



SAVE FOR HEALTH UGANDA (SHU)

"Community solidarity for quality health"

MATERNAL AND NEONATAL HEALTH MICRO-INSURANCE PROJECT

*Reducing delays to maternal and neonatal healthcare services in
Bushenyi district - Uganda*

SEMESTER REPORT

Period 1st July 2010 to 31st December 2010

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SHU/HMPP/ KEM, NJK, & MF/ No 3

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1. CONTENTS

1. CONTENTS-----	1
2. ABBREVIATIONS -----	2
3. SUMMARY -----	3
4. INTRODUCTION-----	5
4.1. THE IMPLEMENTING ORGANIZATION -----	5
4.2. PROJECT IMPLEMENTATION STAGE -----	5
4.3. THE OPERATING CONTEXT – AN UPDATE-----	6
5. OBJECTIVES, TARGETS AND ACTIVITIES OF THE SEMESTER-----	7
5.1. OBJECTIVES AND SEMESTER TARGETS-----	7
5.2. ACTIVITIES CARRIED OUT DURING THE SEMESTER -----	8
6. RESULTS BY END OF DECEMBER 2010 -----	9
7. NEXT SEMESTER (JANUARY TO JUNE 2011) TARGETS-----	16
8. NEXT SEMESTER ACTIVITY IMPLEMENTATION TIMETABLE-----	17

2. ABBREVIATIONS

ANC	Antenatal care
CHF	Community health financing
CIDR	Centre international de développement et de recherché
CORDAID	Catholic organization for relief and development Aid
EC	Executive committee
IAH	Ishaka adventist hospital
MCH	Maternal child health
MHN	Maternal and neonatal health
MMR	Maternal mortality ratio
NHIS	National health insurance scheme
NMR	Neonatal mortality ratio
PC	Prepayment cashier
PNC	Postnatal care
SHT	Scheme health team
SHU	Save for Health Uganda
UNHCO	Uganda national health consumers organization

3. SUMMARY

Introduction

The period July 2010 to December 2010 has marked the end of the third semester and the end of one year and a half implementing the project. The “reducing delays to maternal and neonatal healthcare services in Bushenyi district” is a three-year pilot project funded by Cordaid and implemented by Save for health Uganda. It is to test the possibility of improving utilization of maternal and neonatal healthcare (MNH) services by rural families using the health micro-insurance approach. Having piloted the original approach where financial pooling is by all parish¹ families but benefits limited to pregnant women and the newborns (within their first 28 days) for one year, SHU in consultation with Cordaid added two approaches to realizing the project objectives after several complaints of exclusion raised by the other community residents who were not direct beneficiaries. The two additional approaches are: 1) two products in one scheme: The first product for obstetrics services with automatic membership after a fixed parish premium is paid, and the second being a voluntary membership arrangement covering general medical services excluding obstetrics care; 2) Universal coverage – This approach will automatically cover all village residents after the village pays a fixed premium. Access to obstetrics care is with better facilitation including transport. Communities will now have the opportunity to choose the best option. During the semester, Bushenyi district was divided into 5 districts. The project activities now fall in a new district of Sheema. Within the district, activities have been implemented in six parishes.

Expected outputs by the end of the semester July 2010 to December 2010

- 1) Six functioning schemes covering 2,000 women.
- 2) Fundraising for the parish obstetrics insurance fund is by at least 80% of the village families
- 3) Two service providers contracted by schemes
- 4) Capable and motivated leaders managing the schemes on a day-to-day basis
- 5) Utilization of obstetrics services by each pregnant women covered by the schemes high at more than 80%

Results by 31st December 2010

Two schemes (Kasaana East and Muhiito) were functioning and covering 845 women by the end of the semester. The additional four expected schemes (Kasaana West; Karugorora; Kyamurari; and Rwenkuriyo) are still under creation. Kasaana West and Karugorora are expected to be

¹ A parish is an administrative unit composed of several villages – usually ten to fourteen villages

inaugurated early February 2011. The two running schemes have contracted Kitagata Government Hospital and Ishaka Adventist Hospital as their service providers. With Kitagata hospital, the schemes have contracted services in the private wing only; and members access all the other services free of charge as other patients do. Kitagata hospital which is closest to both schemes is the most used.

