USAID/UGANDA PRIVATE HEALTH SUPPORT PROGRAM

(JUNE 2013-JUNE 2018)

FINAL REPORT

Contract No.: AID-617-C-13-00005

Mothers and infants awaiting treatment at St Francis Health Care Services in Njeru (January 2018)

September 2018

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Submitted by:
Cardno Emerging Markets USA, Ltd.

Submitted to:
USAID/Uganda

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AID-617-C-13-00005

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Acronyms

A2F	Access to Finance
AGYW	Adolescent Girls and Young Women
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Antiretroviral
BDS	Business Development Services
Cardno	Cardno Emerging Markets USA, Ltd.
CBO	Community-Based Organization
CDCS	Country Development Cooperation Strategy
CDOs	Community Development Officers
CLA	Collaborating, Learning and Adapting
CPD	Continuing Professional Development
CWD	Children with Disabilities
DCA	Development Credit Authority
DHIS 2	District Health Information System 2
EID	Early Infant Diagnosis
EMHS	Essential Medicines and Health Supplies List
FBO	Faith-Based Organization
FP	Family Planning
GOU	Government of Uganda
HaaB	Health as a Business
HCB	Healthcare Business
HIPS	USAID/Uganda Health Initiatives for the Private Sector Project
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HMIS	Health Management Information System
HMO	Health Management Organization
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
IDI	Infectious Diseases Institute
IHA	Insight Health Advisors
IPT	Isoniazid Preventive Therapy
IPTp	Intermittent Preventive Treatment of Malaria in Pregnancy
IRCU	Inter-Religious Council of Uganda
IUD	Intra-Uterine Device
KCCA	Kampala City Council Authority
MGLSD	Ministry of Gender, Labor and Social Development
MNCH	Maternal, Newborn and Child Health

MOH	Ministry of Health
NDA	National Drug Authority
NHIS	National Health Insurance Scheme
NTLP	National Tuberculosis and Leprosy Program
OVC	Orphans and Vulnerable Children
OVC MIS	Orphans and Vulnerable Children Management Information System
PEPFAR	President's Emergency Plan for AIDS Relief
PFP	Private for Profit
PHP	Private Healthcare Provider
PHS	USAID/Uganda Private Health Support Program
PITC	Provider-Initiated Testing and Counselling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PNFP	Private Not-For Profit
PPPH	Public-Private Partnerships for Health
PSA	Private Health Sector Assessment
QI	Quality Improvement
SACCOs	Savings and Credit Co-operatives
SMC	Safe Male Circumcision
SQIS	Self-Regulatory Quality Improvement System
STI	Sexually Transmitted Infection
TB	Tuberculosis
TT	Tetanus Toxoid
UHC	Universal Health Coverage
UHF	Uganda Healthcare Federation
UMA	Uganda Manufacturers Association
USAID	United States Agency for International Development
USG	United States Government
VHTs	Village Health Teams
VMMC	Voluntary Medical Male Circumcision
VSLA	Village Savings and Loan Association
WAOS	Web-based HIV/AIDS Ordering and Reporting System

Executive Summary

USAID/Uganda Private Health Support Program (the PHS Program) was a USAID-funded 5-year, $37.4 million flagship program in the private health sector in Uganda. Its goal was to improve the credibility and cohesiveness of the private sector and expand the capacity of service providers. The Program provided technical expertise, enhanced quality standards, improved access to capital, supported accreditation, and empowered professional associations and advocacy groups to provide leadership in the private sector. The Program sought to achieve this through three main intermediate results: 1) Expanded availability of health services by private providers; 2) Increased affordability of private health services and products; and 3) Improved quality of private health sector facilities and services.

The private health sector, which represents half of all health services delivered in Uganda, has an important role to play in the country's development. Improvements in quality, availability, and access to health services in this sector can increase its already considerable contribution to reducing Uganda's disease burden. In addition, the private healthcare industry can support economic development by providing employment and business opportunities, while contributing to the country's fiscal base.

The USAID/Uganda Private Health Support Program built on Cardno's long-standing development experience, which spans the economic, financial, fiscal, and social sectors, and includes a deep understanding of the Ugandan context. The PHS Program worked to strengthen, organize, and mobilize the private health sector to provide Ugandans with the option of obtaining high-quality services from Private for-Profit (PFP) and Private Not-for-Profit (PNFP) providers. Through technical assistance, the PHS Program built a network of clinics able to partner with other US Government (USG)-funded HIV/AIDS, malaria, TB, FP, MNCH, Nutrition and Orphans & Vulnerable Children (OVC) programs.

Engaging private providers encouraged them to focus on critical development challenges, such as the needs of women, children, and low-income users. By supporting the development of viable and sustainable business opportunities, the PHS Program also helped fuel the overall expansion of the healthcare industry. Furthermore, strengthening institutions—such as the Uganda Healthcare Federation (UHF), Medical Bureaus and professional councils—contributed to improved regulations and supported entrepreneurship and investment in this important economic sector. In addition, the PHS Program conducted rigorous research and produced evidence to inform Uganda Ministry of Health (MOH) and other key stakeholders on best ways to harness the private sector to achieve Universal Health Coverage (UHC). It is important to acknowledge the main components of the PHS Program, which helped contribute to its success: coordination across implementing partners; cross-sectoral programming; and a flexible management platform with adaptability. See Figure 1 for key PHS Program achievements.

Cardno Emerging Markets USA, Ltd. (Cardno) led this five-year program supported by three subcontractors: Banyan Global, the Infectious Diseases Institute (IDI), and Insight Health Advisors (IHA). Our consortium was comprised of skilled Ugandan and international organizations with proven track records and expertise in all key program areas. Each organization, including Cardno, contributed technical expertise and collaborated with other partners to achieve shared program targets. **Cardno** provided overall strategic direction for the PHS Program, coordinated all partners and activities, and led private sector engagement activities. A small, U.S. woman-owned business, **Banyan Global,** led business strengthening activities, including access to finance (A2F), business training, and utilization of the Development Credit Authority (DCA) facility. A part of Makerere University's College of Health Sciences, **IDI** provided expertise in clinical services and quality assurance, and trained service providers. **IHA** a Kenya-based, small business consulting firm, contributed international expertise and lessons learned in the East Africa region in the areas of policy and institutional strengthening, and provided significant support for the stakeholder analysis.

In addition, the PHS Program worked with a number of local organizations such as Medical Councils, private sector federations, Medical Bureaus, and Ugandan Non-Governmental Organizations and

Community-Based Organizations (CBOs) by issuing performance-based grants to support a wide range of activities. The Program issued 248 grants, delivering $13.7 million in funding to local institutions. Implementing such a robust activity required strong monitoring and compliance systems and rigorous local capacity building.

The PHS Program had a number of modifications. In Year 2, the Program expanded to support access to HIV/AIDS services through the PNFP providers that had previously been supported by USAID through the Inter-Religious Council of Uganda (IRCU). At the end of Year 3, the Program received additional funding to improve Health Management Information System (HMIS), institutionalize the Self-regulatory Quality Improvement System (SQIS), sustain support for OVC, and provide further support to PNFPs. The modification specifically mandated that the Program strengthen a faith-based network of 134 facilities within the Medical Bureaus to build a strong foundation for sustainable scale up of HIV/AIDS services.

The Program was considerably impacted by the rationalization process, which resulted in significant reduction of PHS Program partner facilities. In Year 4, USAID/Uganda directed Cardno to gradually transition sites to other regional implementing partners. Our team organized and coordinated multiple meetings with various implementing partners to ensure smooth transition of sites. In the final year, the PHS Program worked with only 12 service delivery sites, focusing main efforts on above-site activities and OVC service delivery.

Also during the final year, USAID informed Cardno that it could not fund the activity beyond the amount already obligated. Our team immediately made the necessary programmatic adjustments and had to effectively suspend activity implementation. Aside from the reduction in services supported at health facilities, two central activities were particularly impacted: 1) systems strengthening activities with the faith-based PNFP medical bureaus; and 2) technical assistance to the recently-initiated DCA Loan Guarantee with DFCU bank.

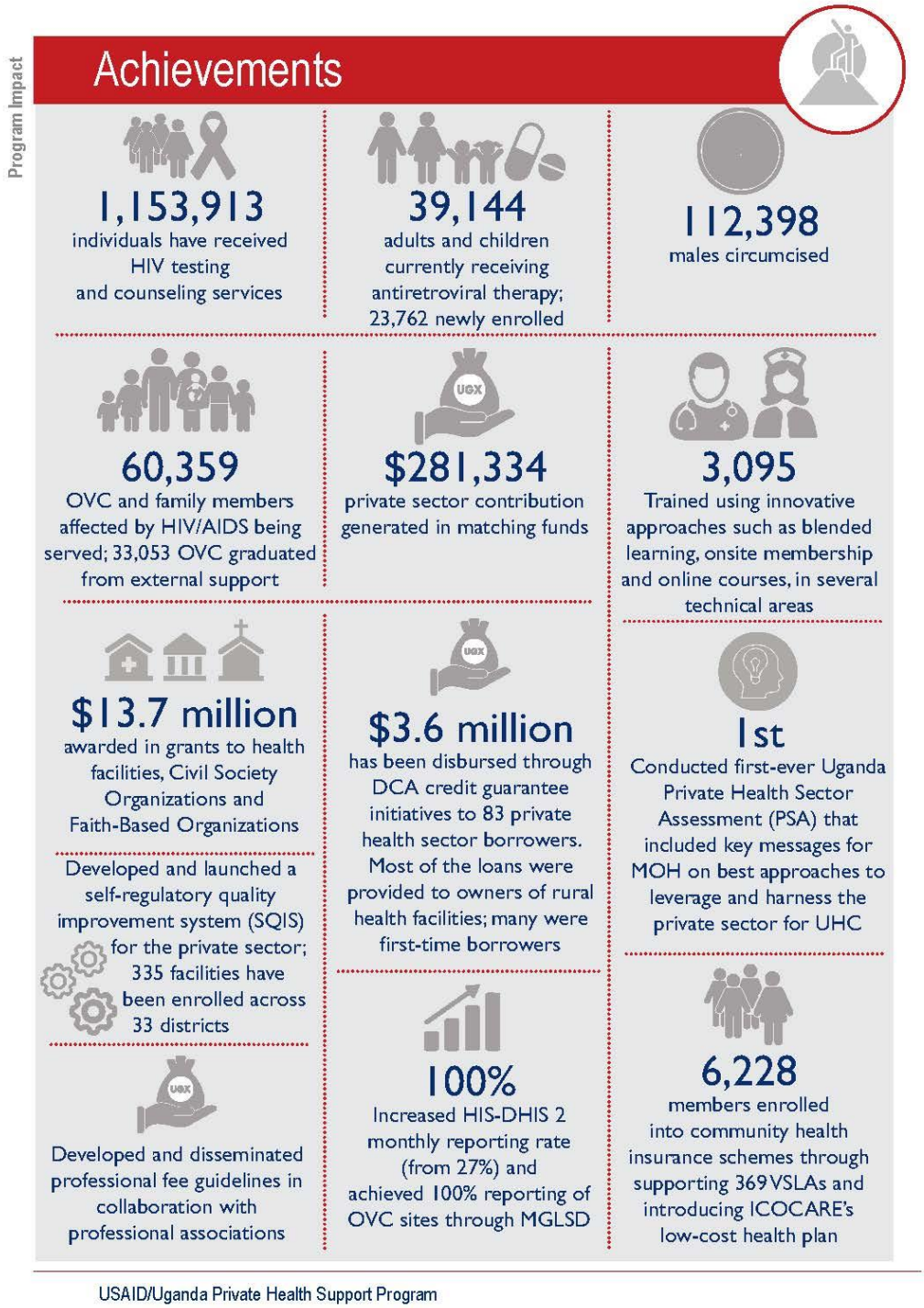
Despite the above modifications to its original scope and the funding limitation, the PHS Program remained responsive to the needs of the Mission, stakeholders, and beneficiaries in order to achieve its goals and promote sustainability beyond its life. The PHS Program enjoyed particularly strong support from USAID/Uganda, including the Health Systems Strengthening Team and Contracts Office staff. Successful implementation of such a complex program with a wide range of activities and the large portfolio of performance-based grants would not have been possible without their consistent programmatic and contracting support.

The PHS Program's contributions to PEPFAR priorities and alignment with the CDCS: The PHS Program has contributed to building overall capacity in a sector that is critical to the success of health and nutrition programs under USAID/Uganda's CDCS 2017-2021 development objectives. By establishing a cadre of trusted providers, and helping to lower the price of health commodities, the Cardno PHS Team increased the impact of USG-supported HIV/AIDS, TB, malaria, MCH, Nutrition and RH programs. The PHS Program also contributed to PEPFAR's Continuum of Care by linking the private sector's HIV/AIDS testing, care, and treatment services, and supporting Anti-Retroviral Therapy (ART) and TB accreditation of private providers. By increasing access to training and Continuing Professional Development (CPD) opportunities, and coordinating with other programs to strengthen regulatory institutions, the Program supported the expansion of Human Resources for Health (HRH) to meet health objectives. Our team's capacity-building efforts were aligned with USG-funded health financing initiatives, which aimed to provide Ugandans with care and treatment options beyond the public and NGO sectors.

The PHS Program's team took into consideration and incorporated PEPFAR priorities, such as: 1) Focus on men older than 20 years—linking them to care and treatment and achieving viral suppression; 2) Integrate OVC platforms with the 90:90:90 strategy to scale up the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored and Safe) program; 3) Regain Voluntary Medical Male Circumcision (VMMC) momentum and target 15-29 year old men; 4) Target comprehensive programs for priority and key populations; and 5) Provide critical support for supply chain, HRH, lab, and systems improvement.

The PHS Program also supported roll-out of the new and updated guidelines for the private health sector towards epidemic control, including: test and treat, differentiated service delivery, targeted HIV testing policy, pre-exposure prophylaxis of HIV infection (all published in December 2016), and tetanus toxoid (TT) vaccination policy for VMMC (changed March 2017).

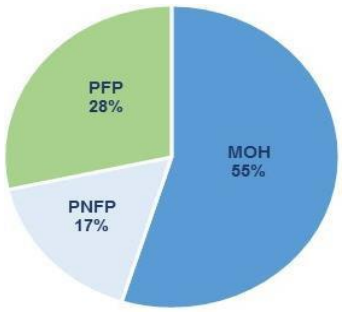
Figure 1: Key Achievements USAID/Uganda Private Health Support Program



Contextual Overview

The private health sector, which represents half of all health services delivered in Uganda, has an important role to play in the country's development. Improvements in the quality, availability, and access to health services in this sector can increase its already considerable contribution to reducing Uganda's disease burden. The private sector represents a large number of service delivery outlets and inpatient facilities that could be leveraged to achieve UHC. The last Health Facility Inventory (conducted in 2012) registered 5,229 health facilities in Uganda, 45% belonging to the private sector (see Figure 2). The faith-based sector in Uganda has a long history of providing access to essential services to some of the country's poorest and most vulnerable populations. Faith-based health facilities provide up to 35% of Uganda's primary health care services and 18-20% of Uganda's HIV/AIDS treatment services.

Figure 2: Distribution of Health Facilities by Ownership; N=5,229



Source: Uganda Health Facility Inventory 2012

In the absence of third-party payers, such as employers, insurance companies, or donor-funded programs, services provided by the PFP sector are primarily financed through out-of-pocket payments (OPP). Thus, the range, affordability, and quality of services are constrained by patients' ability to pay. Because low-income households and other vulnerable groups are the least likely to be able to afford them, increased delivery of services through the PFP sector should not be met by increased OPP, but through health financing approaches that shift the burden of service costs away from households. In recent years, donor-supported vouchers for RH and safe delivery services have made it possible to equitably leverage the PFP sector. In addition, USAID/Uganda's Health Initiatives for the Private Sector Project (HIPS), a predecessor program (to PHS) implemented by Cardno, supported partnerships that facilitated the development of employer-sponsored health services at the workplace and in surrounding communities to effectively leverage the PFP health sector.

The affordability of products and services in Uganda's private health sector is subject to the cost of procuring and distributing commodities, the ability of health providers to manage their costs, and the inclusion of PFP providers in health financing initiatives. Voucher-supported services, franchised provider networks, and social marketing programs have enabled the private sector to provide FP products and services affordably. For other types of services, however, providers are subject to costs that they cannot always control. Medicines and other products must be procured from suppliers who face their own challenges in production, importation, and distribution. Uganda's local manufacturing industry, which has the potential to contribute to reducing the cost of certain drugs, is plagued by insufficient access to capital, poor implementation of fiscal exemptions, and limited business opportunities. Improving the affordability of products and services in the private health sector therefore requires addressing the root causes of high prices, and the use of private or demand-side health financing mechanisms.

The quality of services within the private sector is subject to health regulations and their consistent enforcement, the willingness of providers to meet standards of care, and the availability of CPD services. Health regulatory bodies, which include four medical councils and the National Drug Authority (NDA), are collectively responsible for regulating professional practice and provision of CPD services. But weak and outdated laws (combined with insufficient resources) prevent the councils from fulfilling their missions. As a result, many health professionals practice without regulatory supervision and lack access to training and mentorship from qualified institutions. Private health providers, once they have completed their studies, also have few opportunities for in-service training and professional development causing them to fall behind their public sector colleagues in the treatment of complex conditions such as HIV/AIDS. There is, however, growing support from regulatory and professional associations in Uganda for both voluntary and self-

regulating programs in the private health sector (as demonstrated by their support for SQIS, which was established by the PHS Program).

Uganda has an estimated 17 million children bellow the age of 18, of whom 11% have been orphaned. 45% of the orphans are due to HIV/AIDS. Such conditions negatively affect the health, skills development, and nutrition of these children—jeopardizing their chances for a prosperous future. Support for OVC requires an integrated approach to address the complex challenges they face. This includes: empowering children, youth, and their caregivers to access core services like education and healthcare; strengthening systems to provide these core services delivery systems; and improving coordination of community-based services for efficiency and effectiveness along a range of care needed by each vulnerable child. USAID partners with the Ministry of Gender, Labor and Social Development (MGLSD) to ensure OVC receive support services that reduce their vulnerability during times of need.

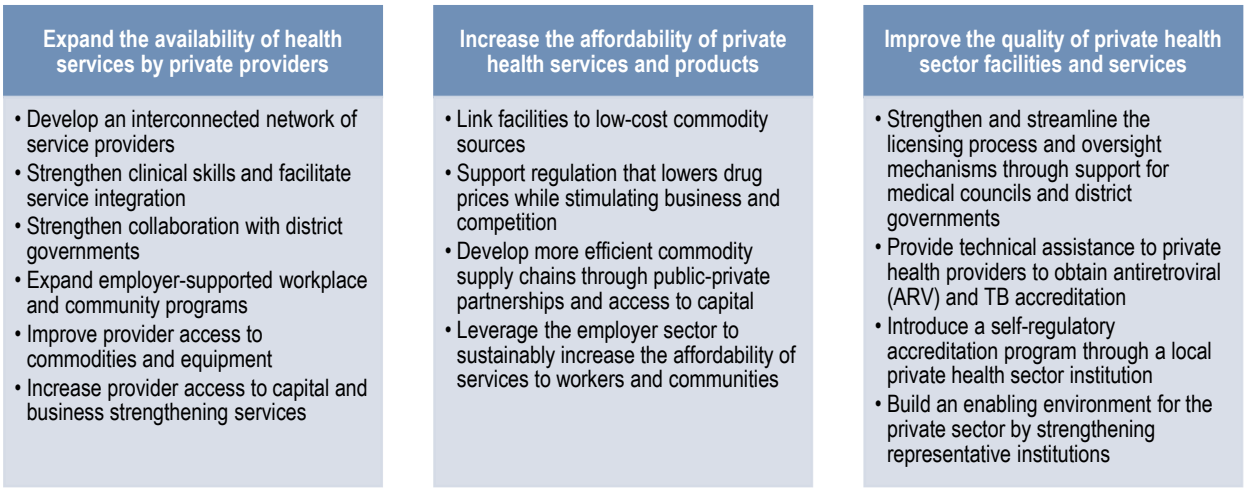
Harnessing the private sector's full potential to contribute to health and development goals requires technical assistance and policy interventions that address challenges described above. The PHS Program worked to strengthen, organize, and mobilize the private health sector to provide Ugandans with the option of obtaining high-quality health and OVC services from PFP and PNFP providers.

Program Objectives

The PHS Program's ultimate goal was to improve the credibility and cohesiveness of the private sector and expand the capacity of private sector providers. To achieve this, the Program was structured around three main intermediate results: 1) Expanded availability of health services by private providers; 2) Increased affordability of private health services and products; and 3) Improved quality of private health sector facilities and services.

The PHS Program used a multi-level model which focused on proving technical expertise, enhancing quality standards, improving access to capital, supporting accreditation, and establishing leadership in the private health sector, including with PFP and PNFP providers.

