SAVE FOR HEALTH UGANDA (SHU)

"Community solidarity for quality health"

ANNUAL REPORT 2012

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SAVE FOR HEALTH UGANDA (SHU)

Community solidarity for quality health

Vision:

Healthier families with simplified access to quality health care

Goal:

To contribute to: the reduction of the disease burden in Uganda; and the achievement of Uganda's millennium development goals (MDG) 4 and 5 commitments.

Mission:

To improve the quality of health of Ugandans through self managed health financing approaches.

CONTENTS OF THE REPORT

LIST OF ABBREVIATIONS

ANC	Antenatal Care
BftW	Bread for the World -Protestant Development Service
CHF	Community Healthcare Financing
CHI	Community Health Insurance
CIDR	International Center for Development and Research
CORDAID	Catholic Organization for Relief and Development Aid
EED	Evangelischer Entwicklungs Dienst (now BftW)
FUE	Federation of Uganda Employers
HCP	Healthcare Provider
ITN	Insecticide treated Net
MBUSO	Munno Mu Bulwadde Union of Schemes' Organization
MOH	Ministry of health
NGO	Non Governmental Organization
NHIS	National Health Insurance Scheme
PNC	Postnatal Care
SHU	Save for Health Uganda
TTC	Text to Change
UCBHFA	Uganda Community Based Health Financing Association
UNHCO	Uganda National Health Consumers' Organization
WATA	West Ankole Tweragurize Association

INTRODUCTION

This is our 2012 annual report. The report gives highlights of the work done by Save for Health Uganda (SHU) during the year 2012, the organisation's achievements, the challenges faced and the next year plans.

SHU the Non Government Organization (NGO)

Save for Health Uganda (SHU) is a local NGO in Uganda mandated to implement activities aiming at improving access to quality health care and facilities country-wide. SHU is implementing 5 programs: community health financing (CHF); women's health and empowerment; family livelihood; health care delivery; and institutional development.

The programs are being implemented in 5 Districts of Luwero, Nakasongola, Nakaseke, Bushenyi and Sheema. SHU has been in existence since 2002 and is run by a board of directors (BOD) committee and a management team. The members of the BOD during the year were: Dr. Lorna B. Muhirwe -Chairperson (Program Coordinator -World Education, Inc); Sr. Ernestine Akulu- Vice chairperson (In-charge Bishop C. Asili Hospital); Dr. Joseph Baguma- Treasurer (Executive Director THETA); Mr. Fredrick Makaire- Secretary (SHU Executive Director); Mr. Zakariya Kasirye M- Member (Program Manager, Save the Children); and Ms Rachael Kisakye- Member (Legal Officer with Uganda's Tax Appeals Tribunal). The senior managers are: Mr. Fredrick Makaire- Executive Director; Ms. Nazibanja Juliet- Programs Officer; Ms. Asio Veronica- Finance and Administration Officer; and Mr. Mugisa Kumaraki Eria- Monitoring and Evaluation Officer.

SHU has worked with a number of partners to implement the programs. SHU wishes to thank all the partners for their contributions and support. In a special way, SHU thanks Bread for The world (BftW) and the catholic organization for relief and development aid (Cordaid) for the financial contributions that have made implementation of activities possible. The partners with whom SHU has worked during the year are the following:

1. Bread for the World (BfW) Financial & technical partner
2. CORDAID Financial partner
3. Ministry of Health Line ministry
4. MBUSO Network of SHU schemes in the central region
5. WATA Network of SHU schemes in the western region
6. Health care facilities
   - Kiwoko hospital
   - Ishaka Adventist hospital
   - Kitagata hospital
   - Bishop C. Asili hospital
   - Franciscan health center
   - Laura health center
   - Hope medical center Service providers and co-schemes promoters
7. UCBHFA National umbrella for CHF schemes promoters
8. District authorities SHU supervisors and support to the projects
9. CIDR Technical support

10. Just Like My Child Foundation Livelihood project partners in Luwero District
11. UNHCO Consumer rights awareness and communication channels development between communities and health care service providers
12. TTC Service providers/ partners on communication with beneficiaries using mobile phone technology

Context up-date

The biggest proportion of Uganda's population is young aged 0 -14 years (48.4%) and rural based (84.4%). Agriculture still employs most of Uganda's labour force (71.6%) . With regards to health care, the environment has not changed significantly since last year. Uganda still implements a free healthcare policy in Government health care facilities and the same challenges of high levels of drugs stock-outs and a non motivated workforce still persist. Out of pocket expenditure for health continues to increase and now households contribute about 50% of the total expenditure on health. The spending is mainly on purchasing drugs, on informal payments at public facilities, on paying user fees at private for profit (PFP) and private not for profit (PNFP) facilities. The proposed national health insurance scheme (NHIS) is still at the 1st parliamentary council for scrutiny before being presented to parliament for debate.

