SAVE FOR HEALTH UGANDA (SHU)

"Community solidarity for quality health"

Reducing barriers to quality healthcare services of the rural poor in Luwero, Nakaseke, Nakasongola and Bushenyi districts

Semester Report

Period 1st July 2010 to 31st December 2010

SHU/HMPP/ KEM, NJK, & MF/ N° 17

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A. CONTENTS

B. LIST OF ABBREVIATIONS

CBO	Community based organization
CHF	Community-based Health financing
CIDR	Centre international de développement et de recherché
EED	Evangelische Entwicklungs Dienst
HC	Health center
HCP	Healthcare provider
HMPS	Health Micro-Prepayment schemes
LC	Local council
MBUSO	Munno mu Bulwadde union of schemes Organization
NGO	Non-governmental organization
NHIS	National health insurance scheme
SHU	Save for health Uganda
UCBHFA	Uganda community based health financing association

C. INTRODUCTION

C.1. The organization

Save for health Uganda (SHU), a local Ugandan Non Governmental organization (NGO) operates in six districts of central and Western Uganda. SHU's mission is to improve the quality of health of Ugandans through community Health financing (CHF) in the target districts. The organization currently targets the rural communities in: Luwero, Nakaseke, Nakasongola (all in central region); and Bushenyi, Mitooma and Sheema districts in Western Uganda. To accomplish its mission, SHU implements a Health Micro prepayment project financially supported by EED. The organization also partners with CIDR for technical support and advice; and is a member of the Uganda community based health financing association (UCBHFA) the umbrella body of all CHF initiatives in the country. SHU also receives support from, EED's Local Support Services.

C.2. Context 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

The Luwero area has been dry throughout the semester with a lot of food scarcity. According to the meteorological projections, the dry season will continue until late April 2011. Generally the economic situation is still poor despite the coffee harvest season in December and currently pineapples in a few sub-counties. Bushenyi area on the other hand experienced generally favorable weather conditions throughout the semester. There were two harvest seasons; i.e. May- August and a mini coffee season in December. Unlike Luwero, Bushenyi area has not suffered from food scarcity. In terms of healthcare, Bushenyi district has new additional players in health 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 not clear how long this offer will go even if people are hesitating to renew membership in schemes because of this offer.

D. OBJECTIVES OF THE SEMESTER

Each semester, the focus is on four major objectives linked to expected outcomes at the end of the phase (end of June 2011). The objectives are;

1. **The access to and the quality of healthcare services have improved**
   - To increase the number of schemes from 27 to 35 covering 18,577 beneficiaries.
   - To increase penetration to 18% overall.
   - To control claims ratio at 70% in each scheme
   - To recover loans in micro-credit schemes to 80% of all new loans issues during the semester, and 70% of all old loans
2. **The quality of the local healthcare system has improved**
   - To support schemes pay all healthcare bills and on time
   - To support HMPS and healthcare service providers respect their collaboration contracts to at least 95% level
   - To support schemes and contracted healthcare providers in the Luwero area to implement a referral system.
3. **Community-based health initiatives have strengthened the civil society**
   - To support the Bushenyi health micro-insurance schemes (HMIS) create a union of schemes organization
   - To support all new schemes become community based organizations (CBOs).
   - To build schemes capacities to negotiate and influence healthcare providers decisions to at least 7% of all decisions made during the semester
4. **The role and leadership of women in schemes are strengthened:**
   - To advocate in new schemes for women members to be elected to leadership positions to a proportion of at least 30% of the top positions in schemes
   - To support new schemes draft and adopt gender sensitive internal regulations that provide for at least one of the two scheme representatives to the union parliament to be female.

E. RESULTS

Results in this report have been categorized into two: the first part reports about the impact of the project; while the second part focuses on results against set semester targets as well as phase targets.

E.1. Results related to impact of the project in the areas of operation

The evaluation report of 2011 details most of the impact created by the project. In this report, a few of the impacts are presented for emphasis. All the mentioned impacts below are drawn from the Luwero area schemes:

First is recognition the schemes and their union organization are enjoying. Recently, all the five sub-counties where schemes are running accepted the union request for office space and provided them at each of the sub-county headquarters premises. The union now has offices at each of the five sub-counties with union agents stationed there. Some local authorities are even willing to offer public land for constructing union permanent structures. In the photograph below, the local council three (LC III) chairman of Kikamulo sub-county is handing over a union office in the sub-county to a union board member in December 2010.