Figure 3: The USAID/Uganda Private Health Support Program – Program Design Model



As part of the expanded PNFP support, the PHS Program was directed to integrate its private sector interventions into the faith-based sector, to strengthen regulatory systems, improve reporting and financing, and build public-private partnerships. The aim was to strengthen faith-based sector health systems to expand the availability of and access to quality and sustainable essential health services, as well as HIV/AIDS services. These interventions included: adoption of self-regulatory quality improvement standards; A2F initiatives like the DCA; and support to private sector umbrella institutions. With regard to health systems

strengthening (HSS), the Program engaged in a private sector systems support model that transcends all six HSS building blocks[1]:

Figure 4: USAID/Uganda PHS Program – HSS Support Model

(1) Service Delivery	› Strengthened critical and differentiated service delivery in private sector facilities (including PFP and PNFP facilities).
(2) Health Workforce	› Strengthened skills among health workers; provided targeted Continuing Professional Development (CPD); institutionalized innovative approaches to task sharing and task shifting; disseminated policies, guidelines, standard operating procedures and job aids.
(3) Health Information Systems	› Mentored health facilities to access and ensure higher reporting rates [i.e. District Health Information System 2 (DHIS2) and Orphans and Vulnerable Children Management Information System (OVC MIS)]; › SQIS—enhanced service quality improvement within facilities; › Web-based HIV/AIDS Ordering System (WAOS)—strengthened forecasting, reporting, ordering, and stock management; › Web-based professional licensing platforms—facilitated registration and licensing of private sector health providers by three Ugandan medical professional councils; › Uganda electronic medical records (EMR)—rolled out recommended national electronic medical records system.
(4) Access to essential medicines	› Supported accreditation of facilities, strengthened logistics management information systems, and provided essential medications and supplies (i.e. ART, HIV Testing and Counseling (HTC), TB, malaria, FP/RH and maternal newborn and child health (MNCH) supplies, and safe male circumcision supplies and TT vaccines).
(5) Financing	› Diversified funding sources for PFP and PNFP facilities; identified cost efficiencies in financial management systems; facilitated fundraising and local resource mobilization; conducted training and counseling in business and financial management skills; supported adoption of best business practices; linked with key stakeholders from the private healthcare sector (i.e. franchise networks and healthcare associations); reviewed procurement systems; advocated to the Government of Uganda (GOU) for policy and resource allocation; facilitated opportunities to access financial loans under the DCA.
(6) Leadership and governance	› Engaged district health leadership and professional councils in the supervision of facilities, conformed to the required MOH standards; supported private health facilities to report to districts and MOH to facilitate accountability and sustainability; promoted governance functions of health facilities, regulated policies and standards, enhanced health facility reporting and accounting; supported private sector umbrella associations, including faith-based medial bureaus to strengthen capacity and enhance strategic planning.

The PHS Program employed a client-centered approach in the private health sector that supported the provision of: Targeted HTC aimed at identifying HIV-positive clients by targeting key and priority populations[2]; TB-related HIV services; VMMC for HIV prevention services; Malaria control; FP/RH services; MNCH services; and Prevention of mother-to-child transmission (PMTCT) services.

The Program leveraged the private sector's strengths, while at the same time addressing longstanding concerns about capacity, quality, and interests of the private sector. More specifically, the PHS Program

[1] Everybody's business: Strengthening health systems to improve health outcomes. WHO's framework for action. Geneva: World Health Organization; 2007

[2] Commercial sex workers, fishermen, pregnant and lactating women and their spouses, children and adolescents

helped Uganda's private health sector to build the capacity to meet the needs of large population groups, including those living in rural areas.

Furthermore, the Program pursued opportunities to leverage resources of other USAID and USG implementing partners to provide a comprehensive health package to its clinics. For example, the Program partnered with the USAID Food and Nutrition Technical Assistance (FANTA) Project for nutrition services and with the Program for Accessible Health, Communication, and Education (PACE) and Marie Stopes Uganda (MSU) to create demand for RH/FP services, due to their extensive expertise. The Program sought to tap into PACE's marketing expertise to create demand for these services at partner sites. The Program also introduced the USAID/Sida-supported DCA program to PACE's 200 Profam clinics.

Program Implementation and Results

Objective 1: Expanded Availability of Health Services by Private Sector Providers.

Key Achievements Under Objective One

USAID/Uganda Private Health Support Program has:

- *Supported 112 (95 PFP; 17 PNFP) facilities, and 36 faith-based community organizations across 40 districts to strengthen and integrate HIV/AIDS, TB, malaria, MNCH, FP/RH, nutrition and OVC services.*
- *Provided HTC services to 1,153,913 individuals, offered on-going ART to 39,144 adults and children, and newly enrolled 23,762 PLHIV on ART*
- *Increased Total Annual Client Load by 17% in PHS Program-supported facilities.*
- *Provided TT vaccination and circumcised 112,398 males*
- *Issued 248 grants delivering US$13.7 million in funding to local organizations*
- *Served 60,359 OVC and their caregivers, providing a comprehensive package of services and graduated 33,053 OVC from external support*
- *Created linkages between CBOs and private sector companies and generated over US$280,000 in cash contributions from the private sector*
- *Established LabNet Uganda, a network of private laboratories with uniform identity and quality of services*
- *Disbursed US$3.6 million through DCA credit guarantee initiatives to 83 private health sector borrowers; most of the loans were provided to owners of rural health facilities, many of whom were first-time borrowers.*

1.1. Expanded Access and Availability of Health Services

Over the last five years, the USAID/Uganda PHS Program has worked with health service providers and other key players in both the private and public sectors to expand availability of health services through the private sector. Focus in this area was towards building capacity of Private Healthcare Providers (PHPs) and PNFPs for improved geographical coverage and expanded service offerings (such as HCT, ART, VMMC, MNCH, FP, TB, PMTCT-Option B+, and nutrition services) targeting adolescents and young adults. The PHS Program undertook various strategies and activities towards expansion of availability of health services by private sector providers.

It was especially important for the PHS Program to engage large employers and new private sector partner sites in target districts to assess their capacity (and interest) in expanding health services to include VMMC, MNCH, FP, TB, PMTCT, ART, and nutrition, as well as services targeting adolescents and women. Large employers often have onsite workplace clinics that provide HIV/AIDS treatment to employees, their dependents, and surrounding community members. Furthermore, the PHS Program pursued opportunities

to leverage resources of other USAID and non-USAID implementing partners to provide a comprehensive health package to its clinics.

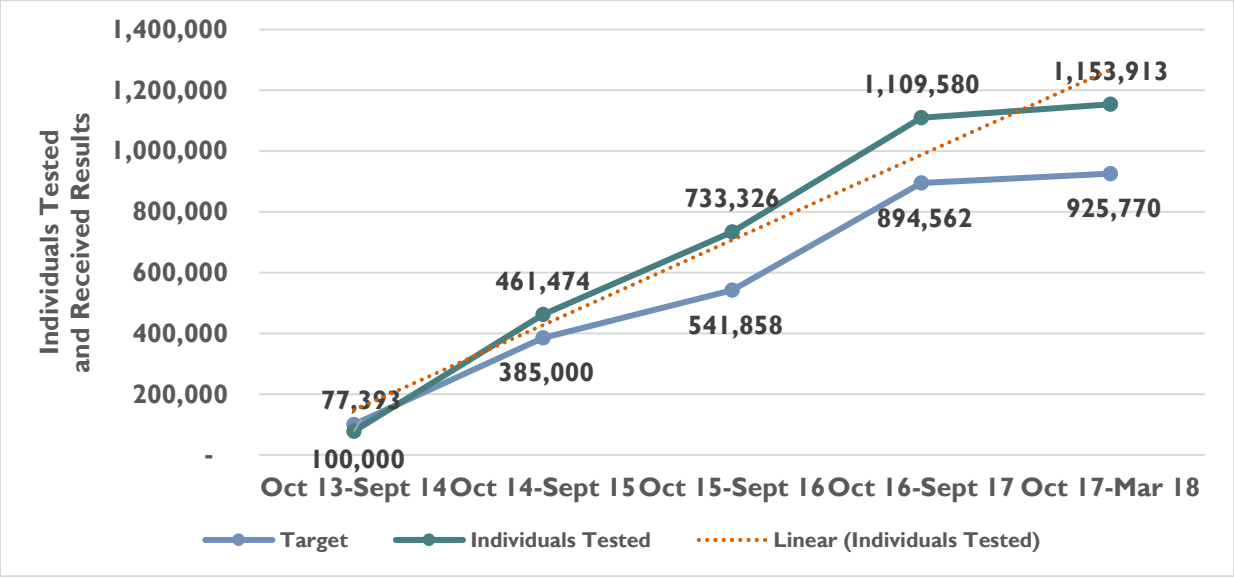
The PHS Program worked with low-volume ART sites to establish client referral linkages to high-volume sites, especially for services that could not be offered at low-volume sites. Examples of established referrals included Eskom Uganda Limited, a Njeru clinic in Buikwe district which refers HIV+ clients to St. Francis Health Care Services for enrollment into care. Another example was the referral and linkage of HIV+ clients from Dokolo home-based HTC program at Adok Health Center II to the ART Clinic at Agwata Health Center IV for enrollment into care, treatment, and support.

1.1.1. Integration of services at the private health facilities

The goal for this activity was to minimize missed opportunities towards provision of quality care by using unique and specific interventions (depending on current service capacity and comprehensiveness) with emphasis on integration of HTC, FP, TB, VMMC, and malaria prevention and management into existing MNCH, HIV, Out Patient Department (OPD)/In-Patient Department (IPD) services and community outreach, among others. The PHS Program achieved this goal through skills building (CME, training, learning sessions, mentorship, and coaching sessions), logistical support with supplies (for VMMC and FP), and data tools and integrated outreach with the facilities to deliver integrated services to target populations. Outpatient data from the 112 supported sites over four years showed an increase of 17% from 1,336,217 in 2014 to 1,603,939 in 2017.

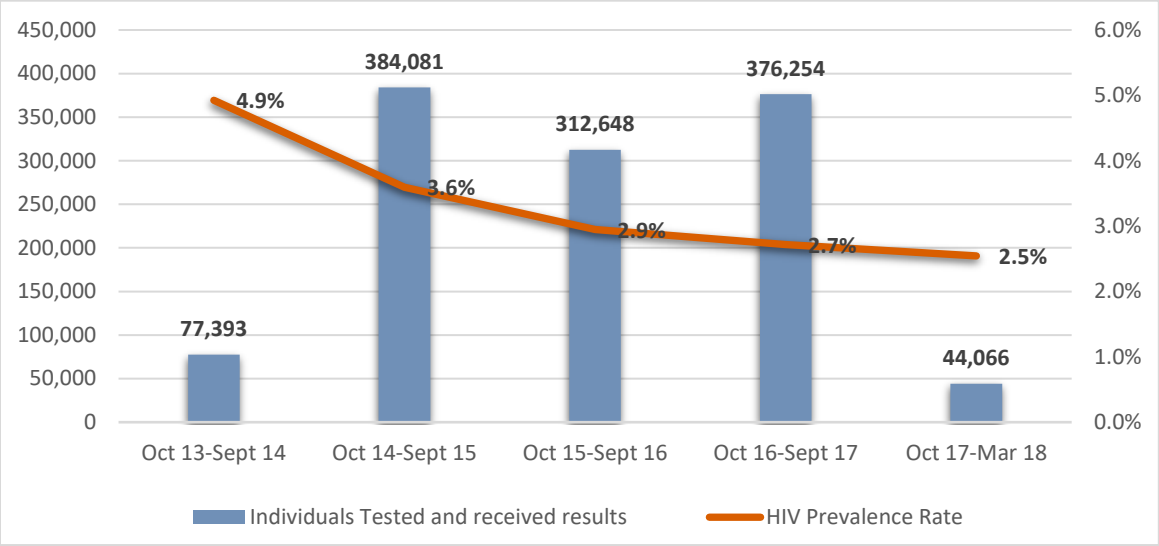
Integration of HIV Testing Services (HTC): During the life of the Program, 112 service outlets provided HTC to 1,153,913 individuals. The high achievement of the HTC targets with same-day results was attributed to the integration of HTC into other services (like VMMC and MNCH). In addition, health workers were encouraged to use Provider Initiated Testing and Counselling (PITC)—as opposed to Voluntary Counseling and Testing; they also received necessary training and mentorship, as well as HIV test kits and technical assistance to ensure timely and accurate reporting.

Figure 5: Cumulative HIV Counselling and Testing Services



Three percent of tested individuals (38,011) were identified to be HIV positive. Of the individuals who tested HIV positive, over 80% were linked into care.

Figure 6: Individuals Tested and HIV Prevalence Rates 2013-2018



The highest yield for HIV positive results was through the TB clinic and index client testing, while VMMC sites yielded the lowest number of positive results. The PHS Program performed fairly well in providing targeted HTC for men, due to implementation of mixed methods (such as using male champions and opinion leaders, emphasizing the benefits of early enrollment in care, and conducting community health campaigns using a multi-disease approach). Other strategies included creating male-friendly HTC at the facility and community levels, as well as prioritizing couple testing at PMTCT sites.

It should be noted, a greater proportion of men were tested in PFP facilities than in PNFP facilities—possibly due to short waiting times and flexible hours of service. PNFP facilities that had strengthened community components had better rates of linkage to care and treatment.

Strengthening care and treatment of HIV positive clients: The PHS Program provided a comprehensive chronic care and treatment service package to a total of 40,644 HIV positive individuals. The care package included assessment, diagnosis, and treatment of TB and sexually-transmitted infections (STIs), provision of cotrimoxazole prophylaxis, psychosocial, spiritual, and home-based care. Of the individuals who received care, 27,391 PLHIV were newly enrolled in care. Cotrimoxazole prophylaxis was provided to 38,438 individuals.

Figure7: Number of HIV Positive Clients Newly Enrolled in Care

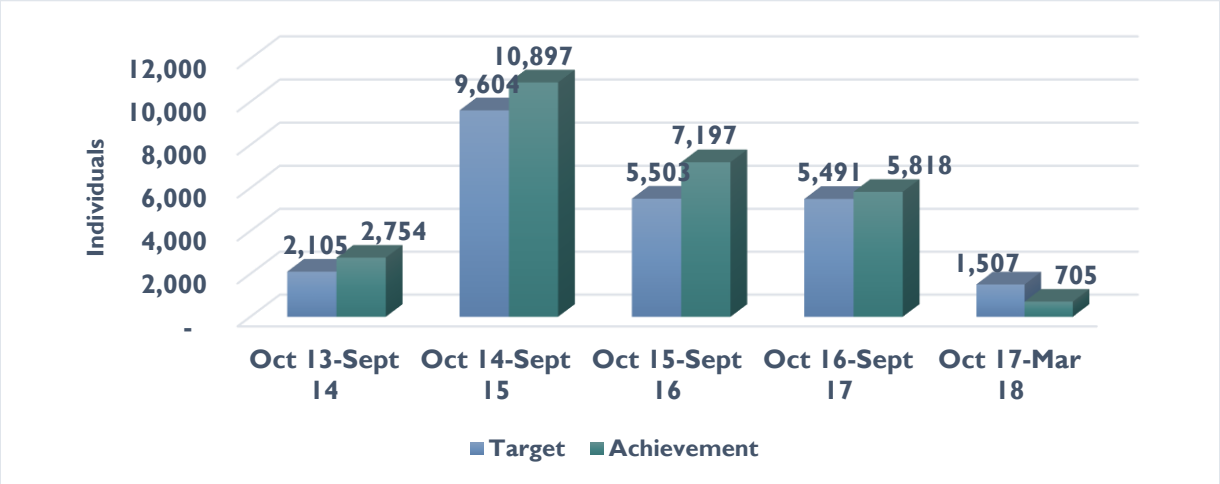
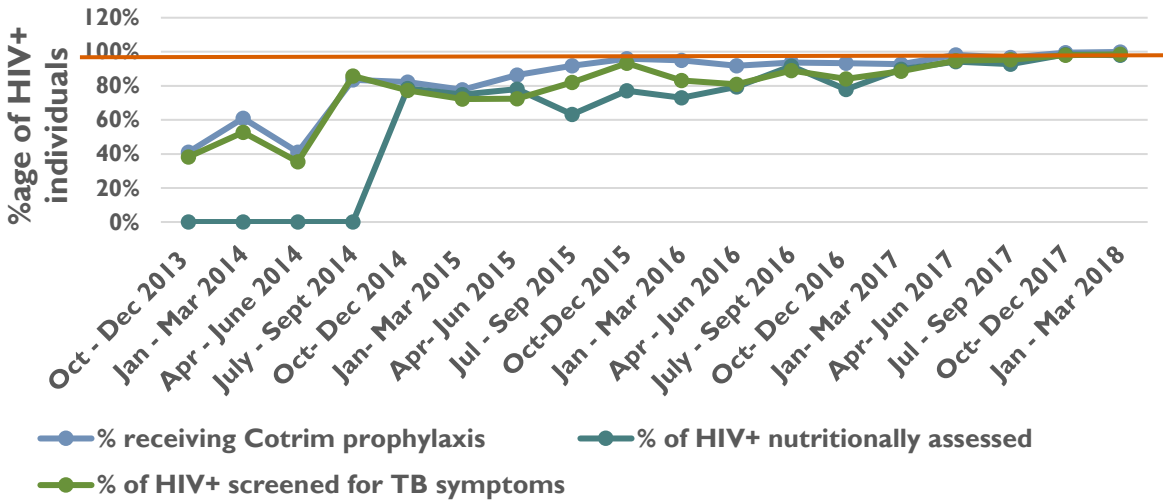
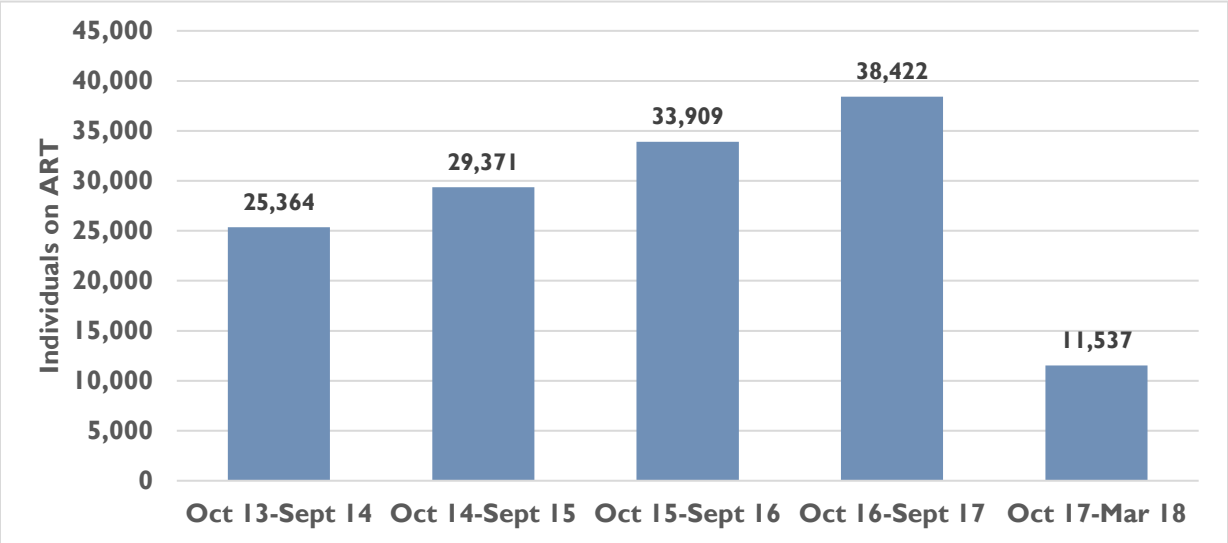


Figure 8: Percentage of HIV Positive Individuals Receiving Care Services



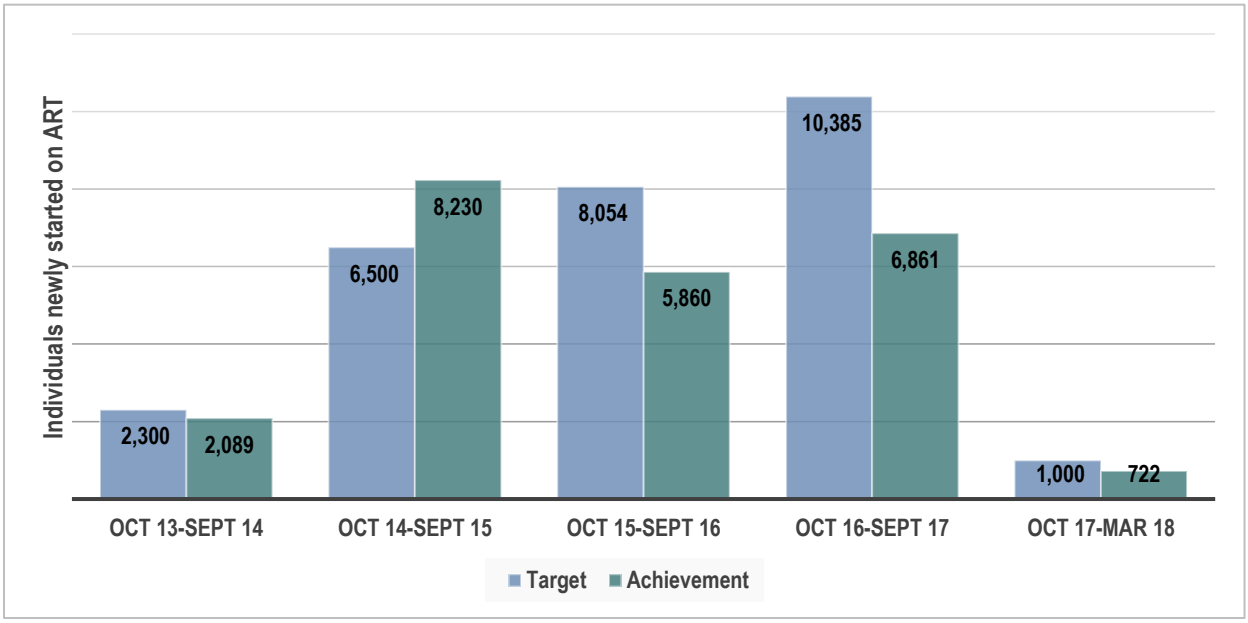
The PHS Program provided ART to a total of 39,144 individuals in 74 service outlets and a total of 23,762 (PNFP 14,900; PFP 8862) HIV positive individuals were newly enrolled on ART.

Figure 9: Number of Children and Adults Currently Receiving ART



The PHS Program rolled out the new consolidated guidelines for prevention and treatment, including the "Test and Start" strategy. Despite this, the Program was unable to achieve the target for new patients initiated on treatment, as well as current clients on treatment due to: the delayed roll-out of the consolidated guidelines and loss to follow-up of those on ART.