The work done by SHU during the year

SHU programs generally speaking aim at increasing access to health care. The activities that have been implemented focused on getting families to prepay into the community health financing (CHF) schemes, getting people (members of the CHF schemes) to utilize and in time the health care services when need arises, boosting family incomes, engaging partner health care facilities to improve service delivery and quality, empowering women in the CHF schemes to participate in decision making, and building SHU's capacity to fulfill its mandate. The details about what we did and the current achievements are detailed in the report. Information about our next year plans is also provided.

PROMOTING COMMUNITY HEALTH FINANCING (CHF) SCHEMES

The community health financing (CHF) schemes are located in 5 target districts of Luwero, Nakasongola, Nakaseke, Bushenyi and Sheema. The schemes are of three types: Pure insurance (medical bills covered by the scheme), pure credit (medical bill cleared by the scheme but becomes a loan to the family), and the mixed credit and insurance (part of the bill is covered by the scheme while part becomes a loan).

During the year, we have offered support to both new and old communities to see them create, run, and sustain the CHF schemes. The key activities we have performed include: sensitization, health education, health insurance education; monitoring operations, and capacity building of scheme leaders for self management. As a result;

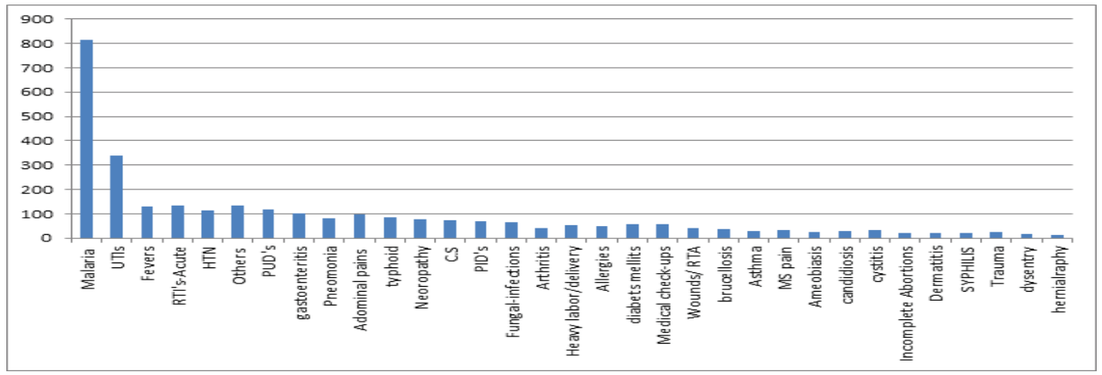
1. The number of schemes has grown from 53 last year to 68. The individuals protected by these schemes have also increased from 25,566 to 29,547.

Table No1: Details of the current SHU supported CHF schemes

Districts where schemes are located	Pure Insurance	Pure Credit	Mixed Credit and Insurance	Total	
				schemes	beneficiaries
1. Luwero	2	8	8	**18**	**9457**
2. Nakasongola	0	0	6	**6**	**3,221**
3. Nakaseke	2	2	13	**17**	**6649**
4. Bushenyi	17	0	0	**17**	**6,096**
5. Sheema	10	0	0	**10**	**4,124**
Total schemes	**31**	**10**	**27**	**68**	**29,547**
Total beneficiaries	**11,232**	**5,969**	**12,346**		

2. Beneficiaries have utilized the medical services from the 7 contracted health facilities. Malaria remains the most common disease presented by schemes beneficiaries as the figure below shows.

Figure No1: Presented cases of illness by scheme members in Luwero, Nakasongola, Nakaseke and Bushenyi



A total of 3,937 medical claims were made during the year costing the schemes a total of UGX 122,386,470. The table below shows more details.