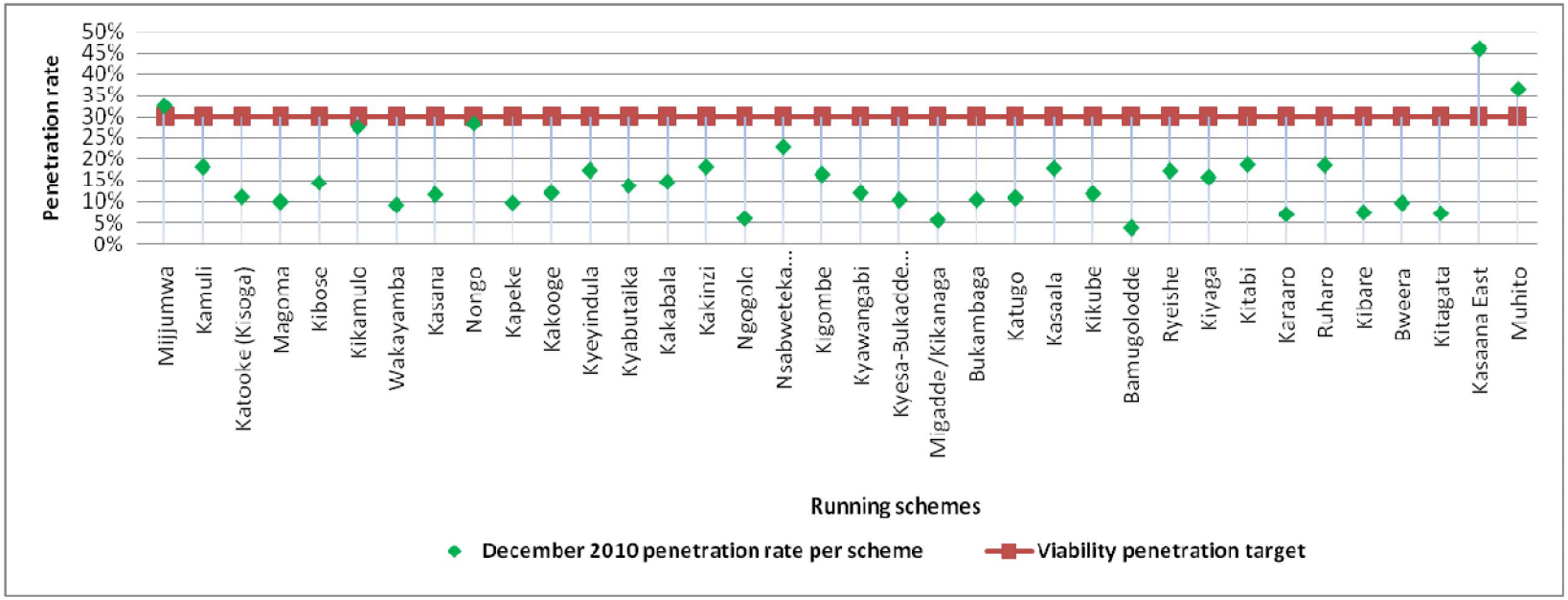
Second is the grown interest in health micro-prepayment schemes as seen from the many and continuous demands coming from non target sub-counties asking to extend the project. During this semester, two schemes have been created as a result of these requests. Where requests are responded to, the creation process is much faster than where SHU decides to extend the scheme

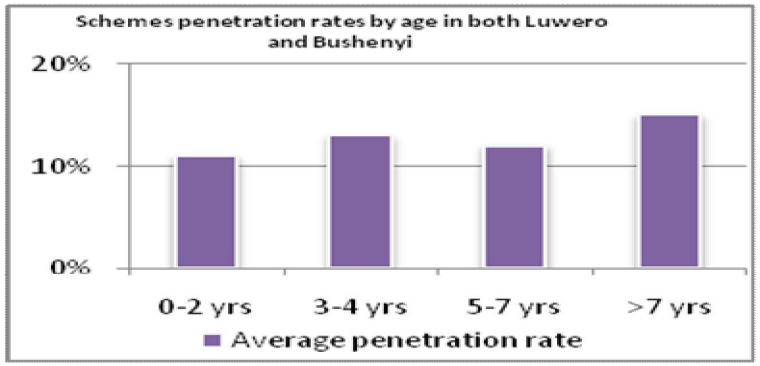
Lastly is the developed capacities exhibited by scheme leaders participating in the creation of new schemes. In the last 2 years, 4 schemes have been created by scheme leaders with minimal support from SHU.