Figure 10: Number of Children and Adults Newly Enrolled on ART

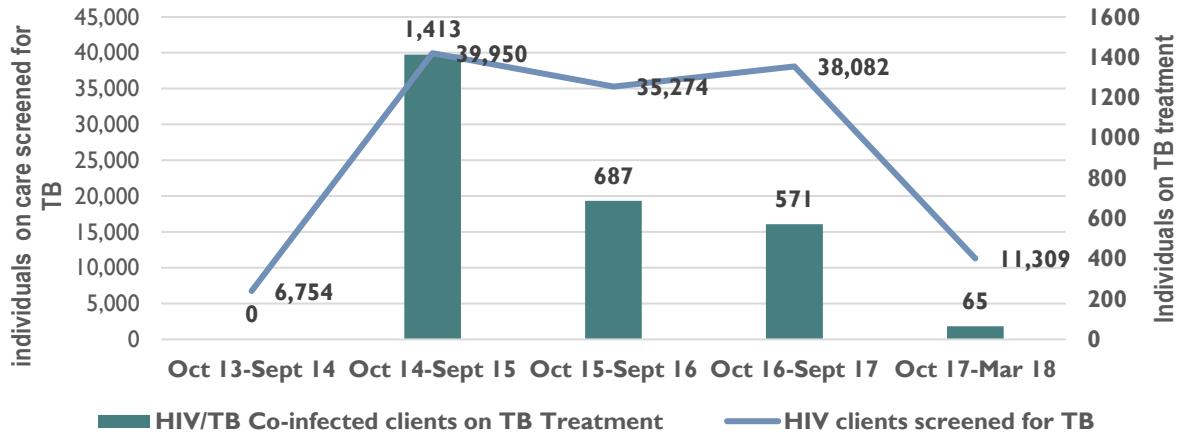


The Program achieved 53% coverage for viral load (VL) testing, with an average suppression of 88%. It should be noted that children and adolescents contributed to lower viral suppression rates. The PHS Program continuously supported private sector sites to improve access to viral monitoring by removing cost barriers attached to immunological laboratory investigations. To access Cluster of Differentiation 4 (CD4) cell count testing and viral load monitoring services, the sites were linked with the regional sample transportation-hub network motorbike riders.

Integration of TB/HIV services: TB services remained an integral part of the chronic care package. The PHS Program worked closely with National Tuberculosis and Leprosy Program (NTLP) and the Regional and District TB and Leprosy Supervisors (DTLS) to strengthen integration of TB/HIV services at all service delivery entry points. The Program focused on intensified TB case finding, Isoniazid Preventive Therapy (IPT) accessibility, TB infection prevention and control and initiation of TB treatment for all confirmed cases. HIV positive clients were screened for TB at every ART clinic visit, and TB patients were screened for HIV co-infection. The Program supported dissemination of national TB guidelines and worked with partner facilities to ensure availability of TB drugs, including isoniazid for prophylaxis and reagents for ZN, and facilitated the availability of Gene Xpert testing at district hubs.

As a result, a total of 39,950 HIV positive individuals were screened for TB using the intensified case finding guide. Consequently, 4,809 new TB cases were identified and started on TB treatment. PHS Program partner facilities reported a 71% TB treatment success rate. 85% of patients with new and relapsed cases of TB had a documented HIV positive status. Figure 11 demonstrates the number of Co-infected patients screened and started on TB treatment.

Figure 11: HIV/TB Co-infection

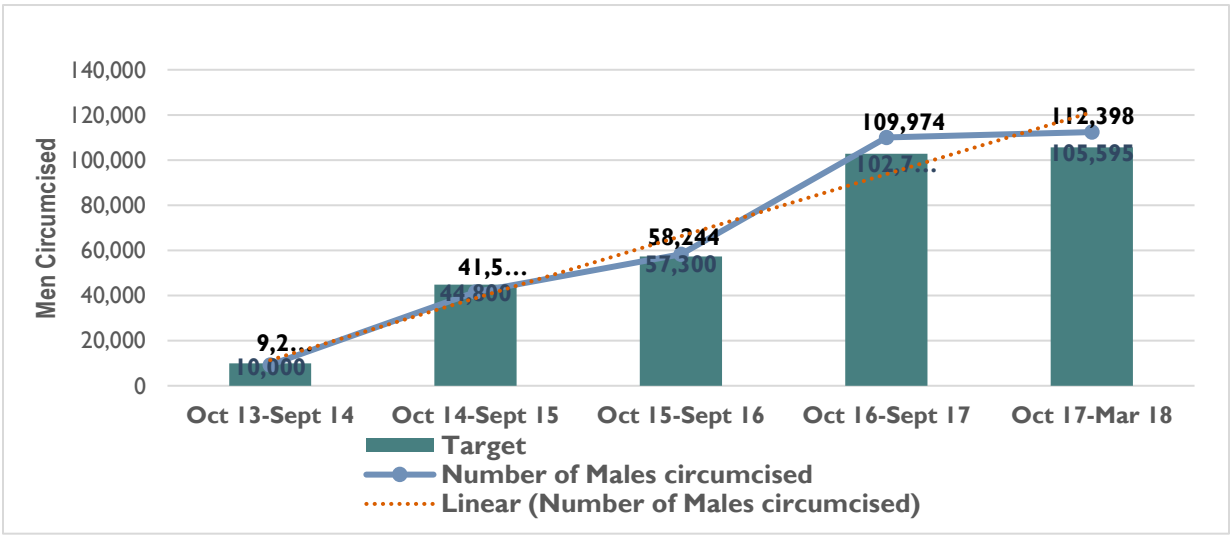


The PHS Program provided onsite training, mentorship, and coaching with emphasis on priority areas such as: TB case identification using index client model; treatment retention; proactive identification of children with probable TB using the intensified TB case finding form (ICF); management of pediatric TB; use of Gene Xpert (indication for use, sample collection, packaging and transportation and interpretation of results); infection prevention and control; HMIS support; and supply chain management for TB commodities.

Integration of VMMC services: The PHS Program supported VMMC sites (16 PNFP and11 PFP) in 27 districts. 112,398 males received TT and were circumcised. Of those, over 55% were within the priority age pivot of 15-29. As part of VMMC services, HIV testing was offered, and 96% of males tested for HIV and received results.

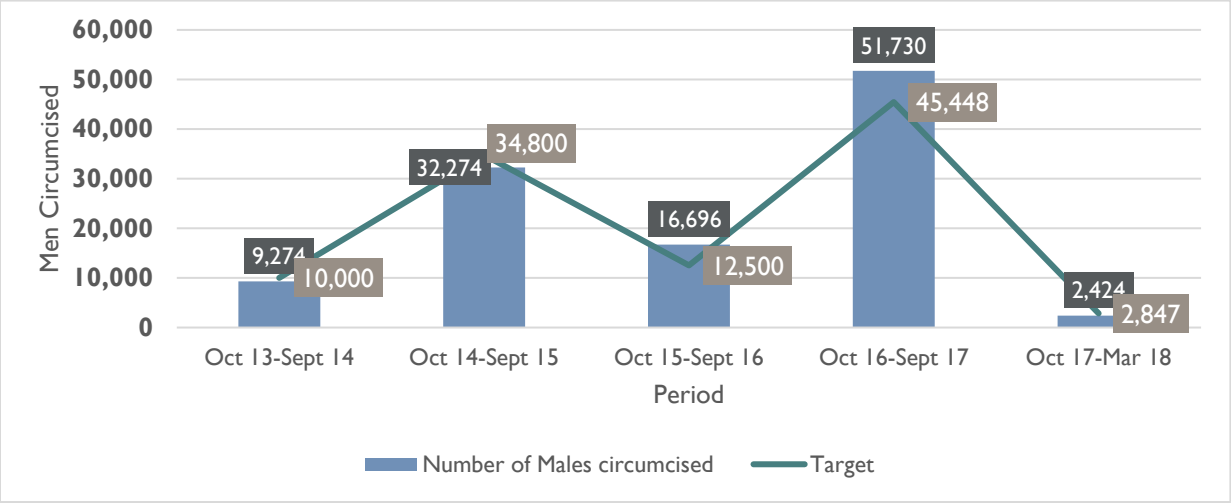
The PHS Program constantly surpassed Country Operational Plan targets. This is attributed to the intensified follow up and circumcision of clients who had initially received one dose of TT, but had not returned. Other strategies included reassessing and determining individualized VMMC site capacity against performance and putting in place tailored mechanisms that enabled sites to achieve high results. Strategies included mobilization through radio programs, peer-to-peer mobilization (especially for older boys) and using role models in the community as champions for circumcision.

Figure 12: Cumulative Number of Males Circumcised



The PHS Program utilized continuous quality improvement approaches and provided onsite coaching and mentorship at all private sector VMMC sites. Coupled with routine data validation activities and results, this indicated that the data reported was of good quality. Through AIDSFree, the Program continued to work with Green Label waste management company and the VMMC waste was adequately managed.

Figure 13: Males Circumcised vs Annual Targets



91% of males who received VMMC services were followed up within 48 hours, 71% within 7 days, and 21% beyond 7 days. The Program maintained good performance on follow up rates, especially at 48 hours and 7 days; this was due to intensified follow up by partner facilities. The facilities sustained dedicated VMMC teams to conduct follow up in the community and also emphasized to clients the benefits of returning post-circumcision for review.

Results indicated that 1,042 adverse events (AEs) were encountered, representing less than 1% of circumcised patients.

Integration of FP services: The PHS Program worked to strengthen integration of FP services into HIV care and treatment. The Program supported 62 facilities (47 PFP, 15 PNFP) to provide high-quality voluntary FP counseling and services through capacity building of health workers (training, mentorship, and coaching), and provision of FP commodities and data management tools. Health workers were mentored to integrate FP into other existing services (like HIV/ART, VMMC, and MNCH) with emphasis on FP, prong 2 (elimination of mother-to-child HIV transmission), and preventing unwanted pregnancy among women living with HIV.

In line with the strategic objectives of the MOH National Implementation Plan (2017-2020) for long-term reversible contraceptives (LARC) and permanent methods (PMs), the PHS Program worked to address skill gaps among health workers in providing LARC/PMs. The increase in the number of LARC/PMs noted in Year 4 is attributable to 10-day simulation and practicum training—245 health workers (from 46 private health facilities) were trained in LARC and PM. The WHO Medical Eligibility Criteria wheel for contraceptive use was provided to each training

Medical officers training in LARC/PM.

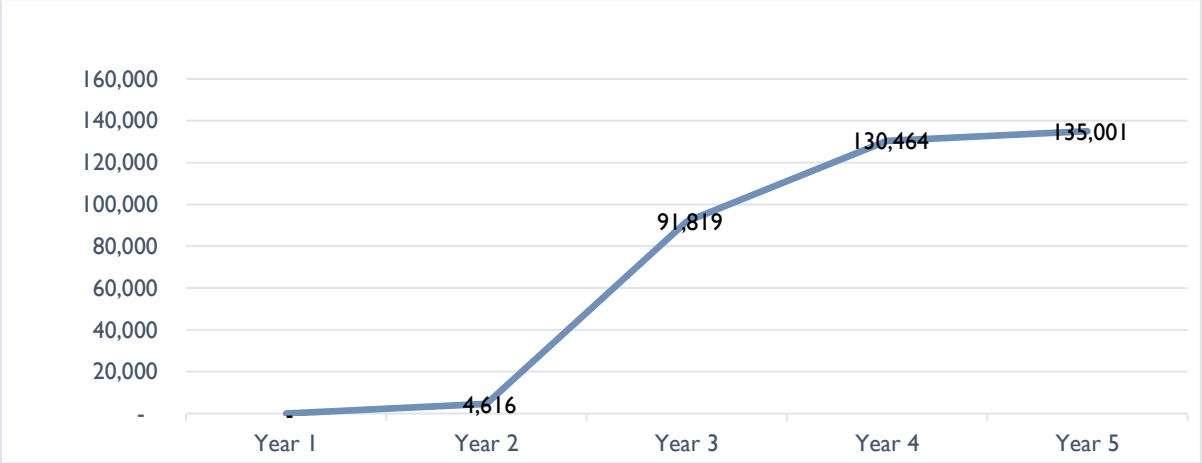
participant to support health workers in selecting the best FP choice, based on pre-existing medical conditions.

The Program also supported use of a consumption-based supply system and integration of FP services, and promoted principles of voluntarism and the client's right for free, informed choice.

As a result of the above, a total of 135,001 new acceptors (88,938 PFP; 46,063 PNFP) accessed FP services. Higher attendance at PFP sites was due to flexible hours, availability of mixed methods at the facilities, skilled personnel, and willingness of service providers to provide modern methods of contraception.

85% of targeted service delivery points offered FP services by the end of the Program. Cumulative information for annual performance on new acceptors of FP services is provided in Figure 14 below.

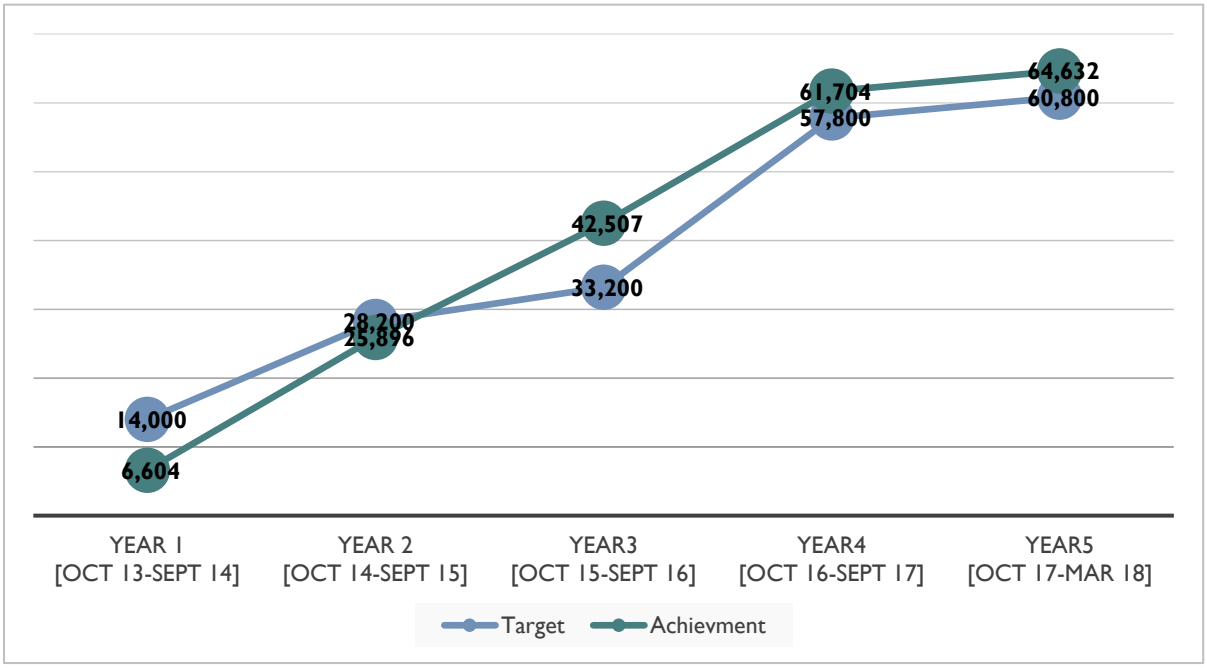
Figure 14: Cumulative Number of New Acceptors of FP Services



Integration of malaria services: The PHS Program supported PFPs and PNFPs to strengthen the integration of malaria management into general care, MNCH and HIV/ART care. The Program emphasized support for malaria in pregnancy, integrated case management of complicated malaria (in line with revised guidelines), and use of a rapid diagnostic test for evidence-informed malaria treatment among pregnant women and children under five. The Program addressed the following health worker skill gaps and facility-level challenges noted during the facility-based post-training follow-up period: lack of updated Information Education and Communication (IEC) materials, lack of laboratory malaria standard operating procedures, failure to implement intermittent presumptive therapy (IPTp) and directly observed treatment (DOTS), inadequate information provided to clients during health talks on proper use of Long Lasting Insecticidal Nets (LLINs), non-adherence to updated clinical treatment guidelines (e.g. use of artesunate for management of complicated malaria), stock outs of malaria-related commodities, and insufficient malaria data analysis to guide practice. As a result, a total of 64,632 pregnant women (38,623 PNFP; 26,009 PFP) received two or more doses of IPTp in PHS Program-supported facilities. As indicated in the chart below, the Program surpassed the targets for this indicator.

The Program trained 253 health workers from both PNFP and PFP sites in integrated management of malaria and conducted post-training follow-up mentorship sessions. Additionally, the Program supported coordination between the district health teams, warehouses and private health facilities in order to strengthen logistics management for malaria medicines, diagnostic kits and supplies, including insecticide-treated bed nets. In collaboration with USAID/Uganda's Communication for Health Communities (CHC) Program, the PHS Program disseminated IEC materials to: enhance the reach and intensity of behavior change communication, support malaria-related health education talks, guide counseling sessions, and facilitate adherence to the national malaria treatment guidelines.

Figure 15: Cumulative Number of Pregnant Women Who Received Two or More Doses of IPTp



Integration of MNCH and PMTCT services: PHS Program-supported facilities provided an essential package of MNCH services, ensuring skilled attendance during pregnancy, delivery, and postpartum. The Program focused on identification and management of obstetric complications, including early referral, IPTp, identification and management of infections, nutrition assessment, TT vaccination, and PMTCT using the continuum of care approach. During the first antenatal care (ANC) visit, women received iron and folic supplementation and LLINs.

In maternity wards, partographs were used to monitor delivery and outcome of labor, and to perform active management of third stage of labor (AMTSL). Neonatal resuscitation was performed for infants with poor Apgar scores. At birth, all 94,738 babies were provided with newborn care that included: airway assessment, breathing and circulation assessment, thermal protection (skin to skin), cord care (health workers encouraged to use chlorhexidine recommended by the new guidelines in essential newborn care), exclusive breastfeeding initiation, infection prevention-including eye care (tetracycline eye ointment) and immunization. Facilities that reported at least one neonatal death earlier in the year had a perinatal death review/audit carried out. The PHS Program supported health facilities in setting up and institutionalizing perinatal death review committees through other existing committees for quality improvement , mentorship and coaching in partograph use, neonatal resuscitation using simulators, essential newborn care (cord hygiene, infection prevention and control—including early initiation of breast feeding), and helping mothers survive. Techniques focused on preventing primary post-partum hemorrhage—one of the leading causes of maternal death in Uganda—and improvement in documentation. Facilities were given the BABIES matrix information to improve processes and systems for better perinatal outcomes.

Ms. Namubiru Betty, a registered comprehensive nurse at Kinyara HC III in Masindi District in Uganda educating mothers about cervical cancer during the eMTCT campaign at Kinyara Sugar Limited

The PHS Program strengthened systems to retain mother-baby pairs in care, eliminate mother-to-child HIV transmission, and maximize child survival. The Program supported 63 (PFP 48; PNFP 15) private health facilities to integrate and offer high-quality comprehensive PMTCT services in line with the globally- and nationally-accepted four-pronged strategy. An ANC package was delivered to all pregnant women, regardless of HIV status. A total of 122,926 pregnant women attended ANC in PHS Program-supported facilities for the first time during their current pregnancies. The Program identified 10,559 HIV+ pregnant women, and 77% of them received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission. As a result, the mother-to-child transmission rate declined from 5% to <2%.

Health workers were trained in elimination of mother-to-child HIV transmission course (eMTCT) that covered: chronic care, including ART to HIV-infected pregnant and lactating women, and care and treatment for HIV-exposed and infected infants and children; management of logistics for implementation of Option B+ at the facility; and correct documentation and submission of PMTCT Option B+ reports.

1.1.2. Reliable access to commodities, essential medicines, test kits and supplies

The PHS Program worked to strengthen access to essential medicines, test kits, and supplies using multiple concurrent strategies. The Program conducted logistics performance assessment and mentoring of health facility staff at 71 sites; reviewed ordering, storage, distribution, and dispensing practices at each facility; printed and distributed standard operating procedures to staff for future reference; and analyzed electronic copies of facility ARV orders to determine their completeness, correctness of submitted information, and adherence to current guidelines when enrolling new clients.

The Program used quarterly visits to assess health facilities. Some gaps identified during such visits included: poor coordination in the supply of TT vaccines, TB, and FP commodities (which caused frequent stock outs—especially of TB commodities—and excess stocks—especially of FP commodities) at the facilities, inappropriate storage practices, and inadequate space—particularly in PFP sites; lack of skills amongst health workers for appropriate stock control and logistics management. Strengths noted included facilities that had the knowledge and skills to determine which medicines to order using the dispensing logs, and had access to computers and connectivity. The identified gaps and challenges were addressed through tailored management and training strategies provided by the PHS Program. For 10 PFP health facilities that were experiencing storage challenges, the Program procured and distributed storage cabinets.

Rolled out the Web-Based ARV Ordering System (WAOS): The PHS Program worked with the medicines and logistics warehouses (JMS) to support the acquisition of user rights and conducted on-the-job training for all staff involved in ordering of ARVs using WAOS. By Program Year 5, all supported sites had WAOS user rights to enable them to input their orders directly into DHIS 2. This reduced delays, as it highlighted and corrected obvious errors in filling order forms before they were sent to the medicines and logistics warehouse.

To minimize stock outs, prevent expiration and pilferage, and reduce the risks of disrupting service delivery, the PHS Program worked with JMS and the MOH (NTLP, Uganda National Health Laboratory Services and AIDS Control Program) to ensure a stable and constant supply of medicines [ARVs, test kits, Safe Male Circumcision (SMC) kits and related supplies and FP commodities]. The PHS Program developed a warehousing and distribution system to hold excess stock that would be supplied to the private health facilities on a bi-monthly order and delivery schedule.