Table No2: Details of medical claims by CHF schemes members during the year 2012

Health Care Provider	Patients		Cost of care/bills		Total	
	OPC	IPC	OPC	IPC	Pa-tients	Cost/Bill
AMG Bugongi	123	25	3,659,150	1,296,050	148	4,955,200
Kitagata Hospital	265	17	566,000	275,500	282	841,500
Ishaka Adventist Hospital	833	316	14,821,070	15,226,900	1,149	30,047,970
Laurah Health centre	201	0	3,591,000	0	201	3,591,000
Kiwoko Hospital	1,056	401	23,968,800	29,724,600	1,457	53,693,400
Francisacan	130	70	3,557,500	4,178,500	200	7,736,000
Bishop C.Asili	343	157	7,884,100	13,637,300	500	21,521,400
Total	**2,951**	**986**	**58,047,620**	**64,338,850**	**3,937**	**122,386,470**

The number of claims went down from 4,690 to 3,937 with outpatient claims dropping by (21%)due to long distances from the contracted facilities especially for the new schemes, while the admissions claims increased by 2.7% which is normal because membership increased but could also be due to adverse selection in the new schemes.
The health care loan repayment in the credit and mixed schemes is still problematic and stood at 31% of all year loans recovered.

For the 10 schemes in Sheema district that have a special focus on maternal and child health with products covering the pregnant women's medical bills and transport (contracted boda-boda motorcycles) costs, obstetrics services have been utilized adequately. Out of the 58 pregnant women expected to have completed the 4th ANC by December 2012, 46 of them did. Out of the 46 pregnant women expected to have delivered during the year, 36 of them delivered from the contracted healthcare providers.

3. The networks of schemes (federations) structures have been strengthened by both SHU but also by the member schemes. The Munno Mu Bulwadde Union of Schemes Organization (MBUSO) now brings together a total of 41 schemes while the Western Ankore Tweragurize Association (WATA) has 27 member schemes. The members of the MBUSO network have during the year 2012 finance the MBUSO budget up to a tune of 18%.WATA is still new and still fully supported by SHU.

4. Health insurance knowledge has been improved among the target communities. This has been done mainly through sensitization, training meetings, and through exchange of experience visits.

Members from Bushenyi and Sheema schemes at a meeting with their hosts in one of the schemes in Luwero. It was during an exchange of experience visit.

Two exchange visits between members of WATA and MBUSO were organized during the year. The schemes' positive fidelity is largely attributed to the improved understanding and appreciation of health insurance.

5. We have been following the progress of the proposed National Health Insurance Scheme (NHIS) to which we wish to link our supported CHF schemes but not much has happened this year. In fact, the process seems to have stalled. It is not clear when the draft bill will be presented to parliament for debate.

Challenges

The main challenge has remained the low incomes at household level. This situation has affected the fast growth of the schemes as the capacity to pay the "actual" contributions is low and every attempt to raise the amount has seen a sharp drop out of members. Other families drop out even when contribution amounts remain unchanged! During the year 2012, the schemes registered a 24.6% drop out. The drop out was 10.4% in 2011. Meeting attendance and voluntary leadership at the scheme level are still major challenges too. The schemes being member-managed require the active participation of members yet they are not available regularly and some leaders demand to be paid for their time. As a consequence, activities drug and are poorly performed. At the national level, a policy to guide and promote CHI operations is still missing. As a consequence, CHI is not promoted by authorities and takes us a lot of time to win a community's confidence and trust.

Way forward and next year plans

In 2013, we will extend our services to new communities and create 19 new schemes. To boost household incomes, we will continue to link our livelihood projects to the CHF schemes while we will pilot a paid scheme agent working for a scheme/ a number of schemes performing most of the key and time consuming activities at scheme level.

EMPOWERING WOMEN AND IMPROVING THIER HEALTH

The adult women in the target districts do not participate adequately in decision making at home and at community level. For those who get pregnant, visiting health care facilities for antenatal care clinics and delivery is inadequate and sometimes foregone. Malaria in pregnancy is still a major cause of morbidity and mortality among pregnant women and new born babies. SHU has developed interventions to improve the plight of women in the target districts.

During the year, we have offered support to women through the CHF schemes. The key activities we have performed include: lobbying for inclusion of clauses in the schemes' constitutions that guarantee women participation in schemes leadership; health education; sensitizing men about the role of women in leadership and decision making; training the women scheme leaders in their roles; and monitoring progress. As a result;

1. All the individual schemes and their networks' constitutions provide for women participation in leadership. Overall, about 40% of all the leadership positions are occupied by women.