E.2. Results in relation to semester and phase targets

Outcome objective	Baseline indicators (June 2009)	Target by end of phase (June 2011)	Results at the end of year one (June 2010)	Results at the end of semester (December 2010)	Comments
1. The access to and the quality of healthcare services have improved	20 schemes	35 schemes	27 schemes	34 Schemes	26 of the 34 schemes are in the Luwero area, while the remaining 8 are in Bushenyi district. The semester objective of increasing the number of schemes to 34 was achieved
	10,665 beneficiaries	28,000 beneficiaries	14,866 beneficiaries	18,955 beneficiaries	14,228 beneficiaries are from the 26 Luwero area schemes, while 4,727 beneficiaries are from the 8 schemes in Bushenyi district. Out of the total, 3,258 beneficiaries are from the 7 new schemes created during the semester.
	13 % penetration rate	16% penetration rate	12.9% penetration rate	13% penetration rate.	13% penetration rate is an average for all schemes. Significant differences however exist between schemes due to two factors: Age of the scheme; and activeness of leaders. The two figures below illustrates penetration per scheme, and penetration grouped according to scheme age

Figure 1: Individual schemes penetration rates and penetration by age category





Outcome objective	Baseline indicators (June 2009)	Target by end of phase (June 2011)	Results at the end of year one (June 2010)	Results at the end of semester (December 2010)	Comments
1. The access to and the quality of healthcare services have improved	84.1% claims ratio (59.0% for credit schemes, 94.0% for mixed schemes and 99.3% for insurance schemes)	70% claims ratio in all schemes	14.5% in credit schemes, 38% in mixed schemes and 112% in insurance schemes	31% in credit schemes, 52% in mixed schemes, and 74% in insurance schemes	The introduction of a range system has had an impact on adverse selection and thus a reduction in the claims ratio to 74%. Members in credit schemes, fear to take up loans, therefore they do not utilize the funds as much as expected. Funds utilization in mixed schemes is relatively higher than in pure credit schemes because members in the mixed schemes refund less money (credit) as some portion of the medical bill is covered by the insurance fund.

Outcome objective	Baseline indicators (June 2009)	Target by end of phase (June 2011)	Results at the end of year one (June 2010)	Results at the end of semester (December 2010)	Comments
	37% un-recovered loans	95% of all loans are recovered	34% of all loans recovered. - 39% of pending loans from July 2009 and before - 44% of pending loans from July to December 2009 - 19% of loans given during January to June 2010.	47% of all loans are recovered - 46% of loans from July 2009 and before. - 57% of loans from July-December 09 - 52% of loans from January to June 2010. - 35% of the loans given out between July and December 2010.	More than half of all loans given out during the reporting semester were still in the repayment period by the end of the semester. This explains the reasons why many of the loans given out in one semester are recovered in the subsequent semester.
2. The quality of local healthcare system has improv	100% bills paid 77% bills paid on time	100% bills paid 100% bills paid on time.	100% bills paid 70% of the medical bills paid on time.	100% (All) bills paid 47% bills (32% in Luwero and 61% in Bushenyi) were paid on time.	The delay in bills payment is due to two factors: First is the increased number of schemes to which individual bills have to be presented; and the flopping meetings where bills are expected to be verified and approved. As a solution, the payment has now been

Outcome objective	Baseline indicators (June 2009)	Target by end of phase (June 2011)	Results at the end of year one (June 2010)	Results at the end of semester (December 2010)	Comments
ed					centralized at union level
	70% compliance with contracts	95% compliance level with contracts	No medical audit done Subjectively, compliance is high	A medical audit was done Compliance measured at 80% generally	Kiwoko hospital was found to be the most complying facility; Bishop C.Asili health centre and Ishaka Adventist hospital are complying as well. The major weakness identified was related to changes in drug prices without prior notice to schemes as written in the contracts.
	No formal referral system in schemes	A referral system is working among the healthcare providers serving the schemes.	No referral system  Kiwoko Hospital and Bishop Asili representatives together with the Luwero union board members and SHU representatives shortly after the negotiation meeting for providers to have a formal referral mechanism for scheme patients	No referral system	The system will start working in March 2011. The referral system in Luwero has been designed and discussed with HCPs. Negotiation between four parties (2 service providers, the union and SHU) were completed and all parties have reached consensus. The MOU has been signed.