Streamlined TB Supply Chain Systems: The Program noted that TB medicines and supplies were the most frequently stocked out items in the private sector. The main cause of this was uncoordinated ordering and supply systems which did not prioritize the private sector. The Program continued to advocate for a more streamlined supply system for TB medicines in the PNFP and PFP sectors, including granting access to the TB web-based ordering system for private facilities.

1.1.3. Facilitated Establishment of the Private Laboratory Network

Uganda lacks the governance structure to manage a mixed health delivery system; as a result, it still has a largely unregulated private sector, where labs, drug shops, and health providers operate outside of the official health system. Lack of effective laboratory services—an essential component of a functional healthcare system—results in delayed and inaccurate diagnosis of disease, leading to preventable morbidity and mortality, drug wastage, high expenditure for government/organizations and individuals, as well as loss of confidence in the healthcare system.

Uganda Labnet Logo Identity

Comprehensive health services must be augmented with good laboratory services. Although medical laboratory systems and public health laboratory networks are a vital component of Uganda's health system, the private sub-sector has been one of the least developed and most neglected. In Year 4, the PHS Program embarked on a process of supporting the formation and operation of a private for-profit medical diagnostic laboratory network, Labnet Uganda.

Labnet Uganda draws upon Cardno experience in Kenya. The Association of Kenya Medical Laboratory Scientific Officers (AKMLSO) launched the *Labnet* network in 2015; it currently has 90 members. Labnet offers consumers of all income levels a clearly-identifiable place to obtain accurate diagnostic tests at an affordable price, with opportunities for standardizing quality, lowering prices, mitigating competition from unregulated informal market players, and offering better overall health outcomes for patients.

Labnet Uganda is comprised of Uganda Medical Laboratory Technology Association (UMLTA) members who operate independent for-profit private medical laboratories. The network follows a franchise model; the PHS Program supported UMLTA to adopt the Labnet name with a goal of achieving a uniform East African Community-wide identity for qualified independent medical laboratories.

Labnet Uganda is a for-profit commercial organization owned and operated by its members. The PHS Program provided the organization with technical assistance to develop a shareholding structure with Labnet members in the majority. Minority shares were set aside for potential financial investors to take an equity stake.

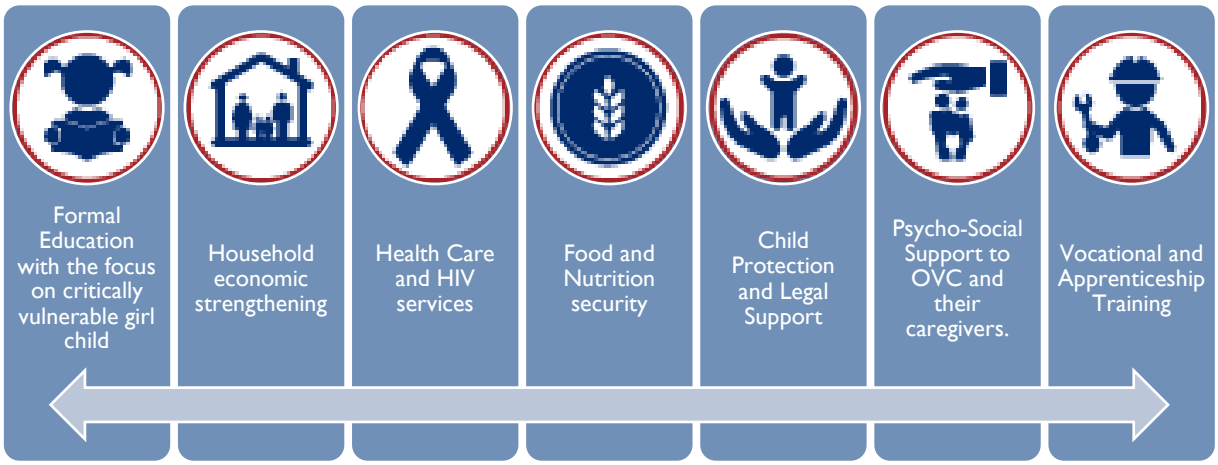
The Program also provided following technical assistance to Labnet:

- Supported official formation of board committees, with each committee assigned a chair. Committees included membership and quality standards, marketing and communications, supply chain and procurement, and finance.
- Developed branding guidelines, including a logo for Labnet Uganda.
- Finalized the company registration process.
- Provided quality standards and business skills training for 28 Labnet members.
- Completed review of the Standard Operating Procedures.
- Conducted a training on market-based approaches that covered the basic concepts of the Making Markets Work for the Poor (M4P) approach. This training was attended by 30 participants.

1.2. Expanded OVC service delivery

The PHS Program, in line with USAID, PEPFAR and MGLSD priorities, worked through 46 CBOs in 28 districts to support a total of 60,359 (30,783 female and 29,576 male) OVC and their families to access a package of comprehensive services. Interventions for OVC were child-focused (recognizing children's needs at different ages and stages of development) and also family-centered. See Figure 16 for the list of services provided by the PHS Program.

Figure 16: Comprehensive Service Package Provided to OVC



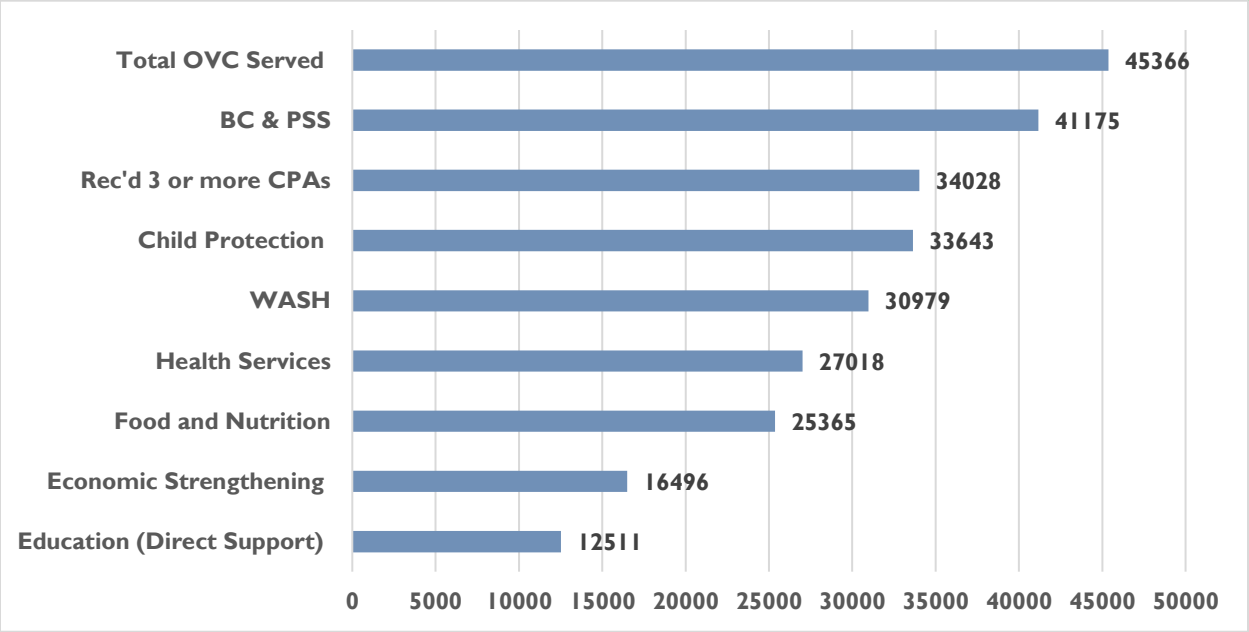
The PHS Program has utilized multiple methodologies to meet the needs of OVC. This involved:

- Family-based approaches to care and support of OVC
- Case management approaches with standardized procedures in line with MGLSD guidelines in identifying, assessing, enrolling and monitoring beneficiary OVC and their families
- The "UNAIDS 90-90-90" approach of intensifying HIV testing, linking the HIV-positive children into care, and promoting adherence to treatment as a way of suppressing viral load
- Promoting the DREAMS Stepping Stones model to continue empowering AGYW
- Facilitating formal education support for OVC from critically vulnerable households by providing school subsidies for girls to transition from primary to secondary level
- Strengthening child protection and safeguarding
- Promoting sexual reproductive health for adolescent girls to reduce HIV infections and unwanted pregnancies
- Preventing Gender Based Violence (GBV) and Violence Against Children (VAC) and supporting survivors to access healthcare and legal support,
- Giving special attention to children with disabilities (CWD).

Program activities were focused on creating enabling structures/systems for OVC to access to education, safety, health services, and economic stability. See figure 17 for OVC supported per service area.

The PHS Program and grantees actively participated in district and sub-county OVC committee meetings and other coordination activities, engaged the Community Development Officers (CDOs) in supervision of home visits and in community dialogues. District extension workers were also part of the food and nutrition training activities, as they provided technical input for caregivers during demonstrations on back-yard gardening. The Program took part in regional review meetings for the OVCMIS and participated in OVC working group meetings to share lessons learned and report program challenges and accomplishments.

Figure 17: OVC Supported per Service Area



1.2.1 Education

Despite GOU's Universal Primary Education (UPE) and Uganda Secondary Education (USE) programs, many children from vulnerable households keep away or drop out of school, due to auxiliary school demands (such as uniforms, lunch, books, sanitary materials for girls), as well as inadequate parenting. The PHS Program focused on addressing barriers to accessing formal education by OVC. The program applied the Vulnerability Index tool (developed by MGLSD) to assess the level of household vulnerability to determine OVC who needed continued external material assistance in order to enroll and remain in school, while focusing on economic empowerment of their caregivers. 30% of households were assessed as critically vulnerable, and their children were supported with scholastic materials, including sanitary materials for girls. The Program supported a total of 12,511 OVC by paying school fees and providing scholastic materials, with the focus on transitioning girls from primary to secondary level and ensuring their retention. Social workers from supported CBOs collaborated with teachers to monitor student attendance and conducted follow-up visits for those who were missing school.

Aware that limited or lack of access to sanitary towels is among the leading cause of poor school attendance, poor performance and drop out among adolescent girls, the Program trained adolescent girls to make cost-friendly, hygienic re-usable sanitary towels.

1.2.2. Household Economic Strengthening

The HIV pandemic affects the economic stability of families and the children in their care by interrupting income streams, depleting assets, introducing labor constraints, and increasing dependency ratios. Household economic empowerment remained key to the provision of essential services to OVC. The PHS Program focused on enhancing capacity of OVC and caregivers to increase their incomes and asset growth through establishment of Village Saving and Loan Associations (VSLAs); training of caregivers and OVC on business initiation and management; linking them to lending institutions; and training them in entrepreneurship skills like soap- and candle-making.

The Program supported establishment of 466 VSLAs, reaching 11,650 members. VSLAs were supported to build their savings portfolio and loan activities. Group funds steadily grew to an average of UGX

3,000,000—increasing access to business start-up capital for individual members. Continuous technical assistance was provided to VSLA leaders to educate them on basic book keeping, records management, and roles/responsibilities, and to ensure sustainability of the VSLAs. A total of 3,250 (906 male; 2,344 female) group leaders were trained across all 466 VSLAs. All groups were encouraged to establish loan management committees. These committees were a pre-requisite for successful management of loan funds, since they were responsible for assessment, disbursement, and recovery of loans advanced to members.

Caregiver and an OVC at her food/market stall that she started after borrowing money from a VSLA in Wakiso

Many OVC caregivers who joined VSLAs continue to successfully run small businesses. However, the major factors constraining growth and development of income generating activities include limited access to finance, lack of technical skills and low economies of scale. Access to credit for start-up capital from commercial lending institutions and comparative high interest rates remained an obstacle to most poor caregivers in initiating credible businesses—despite their desire to get out of poverty. Realizing this, the Program mentored grantee staff on strategies to link OVC caregiver groups to low-interest Savings and Credit Co-operatives (SACCOs)—poor-friendly banks (such as Centenary Bank), and government poverty alleviation programs such as Community Driven Development (CDD), National Agricultural Advisory Services (NAADS) and Northern Uganda Social Action Fund (NUSAF). In addition, the Program leveraged private sector support and economic opportunities for OVC and their caregivers. *See section 1.2.9 for more details*.

The PHS Program provided entrepreneurship skills training to 130 adolescent girls and young women (AGYW) at risk of contracting HIV on soap-making and baking, which enabled them to meet personal basic financial needs and reduced their exposure to unstable, exploitative sexual relationships. The training also empowered OVC with life skills that resulted in high self-esteem and involvement in decision-making on issues that affect their lives. The program also trained a total of 11,524 caregivers in business initiation and management of income generation projects.

Teenage mothers undergoing skills training organized by Masanafu Child and Family Support in Rubaga Division, Kampala City, April 2017.

1.2.3. Support to Apprenticeship and Vocational Training for out-of-school OVC

Some of the apprentices who received start up kits at Chain Foundation in Mukono

The PHS Program organized vocational training for 5,615 out-of-school OVC to support them in acquiring technical and vocational skills to facilitate their entry into the labor market. The Program trained 260 artisans and vocational instructors to use Apprenticeship training manuals to improve their pedagogical, testing and assessment skills. Follow up to ensure that trained instructors were using the knowledge and skills acquired revealed that most were making lesson plans before commencing trainings. This greatly improved the training and assessment of trainee's progress before graduation and distribution of business startup kits.

The Program procured and distributed start-up kits to OVC who had completed vocational training. Kits included equipment and supplies for tailoring, metal fabrication, hairdressing, shoe-making and repair, carpentry, building and concrete practice, and baking/confectioneries. Before distribution of these kits, the OVC were assessed by the Directorate of Industrial training (DIT) to ascertain their readiness. Due to limitation of funding, the PHS Program was unable to provide start-up kits to 80 OVC from Mbarara and Kakinga. We recommended to USAID and in-coming USG regional implementing partners to consider procurement of start-up kits for OVC who successfully completed the course.

1.2.4 Healthcare and HIV services

The PHS Program enabled 42,593 active beneficiaries receiving support from PEPFAR OVC programs to access HIV services. The Program used a number of methods, including: home-based HTC, community outreach [working closely with trained volunteers/village health teams (VHTs) and facility-based focal persons], and referrals to health facilities. The Program focused on identifying and enrolling OVC who were infected and directly affected by HIV, increasing the number of OVC who knew their HIV status. As a result, 25,693 OVC were tested for HIV and 1,257 who tested positive and were linked to care and treatment services.

Aware that adolescent girls are at a higher risk of acquiring HIV, unwanted pregnancies, and facing domestic violence, the Program used the DREAMS Stepping Stones model to continue empowering AGYW and to create enabling structures/systems for their access to education, safety, health services and economic opportunities. A total of 42 adolescent peer leaders/educators representing in and out-of-school OVC and 126 female/male adult mentors were identified from 42 organizations and trained in HIV prevention, sexual reproductive health, life skills, communication skills, and negotiations skills. The adult mentors (including teachers previously trained in psycho-social support and health facility youth-friendly services focal persons) received additional training on setting up safe places, facilitating adolescent peer activities, managing referrals, reporting, and developing a work plan for their respective sites.

1.2.5. Food and Nutrition Security

The Program trained community volunteers and VHT members on nutrition assessment, counseling, and food security. A key objective of the training was to build capacity of community systems to link malnourished children to HIV care points to assess their HIV and TB status. A total of 1,156 (760 Female, 396 Male) community volunteers and VHT members were trained.

Left Photo: Community Volunteers in Mbarara Archdiocese conducting mid-upper arm circumference measurement to identify malnourished children.

Right photo: OVC and their caregivers at an HCT outreach center mobilized by KORD Jinja.

The PHS Program, with support of community volunteers, trained a total of 22,293 caregivers on food security and nutrition. Nutrition trainings focused on: food groups and food mixes; food handling and preparation; infant and young child feeding; proper hygiene practices; and prevention and management of malnutrition at the community level. Food security trainings focused on: kitchen gardening; modern farming techniques; post-harvest produce handling; value addition, energy saving techniques; and referral and linkages with other actors. The immediate outcomes observed by CSOs included increased knowledge on how to make the food mix commonly known as "*ekitoobero*" using locally-available materials, improved water and sanitation practices, and better identification of malnutrition cases in the community.

1.2.6 Child Protection and Legal Support

The PHS Program worked with communities to increase awareness about the importance of birth registration. The Program team worked with local government structures to reduce the cost of birth certificates to remove financial barriers for OVC in obtaining this important document. For example, Kiwanyi Moslem Support Initiative in Iganga negotiated the reduction of the cost of birth certificates to an affordable fee of UGX 3,500. The Program was able to assist 31,643 OVC to acquire birth certificates.

Sensitization on child rights and prevention of child abuse (both at home and school) were important initiatives supported by the PHS Program. The Program partnered with MGLSD's National Trainers on Child Safeguarding to train OVC grantee staff (program coordinators, social workers and monitoring and evaluation staff) to institutionalize child safeguarding.

A total of 88 (42 male; 46 female) OVC grantee staff from 46 CSOs/FBOs were trained. The immediate outcomes were development of child safeguarding policies and approval by their respective organizations' boards. The grantee organizations agreed on the roll-

OVC in Lira were supported by AMUCA-SDA to obtain birth certificates—critical to child protection and access to essential services.

out plan to train community volunteers and signed the code of conduct. All OVC partners identified Focal Persons to implement this important initiative.

Through partner CSOs, the Program reached 15,702 with child protection services that targeted OVC, caregivers, community volunteers, and VHTs. These sessions focused on children's rights and prevention of violence against children. The community volunteers and VHTs were also trained in use of the *Sauti Child helpline 116* in reporting cases about child abuse for immediate attention. Some community volunteers formed Child Rights Clubs (as an avenue for information sharing), such as the Family Concepts Center in Iganga District. In Year 4, the Kumi Diocese, International Needs Uganda, Family Spirit Children's Center, South Rwenzori Diocese, Caritas Maddo, Family Concepts Center and Bukedi Diocese handled 24 (12 male; 12 female) cases of child labor and re-integrated seven (2 male; 5 female) children with their families.

1.2.7. Support for Children with Disabilities (CWD)

Despite being critically vulnerable and in need of external assistance, CWD continue to be left out of most OVC programs and interventions, due to the stigma associated with their disability. Only 5% of CWD access education within inclusive regular schools, while 10% access education through special schools. To address this challenge, the PHS Program encouraged grantees to promote inclusion of CWD into existing child-centered early childhood development services and to include activities for and targeted at particular, relevant disability needs of CWD into the work plan. The Program conducted a needs assessment and worked in collaboration with partner CSOs, such as Mulago Hospital Orthopedic Department and Katalemwa Children's Home to provide assistive devices to 354 CWD. All recipient CWD and family members were trained on device use/repair and counseled by experts. After receiving assistive devices, some older CWD were able to access vocational training, such as shoe-making, knitting, and tailoring. The Program documented some success with CWD starting their own small businesses and generating income. *See Appendix 8 for examples (success stories).*

A child with a disability, supported by Buddu Social Development Association (BUSODA) in Masaka.

1.2.8. Psycho-Social Support to OVC and their caregivers

Provision of basic care and psycho-social support to OVC and their households remained a priority cross-cutting OVC intervention for the PHS Program. A total of 41,175 (20,999 female; 20,176 male) received psycho-social support services. Home visits were conducted by community volunteers, para social workers, VHTs, and CSO staff. Emerging issues that needed redress were taken into consideration and followed up. Recreational activities like football, net ball, and drama were also conducted for OVC, both in schools and the community. Counseling and guidance were provided to OVC and their caregivers. CBOs continued to conduct memory book writing trainings for the caregivers and adult OVC. Adult OVC continued to be engaged in life skill training sessions, and this was coupled with debates to discuss psycho-social issues that affected their well-being.

In addition, the PHS Program trained 1,271 teachers on provision of psycho-social support to OVC. The teachers were able to identify danger signs of psycho-social distress among OVC (especially those related to HIV/AIDS), respond appropriately and (where necessary) engage with caregivers to find solutions. Agape Nyakibale, SOS Children's Villages, ABC, Bringing Hope to the Family, and Family Concepts Center carried out Center Days, where OVC were brought together for recreational and counseling activities at the school and community levels.

1.2.9. Private Sector Engagement

The PHS Program team worked very closely with 15 private companies to leverage their support for OVC interventions and generated US$ 281,334 in cash contributions from the private sector. The companies provided cash and in-kind support for various OVC activities. For example, Eco-Agric Company Limited conducted trainings for the out-of-school OVC on farming, provided seeds, and supported these OVC to set up gardens for maize, ground nuts, beans and sweet potatoes; Buikwe Diary Devt Coop Society and Traidlinks supported trainings in entrepreneurship and marketing skills for caregivers and provided access to markets for agricultural produce of OVC households; DHL provided school fees; Barclays Bank Masindi (in partnership with Family Spirit Children's Center) conducted a car wash fundraising event where funds were raised for support of OVC in Miirya and Pakanyi; Bamuganzi Company Limited transported water tanks to schools for improved water and sanitation; Kakira Sugar Limited covered school fees, supported child labor awareness campaigns, and provided internship opportunities for OVC in electrical wiring and plumbing; and MNT Uganda provided school meals and scholastic materials.

To maintain momentum and ensure sustainability of such productive partnerships, the Program facilitated linkages between private companies and CSOs and mentored local organizations in fundraising and advocacy.

1.2.10. OVC Households Graduation and Transition

The PHS Program carried out household vulnerability assessments of all supported households to determine which OVC were eligible for graduation and transition from external support. Based on the results, 33,053 OVC graduated from external support. Other OVC who still required support from USG-funded programs were transitioned to new and existing USG regional implementing partners. According to USAID/PEPFAR guidance, four PHS Program sites from Nakasongola, Alebtong, Kumi and Bukedia districts were transitioned by end of September 2017; four sites from greater Masaka and West Nile Regions were transitioned by end of December 2017; the rest (38 sites) were transitioned by end of March 2018. The Program collaborated closely with USAID's OVC Advisor, Catholic Relief Services (CRS), Sustainable Outcomes for Children and Youth in North and Eastern Uganda (SOCY) project, Better Outcomes for Children and Youth in North and Eastern Uganda (BOCY), Walter Reed, IDI and other implementing partners to gradually phase over responsibilities for OVC support and ensure smooth transition.