2. Health education sessions focusing specifically on safe motherhood and newborn health were conducted in Sheema District. Through the partnership with Kitagata hospital, Ishaka Adventist Hospital and Hope medical center Bugongi, over 50 health education meetings were held in the 10 parishes where CHI schemes are running.

One of the outreach/ health education sessions organised by SHU in Kyeibanga East at Kyeitamba Health Centre II. Kitagata hospital staff conducted the activity

In addition, several health education radio talk shows were held. In addition to the health workers from our partner health facilities in Bushenyi and Sheema, the sessions were attended as well by the District Health Officer (DHO) of Bushenyi District.

Text messages were also used to educate the families and messages focused on all subjects related to safe motherhood.

3. Malaria in pregnancy and in new born babies was prevented by giving Insecticide Treated Bed Nets (ITN) to pregnant women who enrolled into the CHI scheme.

Pregnant women after receiving Insecticide Treated Bed Nets

In total during the year, 500 ITNs were issued out to pregnant women, new born babies and other schemes members. Even if malaria remains the most common disease treated in the schemes, there has been a decline in the number of people coming for treatment during the year. The main two reasons for the decline is the use of ITNs and then the long distances to the health facilities for families in some schemes.

4. Pregnant women enrolled in the 10 CHI schemes of Sheema District were facilitated to attend all the 4 recommended antenatal clinics, to deliver from health facilities and to return for postnatal care. The facilitation was in three ways: First the medical / consultation fees were covered by the CHI schemes; secondly, transport means were organized by the schemes.

A Pregnant scheme member arriving at Kitagata Hospital for Antenatal care

Boda-boda (motorbikes) motorcyclists were contracted by the schemes to transport pregnant women to and from a health facility for all obstetrics services; and lastly transport bills were covered by the scheme. At the end of 2012, institutional delivery was 78% while ANC 4 attendance was 80.4%.

Impact

Because of the health and insurance education and having seen how the initial (2011) CHI schemes that focused on pregnant women and new born babies to which they contributed, community members unanimously decided that the schemes' products be reviewed to cover the entire family. It is the reason all the 10 schemes in Sheema District have opened up to cover the entire family even if the transport benefit is limited to pregnant women only.

Challenges

When the schemes in Sheema District opened up to all family members, the premium to pay by a family increased. Because of the high amount of premium, the original idea to cover women of 14 – 49 years automatically for obstetrics and transport was dropped. The assumption that enrolment remains voluntary

for everybody but with an attractive benefit for pregnant women has not fully worked as some families have remained out.

Way forward and next year plans

Our focus will still be on getting more women to use obstetrics services by creating new schemes with a safe motherhood product but to also negotiate with running schemes to expand their products to cover transport for pregnant women when utilising obstetrics services. We will empower men and women to increase the participation of women in health care organization and utilization decision making both at home and CHF schemes level.

IMPROVING HEALTH CARE DELIVERY

Uganda's health care system still faces challenges. The users of the health services in the SHU target areas have little say in what and how the health care services are provided and sometimes are unable to get all the services they expect at a particular facility. In an effort to improve the system, SHU is working with a number (target) of health care facilities to improve services and their delivery and the CHF schemes through: formal contracting of health care services by the schemes; improved community participation in the services delivery by the contracted facilities; and payment of medical bills in full and in time. As a result;

1. By the end of 2012, the number of health facilities contracted by the schemes was seven. The health care facilities are: Kiwoko hospital, Ishaka Adventist hospital, Kitagata hospital, Bishop C. Asili hospital, Franciscan health center, Hope medical center, and Laura health center. All the seven facilities were re-contracted to provide services to the CHF schemes.

2. Direct communication channels were opened between the CHF schemes and each contracted health facility and have been used. On a monthly basis, a health facility staff (Prepayment cashier) visited each scheme/ the network of schemes' office to present the monthly invoice and receive feedback from the schemes. At the same meeting, the cashiers gave feedback on the previous month issues raised by the schemes.

One meeting between each contracted health facility and the network of schemes took place and reviewed the service contracts. All contracts were later renewed.

Kitagata hospital management with representatives from schemes in a meeting at the hospital

UNHCO Executive Director Ms. Robinah Kaitiritimba (with a hat), Ms. Mabel Kukunda of UNHCO and Mr. Brian Mugisha of SHU at a meeting with one of the complaints committee in Kashekuro parish, Sheema District

In addition to these communication channels, and through the SHU partnership with UNHCO, scheme complaints committees were set up in each scheme in Sheema District. The role of the complaints committees is to engage the health facility management on quality of services, on patient's rights and on satisfaction issues.