The capacity for self management in the two schemes has greatly improved. The leaders are able to record and keep books of accounts with much less help, they are able to sensitize others about the scheme benefits and functioning, and are better at organizing and managing meetings. They still need trainings in micro-insurance principles, and advocacy to increase ownership and involvement of community members

Concerning services utilization during the first seven months (June – December 2010); the trend is still similar to the baseline trend but improving. Women still use antenatal care (ANC) services more than they do for maternity and postnatal care (PNC) services. By the end of December, a total of 254 ANC services (ANC 1 to ANC IV) had been claimed. Of the women who attended ANC services, 50 of them were expected to deliver, while 42 of them were expected to have utilized PNC services. In reality though, 36 (72%) women delivered at the contracted provider while 9 (21.4%) women came back for PNC services. About 5 women in a hard to reach villages were reported to have delivered on their way to the hospital, while some others still went to traditional birth attendants. No maternal deaths have been recorded but rather two still births during the semester. Child immunization for women who attended PNC was 100% while it is not clear if mothers who never utilized PNC services had their babies immunized. Interviews with some of them showed that some had taken their babies immunization at nearby health centers while others had not.

Conclusion

Half way through the project life, it is clear that communities need much more time than previously anticipated to grasp the concept of risk pooling and hence create schemes faster to facilitate women access obstetrics services. On the other hand, it is also clear that the percentage of women delivering from health facilities so far in the schemes (72%) is far better than the 2009/2010 national performance figure at 42%. Adding the two new approaches to our portfolio that aim to cover women for obstetrics services and the rest of the population for general medical services, it is hoped that the schemes will become more attractive to help reach as more women as planned and extend the change in women's lives that is beginning to be seen to other target areas.

4. INTRODUCTION

4.1. The implementing organization

Save for health Uganda (SHU), is a local Ugandan Non Governmental organization (NGO) with a mission to improve the quality of health of Ugandans through community Health financing (CHF) in the target districts. SHU partners with the Catholic Organization for Relief and Development Aid (CORDAID) for financial support, with the Centre international de développement et de recherché (CIDR) for technical support, with Uganda National Health Consumers Organisation (UNHCO) for implementing some aspects of the project, and with health care providers (Ishaka Adventist Hospital, and Kitagata hospital) for co-promotion of the project in the target district. The Maternal Health and Infant Survival Health Micro-insurance Project is being implemented in Sheema district (western Uganda). Sheema district is a newly created district carved out of Bushenyi District. SHU is an active member of a national umbrella association of all community health funds called Uganda community based health financing association (UCBHFA).

4.2. Project implementation stage

The period July 2010 to December 2010 has marked the end semester² three of implementing the project. The “reducing delays to maternal and neonatal healthcare services in Bushenyi district” is a three-year pilot project funded by Cordaid and implemented by Save for health Uganda. It is to test the possibility of improving utilization of maternal and neonatal healthcare (MNH) services by rural families using the health micro-insurance approach. Having piloted the original approach where financial pooling is by all parish³ families but benefits limited to pregnant women and the newborns (within their first 28 days) for one year, SHU in consultation with Cordaid added two approaches to realizing the project objectives after several complaints of exclusion raised by the other community residents who were not direct beneficiaries. The two additional approaches are: 1) two products in one scheme: The first product for obstetrics services with automatic membership after a fixed parish premium is paid, and the second being a voluntary membership arrangement covering general medical services excluding obstetrics care; 2) Universal coverage – This approach will automatically cover all village residents after the village pays a fixed premium. Access to obstetrics care is with better facilitation including transport. Communities will now have the opportunity to choose the best option. The new approaches to reaching the project objectives have been introduced to the target communities only in the last half of the semester.

² A semester is six months

³ A parish is an administrative unit composed of several villages – usually ten to fourteen villages

4.3. The operating context – An update

National

The free healthcare policy in Uganda still exists with challenges. To increase funding of the health sector, government is trying other strategies, one being the private wing at hospitals and now a national health insurance scheme (NHIS) still under design. On the political scene, the country is preparing for general elections to take place in February 2011. So far, the campaigns have been generally peaceful and fears of war after elections are minimal compared to previous elections. Economically, the Uganda shilling has continued to lose value against the major international currencies. The cost of living has gone up and inflation is now estimated at 13% up from 6% a year ago. Fuel and other utility prices have gone up steadily.

Local

Generally the Bushenyi area districts experienced favorable weather conditions throughout the semester. There were two harvest seasons; i.e. May- August and a mini coffee season in December. Unlike other parts of the country, this area has not suffered from food scarcity. In terms of healthcare, Bushenyi district has new additional players in healthcare financing. Kampala international University Hospital is introducing a health insurance programme whose date of launching is not yet clear. The scheme is planned to be commercial and managed by the university. In the same area, a politician who owns a health centre started offering free services during parliamentary political campaigns. It is still not clear how long this offer will remain in force. Communities targeted by this project are however not close to this facility.