1.3. Increased Access to Capital and Business Services

In the first two years of the PHS Program, the A2F team worked to identify constraints and opportunities for financial institutions in Uganda to serve the private health sector. In 2014, the Program worked with Compuscan, Uganda's sole licensed credit reference bureau, and with Centenary Bank to collect demand-side data on existing private health sector borrowers. In addition, the PHS Program's overall baseline survey provided information on the use of financial services by private health providers and their projected future financial needs. The A2F team used this market and survey data to write the Private Health Lending Report, providing an overview of existing lending activities to the private health sector, of private health providers' degree of financial inclusion, and of providers' potential financing needs. This report provided an evidence base for the PHS Program's role in expanding financial outreach to the private health sector, with the

following key highlights: the financial sector had been gradually increasing lending to healthcare business (HCB) owners over three years prior to the start of the PHS Program (2011-2013). While these trends revealed positive growth in health sector lending, the value of overall health lending represented only one percent of Uganda's commercial bank loan portfolios.

1) Healthcare facilities faced many of the same constraints in A2F as did other small and medium enterprises (SMEs) in Uganda:
    a. SMEs generally lacked financial acumen and understanding of the formal financial sector, and
    b. Many SMEs complained about the financial sector's high interest rates and lack of pro-active outreach to the private healthcare sector.
2) The key reasons banks did not lend to healthcare facilities included:
    a. HCBs' limited business and financial management expertise;
    b. HCBs' lack of collateral required by financial institutions;
    c. HCBs' poor infrastructure (physical premise and equipment) and limited staff skills to serve as the basis of expanding operations;
    d. Loan officers' sales targets (loan volume) and incentives were not aligned with the (generally small) loan amounts required by PHPs; instead, loan officers were incentivized to focus on larger loans; and
    e. Banks' perception of the private health sector as small, with limited profitability potential.

As described below, the PHS Program implemented activities in strengthening A2F and business strengthening, focused on alleviating constraints identified in the Private Health Lending Report.

1.3.1. Working with DCA banks to expand lending to the private health sector in Uganda

To encourage commercial bank lending to the private health sector in Uganda, USAID structured two DCA guarantees, co-funded by the Swedish International Development Agency (Sida). The first DCA agreement was signed in 2012 with Centenary Bank; the second was signed in 2013 with Ecobank. A third health DCA guarantee, funded solely by USAID, was signed with DFCU Bank late in 2017. USAID DCA guarantees aimed to encourage lending by sharing credit risk with partner banks. The DCA helped the banks reduce collateral and other lending requirements for PHPs, thus increasing the banks' lending activities to the private healthcare sector.

The PHS Program's A2F team provided direct technical assistance to all three DCA partner banks. With Centenary and Ecobank, the Program worked with the financial institutions to develop a pipeline of private healthcare facilities interested in borrowing, and to develop appropriate processes and policies for lending to them. The A2F team worked with Centenary and Ecobank to map out their credit processes and identify bottlenecks and constraints in lending procedures. Proposed solutions to reduce or eliminate these bottlenecks were identified and shared with the banks, to decrease cost and delays in the loan process.

The specific implementation and results of the assistance provided to each bank, as well as the DCA borrower outcomes, are described below. The Program also worked with non-DCA financial institutions, primarily through A2F trainings focused on PHPs' equipment financing needs.

Centenary Bank DCA: In September 2012, USAID and Sida signed a seven-year health DCA agreement with Centenary Rural Development Bank – Limited for a US$ 3 million (UGX 7.65 billion) loan portfolio guarantee. The Centenary Bank DCA provided a 60 percent guarantee, (30 percent Sida and 30 percent USAID). This was the first DCA targeting the private health sector in Uganda. The guarantee expires on September 27, 2019, and the final date for the bank to place loans under coverage is September 27, 2018.

To encourage portfolio diversification and ensure that the guarantee's benefits would be used where the need for health services was considered most urgent, the DCA agreement stipulated that at least 30 percent of the guaranteed portfolio be lent to health providers outside of the Central region. As shown in Table 1 in appendix 4, this requirement was met, with nearly half (46 percent) of the guaranteed loans made to providers in the North, East, and West Regions.

At the end of the Program, according to data provided by the bank, utilization of the health DCA at Centenary Bank had reached a cumulative total of UGX 6,592,000,000, or 86.2 percent of the total guarantee amount[3]. A cumulative total of 123 loans had been disbursed to 89 borrowers (61 rural and 28 urban), for an average amount per borrower of UGX 74 million. Eighty-six loans worth UGX 4,594,000,000 (or 60 percent of the total guarantee amount) had been fully paid off by Program closing. The bank indicated that another UGX 300-500 million is planned to be disbursed in June, prior to the final date to place loans under coverage, which would represent a final DCA utilization rate of over 90 percent. Loan tenors may extend past the guarantee expiration date, so long as Centenary Bank accepts the full risk exposure on those loans after the guarantee expires.

The overall quality of the Centenary DCA portfolio was very good. Out of the 123 DCA-backed loans, borrowers defaulted on only five loans with initial amounts totaling

Business Training and the DCA Support Rural Clinic Expansion

The Divine Community Health Centre is changing the lives of thousands of poor Ugandans by providing access to affordable health care in its new facility. The construction of the 17-room clinic was supported by a USAID DCA loan guarantee. According to Centenary Bank, the Centre would not have been eligible to receive its loan of UGX 50 million without the support of the DCA.

In April 2014, the proprietor of Divine Community Health Centre, Mr. Richard Wasukira, participated in the PHS Program's business training. The Program taught him about financial record keeping, accounting systems, and general management. The Divine Community Health Centre also received hands-on technical assistance to develop financial and client records.

Mr. Wasukira used the tools he received from the Program to increase efficiency and improve overall management of the clinic. The clinic's growth included tripling its employees and an 85 percent annual growth in sales revenue. For the first time, Mr. Wasukira was able to formally document his annual net profit of UGX 72 million. The investments made in the clinic directly led to a 425 percent growth in client volume, meaning that this facility was serving 510 clients per month.

"The DCA loan has made it possible for us at Divine Community Health Centre to achieve growth in a relatively short time. We have not only introduced a wider range of health care services but have also been able to serve a growing list of clients."

– Richard Wasukira (Proprietor, Divine Community Health Centre)

[3] The bank's internal data may not exactly match current data in USAID's Credit Management System, due to timing and exchange rate differences.

UGX 343 million. At the time of Program closing, Centenary had written off three of these loans (with remaining balances totaling UGX 178 million, or less than three percent of total loans disbursed under the DCA). The bank was preparing to submit claims against the guarantee for a fourth loan with an outstanding principal balance of UGX 98,877,281, or one percent of the DCA portfolio. The fifth loan under default was being restructured, and USAID's consent was to be obtained before restructuring terms were finalized between the bank and the borrower.

Table 1 in Appendix 4 and Figures 18-20 below show the details of the Centenary Bank DCA loan portfolio.

Figure 18: Centenary DCA Cumulative Loan Values in USD

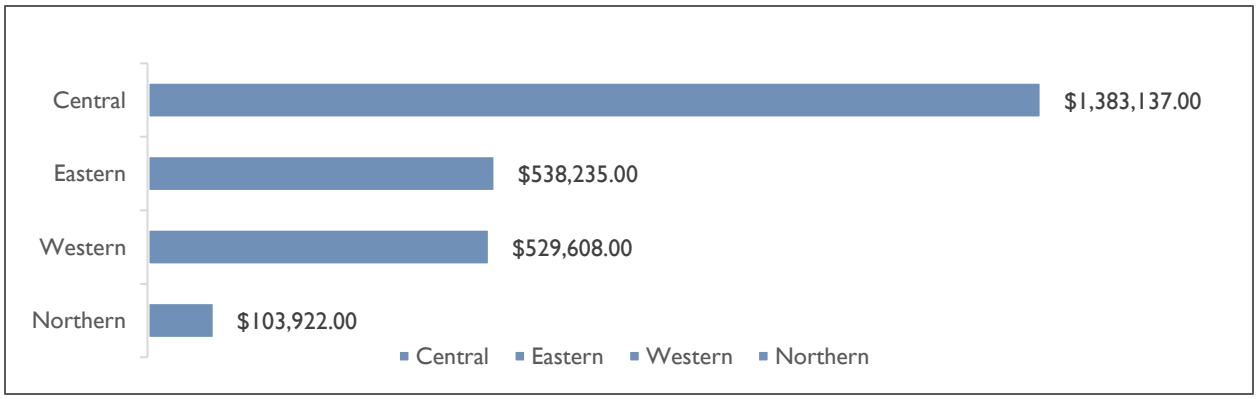
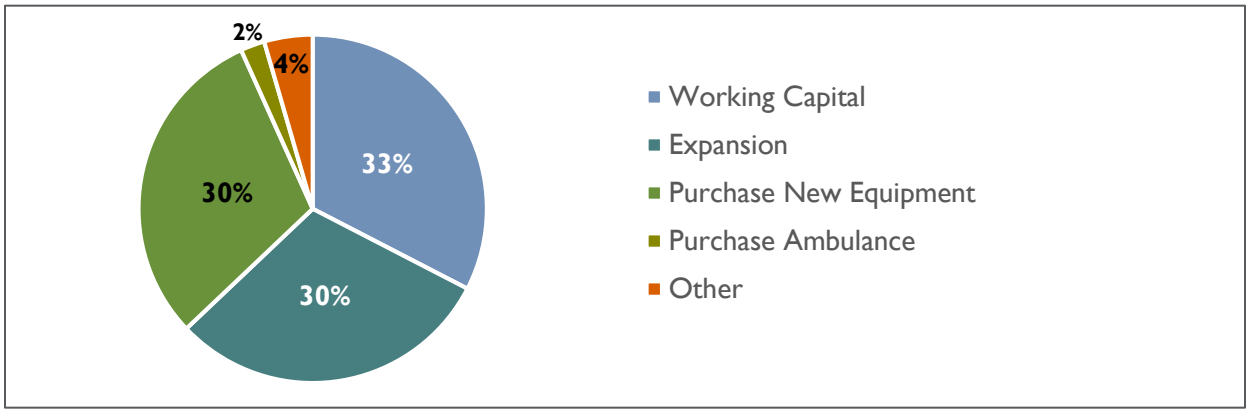


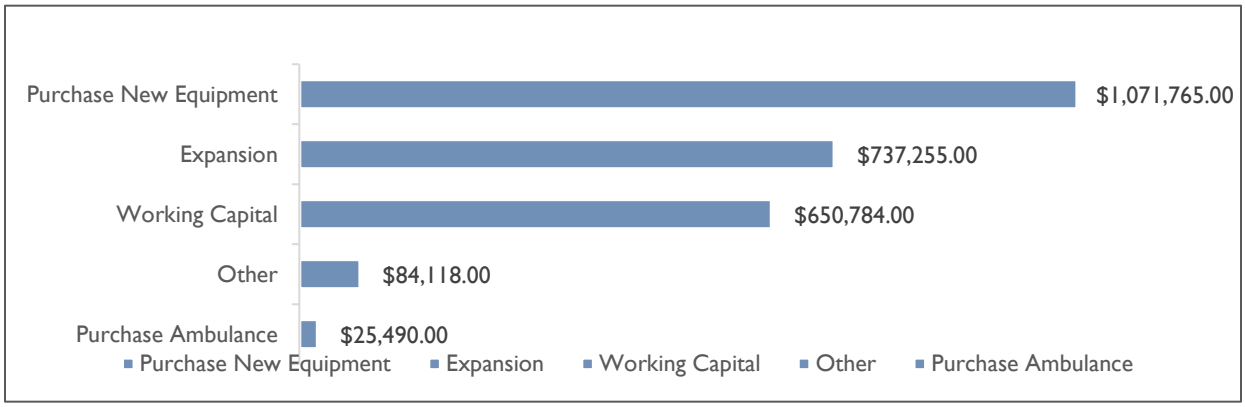
Figure 29: Centenary DCA Cumulative Loan Values in USD



With the DCA guarantee, Centenary Bank was able to offer the following additional benefits or innovations to its PHP borrowers:

1. Repeat loans with increased loan amounts and reduced interest rates. Under the DCA, Centenary made 34 repeat loans totaling UGX 1.6 billion to HCBs that successfully reimbursed their first DCA loan. As Centenary became more comfortable with these borrowers, the bank approved larger average loan amounts (UGX 50 million) and reduced interest rates by an average of one to two percent.
2. Under the DCA, the bank decreased the amount of collateral that borrowers were required to provide, from an average of 150 percent of the loan amount to 60 percent.
3. Centenary Bank began accepting unregistered property as collateral (*Kibanja* holders or lease offers).
4. Centenary made 36 loans worth UGX 2,331,500,000 to first-time or new borrowers. Without the DCA, these loans would likely not have been made.

Figure 20: Centenary DCA Borrowers by Loan Purpose as of March 31, 2018

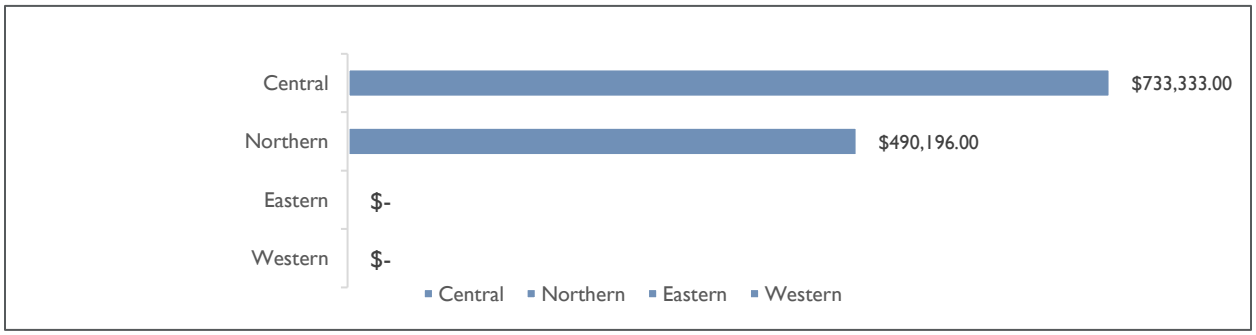


Ecobank DCA: In September 2013, USAID and Sida signed a seven-year health DCA agreement with Ecobank Uganda – Limited for a USD 7 million (UGX 17.85 billion) loan portfolio guarantee. The Ecobank DCA provided a 50 percent guarantee (25 percent Sida and 25 percent USAID).

Despite the intensive support provided by USAID and the PHS Program's A2F team, Ecobank's utilization rate of the DCA was poor, and USAID and Sida formally terminated the guarantee in the second quarter of fiscal year 2018. By the time of termination, utilization had reached a cumulative total of only UGX 3,120,000,000, or 17.5 percent of the total guarantee amount. A cumulative total of four loans had been disbursed to four borrowers (three rural and one urban). The portfolio quality of the DCA loans was also unsatisfactory, with one loan worth UGX 1.1 billion, composing 40 percent of the utilized guarantee amount, going into default. The bank made a claim on the DCA for the 50 percent guaranteed portion of that loan. No loans were active by the time the DCA was terminated.

To encourage portfolio diversification the DCA agreement stipulated that at least 50 percent of the guaranteed portfolio would be restricted to lending outside of the Central region, and at least 15 percent was to be used for loans to businesses owned by women. The PHS Program's A2F team provided a training workshop to senior credit staff on gender-based lending and targeting of female borrowers. However, neither of these conditions was respected: 60 percent of loans were made in the Central region, and no loans were made to female borrowers. See Figure 21 and Table 2 in Appendix 4 for details.

Figure 21: Ecobank DCA Cumulative Loan Values in USD



DFCU Bank DCA: In September 2017, USAID signed a five-year health DCA agreement with DFCU Bank Limited for a US$ 5 million loan portfolio guarantee, with a special focus on leasing of medical equipment. USAID provided an average 50 percent guarantee on loans made by DFCU Bank to healthcare providers, with DFCU Bank having the option of a variable rate guarantee coverage ranging from 20-60

percent for each individual loan. As of the closing of the PHS Program, no loans had yet been approved under the DFCU DCA.

Although the DCA agreement was signed eight months before the PHS Program was originally scheduled to close (June 2018), the bank did not fulfill all the requirements for entry into force of the guarantee until the beginning of March 2018, losing over five months of planned TA from the Program. This, in combination with the funding limitation, reduced the support that the A2F team could provide to DFCU. Bank management was very unhappy about the loss of TA, stating that the board of directors had approved the DCA agreement based on the promise of technical assistance to help the bank learn to work with the private health sector.

The following limited scope of TA was negotiated with the bank and executed during the last two months of the Program:

1. Supported USAID/Uganda and the Office of Development Credit to onboard DFCU staff to work on the DCA. The onboarding included:
   - An overview meeting with the bank's managing director;
   - An in-depth meeting with key bank staff to discuss legal agreement terms and USAID impact expectations;
   - Presentations by the bank's head of credit and head of risk, with discussion on the bank's strategy for disbursing under the guarantee and any required operational changes needed to maximize disbursements;
   - Presentation by the PHS Program on best practices for guarantee implementation; and
   - Sharing key documents with DFCU.
2. Provided the bank with a list of contacts of healthcare businesses known to have financing needs (either from the PHS Program's A2F workshops, our Health as a Business (HaaB) training program, or other sources), to help DFCU establish a pipeline of health loans.
3. Supported the bank's marketing/communications team in:
   - Identifying a list of HCBs that would be invited by the bank to the formal USAID/DFCU launch of the DCA in early May;
   - Determining the nature of and messaging for the launch event. The event was packaged as a marketing event for a new "health product" targeting the private health sector.
4. Delivered an A2F workshop to 35 HCBs which the PHS Program's A2F team had pre-identified as potential borrowers for the DFCU DCA.

Outcomes of the DCA Loans: The PHS Program evaluated outcomes for DCA loans in terms of borrowers' business and financial performance, diversification of service offerings, and changes in the volume of healthcare delivery through three surveys:

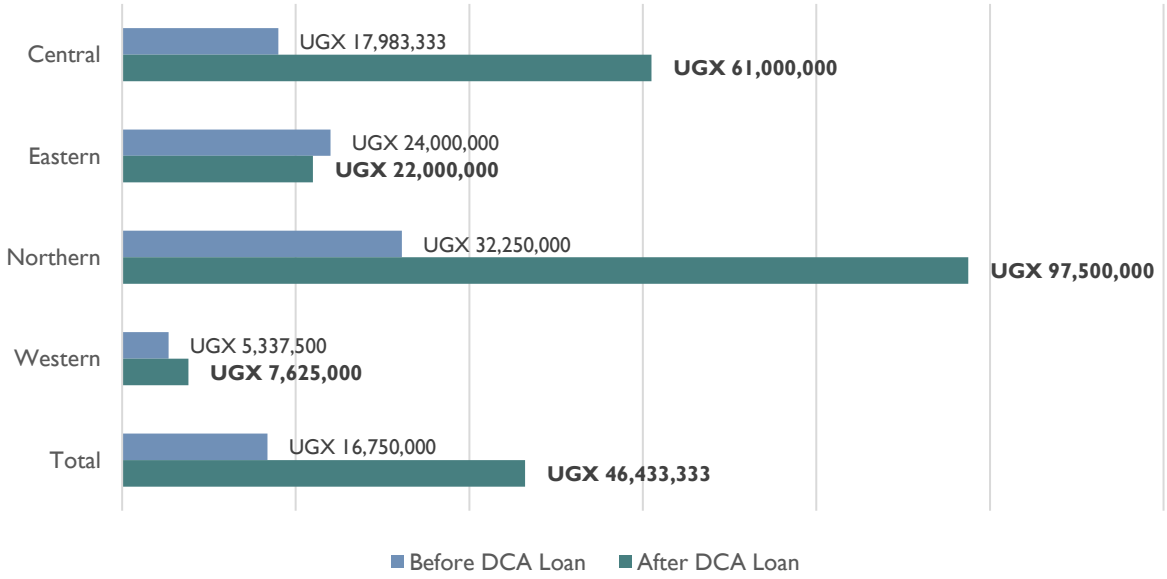
1. A baseline study in 2014 of DCA borrowers who took out a DCA loan prior to December 31, 2013, reported in "Baseline Survey Report of DCA Borrowers," in October 2014.
2. A follow-up midline study in 2016-2017 of the same borrowers from December 31, 2013 or earlier, reported in "DCA Borrowers, Midline Assessment," on May 15, 2018.
3. A second baseline study in 2016-2017 of DCA borrowers who took out a loan after January 1, 2014, reported in "New DCA Borrowers, Baseline Assessment 2017," on May 15, 2018.

The midline assessment provided some of the best available information on the outcomes for PHPs/HCBs that received DCA loans.

Key findings of the midline assessment included:

> Eighty percent of HCBs surveyed noted an increase in their facility's average monthly revenue at midline, compared to the average monthly revenue the facility recorded prior to receiving the DCA loan—with an average increase of 177 percent (see Figure 22 below). Among the surveyed HCBs, owners attributed the observed increase in revenue to the improved quality of clinical services, the introduction of new clinical services, and the expansion of the facility's infrastructure, ultimately contributing to an increase in clients served.