The hospital treasurer trying out the bike while the MS looks on

In total 30 committees were formed and trained. During the year, the UNHCO team supported the committees who reported additional committees were established.

Ishaka Adventist Hospital the referral hospital for the schemes in Bushenyi and Sheema was supported with a motorbike to ease their communication with schemes members.

3. The Kitagata hospital maternity ward was partitioned with SHU's direct funding. New mothers and their caretakers now enjoy privacy and are very happy. The hospital management too appreciated the support and acknowledges that clients are happy with the partitioning.

Kitagata hospital maternity ward being partitioned

4. SHU organized and conducted training in Patient Centered Care (PCC) for the health workers at the SHU partner health facilities. The training followed an assessment of the performance of the contracted health care providers in 2010 that established that not all SHU and schemes beneficiaries' expectations were being satisfied specifically, the schemes were complaining about: rude staff; absence of people to help guide them on the procedures for accessing care; the long waiting time; being discriminated against because they hold scheme cards; and being looked at as bad because they raise complain a lot. The PCC training was successfully held and attended by 26 health workers from all the 7 partner facilities.

Participants and facilitators pose for a group photo

Dr Mubangizi Vincent the training facilitator making a presentation

SHU Executive Director closing the training

Prof. Bart Criel discussing a point at the training

Also in attendance were 5 from SHU team members, 1 person from the Uganda Protestant Medical Bureau, and one person from the Ministry of Health.

Impact

At the recent (November 2012) SHU partners' meeting, all the partner health care facilities reported that the CHF schemes have reduced the runaway cases and that schemes members are reporting earlier than other patients for treatment. Using the testimonies of Ishaka Adventist Hospital (IAH) as presented to the partners' meeting,

a. "in the year 2007 we collected UGX 861,700 from the one scheme that had contracted with us; last year 2011, the hospital collected a total of UGX 30,000,000 (UGX 22,630,285 from schemes direct payments & UGX 8,312,000 from co-payments) representing 3.7% of the total hospital budget".

b. "Before the launch of these schemes, we were registering a lot of patient run-away cases. This gap is gradually being minimized by these schemes. In the year 2006, the hospital wrote off UGX 30 millions as bad debt expense. From 2007-2011 the hospital management is considering writing off UGX 18 millions".

c. "Conducting health education and outreaches to prevent diseases and ease access to our services has become easier for the hospital. The Tweraguzize schemes mobilize people and we meet them with less hustle and with good turn up".

Challenges

Services at Kitagata Government hospital still need to improve a lot. The hospital depends largely on Government funding which is insufficient and not received on time. It being the main service provider for the CHF schemes in Sheema District, some drop outs from the schemes have been attributed to the quality of services at this hospital among other factors.

Way forward and next year plans

In 2013, we will continue to support and work with the current 7 partner health facilities. At least 4 new health care facilities will be contracted during the year to become service providers for the CHF schemes. A follow up on the PCC training shall be held to assess the impact of the training and identify additional needs if any. Work on patient's rights awareness in partnership with UNHCO shall be extended to all the new schemes in Sheema and Bushenyi Districts.

IMPROVING FAMILY LIVELIHOODS

The family willingness to enroll into and remain members of the CHF schemes is very high. The families' capacities to pay the schemes contributions every year however differ with many failing during some periods and thus dropping out, while others adversely select their family members to join the schemes. The dangers are twofold: first, each scheme has failed to reach the desired critical mass of members; and secondly, the families enrolled lack total peace of mind because of the occasional dropping out and because of the non insured members of their families.

During the year, we have offered support to families with the intention to boost their household incomes. The key activities we have performed include: Identifying appropriate income generating activities (IGA) and training interested families on them; training families and distributing to the trained families dairy goats that were provided by our partners Just Like My Child Foundation (JLMCF) and Bishop C. Asili Hospital. Loans have been availed to families wishing to start up an IGA, or to boost their current IGA. Loans to prevent catastrophic expenditures are also provided. They are: emergency transport loans and shool fees loans. As a result;

1. Soap (bar and liquid) making was identified as a viable IGA because of the readily available market.

One of the soap making training sessions in Nakaseke

A total of 222 individuals were trained in soap making. By the end of the year, 85 individuals were actively producing soap and selling to the local market.