5. OBJECTIVES, TARGETS AND ACTIVITIES OF THE SEMESTER

5.1. Objectives and semester targets

The ended semester objectives were in line with the overall project objectives and are summarized in the table below:

project objectives		Project targets	December 2010 targets
Overall	Specific		
Access to care of pregnant women has improved (increase by 30% ANC and institutional deliveries)	To Empower families in decision making	MMR lower than national and district average per year	MMR in the schemes is lower than the district average
		Still births averages are lower than the national and district averages	Still births in the running schemes lower than district average
	To enable pregnant women seek timely care at health facilities	80% of all covered women complete the 4 ANC visits per year	- Cover 2,000 women between 14 and 49 years of age 80% of covered women complete the 4 ANC visits
		80% Institutional deliveries by covered women per year	- Contract 2 service providers 80% Institutional deliveries by covered women
	To improve financial capacities of families to access care	At least 80% of all target village families contribute to the schemes fund per year	At least 80% of all target village families contribute to the running schemes fund
		Subsidize regressively the premiums at 40%, 30%, 10% and 0% per year	Subsidize each running schemes at 40%
Child survival rates have improved (reduce NMR by 30% and increase immunization coverage by 50%)	To increase families' knowledge about MCH using community-based interventions	80% of covered women attend PNC per year	80% of covered women attend PNC
		70% of covered newborns complete the 3 doses of DPT per year	70% of covered newborns complete the 3 doses of DPT
		NMR to be 30% lower than the national and district ratios per year	NMR to be 15% lower than the national and district ratios
Quality of healthcare services has improved (decision making,	To improve the quality of services at health care facilities	More than 50% respondents (members and non members) perceived quality positively in all participating facilities per year	More than 50% respondents (members and non members) perceived quality positively in all participating facilities
		Contracts between providers and schemes respected to 100% per	Contracts between providers and schemes respected to 100%

project objectives		Project targets	December 2010 targets
reception and referrals)		year	
		At least 50% of scheme members (families) participate in scheme activities per year	At least 50% of scheme members (families) participate in scheme meetings
Level of solidarity among community members has improved (community-based interventions)	To create community-based schemes	12 running parish-level schemes	• 4 running parish-level schemes • 4 village-level schemes (new approach) under creation • 40% capacity levels for self management in schemes
	To increase families' participation through enrolling into the schemes	At least 80% of the villages in each target parish contribute to the scheme fund each year	At least 80% of the villages in each running scheme contribute to the scheme fund
Health management information system at the district has improved. 100% accurate information about the target population's MCH indicators and make sure the information is used.	To have accurate information about MCH in target population	100% scheme MCH indicators captured per year	All monitoring tools developed
	To share the information with the local health authorities about MCH in the target population	All (100%) project data and progress reports shared with the district health authorities per year	Semester report presented to the district authorities
	To make the local health authorities use the MCH information provided	90% of the scheme information is captured by the district health management information system	Partner hospitals to capture scheme indicators in their HMIS reports

5.2. Activities carried out during the semester

Some of the activities that were carried out included: identification of new parishes where to create new schemes; sensitization of the communities in the new parishes; promotion and marketing of the schemes in all the parishes; community mobilization with the help of local authorities; training of scheme leaders using workshops and exchange of experience visits; formalizing the partnership with UNHCO⁴ and introducing its activities to partners; negotiations and contracting with Kitagata hospital was finalized; several health education meetings were held; a medical audit was done; and several team trainings and planning meetings.

⁴ Uganda national health consumers' organisation

6. RESULTS BY END OF DECEMBER 2010

project objectives		Project targets	December 2010 targets	Results	Explanations for variances
Overall	Specific				
Access to care of pregnant women has improved (increase by 30% ANC and institutional deliveries)	To empower families in decision making	MMR lower than national and district average per year	MMR in the schemes is lower than the district average	No maternal deaths have been recorded	Nationally, the MMR is at 435 for every 100,000 live births
		Still births averages are lower than the national and district averages	Still births in the running schemes lower than district average	Two still births during the semester	These still births were as a result of late arrivals to hospital. The two had not attended ANC at Kitagata hospital.
	To enable pregnant women seek timely care at health facilities	80% of all covered pregnant women complete the 4 ANC visits per year	- Cover 2,000 women between 14 and 49 years of age 80% of pregnant women complete the 4 ANC visits	845 women covered 254 ANC clinic attendances.	- Girls and women who do not expect to become pregnant do not pick their cards - Figures 1 & 2 illustrate
		80% Institutional deliveries by covered women per year	- Contract 2 service providers 80% Institutional	2 contracted providers (IAH and Kitagata hospital)	In Kasaana scheme, women from one specific area (picture 1) used a TBA to deliver. Some of them reported to have