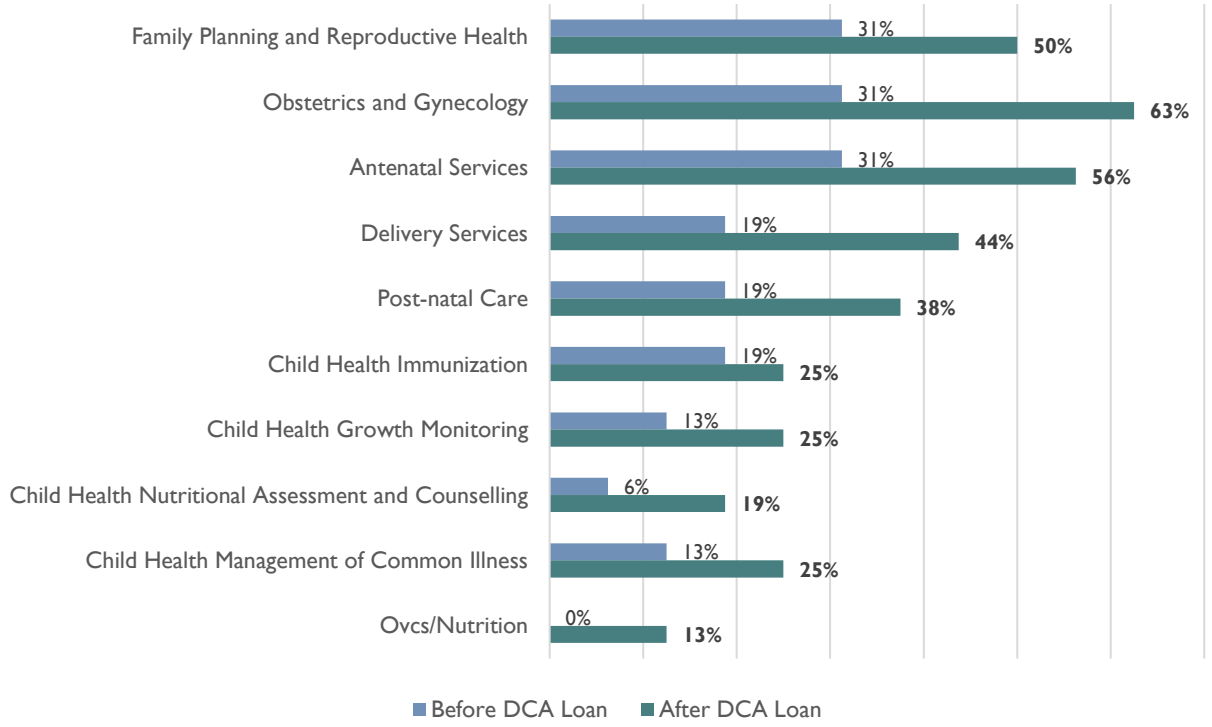
Figure 22: Average Monthly Revenue (n=15)



The Program observed an increase in the number of employees in 80 percent of the surveyed HCBs. Among these 12 businesses, the Program observed a 44 percent increase in employees. Over two-thirds (69 percent) of individual DCA borrowers surveyed stated that they had seen an increase in the numbers of clients served after they received the DCA loan. Only six percent reported a reduction in numbers served, and 25 percent saw no change in number of clients served. The Program observed an average of 3,941 clients a month at midline among surveyed facilities, demonstrating an average increase of 105 percent, or more than double the baseline number.

The majority of HCBs surveyed at midline demonstrated a diversification of their service offerings after utilizing their DCA loan, adding a wider range of services relevant to their specialty. The program recorded a total of eight new facilities that introduced HIV/AIDS-related services after using the DCA loan. Regarding MCH, the Program observed an 81 percent increase in the number of clinics offering ANC services, a 132 percent increase in those offering delivery services, and a 217 percent increase in the number of facilities providing child health nutrition assessment and counselling after utilizing the DCA loan (see Figure 23). At midline, the Program observed an increase of 81 percent in the number of DCA borrowers providing malaria services and a 100 percent increase in the provision of TB diagnostic and treatment services.

Figure 23: Percentage of Surveyed HCBs Providing MCH and Nutrition Services (n=16)



The results of the midline assessment of DCA borrowers suggested that the Program's strategy to increase A2F and business development services (BDS) in order to support the availability, affordability, and quality of health services provided by private sector providers was effective. The PHS Program not only supported DCA partner banks in lending to the private health sector, but also helped increase PHPs' access to finance by strengthening their business and financial management skills through training and coaching. The assessment concluded that:

1. The DCA loan guarantee, along with the Program's A2F and business development service activities, strengthened and supported the expansion of healthcare borrowers' businesses.
2. The PHS Program, through the use of the DCA, strengthened and supported the expansion of quality clinical services among DCA borrowers.
3. Reducing HCBs' financing constraints through DCA loans is likely to support the improvement and expansion of quality healthcare service provision.

Provided assistance to current and potential borrowers of DCA Banks and other banks currently involved in lending to the health sector: In addition to the long-term HaaB business training and coaching program described in Section 1.3.2, the PHS Program provided shorter A2F workshops to help PHPs access financing. The team developed a targeted three-hour A2F workshop module with two objectives: (1) to offer an initial introduction on financing (i.e., Why should health clinics borrow? How do financial institutions evaluate a financing request?); and (2) to provide a platform for banks to introduce their offerings and to prospect potential borrowers for the banks' health loan pipelines. In Years 1 and 2, the Program held 13 A2F workshops for 133 PHPs drawn from the ProFam, Blue Star, and GoodLife franchise networks in ten regional towns and cities. Trainings were conducted in conjunction with the DCA partner banks. The A2F workshops equipped potential borrowers with the skills to prepare viable project proposals backed with financing plans. After the A2F workshops, participants who planned to borrow from the DCA banks received one-on-one assistance with their loan applications. This support included developing

financing plans, assistance in setting up financial record-keeping systems, making cash flow projections, and projecting cash flow needs.

In Year 3, the PHS Program expanded the A2F workshops to help connect health providers, medical equipment vendors, and additional financial institutions. The A2F team met with several financial institutions and medical equipment vendors to determine their interest in partnering to offer equipment financing products. The PHS Program then held five regional medical equipment A2F workshops in Arua, Lira, Jinja, Kampala, and Gulu for 107 potential borrowers (all clinics). These workshops included two medical equipment vendors and three commercial banks (Stanbic Bank, DFCU Bank, and Centenary Bank) interested in equipment financing. Together the PHPs, medical equipment vendors, and banks were brought into a partnership to develop solutions for medical equipment financing.

The A2F team followed up on the 62 leads generated from these workshops to build an equipment financing pipeline for both bank and vendor financing. The team provided technical assistance to several HCBs interested in accessing financing, mainly for purposes of medical equipment purchase. Some of the assistance included negotiating with vendors to extend more favorable terms and conditions—for example, a reduction in the cash down payment required—to these potential borrowers.

The Program also supported the DCA banks in client monitoring. The A2F team provided direct support to several providers who encountered difficulties repaying their DCA loans, working with them and the banks to find ways to restructure and allow the borrowers to catch up on their payments.

The program's A2F technical assistance was effective in helping PHPs access financing through both DCA and non-DCA loans. The loan proposals of 52 of the 89 Centenary Bank DCA borrowers (58 percent) were a direct result of the PHS Program's A2F team's support efforts to HCBs. This included the 62 clinics that were deliberately targeted by the Program's A2F workshops and/or one-on-one coaching. In addition, at Program closing, the A2F team had documented 10 non-DCA deals that had been negotiated through A2F workshop connections. The financing totaled UGX 646 million, including four bank loans and six vendor-financed deals. Rural HCBs received UGX 446 million of this funding, equal to almost 70 percent of the documented non-DCA financing.

GROWING BUSINESS GROWS HEALTH SERVICES

Kumi Community Clinic and Imaging Centre shows how non-DCA financing is making a positive impact. This clinic is based in Eastern Uganda and serves a rural clientele. The owner, Dr. Opio, participated in a PHS A2F workshop, and the program provided TA, linking the doctor to suitable equipment vendors. With the support given to the clinic, they submitted a financing request to Centenary Bank for UGX 291 million to purchase medical equipment. The clinic contributed UGX 80 million of its own capital, to acquire medical equipment worth UGX 371 million. With the experience that Centenary Bank has gained working with the private health sector, the bank was comfortable making the loan without the coverage of the DCA guarantee.

Kumi Community Clinic and Imaging Centre's investment in this equipment directly led to a 62.5 percent growth in client volume, serving 160 clients per month, along with a 100 percent annual growth in sales revenue. The clinic has posted an overall monthly net profit of UGX 10 million. The clinic's growth included increasing its staff from seven to 16 health care professionals.

In the photo: Dr. Opio is operating X-ray machine which he recently purchased.

1.3.2 Provided business strengthening assistance to Private Health facilities

The biggest constraint to credit access for both borrowers—the PHPs—and lenders alike is the providers' low level of business management skills. The owners and operators of HCBs are often medical professionals with no training in basic business skills or financial literacy, and they are not always aware of available financing options. In addition, HCBs' lack of business planning and sound accounting practices is cited as a key limitation to access to financing for these businesses.

The PHS Program established the Health as a Business (HaaB) Project to address these problems through business and financial management training and counseling for HCBs. The HaaB Project had two phases: HaaB I was launched in October 2014, and HaaB II began in March 2017. Table 1 compares client loads in priority service areas after the HaaB I activity (as a baseline) to those at the HaaB II endline survey. Results indicate that providing training and coaching to improve management and support the growth of HCBs led to increased patient services.

Table 1: Changes in Health Service Provision between HaaB I and HaaB II

Service Area	Annual Client Load at Baseline (HaaB I)	Annual Client Load at Endline (HaaB II)	Percentage Change
Total Annual Client Load	**6,630**	**7,777**	**17%**
Malaria	1,653	1,697	3%
HIV/AIDS Counseling and Testing	683	3,243	375%
HIV/AIDS PMTCT	122	37	-70%
Family Planning & Reproductive Health	434	585	35%
Maternal & Child Health	2,471	6,368	158%

HaaB I: The PHS Program awarded two performance-based grants to two grantees, Private Sector Foundation Uganda (PSFU) and Makerere College of Health Sciences (Makerere), to deliver the first phase of the HaaB Project from October 1, 2014, through September 30, 2015. At least 185 HCBs and 285 individual participants (up to two participants from each HCB), received training or coaching under HaaB I. PSFU worked with at least 123 HCBs, and Makere worked with 62.

Detailed results from Makerere's interventions include:

- Makerere conducted a due diligence/baseline survey of 74 HCBs to establish the gaps in business and financial management, the interests of the HCBs in BDS, and the baseline data for the performance management plan. Consequently, 12 business training modules were developed, customized for the most prevalent needs of the HCBs. Based on the baseline data, selection criteria for HCBs to receive BDS support were developed.
- Makerere conducted 24 two-day business training workshops for HCBs. The training recorded high participation rates.
- Six on-site, one-on-one counseling visits were provided to the HCBs by Makerere, resulting in tremendous improvements in business operational systems by the close of the grant period. See Box 1.

Box 1. Results of the Counseling Visits

- ✓ 62 (100%) of HCBs receiving BDS support established journal and ledger systems and began producing monthly income statements;
- ✓ 50% of HCBs produced quarterly balance sheet for the first time;
- ✓ A daily client load and services consumption tracking system was introduced
- ✓ 60% of HCBs formulated an operating budget for the first time; and
- ✓ 80 % of HCBs formulated written growth strategies for the first time.

At end of Year 1, an endline survey was conducted in 59 out of the 62 HCBs that received BDS support from Makerere, with the following results:

- Over the six months in which HCBs received BDS support, average monthly revenue increased from UGX 6,000,000 at baseline (November 2014) to UGX 9,674,985 (May 2015), and average monthly expenses decreased from UGX 3,970,000 at baseline to UGX 3,713,195.
- Improvements in the caliber of healthcare human resources and healthcare equipment were noted, a positive development for the quality of care provided by the private health sector.
- Many HCBs undertook space expansion projects (nine built a new structure, eight made extensions to current premises, and seven rented additional rooms) and introduced new services (including laboratory services, ART, and dental services), a positive development for the availability of health services in the private sector.

HaaB II: HaaB II was implemented by Makerere under a subcontract to work with 82 pre-selected HCBs that had graduated from HaaB I: 72 small-to-medium HCBs and 10 larger ones (hospitals). The four main objectives for HaaB II were: (i) to train the small-to-medium HCBs in additional business skills critical to managing growth; (ii) to mentor the small-to-medium HCBs in establishing additional systems essential to managing growth; (iii) to train the hospitals in additional skills essential for efficient and sustainable operation of large businesses; and (iv) to mentor the hospitals in establishing additional systems essential for efficient and sustainable operations. HaaB II was implemented from March 1, 2017 through March 31, 2018.

The HaaB II results with the 72 small-to-medium HCBs included:

- 97 percent established internal controls of key business processes;
- 90 percent developed and established a written medicines management policy and established a risk matrix and risk register;
- 71 percent had done financial analysis on their businesses (trend, quarterly common size ratio analysis and specific ratio analysis);
- 86 percent developed a business improvement plan, including action and monitoring plans;
- 93 percent developed written standard operating procedures for the key operating areas; and
- 94 percent institutionalized a learning plan for business and financial management.

As a result of HaaB II support to the 10 hospitals, the following results were achieved:

- 90 had developed written standard operating procedures for the key operating areas and completed their risk registers;
- 50 percent had established written internal controls for key business processes;
- 40 percent had developed a written knowledge and skills development plan;
- 60 percent had developed written business improvement plans; and
- 80 percent had developed and established management policies (risk management policy, internal audit charter and a medicines management policy) respectively.

Objective 2: Increased Affordability of Private Health Services and Products

Key Achievements Under Objective Two

USAID/Uganda Private Health Support Program has:

- *Provided actuarial consultancy services to select private health insurance providers and health management organizations (HMOs) to enable them to enroll more members and develop a health insurance product that they could integrate with the proposed national health insurance scheme (NHIS)*
- *Supported the establishment and registration of four private service provider associations in the districts of Wakiso, Lira, Jinja, and Mbale to help conduct pooled procurements of pharmaceuticals and medical supplies*
- *Developed and disseminated professional fee guidelines, in collaboration with the professional associations, to curb widespread variation in consultation and procedure fees*
- *Provided technical assistance to the NDA to update and disseminate its recommended medicines price list*
- *Supported over 369 VSLAs to enroll 6,228 members into community health insurance schemes. Identified eligible private health centers to participate in the scheme and provided technical assistance to partner CBOs to redesign and expand ICOCARE's[4] low-cost health plan to districts where health plans were non-existent*
- *Conducted census of PHPs and pharmacies. The Kampala City Council Authority (KCCA) is currently using this data to monitor health service provision and quality within the Kampala region.*
- *Updated referral guidelines (last updated in the 1990s) to help enforce referral systems and provide implementation recommendations for MOH.*

2.1. Financing strategies for services delivery

Supported the health financing strategy and the National Health Insurance Bill. The PHS Program worked with UHF to get health financing on MOH's agenda, particularly with the Planning Department and to ensure that PHPs are included in MOH's upcoming Performance-Based Financing initiatives. The Program provided technical assistance to UHF for reviewing Management Sciences for Health's developed terms of reference on costing the national health insurance and provided recommendations to ensure private sector participation and adoption of best practices from other successful East African health insurance programs.

The PHS Program provided actuarial consultancy services to select private health insurance providers and HMOs to enable them to enroll more members and develop a health insurance product that they could integrate with the proposed NHIS, once various MOH initiatives on costing the NHIS were concluded. For each participating company that provided sufficient health insurance information, actuarial reports were provided. These reports included an overall business overview; relevant trends in experience and profitability, information on claims; premium and pricing adequacy; adequacy of reinsurance arrangements; asset and liability management; and solvency and capital requirements for each.

The Program further developed an action plan for the private health insurance industry (including HMOs), to engage with MOH as the proposed NHIS was being implemented. A major finding of this study was that a minimum benefit package for an average Ugandan who can afford private health insurance could be priced as follows:

[4] ICOCARE is a low-cost health insurance product for rural low-income earners that targets community members participating in VSLAs.

Table 2: Cost of the Benefits Package for Ugandans who can afford Private Health Insurance

Benefit Package	A. Limit for shared family benefit	B. Limit for individual benefit
Outpatient (excluding Dental and Optical)	UGX 1.5M per family (USD 420)	UGX 500,000 per person (USD 140)
Outpatient Co-pay amount per visit	UGX 5,000 (USD 2)	UGX 5,000 (USD 2)
Inpatient Cover with standard exclusions	UGX 5M per family (USD 1,400)	UGX 3M per person (USD 835)
Chronic Limit within Inpatient	40%	40%
Maternity Limit within inpatient	UGX 1M per family (USD 280)	UGX 1M (USD 280)

The pricing was based on the type of private health facility that would be providing the package, i.e. whether it was an insurance company or an HMO which owned its own hospital facilities, and whether it was an individual or shared benefits/family plan being purchased.

Table 3: Proposed Pricing for the Individual Benefit Package

Proposed Pricing for the individual benefit package	Private Health Insurers (UGX)	Health Management Organizations (UGX)	Private Health Insurers (USD)	Health Management Organizations (USD)
Outpatient Premium	105,762	114,107	30	32
Inpatient Premium	47,256	45,944	13	13
Maternity Premium	487,482	422,964	135	117
Total Premium	**640,500**	**583,015**	**179**	**162**

The Program developed a scope of work to estimate the cost of providing a drug benefit plan (DBP) under the proposed NHIS. The scope of work included:

> Undertaking a market survey to determine average prevailing retail and wholesale prices to determine prices for the different elements (drugs or medicines) in the DBP package.

> Determining a reimbursement price by a) adding an agreed dispensing mark-up to the average wholesale price already determined, or b) negotiating and agreeing with pharmacies on the reimbursement prices, without necessarily going into costs and dispensing fees or mark-ups.

> Quantifying the drug package to manage service cases and utilization levels annually.

> Estimating the total cost of the drug package. The total annual cost for the NHIS package (or the agreed DBP) would then be estimated afterwards by using a determined feasible average price.

The purpose of the DBP was to address challenges, particularly for the poor, in obtaining prescribed drugs and medicines, with the aim to have the proposed benefit package rolled into an eventual NHIS in Uganda. The plan outlined a basket of essential drugs and health products through qualified, quality private drug shops that Ugandans, covered under the NHIS, could acquire at no extra cost.

Expanded the scope of the voucher program. The Program sought to leverage USAID implementing partners' expertise in using vouchers to increase uptake of MCH services and create demand for RH/FP services at Program partner clinics. The Program worked with Marie Stopes Uganda (MSU) to develop a mechanism to identify and include five Program-supported clinics in MSU's voucher scheme. The Program developed an MOU with MSU under which MSU assessed the private clinics for viability to participate. Through this collaboration, the Program approached two companies, Sugar Corporation of Uganda (SCOUL) and Kakira Sugar Works Limited, to expand the scope of health services they provided via MSU's voucher program. Both companies requested and received support in areas such as permanent FP methods and cervical cancer screening.

The PHS Program also embarked on a process of documenting the maternal health voucher program at the Family Health Resource Center (FHRC), in Kiruhura. The Program found that the FHRC's self-financed voucher scheme contributed immensely to the improvement of health seeking behaviors among women of Kiruhura district. The recommendations below were developed based on the review of the FHRC voucher program, for scaling up similar approaches:

> There is a need to link the innovative voucher scheme to the country's strategic health financing plan to increase its strategic importance.

> Beneficiary awareness is important for the voucher system to succeed. Increasing awareness of voucher benefits is necessary to create demand. Awareness of subsidized services and financial benefits covered by voucher *among women* required expanding demand creation channels at the community level.

> There is a need to link the marketing power of other voucher schemes provided in the private sector using social franchise umbrella CSOs. Because the funding was low (especially for startup), continuation would require working in combination with a social franchise—which are becoming much more interested in the voucher approach.

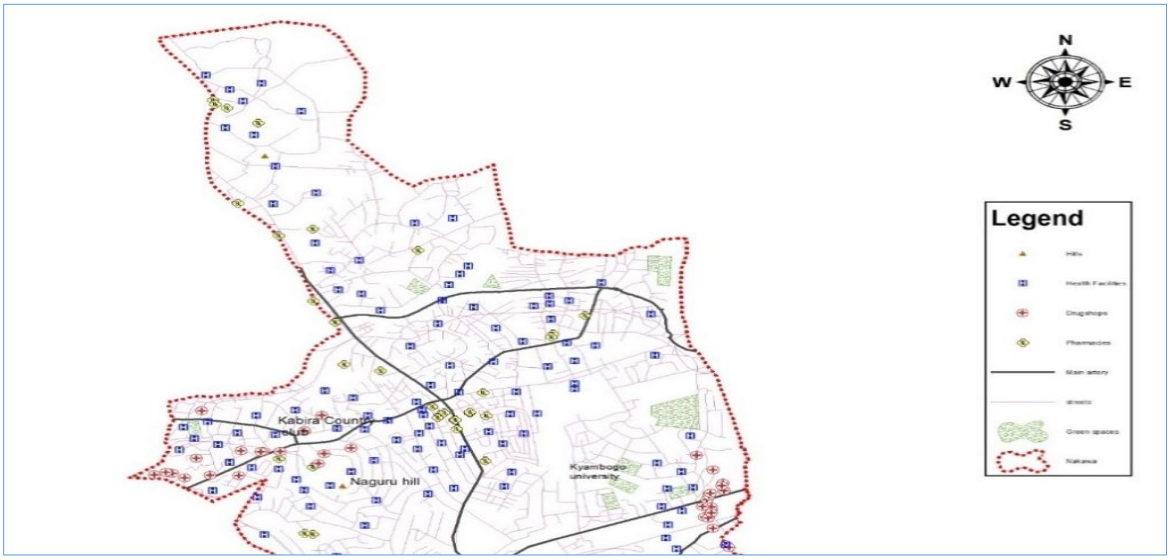
> In addition to treatment, the voucher should cover emergency transportation cost.