2. A total of 405 individuals were trained in dairy goats keeping and domestic vegetable farming.

The vegetable growing trainings and one of the gardens

The scheme agent of kyawangabi scheme in Luwero District with the goats that were distributed to families in their scheme

By the end of the year, a total of 310 dairy goats had been given to CHF schemes member families in Luwero District.

3. Several people expressed interest to take the micro-loans. A total of 119 received because the fund is still small. Of the 119 loans issued, 82 were for starting and boosting IGAs while 37 were for emergency expenditures. Of all loans issued, 99.5% of them were put to proper use while 104.4% of those that were due for refunding were recovered.

Families have received very well the livelihoods projects. We cannot tell at this stage if there has been impact created already on the CHF schemes. What we know now is that people are happy with the schemes in Luwero because it is because of these schemes that the projects have come.

Challenges

The loan fund available is too small to satisfy the demand from the schemes members. Secondly and because of the loan fund is very small, members interested in long tern agricultural loans are served yet they are the majority.

Way forward and next year plans

Efforts will be made to identify and partner with organizations involved in household livelihoods improvement including microfinance institutions. More efforts shall be put on increasing the loan fund including negotiating with schemes to make available some of their own savings for micro loaning.

STRENGTHENING SHU AS AN INSTITUTION

Guided by our new strategic plan, The SHU board and management have moved and acted on various areas including revising and getting the appropriate legal mandate, enhancing capacities of staff and board, interacting and accounting to partners, and improving the organizations' visibility. The following are the achievements of the year.

1. SHU became a country-wide operating local NGO. The new status was granted mid 2012. SHU is now free to extend its services to other areas especially the North and Eastern parts of Uganda that were singled out in the strategic plan.

2. SHU became a member of the Federation of Uganda Employers (FUE). FUE is a representative body and voice of employers in Uganda on social and economic issues. We have received very important documents from the federation to enable us develop and maintain good relations between SHU and the workers as well as observe fair and equitable conditions of employment. Among the documents received include: The labour disputes act, 2006; the employment act, 2006; the occupational safety and health act, 2006; the labour unions act, 2006; guidelines on developing and implementing an organization policy on HIV/AIDS; and a guide to the labour laws.

3. SHU exhibited its work and products at the national civil society organisations (CSO) exhibition to mark 50 years of Uganda's independence. This followed a formal invitation by the NGO forum to participate in the event. The SHU stall was visited by many people allowing us a chance to explain to fellow exhibitors and the general public our work and to share with them more about SHU.

The SHU stall at this years' CSO exhibition

4. The governance and management functions were strengthened. The SHU Board and senior managers attended training in corporate governance in May 2012 at Eastern and Southern African Management Institute (ESAMI) Arusha Tanzania. The training aimed at promoting good governance and enhancing the capacity of Board members and senior managers to carry out their duties effectively.

Board and senior management members at the training in Arusha Tanzania

Following the training, the board developed and documented a board charter that is now guiding board operations.

The board functioned as a unit with full membership. One board member Mr. Bagatuzayo Clement retired during the year and was replaced by Mr. Kasirye Zakaria as board member.

Mr. Bagatuzayo handing over to the Board Chairperson. Mr. Kasirye Zakariya (in white shirt) replaced him

On the side of management, various Staff members attended formal trainings and in various fields: 1) the 3 administrative assistants attended an executive/administrative assistants training organized by FUE in November 2012; 2) Eight team members involved in monitoring and evaluation activities attended an SPSS training in May 2012; 3) Fifteen staff attended an in-house training in community health insurance principles and product development. It was done in September 2012; 4) fifteen staff attended training in feasibility studies for CHI. This was an in-house training done in April 2012; 5) Field Officers attended a Training of Trainers session in December 2012.The training was delivered by Development Initiatives Services (DIS) under the Local Support Services (LSS) arrangement funded by BftW.

The other trainings for management were done in form of meetings and support missions. As part of the culture, SHU holds weekly team meetings, quarterly joint team meetings, and an annual strategy review and formulation workshop. The support missions are both internal and external. During the year, one external support mission by CIDR was received. The mission focused on assessing the projects performance and formulated strategies for improvement where it was found necessary. The internal support missions were done by the senior managers at the head office. These missions took place in most occasions at the field offices and addressed different programmatic subjects.

5. SHU held its 4th partners' meeting. The meeting took place on the 16th of November 2012 at the silver springs hotel in Kampala.