Outcome objective	Baseline indicators (June 2009)	Target by end of phase (June 2011)	Results at the end of year one (June 2010)	Results at the end of semester (December 2010)	Comments
3. Community-based Development initiatives have strengthened the civil society	No baseline	7% of the healthcare providers decisions have their origin from the partnership with HMPS	The indicator was not measured in Luwero even if many decisions were made in relation to scheme demands. In Bushenyi, 5 decisions were made by the providers with their origin from the schemes.	This indicator was achieved	According to the evaluation results, healthcare providers confirmed having made several decisions after concerns were raised by scheme members through the feedback arrangements in place.
	Union is not active in healthcare activities	The unions participate in 30% of the activities about healthcare organized by civil society in the area	Schemes and Luwero union participated in many healthcare events both at district and at sub-county levels.	The Luwero union participation has been 100% when invited.	During the semester, one invitation from the Luweero NGO forum was received.

Outcome objective	Baseline indicators (June 2009)	Target by end of phase (June 2011)	Results at the end of year one (June 2010)	Results at the end of semester (December 2010)	Comments
	The union has no membership with UCBHFA	The Luwero union is a member and participates in the National umbrella body of the community based health insurance initiatives	The Luwero union participated to all UCBHFA activities carried out during the semester.	The Luwero union participated to all UCBHFA activities carried out during the semester.	The phase objective has been achieved 100%
4. The role and leadership of women in schemes are strengthened	25% women leaders at scheme top leadership level	Women occupy at least 30% of the top most positions in schemes and at union level.	45% of the Luwero union positions. 60% in the Luwero schemes management 39% for Bushenyi scheme leadership.	52.7% women leaders in the Luwero area schemes and union 46.8% women leaders in the Bushenyi schemes	The phase objective has already been achieved 100%
	No gender-related	All schemes internal	Luwero schemes and union internal	33 out of 34 schemes internal	One of the schemes in Bushenyi was formed under the Catholic

Outcome objective	Baseline indicators (June 2009)	Target by end of phase (June 2011)	Results at the end of year one (June 2010)	Results at the end of semester (December 2010)	Comments
	policy on leadership in schemes	regulations provide at least one of the two schemes representatives to the union parliament to be female.	regulations were reviewed and provide for a woman representative to the union parliament.	regulations provide for woman representative to the union parliament.	church parish, where this bi-law could not be enforced.
	No measurement of the effectiveness of the gender approach	30% of families who joined the scheme say that gender approach is more effective	No impact measured on this indicator	No impact measured on this indicator	This indicator will be measured at the end of the phase.

F. NEXT SEMESTER OBJECTIVES, TARGETS AND STRATEGIES

Objectives (Outcome level)	Targets	Strategies
1. The success to and the quality of healthcare services have improved	To increase the number of schemes to 40. 32 in Luwero union and 13 in Bushenyi union	- Create more schemes - Sub-contracting leaders to create schemes - Promotion and marketing strategy - Use the Sensitization, Information and communication strategy - Use scheme promoters to communicate to families - Review the collaboration contracts with service providers - Finalize the process of creating a union in Bushenyi - Discuss the referral system with service providers - Follow up recommendations from the medical audit
	The number of enrolled beneficiaries is 21,000	
	16% penetration 18% Luwero area 14% in Bushenyi	
	70 % claims ratio	
	95% of the loans are paid on time	
2. The quality of local healthcare system has improved	100% of the medical bills paid and on time	
	The collaboration contracts between the unions and HCP, are respected to at least 95%	
	Functional referral system in both unions	
3. Community-based Development initiative has strengthened the civil society	The Luwero HMPS is a member of the civil society organization	
	The schemes and the union have participated in 30% of the activities about health organized by civil society in the area.	

Objectives (Outcome level)	Targets	Strategies
	Each year 7% of the providers decisions have their origin in partnership with schemes	- Training scheme leaders in managing the health prepayment schemes - Partner with other advocacy organizations to improve customer care at the service providers
4. The role and leadership of women in schemes are strengthened	Both men and women occupy and participate equally in the top most positions of the schemes at all levels	

G. NEXT SEMESTER WORKPLANS

G.1. Luwero area work plan

S. No.	Month	JAN				Feb				March					April				May					June			
A.	**Activities**	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 number of schemes and beneficiaries have significantly increased**																										
1.1	Sub-contracting others to promote the concept and create new schemes																										
1.2	Creating schemes																										
1.3	Support to scheme leaders and building their capacities																										
1.5	To support old schemes re-launch the new financial exercise																										
1.6	Marketing, sensitizing and promoting the concept																										
1.7	Support schemes to implement new initiatives to improve their incomes																										
1.8	Carrying out a local partners meeting																										
2.0	**To strengthen the role and leadership of women in schemes**																										
2.1	Assessing performance of scheme leaders																										
2.2	Monthly follow up of leaders' activities																										
2.3	Training of scheme leaders																										
2.4	Monitoring and follow up of scheme activities																										
2.5	Scheme management meetings to update and follow up the annual year plan																										
2.6	Scheme Management Board meeting to prepare for the leaders compensation																										
2.7	Identify potential persons for the Human resource bank.																										
3.0	**The schemes are managing the health prepayment mechanism with a reasonable degree of professionalism**																										
3.2	Carrying out scheme and union annual financial audits																										
3.3	Meeting with health care providers to discuss medical audit results																										
3.4	Follow up of healthcare loans																										