> VHTs' roles in distributing and marketing the voucher is critical for successful scale-up. The assessment revealed lower utilization of the voucher program in localities where VHTs are not actively engaged.

> Documentation of processes and activities at facilities is crucial in facilitating monitoring and (eventually) measuring impact.

Conducted census of the private health facilities, pharmacies and drug shops in Kampala. The Program partnered with the KCCA's Directorate of Public Health & Environment and the NDA to conduct census and GIS mapping of private health facilities, pharmacies, and drug shops. The purpose of the census was to map all private providers to enable KCCA to monitor and strengthen health service delivery and plan resource mobilization within its jurisdiction.

Figure 24: GIS map for the northern part of Nakawa sub-division, Kampala



The Program shared census findings with key stakeholders to chart a way forward on how best to address inequities in access to health services. The census covered the five divisions of Kampala City: Kampala Central, Nakawa, Makindye, Lubaga and Kawempe. The units mapped for the census included both public

and private facilities and pharmacies (key public pharmacies found in public/government hospitals) and drug shops.

As revealed by the census of the health centers, the biggest number of health facilities in the five divisions of Kampala City are private-for-profit. There has been a remarkable increase in the number of PFPs in the last six years, but licensing and certification compliance is still poor—especially with regard to private laboratories. There is still a big gap in the provision of radiology, specialized services, dental, optical, surgery theatre, and ambulance and mortuary services.

Key findings from the pharmacy and drug shop census included:

> The number of both pharmacies and drugs shops expanded dramatically in the last six years. However, this growth was neither planned nor strategic. Private pharmacies were concentrated in Kampala Central (39%)—mostly around the few major hospitals. Drug shops made up for the lack of pharmacies in these divisions: one could find a drug shop in all five divisions, with a higher concentration in Lubaga. The uneven distribution of pharmacies created access problems.

> The rapid growth in pharma retail outlets had not necessarily resulted in increased capacity in the pharma sector. Most pharmacies were small to medium size, stand-alone businesses that employed fewer than five staff. Moreover, the majority (41%) saw an average of 25 to 50 clients daily, implying that they potentially had excess capacity to provide services.

> The rapid growth was a missed opportunity to increase access to key public health services through private pharmacies and drugs shops. The data showed that more than half (53%) of drug shops offered FP methods, probably because the majority of drug shop owners were retired MOH nurses trained in FP counselling. But a very small percentage offered basic health services.

> Compliance with regulations among private pharmacies and drug shops was uneven. Although, a relatively large number of pharmacies and drug shops were registered (83% and 97%, respectively), most facility licenses were not valid and were expired. Possible explanations for the alarming number of invalid facility licenses included: i) few facilities being aware of recent changes in NDA regulations, and ii) many facilities waiting to register in the new year to avoid paying full licensing fees for a partial year. Moreover, drugs shops dispensed drugs that were not part of their scope.

> In addition to the non-compliance issues, there were several gaps in the systems supporting pharmacies and drug shops. The census highlighted an acute human resources shortage in in the pharma sector. Of the facilities contacted, only 46% had a full-time pharmacist, while 24% had a pharmacy technician/dispenser. Most facilities relied on health cadres—a clinical officer, registered nurse or midwife (who were not trained in good prescribing practices)—to dispense medicines.

In partnership with KCCA, the PHS Program disseminated health facility/private provider census findings to multiple stakeholders. Fora included presentations during the National Quality Improvement (QI) conference and the Parliamentary Forum on QI Task Force meeting. The KCCA is currently using this data to monitor health service provision and distribution within the Kampala region.

2.2. Reduced financial barriers to accessing health services

Conducted an awareness campaign on rational use of medicines and disseminate recommended Essential Medicines and Supplies List (EMHSL) commodity prices. The PHS Program conducted a nine-month campaign using multiple channels of communication to promote the rational use of medicines and also disseminated recommended retail prices for essential medicines. The program collaborated with Coalition for Health Promotion and Social Development (HEPS) on this activity. The PHS Program assessed the success of the campaign throughout retail medicine outlets in Mukono, Jinja, and Kamuli districts. Key results of its assessment showed that in all three districts, the proportion of respondents who reported that private drug providers clearly provided information on use of medicines increased slightly,

from 71% to 73%. Mukono and Jinja registered marked increases, from 62% to 93% and from 56% to 71%, respectively.

The results further showed that the community practices in seeking quality services had improved. For instance, the proportion of respondents who reported that they only went to a licensed health facility (such as a retail medicine outlet, or RMO) to get their medicines more than doubled, from 33% to 72%.

HEPS staff member Mr. J.B. Luyima and Mr. Julius Mayengo of the NDA during a talk show on Radio Simba

The Program achieved a reduction in essential medicines prices sold by RMOs in some areas. The Program monitored trends in medicine prices in the three target districts to track price trends. A July 2017 assessment in Jinja district revealed that 15 PHPs were selling artemisinin-based combination therapy for a cost of UGX 3,500-4,500 and only four facilities (Mwinike drug shop in Buwenge town council, Calvary drug shop in Wanyange subcounty, and Nabweteme & Erunasser drug shops in Mafubira sub-county), were selling artemisinin-based combination therapy in the cost range of UGX 5,000-6,000. The tracking of medicine prices enabled the Program to engage the district drug inspectors in some districts, such as the higher-than-average prices for medicines in Jinja.

The Program also collaborated with private sector associations to engage members of RMO associations and the sub-county local governments over the issue of high trading license fees in Kisozi, Balawoli and Nawanyago that were being transferred to health consumers through high medicine prices. In these specific sub-counties, it was agreed that PHPs would be assessed according to the value of the businesses effective in the 2017-2018 financial year.

Promoted health insurance and linked it to micro and community health insurance. The PHS Program promoted community health insurance and health savings for micro finance institutions (MFIs), OVC VSLAs, and SACCOs by building the capacity of (both formal and informal) established financial institutions, to engage in health insurance/savings.

The Program supported Integrated Community Based Initiatives (ICOBI), the grantee selected to promote the community health insurance (CHI) activity, by conducting a scoping exercise for eligible private health centers to participate in the health insurance scheme. ICOBI worked with community health volunteers to identify and assess existing VSLAs and other savings groups in their communities. The Program worked with ICOBI to redesign and adapt an existing health product (the ICOCARE low-cost health plan), that was introduced to other Program districts where health plans did not exist.

Over 30 community savings groups, including health service providers, were trained to promote CHI. Suitable VSLA groups from among the Program's OVC grantees were identified to work with community volunteers and district CDOs. ICOBI conducted review meetings with the CHI facilitators and stakeholders in districts and sub-counties and strengthened mobilization and follow-up of members who were trained to enroll members within their communities. To date, 223 households (with 892 members) have paid for health coverage via a CHI scheme.

MOUs were signed with five different PHPs after negotiations and sensitizations on how CHI was to be conducted. By the end of the first 12-month phase of the performance-based grant, a total of UGX 35.8 million had been collected for health savings and distributed to the five PHPs.

Provided access to income-generating opportunities for HIV/AIDS peer support groups. To increase the public's ability to afford health services, the PHS Program provided access to income-generating

opportunities through a performance-based grant with Child Health Education and Development Foundation (CEDO), a CSO. The grant promoted skills and livelihood training, enterprise development, and income growth activities among OVC VSLAs and HIV/AIDS peer support groups in Wakiso, Jinja, Sheema and Rukungiri districts. This activity sought to enable people paying for CHI to afford the insurance premiums for their health services. Specifically, the Program conducted the following activities:

> Adaptation of existing training guides to tailor them for starting and improving their businesses

> Selection of groups and strengthening their capacity to manage and sustain a group enterprise

> Strengthening the skills of program participants through tailor-made business improvement training sessions

> Orientation of vocational institutions and local artisans on delivery of apprenticeship and vocational skills

> Facilitating placement of program beneficiaries in vocational centers and provision of non-formal skills development to local artisans to enable them to start their own enterprises

> Placement of older beneficiaries (25+ years) from urban centers in modern small-scale farming

> Mobilization of program beneficiaries to appreciate CHI

> Conducting home visits to individual member households (25 per district) to track behavioral change in the practice of good financial management and other recommended practices

> Convening monthly progress review and coordination meetings to share notes, review progress against set targets, and agree on actions that could ensure quality program implementation.

The grantee conducted the following initial activities in the four target districts of Jinja, Rukungiri, Sheema and Wakiso: 1) Identified targeted beneficiaries and conducted a baseline assessment for targeted households/groups, 2) Mapped available vocational institutions and local artisans in order to offer apprenticeship training opportunities, and 3) Conducted a household livelihoods and market assessment/survey. Of a targeted 2,400 beneficiaries, 2,046 were identified and supported to engage in economic strengthening activities.

2.3. Supported Establishment of Effective Price Regulation Policies

In the private sector, the cost of delivering health services is influenced by several interconnected factors, including: inefficiencies in the supply chain that increase the cost of drugs and related supplies—particularly for remote areas; PFPs not having access to affordable and/or subsidized medicines; health workers not having access to continued training and incentives to prescribe cost-effective treatment; and lack of opportunities to participate in donor-supported programs. The PHS Program examined the cost drivers for providing healthcare in the private sector and identified cost-reduction strategies that were market-based and contributed to reducing structural barriers. High prices of health services and pharmaceuticals continue to present considerable barriers to access for middle- and low-income groups.

Assessed cost drivers for drugs and health commodities. The Program commissioned and completed a cost and pricing study to determine factors that influenced the costs and prices of selected health services in the private sector. The findings informed short and long-term strategies to improve affordability of health services in the Program's target districts. Key study recommendations included:

1) Engaging in partnerships with other programs (such as USAID's Strengthening Health Outcomes through Private Sector, or SHOPS, and the Accredited Drug Shops Initiative) to collaborate on improving services in the private sector
2) Conducting an inventory of available equipment (especially for laboratories at the different levels of facilities) and establishing minimum standards for private sector facilities—e.g. a central laboratory hub for TB and other complicated tests

3) Entering into long-term purchase agreements with wholesalers/distributors in Kampala to reduce prices based on economies of scale of the assured retail market, which would build upon the efforts of previous projects (such as USAID's HIPS)
4) Collaborating with other partners in the health sector to lobby for institutionalization of recommended retail prices for health services and medicines; this is a common practice in Kenya, where there are guidelines and recommended prices for procedures, such as SMC, agreed upon by private practitioners, and
5) Working collaboratively with health insurance schemes and providers to promote awareness to the public and enabling increases in utilization of health insurance services by consumers.

Developed and disseminated professional fee guidelines. The Program supported the Uganda Medical Association (UMA) in embarking on the process of developing professional fee guidelines for private healthcare professionals. UMA had previously set up a technical working group to develop professional fees guidelines, and a consortium of private clinics in Kampala had attempted to develop standard rates for a range of health services; however, these initiatives had stalled. The PHS Program resuscitated these efforts by supporting research to determine the average fees healthcare professionals charge for a select number of commonly-offered procedures or tests.

The Program partnered with the Uganda Medical and Dental Associations and the Uganda Medical and Dental Practitioners Council to develop and disseminate the professional fee guidelines. The Program selected and categorized the 10 most commonly-offered procedures for which to develop professional fee guidelines.

The Program also identified and selected sample health facilities (rural, peri-urban, urban) from which it categorized and collected data on pre-determined variables; i.e. level of specialization, duration of consultation, frequency of visits, and emergency/non-emergency procedures. This information was benchmarked against similar information from neighboring countries, such as Kenya and Rwanda. Using these criteria, the Program developed a list of professional fee guidelines that were piloted across 20 facilities in the country.


TRUTH EVERY DAY

Daily Monitor

NEWS SUMMARY

Kabaka Mutebi's palace torched in arson attack

Medical council sets doctors' fees

Consultation fees. Prompted by the rising cases of patients being detained in hospitals or being denied services, the medical practice regulatory body has set guidelines on fees patients should pay when they visit health facilities in the country. >>p4

09 JAN 2017

Fire guts Health

"Medical Council Sets Doctors' Fees" article in the Daily Monitor, January 9, 2017

Key findings from the preliminary report indicated that most facilities (70%) reviewed their fees on a quarterly basis, while for others it was annually or every two years – with minor changes based on prevailing economic conditions. Some facilities (10%) reviewed the fees as needed. For most facilities (60%), the monitoring mechanism for the fees was done by Drugs and Therapeutic committees, Management Committees, an accountant, or a three-person team comprising of the Medical Superintendent, Hospital Finance Officer and Hospital Administrator. For some facilities, the owner of the clinic set the fee guidelines in isolation.

Supported pooled procurement for PHPs. The Program approached four pharmaceutical companies to share their prices with the private health stakeholders in the five districts it visited during the Public-Private Partnerships for Health (PPPH) district meetings. The pharmacies were Ecopharm Pharmaceuticals, Plus Medic Pharmacy, and Friecca Pharmacy. The Program then approached Abacus Uganda (a pharmaceutical

provider) and Joint Medical Store (JMS) to liaise with the district-based private health associations to extend pooled procurement services. The Program sought the services of a legal firm to assist the district associations in finalizing their registration. The Program supported formation of four associations in Wakiso, Lira, Jinja, and Mbale districts, signed an MOU with JMS so it could provide technical support to district-based associations on procurement and ordering guidelines, and provided training to those associations on the benefits of pooled procurement.

To accelerate the registration process, the Program held two more regional forums in the Eastern and Western parts of the country in conjunction with UHF and JMS. The Program guided the private sector on how to make pooled procurement orders and bulk purchases. Beyond formulating PHP associations, the Program also presented the pooled procurement concept and benefits to the Uganda Private Midwives Association (UPMA), Kampala chapter. The Program also provided legal, coordination and logistical support services to the UHF, UPMA, Uganda Private Health Training Institution Association (UPHTIA), Uganda Community Based Healthcare Association (UBHCA), and Mukono District Private Health Sector Association. Specific activities included training in pooled procurement methods, and legal reviews of the associations' registrations so they could engage in pooled procurement services.

Recommending prices for essential medicines. The Program held six private health stakeholder meetings in Wakiso, Jinja, Kampala, Buikwe, Mubende and Mityana districts to introduce recommended prices for essential medicines to private health stakeholders. During these meetings, the Program found that since the PHPs' current business models benefitted from the lack of a recommended price list, they were not keen on adopting one. This was mainly because current practice was to embed service costs in the prices of medicines. For instance, to attract more clientele, many PFPs did not charge consultation fees, but marked up medicine prices to take their consultation fees into consideration. Some also noted that the public had a perception that cheaper medicines were not as effective as the higher-priced medicines. To address these concerns, the Program met with the Uganda National Health Consumers Organization (UNHCO), a consumer advocacy group that promotes health consumer rights and responsibilities, to encourage it to promote standardized prices. UNHCO expressed openness to work with consumers to raise awareness on reasonable prices for medicines and subsequently developed a recommended price list. The Program shared with UNHCO the current medicine price list from the 2014 Medicines Transparency Alliance (META)/Coalition for Health Promotion and Social Development (HEPS) survey for distribution.

The Program also held meetings with the NDA to acquire and update its outdated price list. The NDA informed the Program that it was coming up with a formulary that would be ready in the next one-to-three years. The NDA advised the Program to use its national drugs registry in the meantime to develop the recommended prices. Following the NDA's recommendation, the Program met with HEPS Uganda to support dissemination of the 2014 NDA-licensed pharmaceutical distributors and retailers list. Providers' knowledge of the approved pharmacies would enable them to purchase quality medicines at prevailing market rates. On a quarterly basis, HEPS interfaces with a network of over 15,000 pharmacies and drug shops countrywide through. HEPS agreed to distribute the NDA list of approved pharmacies at no extra cost to the Program and this was outlined in its MOU.

The Program also supported printing of the NDA's list of approved and licensed pharmacies, which it distributed to over 90 pharmaceutical wholesale distributors in 71 districts through HEPS Uganda.

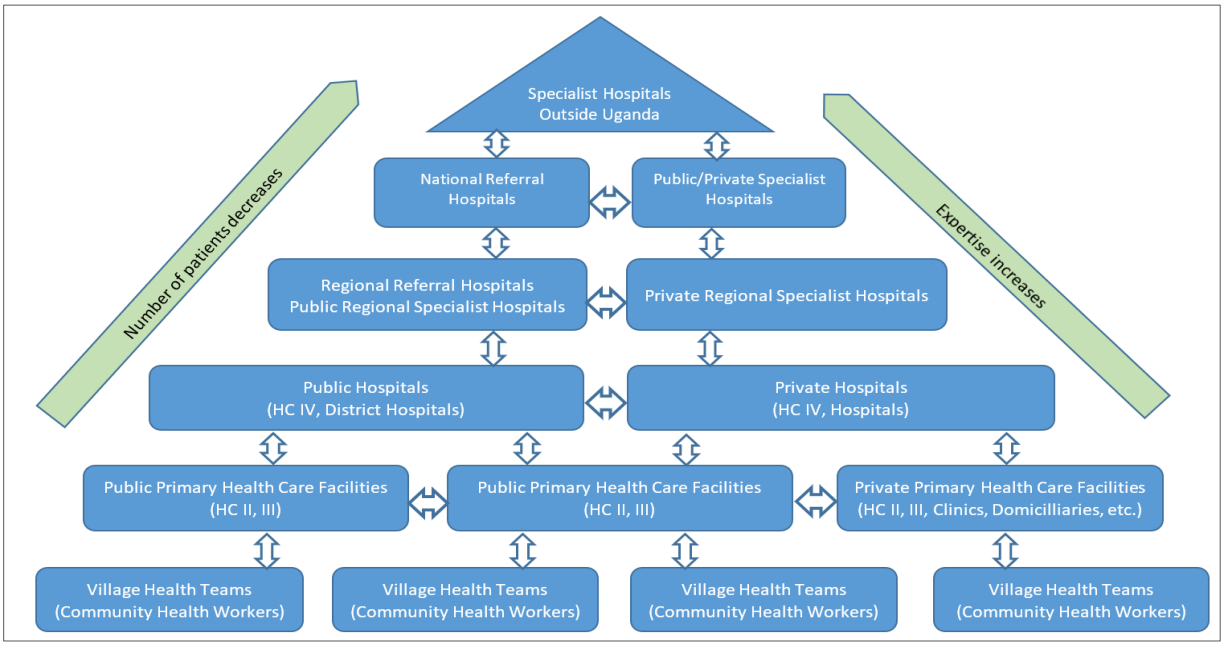
The Program later held six consultative meetings with key stakeholders in the pharma sub-sector to solicit their ideas on how best to regulate prices for medicines on the EMHSL. Respondents noted irrational use of medicines and information asymmetry between drug sellers and the public as key drivers of high medicine prices. They also noted the free market economy and lack of an updated price monitoring policy from the NDA (last update: 2002) as barriers in medicine price regulation. The Program used the above recommendations to develop a scope of work, inviting eligible CSOs to institute an awareness campaign on the rational use of medicines. Key activities undertaken by CSO grantees included: 1) Disseminating the findings of the most up-to-date medicine price monitor for Uganda, 2) Developing and disseminating a

medicine client charter, and 3) Providing technical assistance to the NDA to update its recommended medicine price list.

Explored task shifting to lower cadres to reduce costs. The PHS Program held discussions with the USAID/CAPACITY project, USAID's flagship HRH project in Uganda, on how HRH systems could be strengthened in the private health sector. Following these discussions, the Program collaborated with the four professional medical councils, MOH, and other key partners to ensure the private sector perspective was involved in redesigning the scopes of work for nurses, midwives, and clinical officers. Specifically, the Program solicited for and received proposals from three professional councils with information on how they would address HRH shortages within the private health sector. These proposals formed the basis of the Requests for Applications (RFAs) that were later advertised for capacity building organizations to support the three professional medical councils achieve their HRH regulatory mandates.

Defined levels of practice and enforced referral systems: The MOH approached the PHS Program with a request to review and update national referral guidelines. The Program conducted research to determine the status of MOH health practice levels and referral system guidelines that had been developed in the past. The Program worked with the SQIS developer, Quality Health Consultants Limited (QHCL), to design a concept note for this research. Through consultations with MOH, the Program developed a scope of work to update and enforce these guidelines. Illustrative activities included: conduct a desk review and a physical assessment of the country's current referral system (and any other available referral systems in the healthcare industry) to identify gaps; prepare a guideline to define the referral levels within and outside the country; outline performance expectations and referral practicalities (i.e., which tools to use at each level of care); document steps to be taken when the referral process is not followed (e.g., what happens when a patient who should be managed at a lower facility presents at a secondary or tertiary level facility); and launch/disseminate the referral guidelines.

Figure 25: Proposed Uganda National Health Referral Chain (2017)



The above proposed Uganda National Health Referral Chain showed a more streamlined flow of referred patients from VHTs to higher-level facilities and between facilities of the same level. The flow considered both public and private health facilities. The referral chain also depicted a pyramid-like structure of the

facilities denoting the existence of more abundant lower-level primary healthcare (PHC) facilities than tertiary-level hospitals, and a corresponding expectation that fewer patients and clients should be seeking care at tertiary facilities (where there are fewer, but more qualified personnel). By the end of the Program, the draft guidelines had been presented to MOH for final review and adoption.