The meeting was attended by 54 participants from the MOH, District health officers from Sheema, Bushenyi, Luwero, Nakaseke and Nakasongola; NGO district forums coordinators of Luwero, Nakaseke, Nakasongola and Bushenyi area; secretaries of health from the 5 districts of intervention; representatives of the community health financing schemes in all the 5 districts; the other partners – TTC, UCBHFA, UNHCO, health care providers-; the SHU board and SHU staff.

The years' theme was: "easing access to health care. Have CHF schemes helped?" At the meeting, testimonies were shared and the meeting agreed that CHF schemes have indeed helped the families, the health care providers and the health care system in general.

2012 has been a good year for SHU and for the communities we serve. Challenges aside, big strides have been registered and the organization is in a stronger position than ever before.

We wish to acknowledge once again the valuable support we have received from our partners and stakeholders. In a very special way, we would like to acknowledge the support given to SHU that has made our work easier and appreciated. The support that has done so much in making SHU's work successful during the year is shown in the table below.

Table No3: List of partners and the support/ services they offered during the year 2012

Support	Partner
Discounts to schemes	1. Kiwoko Hospital: UGX 6,118,660 2. Ishaka Adventist Hospital: UGX 1,502,399 3. AMG Bugongi HC: UGX 495,520 4. Laura HC: UGX 179,550
Community mobilization	Sub county down to village-level authorities. The sub counties are: **Luwero District** 1. Luwero 2. Butuntumula 3. Katikamu **Nakasongola District** 1. Kakooge **Nakaseke District** 1. Kikamulo 2. Kasangombe 3. Kito 4. Wakyato 5. Nakaseke **Bushenyi District** 1. Ibaare 2. Bumbaire 3. Kyeisooba 4. Nyabubare 5. Central div **Sheema District** 1. Kasaana 2. Bugongi TC 3. Kitagata
Technical support	1. CIDR 2. UCBHFA 3. DIS/BftW
Financial support	1. BftW 2. Cordaid
Schemes promotion	1. Kiwoko Hospital 2. Ishaka Adventist Hospital 3. Hope medical center 4. Bishop C Asili Hospital 5. Franciscan health Centre 6. Laura Health centre 7. Kitagata Hospital 8. Just Like My Child Foundation
Resources (Information)	Districts health and planning departments: 1. Luwero 2. Bushenyi 3. Sheema 4. Nakasongola 5. Nakaseke

DETAILS OF THE RUNNING SHEMES

MUNNO MU BULWADDE UNION OF SCHEMES ORGANIZATION (MBUSO)

Running Schemes and beneficiaries at the end of December 2012							
District	No	Scheme Name	Sub-county	Year of creation	Parish population	Mechanism	No. of Beneficiaries
Luwero	1	Kakabala	Butuntumula	2001	7,400	Credit	1,141
Luwero	2	Bukambaga	Butuntumula	2010	3,700	Credit	447
Luwero	3	Ngogolo	Butuntumula	2002	6,200	Credit	411
Luwero	4	Kakinzi	Butuntumula	2002	4,700	Credit	778
Luwero	5	Kyawangabi	Butuntumula	2006	5,200	Credit	483
Luwero	6	Bamugolodde	Butuntumula	2010	7,100	Mixed	437
Luwero	7	Kasaala	Luwero	2010	3,400	Mixed	669
Luwero	8	Bweyeyo	Luwero	2004	3,700	Credit	922
Luwero	9	Katugo LWR	Luwero	2010	3,700	Credit	479
Luwero	10	Kigombe	Luwero	2005	4,000	Mixed	406
Luwero	11	Kagugo	Luwero	2006	3,800	Mixed	470
Luwero	12	Kikube	Luwero	2010	2,734	Mixed	561
Luwero	13	Kabakedi	Luwero	2011	5,321	Mixed	460
Luwero	14	Bwaziba	Luwero	2011	3,719	Insurance	268
Luwero	15	Nakikota	Luwero	2011	3,564	Mixed	621
Luwero	16	Union Scheme	Luwero	2011	-	Insurance	254
Luwero	17	Migadde	Katikamu	2006	7,800	Credit	328
Luwero	18	Kyalugondo	Katikamu	2012	12000	Mixed	336
Nakaseke	19	Kamuli	Kikamulo	2003	4,300	Mixed	622
Nakaseke	20	Kikamulo	Kikamulo	2010	1,640	Mixed	376
Nakaseke	21	Kibose	Kikamulo	2010	1,908	Mixed	266
Nakaseke	22	Wakayamba	Kikamulo	2010	3,400	Mixed	256
Nakaseke	23	Magoma	Kikamulo	2008	5,500	Mixed	446
Nakaseke	24	Nongo	Kikamulo	2010	1,380	Mixed	394
Nakaseke	25	Kasana	Kikamulo	2010	4,400	Mixed	410
Nakaseke	26	Kapeke	Kikamulo	2010	3,800	Mixed	427
Nakaseke	27	Luteete	Kikamulo	2011	2,318	Mixed	480
Nakaseke	28	Mijjumwa	Wakyato	2000	2,200	Credit	647
Nakaseke	29	Katooke	Wakyato	2008	3,900	Credit	333
Nakaseke	30	Kirinda	Wakyato	2011	1,860	Insurance	119
Nakaseke	31	Kigege	Nakaseke	2011	3,246	Mixed	355
Nakaseke	32	Kasambya	Nakaseke	2011	2,550	Mixed	385
Nakaseke	33	Nakaseeta	Kasangombe	2011	3,300	Insurance	371
Nakaseke	34	Kito	Kito	2012	3000	Mixed	349
Nakaseke	35	Kivumu	Kito	2012	3000	Mixed	343
Nakasongola	36	Kyabutaika	Kakooge	2002	3,700	Mixed	387
Nakasongola	37	Kyeyindula	Kakooge	2002	3,400	Mixed	626
Nakasongola	38	Kakooge	Kakooge	2001	5,400	Mixed	570
Nakasongola	39	Kyambogo	Kakooge	2011	4,016	Mixed	588
Nakasongola	40	Katuugo	Kakooge	2011	5,059	Mixed	649
Nakasongola	41	Kyankonwa	Kakooge	2011	2,631	Mixed	401
							19,271