project objectives		Project targets	December 2010	Results	Explanations for
			deliveries by covered women	72% institutional deliveries	delivered along the way to the hospital. Nationally, deliveries in a health facility is 42%
	To improve financial capacities of families to access care	At least 80% of all target village families contribute to the schemes fund per year	At least 80% of all target village families contribute to the running schemes fund	72% in Kasaana East 64% in Muhiito scheme	Payment is continuous and leaders are confident that other families will contribute
		Subsidize regressively the premiums at 40%, 30%, 10% and 0% per year	Subsidize each running schemes at 40%	Two schemes Kasaana east and Muhiito have been subsidized	The other schemes are still under creation.
Child survival rates have improved (reduce NMR by 30% and increase immunization coverage by 50%)	To increase families' knowledge about MCH using community-based interventions	80% of covered mothers attend PNC per year	80% of mothers attend PNC	21.4% PNC attendance	Interviews with some of the mothers indicated that health workers were partly to blame as they never asked mothers to return. Other women did not find it necessary.
		70% of covered newborns complete the 3 doses of DPT per year	70% of covered newborns complete the 3 doses of DPT	Result not measured	Measuring this indicator faced challenges as it was discovered that many mothers take their children for immunization to nearby health facilities

project objectives		Project targets	December 2010	Results	Explanations for
					other than those contracted with
		Neonatal mortality rate (NMR) to be 30% lower than the national and district ratios per year	NMR to be 15% lower than the national and district ratios	Only two still births	- The current project monitoring does not capture indicators outside the health facilities - Nationally, NMR is 70 per 1,000 live births

Picture N° 1: Hard to reach areas where all women who delivered went to a TBA while others delivered on the way



Figure N° 1: Utilization of services within the first 6 months

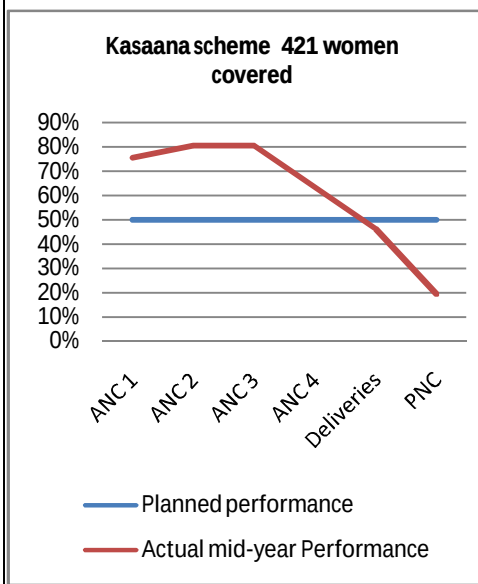
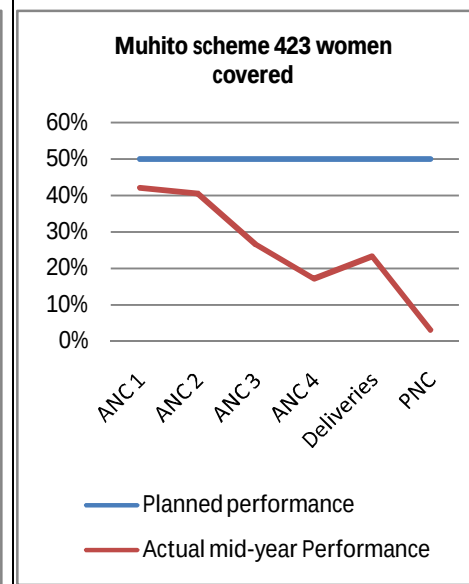


