola	Kakooge	2011	29	205	89	116
27	Kayindu	Luwero	Kalagala	2017	16	102	52	50
28	Kibirizi	Luwero	Bamunanika	2017	10	66	36	30
29	Kibose	Nakaseke	Kikamulo	2010	29	186	102	84
30	Kigombe	Luwero	Luwero	2005	20	129	69	60
31	Kikamulo	Nakaseke	Kikamulo	2010	12	73	35	38
32	Nsabweteka	Luwero	Luwero	2004	45	313	131	182
33	Kireku	Luwero	Kikyusa	2017	22	146	62	84
34	Kirema	Nakaseke	Semuto	2020	10	62	37	25
35	Kito	Nakaseke	Kito	2012	20	130	64	66
36	Kivumu	Nakaseke	Kito	2012	16	90	42	48
37	Kiyanda	Nakaseke	Nyimbwa	2017	22	140	66	74
38	Kiziba	Luwero	Kikyusa	2017	20	146	70	76
39	Kyabutayika	Nakasongola	Kakooge	2002	30	188	79	109
40	Kyalugondo	Luwero	Katikamu	2012	17	109	46	63
41	Kyambogo	Nakasongola	Kakooge	2011	24	164	81	83
42	Kyampogola	Luwero	Kikyusa	2018	18	118	54	64
43	Kyankonwa	Nakasongola	Kakooge	2011	14	106	40	66
44	Nakikoota	Luwero	Luwero	2011	24	167	81	86
45	Kyeyindula	Nakasongola	Kakooge	2002	35	264	119	145
46	Luteete	Nakaseke	Kikamulo	2011	21	170	77	93
47	Mabuye	Luwero	Kamira	2016	16	103	44	59
48	Magoma	Nakaseke	Kikamulo	2008	91	637	287	350
49	Mazzi	Luwero	Kamira	2016	21	129	55	74
50	Mijumwa	Nakaseke	Wakyato	2000	13	108	44	64
51	Mpologoma	Luwero	Bamunanika	2016	9	62	29	33

52	Nakaseeta	Nakaseke	Kasangombe	2011	15	103	47	56
53	Kikube	Luwero	Luwero	2010	46	297	130	167
54	Ngalonkalu	Luwero	Ziobwe	2018	10	59	23	36
55	Katuugo lwr	Luwero	Luwero	2010	27	179	72	107
56	Katikamu	Luwero	Katikamu	2019	10	56	25	31
57	Wakayamba	Nakaseke	Kikamulo	2010	27	178	81	97
58	Wankanya	Luwero	Kikyusa	2016	36	259	112	147
	Total				1,591	10,696	4,821	5,875

**Munno mu Bulwadde Schemes Cooperation
Mechanism - MSCOM**

No.	Name of sub-scheme	District	Sub County	Year Formed	No. Of families	Beneficiaries	Male	Female
1	Namiringa	Kasanda	Kasanda	2014	69	352	146	206
2	Kizibaawo	Kasanda	Bukuya	2014	53	278	139	139
3	Kyamusisi	Mityana	Kalangaalo	2020	74	406	146	260
	TOTAL				196	1,036	431	605

**Busoga Region Association of Tweidhandabe Schemes -
BURATS**

	SUB SCHEME	District	Sub County	Year Formed	Families	Beneficiaries	Male	Female
1.	Bukoyo	Iganga	Bulamagi	2022	37	210	95	115
2.	Calvary Chapel	Iganga	Nawandala	2022	89	499	202	297
3.	Central Busoga Diocese	Iganga	Iganga Municipality	2022	35	200	92	108
4.	Iwawu East	Iganga	Bulamagi	2022	66	392	162	230
5.	Kiwanyi	Iganga	Nawandala	2022	54	306	150	156
6.	Little Sister	Iganga	Bulamagi	2022	26	172	64	108
7.	Namasoga	Iganga	Nawandala	2022	61	376	169	207
8.	Nawangaiza	Iganga	Nawandala	2022	42	237	96	141
9.	Buniantole	Bugweri	Ibulanku	2022	36	188	75	113
10.	Nawansega	Bugweri	Ibulanku	2022	48	216	100	116
11.	Walanga	Bugweri	Igombe	2022	35	213	95	118
12.	Lugolole	Mayuge		2022	71	408	173	235
13.	St Francis - Buluba	Mayuge	Lukone	2022	78	442	188	254
14.	Waihna	Mayuge		2022	34	218	103	115
	TOTAL				712	4,077	1,764	2,313
	Overall performance							
					Families	Beneficiaries	Male	Female
					3,274	18,984	8,588	10,396