Running Schemes and beneficiaries at the end of December 2012							
District	**No**	**Scheme Name**	**Sub-county**	**Year of creation**	**Parish population**	**Mechanism**	**No. of Beneficiaries**
Bushenyi	42	Kiyaga	Bumbaire	2008	4,195	Insurance	460
Bushenyi	51	Numba	Bumbaire	2012	2,784	Insurance	268
Bushenyi	43	Ruharo	Ishaka Div	2009	5,227	Insurance	511
Bushenyi	44	Kainamo	Ibaare	2011	5,027	Insurance	304
Bushenyi	45	Kitabi	Ibaare	2008	3,573	Insurance	510
Bushenyi	46	Ryeishe	Ibaare	2007	5,474	Insurance	737
Bushenyi	47	Karaaro	Kyeizooba	2009	4,899	Insurance	232
Bushenyi	48	Rutooma	Kyeizooba	2012	4,579	Insurance	331
Bushenyi	49	Nyamiyaga	Kyeizooba	2012	2,861	Insurance	315
Bushenyi	52	Kitagata	Kyeizooba	2010	4,805	Insurance	212
Bushenyi	53	Bweera	Kyeizooba	2010	3,883	Insurance	309
Bushenyi	54	Buyanja	Kyeizooba	2011	4,316	Insurance	303
Bushenyi	55	Kitwe	Kyeizooba	2012	5,400	Insurance	304
Bushenyi	50	Nkanga	Nyabubaare	2012	5,975	Insurance	301
Bushenyi	56	Kizinda	Nyabubaare	2012	7,663	Insurance	367
Bushenyi	57	Nyarugoote	Nyabubaare	2012	9,070	Insurance	330
Bushenyi	59	Kigoma	Nyabubaare	2012	5,901	Insurance	302
Sheema	60	Kasaana East	Kasaana	2010	4,288	Insurance	625
Sheema	62	Kasaana west	Kasaana	2011	5,359	Insurance	411
Sheema	63	Karugorora	Kasaana	2011	1,493	Insurance	271
Sheema	67	Buraaro	Kasaana	2012	3,561	Insurance	307
Sheema	68	Kyeihara	Kasaana	2012	1,581	Insurance	336
Sheema	69	Kashekuro	Kasaana	2012	4,971	Insurance	364
Sheema	61	Kyamurari	Bugongi	2011	6,708	Insurance	506
Sheema	64	Muhito	kitagata	2010	5,302	Insurance	627
Sheema	65	Kyeibanga West	kitagata	2012	3,031	Insurance	331
Sheema	66	Kyeibanga East	kitagata	2012	2,870	Insurance	346
		Total			**133,894**		**10,220**