Figure N° 2: Utilization of services within the first 3 months



project objectives		Project targets	December 2010	Results	Explanations for
Quality of healthcare services has improved (decision making, reception and referrals)	To improve the quality of services at health care facilities	More than 50% respondents (members and non members) perceived quality positively in all participating facilities per year	More than 50% respondents (members and non members) perceived quality positively in all participating facilities	The quality of care is positively perceived. (see figures 3); Improvement in care on the other hand is not well perceived for Kitagata and IAH (figure 4)	A medical audit was done which showed good performance on most contractual requirements.
		Contracts between providers and schemes respected to 100% per year	Contracts between providers and schemes respected to 100%	• 100% of the hospital bills paid by schemes • 73% of the bills paid on time. • Not all women who came to Kitagata hospital used private rooms as agreed	The private wing is now more utilized and the hospital has now decided to extend it to the general ward. Private beds will be put with covers around them to be used as extension of the private wing
		At least 50% of scheme members (families)	At least 50% of scheme members	• More than 60% of the	Both families and leaders are still very motivated.

project objectives		Project targets	December 2010	Results	Explanations for
		participate in scheme activities per year	(families) participate in scheme meetings	families attend general meetings On average, 76% of leaders participated in the planned schemes activities	In the new communities where schemes are still being created, participation is very high. People are very interested in participating to designing the schemes, defining policies and other operational guidelines

Figure N° 3: Clients' satisfaction with providers

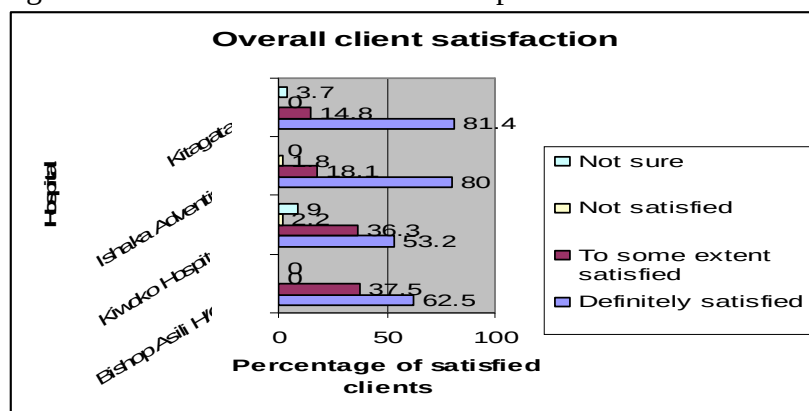
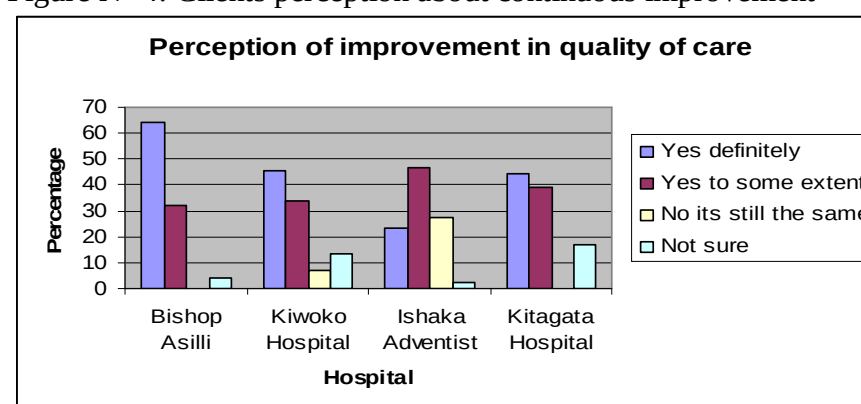


Figure N° 4: Clients perception about continuous improvement



Level of solidarity among community members has	To create community-based schemes	12 running parish-level schemes	4 running parish-level schemes 4 village-level schemes (new approach)	2 running schemes - The four new schemes being created are: Kasaana	Kasaana west is a parish-wide scheme expected to start functioning in March 2011. The others should be launched
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project objectives		Project targets	December 2010	Results	Explanations for
improved			under creation • 40% capacity levels for self management in schemes	west; Kyamurari; Karugorora; and Rwenkurijo • Leaders capacities are estimated to have reached 30%	before the end of the next semester • Leaders' capacities are estimated based on the activities they are able to perform autonomously today out of all that is done in a scheme.
	To increase families' participation through enrolling into the schemes	At least 80% of the villages in each target parish contribute to the scheme fund each year	At least 80% of the villages in each running scheme contribute to the scheme fund	Participation by parish villages is 100%	With the new approaches, some future schemes will be created as village schemes instead of parish schemes. In those parishes, this indicator will be measured at the end of the phase
Health management information system at the district has improved. 100% accurate information	To have accurate information about MCH in target population	100% scheme MCH indicators captured per year	All monitoring tools developed	Not all tools have been developed	Tools to monitor mortality and utilization of services for the general population are not developed
	To share the information with the local health authorities about	All (100%) project data and progress reports shared with the district health authorities per year	Semester report presented to the district authorities	All reports shared with authorities	Good working relationships have been developed with district health authorities. Reports