3.5	Training of healthcare provider staff	
3.6	To design new packages for schemes	
3.7	Sensitize old schemes about insurance	
3.8	Exchange of experience visit for schemes that are turning to insurance	
3.9	Identify and work with partners that can collaborate with schemes on IGAs	
3.10	To encourage members to use government facilities	
4.0	**The union has skilled technical persons in health micro prepayment schemes**	
4.1	Assessing the performance of Union scheme Agents (USAs)	
4.2	Training of USAs	
4.3	Follow up Meetings with USAs	
4.4	USAs monthly reporting	
5.0	**Contracts between union and health care providers are respected and the quality of services is good**	
5.1	To follow up meetings between the union and HCP	
5.2	Monitoring and follow up of the healthcare bills payment	
5.3	Updating the HCP guide	
5.4	Introduce a formal referral system	
1.1	Sensitizing members about the referral system (conditions and procedures	
1.	Follow up the implementation of the referral system	
5.7	Contracting the third HCP	
6.0	**The schemes & the union have a participatory and efficient governance**	
6.2	Reviewing of the union constitution	
6.3	To carry out union governance meetings	
6.7	Support schemes to enter into an objective contract with the union	
6.8	Support the union to Participate in local health events and schemes activities	
8.1	Financial audits of the union	
8.3	Local support mission	

G.2. Bushenyi work plan

	Months	January				February				March					April				May					June			
S no.	*Weeks*	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	**To create new schemes and support the existing ones to expand**																										
1.1	Carrying out Socio-economic survey to identify the parishes																										
1.2	Carry out meetings with community member to discuss the concept and design the scheme																										
1.3	Training schemes leaders																										
1.4	Design sensitization messages for families,																										
1.5	Carry out marketing and promotion of schemes																										
1.6	Select scheme promoters and train them																										
1.7	Follow up of premium collection																										
1.8	Photograph taking and card filling																										
1.9	Inauguration of new schemes																										
1.10	Registering the schemes as CBO's																										
1.11	Midyear Gm to plan for re-contribution and elect new scheme leaders																										
1.12	Review scheme constitutions																										
1.13	Sensitize scheme beneficiaries on procedures of coverage.																										
2	**To develop scheme leaders capacity to manage and participate in scheme activities**																										
2.1	Monthly (MB) /(PC) & SHU follow-up meetings																										
2.2	Schemes and cashiers exchange of experience Internal																										
2.3	Train scheme leaders on new tools and planning																										
3	**To enable schemes manage the prepayment mechanism with some degree of professionalism**																										
3.1	Support schemes' set up performance systems & evaluation																										
3.2	Monitoring and follow up of schemes activities																										

Bushenyi January to June 2011

	Months	January				February				March					April				May					June			
S no.	*Weeks*	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
3.3	Carry out schemes audit.																										
4	**To support schemes have respected collaboration contracts with providers and access good quality of service**																										
4.1	Support the schemes to review & contract with the healthcare providers																										
4.2	To discuss results of the medical audit with HCP and follow up the recommendations																										
4.3	Regular reporting to stakeholders & local authorities																										
4.4	Develop TOR for the referral system																										
4.5	Support HCP to enter into a referral agreement																										
4..6	Sensitize the community on the referral system																										
4.7	Collect the data from government HCP																										
4.8	To identify organization to train providers in customer care																										
4.9	To follow up the training of healthcare providers in customer care																										
4.10	Train the pre-payment cashiers on new tools/updates																										
5	**To have a functioning union of schemes**																										
5.1.1	Steering committee meeting to finalize constitution																										
5.1.2	Sensitizing the community about the union constitution																										
5.1.3	To support schemes, elect union leaders																										
5.1.4	Registering the union as a CBO & Training union leaders																										
5.1.5	Support schemes to enter into objective contracts with the union																										
5.1.6	Support union to create partnership with other networks																										
5.1.7	Support union to set up a functional secretariat																										
6	**To support schemes and the union have participatory and efficient governance**																										
6.1	Update the schemes internal regulations																										
6.2	Training of union leaders																										
6.3	Follow up of schemes and union leadership performance																										