project objectives		Project targets	December 2010	Results	Explanations for
about the target population's MCH indicators and make sure the information is used.	MCH in the target population				are shared at face to face meetings.
	To make the local health authorities use the MCH information provided	90% of the scheme information is captured by the district health management information system	Partner hospitals to capture scheme indicators in their HMIS reports	Indicators captured	Scheme clients are recorded into the hospital information management system which hospitals use to report to the districts

7. NEXT SEMESTER (JANUARY TO JUNE 2011) TARGETS

The next semester objectives will still be in line with the overall project objectives and are summarized in the table below:

Project targets (June 2012)	Next semester (June 2011) targets
MMR lower than national and district average per year	MMR in the schemes is lower than the district average
Still births averages are lower than the national and district averages	Still births in the running schemes lower than district average
80% of all covered women complete the 4 ANC visits per year	• Cover 2,000 women between 14 and 49 years of age • 80% of pregnant women complete the 4 ANC visits
80% Institutional deliveries by covered women per year	• Contract 2 service providers • 80% Institutional deliveries
At least 80% of all target village families contribute to the schemes fund per year	At least 80% of all target village families contribute to the running schemes fund
Subsidize regressively the premiums at 40%, 30%, 10% and 0% per year	• Subsidize first running scheme at 30% • Subsidize new schemes at 40%
80% of covered women attend PNC per year	80% of covered women attend PNC
70% of covered newborns complete the 3 doses of DPT per year	70% of covered newborns complete the 3 doses of DPT
NMR to be 30% lower than the national and district ratios per year	NMR to be 15% lower than the national and district ratios
More than 50% respondents (members and non members) perceived quality positively in all participating facilities per year	More than 60% respondents (members and non members) perceived quality positively in all participating facilities
Contracts between providers and schemes respected to 100% per year	Contracts between providers and schemes respected to 100%
At least 50% of scheme members (families) participate in scheme activities per year	At least 50% of scheme members (families) participate in scheme meetings
12 running parish-level schemes	• 4 running parish-level schemes • 2 running village-level schemes • 40% capacity levels by scheme leaders
At least 80% of the villages in each target parish contribute to the scheme fund each year	• At least 80% of the villages in parish-level schemes contribute to the scheme funds • At least 80% of the families in village-level schemes contribute to the scheme funds
100% scheme MCH indicators captured per year	80% monitoring tools developed
All (100%) project data and progress reports shared with the district health authorities per year	All reports presented to the district authorities
90% of the scheme information is captured by the district health management information system	Partner hospitals capture scheme indicators in their HMIS reports

8. NEXT SEMESTER ACTIVITY IMPLEMENTATION TIMETABLE

		January				February				March					April				May					June			
	Week	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
1.	The village-based health micro-insurance schemes are functioning																										
	Identifying and Contracting health educators																										
	Selecting Scheme Health Team (SHT)																										
	Develop SHT training guide																										
	Training the SHT																										
	Carrying out health education to community members																										
	Training on data collection and monitoring tools																										
	Collecting data on maternal and neonatal health indicators in community & at provider																										
	Develop provider staff sensitization /training guide																										
	Carry out training of the provider staff																										
	Support schemes to plan for launching																										
	Schemes launching																										
	Co-financing schemes																										
	Collect monthly data on still birth at the provider and in the community																										
	Carry out health promotion (Distribution of ITN, PNC & healthy mother & child leaflets)																										
	Monthly Support and follow-up the SHT to collect data on MHC indicators in the schemes																										
2	The access to and the quality of health care services have improved																										
	Collect family phone contacts for the pregnant women																										
	Give reminders by NTIC																										
	Monthly Monitoring of individual women on ANC, Delivery and PNC attendance																										
	Support the old schemes to plan for re-contribution																										
	Carry out scheme promotions and fundraising activities																										
	carry out premium collection data follow-ups																										
	Follow-up on monthly MB/Pc/SHU meetings																										
	Designing sensitization messages for patients rights																										