Objective 3: Improved Quality of Private Health Sector Facilities and Services

Key Achievements Under Objective Three

USAID/Uganda Private Health Support Program has:

- *Strengthened the MOH/PPPH Node's capacity and supported formation of the PPPH Technical Working Group to work on PPPH Strategy, the Uganda Public-Private Partnership (PPP) law and the Uganda National Policy on Public-Private Partnership in Health.*
- *Provided training and mentorship to 3,095 private healthcare workers in various technical areas*
- *Strengthened the institutional capacity of private health sector associations. This support has enabled UHF to become a credible advocacy platform for PHPs*
- *Formed district-based private health associations and supported them in developing leadership, governance and strategic planning skills*
- *Conducted first-ever comprehensive Private Health Sector Assessment and produced recommendations on how to harness the private sector in providing UHC for Ugandans*
- *Improved DHIS 2 monthly reporting rate from 27% to 100% and achieved 100 % reporting of OVC sites through MGLSD*
- *Rolled out the SQIS.* By the end of 2017, a total of 335 facilities had been enrolled on the SQIS platform across 33 districts
- *Provided technical assistance to Medical Bureaus [Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB), Uganda Muslim Medical Bureau (UMMB), and Uganda Orthodox Medical Bureau (UOMB)] and health facilities in their networks to strengthen their capacity for health service delivery.*

The PHS Program collaborated with multiple stakeholders across the public and private sectors to strengthen quality among partner providers and facilities. Key stakeholders included the three Professional Medical Councils (Uganda Medical and Dental Practitioners Council, Uganda Nurses and Midwives Council, and Allied Health Professional Council), the MOH PPPH Unit and district coordinating committees, UHF and the UMA.

3.1. Strengthened Technical Skills of Service Providers

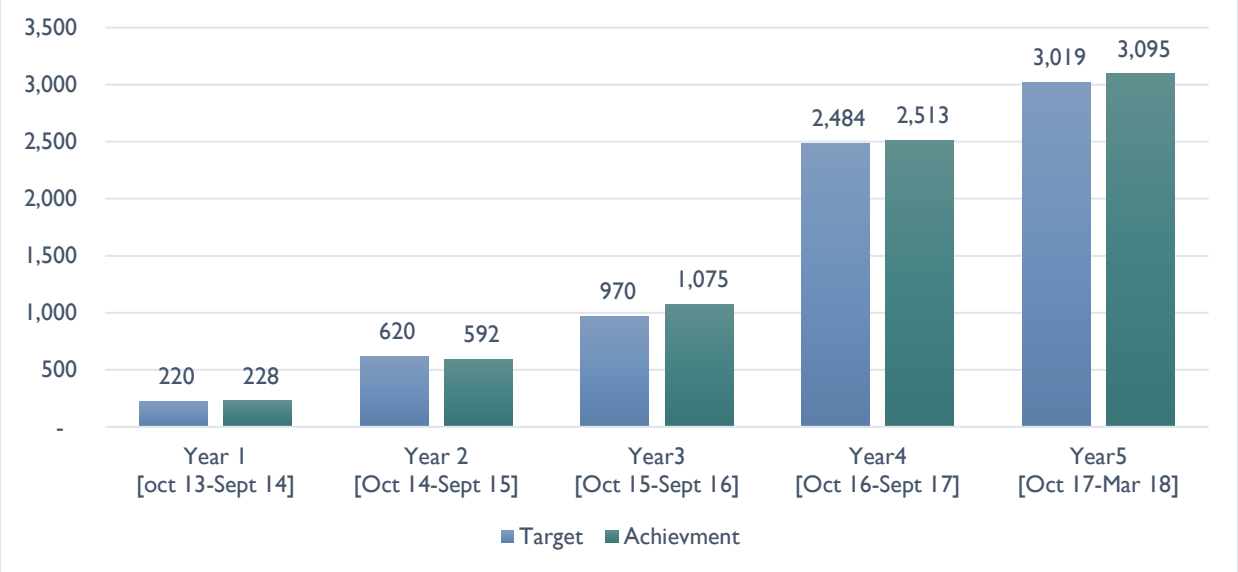
Lack of provider competence and capacity often led to low availability of quality health services in the private sector. The PHS Program worked to improve the technical capacity of PHPs at both the individual and facility levels to provide comprehensive services. The Program conducted a series of capacity assessments of service providers and tailored the training plan to address their needs. The Program conducted various clinical capacity building courses and provided post-training follow up and mentorships to private facilities. The PHS Program partnered with IDI, MOH, AIDS Control Program, the Resource Center and the Central Public Health Laboratory, professional associations and other USG-funded initiatives to ensure compliance with the national clinical guidelines and international best practices.

The Program's Service Delivery Capacity team engaged appropriate regional regulatory bodies (Uganda Medical and Dental Practitioners Council, Uganda Private Medical Practitioners Association, Uganda Nurses and Midwives Council, and Allied Health Professional Council) to review the content of the training curricula to ensure that this training program is recognized in the renewal of medical licenses. Members of these regulatory bodies were invited to participate in the delivery of training, onsite coaching, and mentorship activities.

An MOH facilitator delivering a session during PMTCT training, April 2014

Finding time away from work to attend trainings is a challenge for health workers in the private sector. The PHS Program addressed this challenge by promoting team-based on-site trainings to reach "teams," rather than individuals. For example, the PHS Program worked with MOH to roll out the revised National HIV, ART, eMTCT, and early infant diagnosis (EID) guidelines through this approach. In total, the Program trained 3,095 health workers in different service delivery areas. See Figure 26 for number of health workers trained on an annual basis and Figure 27 for number of health works trained by subject area.

Figure 26: Cumulative Number of Health Workers Trained in the Different Service Delivery Areas

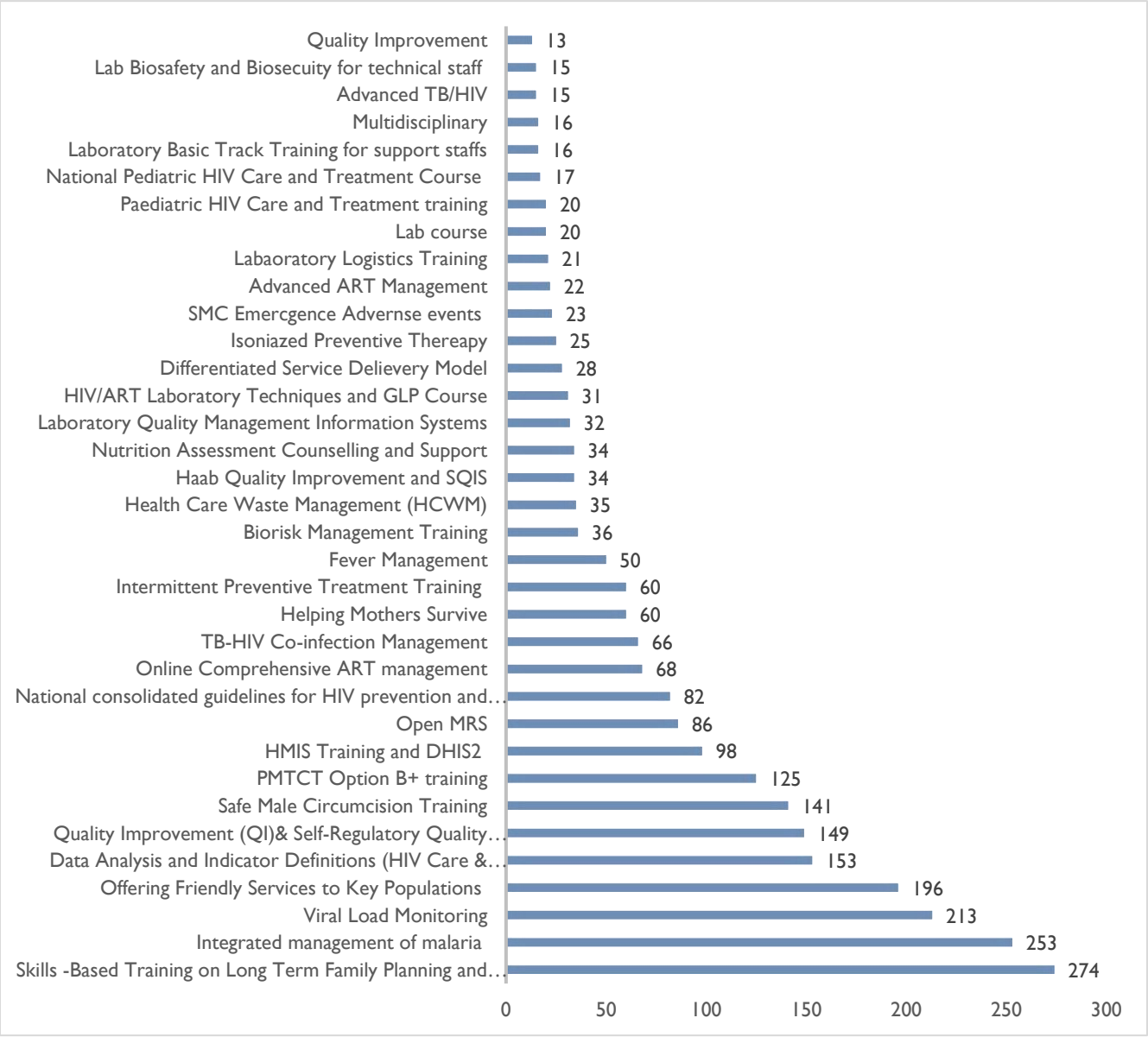


The PHS Program's targeted clinical training program included pediatric and adult HIV management, eMTCT, EID, VMMC, TB/HIV Co-infection, Laboratory practices, HMIS and DHIS2, viral load testing and monitoring, revised integrated HIV/ART, TB guidelines, LMIS, cervical cancer screening and QI.

Through the AIDS Treatment and Information Centre (ATIC) at IDI, private sector health workers were provided with online technical support in the management of difficult cases at their facilities. Through a toll-free number and other platforms (like Facebook, Twitter, and email to ATIC), health workers were provided real-time interaction with online support. Health workers also received SMS messages and quarterly updates on clinical care.

To further strengthen clinical capacity in the private sector, the PHS Program worked with USAID/ASSIST to train partner sites in QI strategies and support formation of functional QI teams.

Figure 27: Health Facility Workers Trained, By Subject Area



The PHS Program adapted the comprehensive ART management course for clinical officers and nurses into an online module. Training started with face-to-face sessions that were followed with online interactions spanning five weeks. This allowed participants to continue to work, while improving their skills and knowledge in providing comprehensive HIV care. At the end of the 5 weeks, another face-to-face session (including a panel discussion) was held to address any outstanding challenges and provide further clarification.

Apart from the technical skills, training topics also included stock, supplies, and logistics management, as well as data management, reporting and M&E systems.

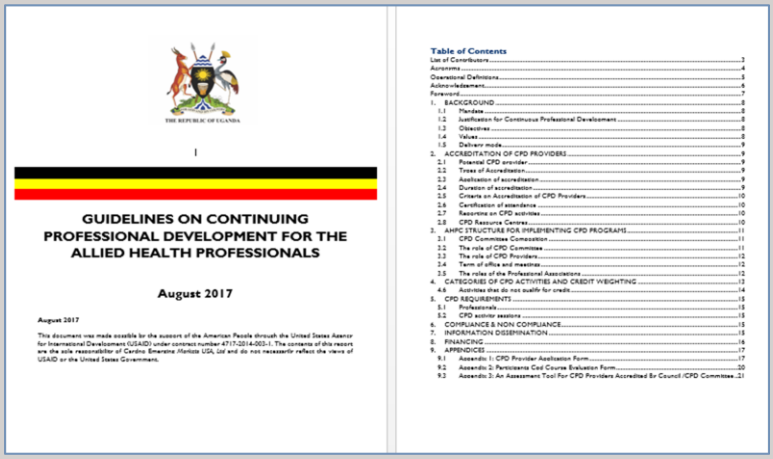
3.2. Established Voluntary Accreditation Program

The PHS Program developed a voluntary accreditation program known as the Self-Regulatory and Improvement system (SQIS), accessible at the following link: http://sqis.med.ug/. By the end of 2017, a total of 335 facilities had been enrolled onto the SQIS platform across 33 districts. Health facilities can now monitor their QI progress by comparing and analyzing different assessments they submit to the system. Health workers are also able to better prepare for pre-licensing inspections.

With USAID support, the Program conducted a learning visit to Kenya, which advised a name change from 'voluntary' quality improvement system' (VQIS) to 'self-regulatory' quality improvement system (SQIS) to enable adoption of the tool by more PHPs. The Kenyan standards and process drew heavily from the PharmAccess "SafeCare" model, which included all private sector stakeholders delivering health; as a result, the Kenyan MOH received an international award for public-private dialogue. Best practices were drawn from the visit to Kenya, which also highlighted the need for the Uganda team to target medium and small clinics that provide a sizable share of health services to the population, but do not yet fully embrace quality-of-care practices.

The Program trained 78 HaaB-participating health facilities across the country, aimed at providing the skills and knowledge to apply QI approaches and the SQIS tool to assess and improve health service delivery in their respective facilities. The training reached 144 participants, which included facility directors (proprietors), administrators, human resource managers and technical health workers. During the trainings and follow-up visits, the sites were taken through the processes for practical facility registration, assessment and reporting, using the SQIS web-based platform.

The PHS Program, together with MOH professional councils and its private sector partners, scaled up the implementation of the SQIS tool and training of national and regional SQIS trainers. The SQIS tool was further disseminated by training 218 frontline health workers, including district QI focal persons and Allied Health Professional Council regional supervisors from approximately 97 PFP and PNFP facilities, in the use of the self-assessment tools to assess, monitor and implement changes to address identified gaps. Self-assessment follow-up was integrated in routine QI mentorship and coaching. The PHS Program also collaborated with USAID/ASSIST to train all high-volume ART sites in QI; At the PHS program end, more than 95% had functional QI teams and are currently running QI projects to improve service delivery.


GUIDELINES ON CONTINUING PROFESSIONAL DEVELOPMENT FOR THE ALLIED HEALTH PROFESSIONALS

August 2017

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PHS supported development and launch of Continuing Professional Development (CPD) guidelines for professional associations..

3.3. Strengthened Professional Councils

The PHS Program supported the three professional Councils to update their Acts and restructure to meet service providers' current needs. Specifically, the Program supported revision of the three health sector laws: 1) The Medical and Dental Practitioners Act Cap 272; 2) The Nurses and Midwives Act, Cap 274; and 3) The Allied Health Professionals Act, Cap 268. None of these laws had been revised, amended or varied in any way since they came into force almost twenty years ago.

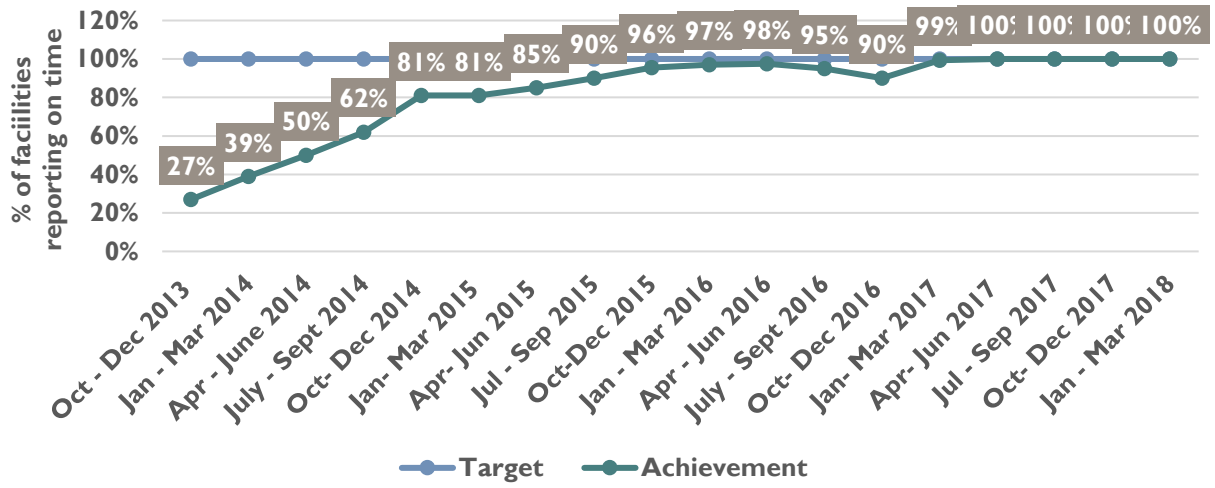
The PHS Program assisted the Councils to design and establish a cloud-based platform that merged three council databases into one, named the "e-Health Licensing Platform", live and available at the following link: www.e-health.med.ug.

The PHS Program also supported the Uganda Medical and Dental Practitioners Council, the Allied Health Professional Council and the Uganda Nurses and Midwifes Council in developing and launching Continuing Professional Development (CPD) guidelines.

3.4. Improved HMIS

The Program provided onsite mentorship and technical assistance to partner facilities to ensure complete, quality and timely submission of HMIS reports. The PHS team worked with district biostatisticians and probation officers to ensure timely and accurate entry of data into the DHIS 2 and OVC MIS. As a result, the DHIS 2 monthly reporting rate of PHS Program-supported facilities increased from 27% in Year 1 to 100% in Year 5 (see Figure 28). The Program also achieved a 100% reporting rate from the OVC sites through the OVC MIS.

Figure 28: Percentage of Supported Health Facilities Reporting On Time in DHIS 2



The Program worked with district biostatisticians and probation officers to facilitate linkages with medical facilities, distributed HMIS tools, and assigned research assistants to health facilities to provide onsite support in documentation and data management, as well as general M&E support. The research assistants carried out brief data needs assessments and developed workplans aimed at bridging identified gaps. Among the activities implemented was onsite mentorship of health workers in using HMIS tools for entry of data into UgandaEMR (OpenMRS), data analysis, and utilization. Some sites continued to face challenges with huge data backlogs that may necessitate future support. The Program purchased and provided 11 computers to health facilitates to support data management. Health facilities were supported through District Health Offices and JMS to receive access to WAOS for timely ordering of ARV and HIV test-kits. Targeted technical support was provided to 34 OVC sites to improve their data management systems, including updating of their integrated registers and case management files.

3.5. Fostered Policy-Enabling Environment for the Private Health Sector

The PHS Program worked with the PPPH Node at the MOH to build its capacity and systems with the aim of translating the PPPH Policy into action. During the first year, the PPPH Node secured funding for seven additional staff. In collaboration with the PPPH Node, the PHS Program assessed the staff's skills base and

systems at the national and district levels, and consulted with the PPPH Node's Director, Dr. Timothy Musila. After completing the assessment and the consultations with the MOH, The PHS Program designed a plan that identified areas for technical assistance and activities requiring financial support to grow PPP capacity within the Ministry. Subsequently, the Program started implementation of the action plan and conducted the following activities:

> Raised awareness and promoted implementation of PPPH policy
> Strengthened skills of the PPPH Node's staff
> Supported private sector associations like UHF to advocate and promote PPPHs
> Designed a strategic investment plan for PPPs
> Strengthened PPPH coordination at both the central and district levels
> Assisted six of the most promising districts to identify and design one PPPH to strengthen private sector quality.

The Program worked with the MOH PPPH Node, the PPPH Policy Technical Working Group, medical councils, and district governments to use the new PPPH policy as a guide to improve the quality of health services. To this end, the Program attended and often hosted the PPPH technical working group's quarterly meetings. Key items discussed included: 1) progress on dissemination of PPPH policy, 2) implementation guidelines for the PPPH updates, 3) Primary Healthcare (PHC) transfers to the private sector, and 4) access rights to DHIS 2 by the private sector.

The Program organized and facilitated a two-part training workshop on PPPH for the central-level MOH staff, district-level PPPH focal persons, Ministry of Finance, private sector representatives and other related individuals/organizations. The Program also organized and hosted the annual PPPH TWG meeting attended by MOH PPPH Node officials, Belgian Technical Cooperation (BTC), and the Medical Bureaus. The outcomes of the meeting were: 1) soliciting PPPH inputs for the next Health Sector Development Plan; 2) getting updates on strengthening the PPPH Node; and 3) receiving progress on the commencement of the World Bank-supported voucher scheme.

The Program worked with the MOH to develop a policy brief of the National PPPH Policy. This simplified four-page brochure helped facilitate popularization of the policy among stakeholders. The policy brief and the PPPH policy was disseminated during the district-level meetings. The Program also continued with efforts towards development of the PPPH implementation guidelines and procedures.

The Program involved UHF in PPPH-related activities as a way to promote a united private sector voice in PPPH policy implementation. UHF was invited for a two-day PPPH training for stakeholders in Kampala, where the acting Executive Director, Board Chair and Vice Board Chair represented UHF. The Program advocated to have UHF represented on the PPPH TWG and the Health Policy Advisory Committee (HPAC). The HPAC serves as an excellent forum for the interaction of policy-makers and researchers.

3.6. Supported Building a More Cohesive and Capable Private Sector

The PHS Program identified private sector champions that included private sector leaders, health providers and public sector key decision-makers in health. These leaders started to advocate for formation of the National Health Professions' Authority using their respective platforms. Below are links to some of the work performed by the champions: http://www.monitor.co.ug/News/National/New-health-regulatory--body-to-be-formed/-/688334/1694754/-/2dskhvz/-/index.html

The Program built the capacity of UHF as a vehicle for private sector cohesion and advocacy; specifically:

> Identified strategies to unify PFP and PNFP sectors in advocacy and other policy-related activities
> Employed organizational development approaches to strengthen UHF's governance and long-term financial sustainability

- Helped UHF to improve membership services, communication strategies and CPD offerings to retain existing members and attract new ones
- Supported UHF in developing the Board of Directors' charter and defining the Board's roles and responsibilities
- Assisted in the design of UHF's five-year Strategic Plan and Capacity Development Plan.

The Program supported UHF to translate the PPPH TWG into a committee that doubled as a public-private sector dialogue forum, meeting on a quarterly basis.

The Program conducted the first-ever Uganda Private Health Sector Assessment (PSA), which explored policies supporting governance of the private health sector; health financing; HRH; size and scope of the private health supply chain; and private sector delivery of key health services, including HIV/AIDS and MCH. The assessment used a representative sample of stakeholders from the entire country, ensuring urban-rural representation.

MOH Commissioner of Health Services Planning, Dr. Sarah Byakika, launching the Private Sector Health Assessment. Kampala, Uganda. February 8, 2017

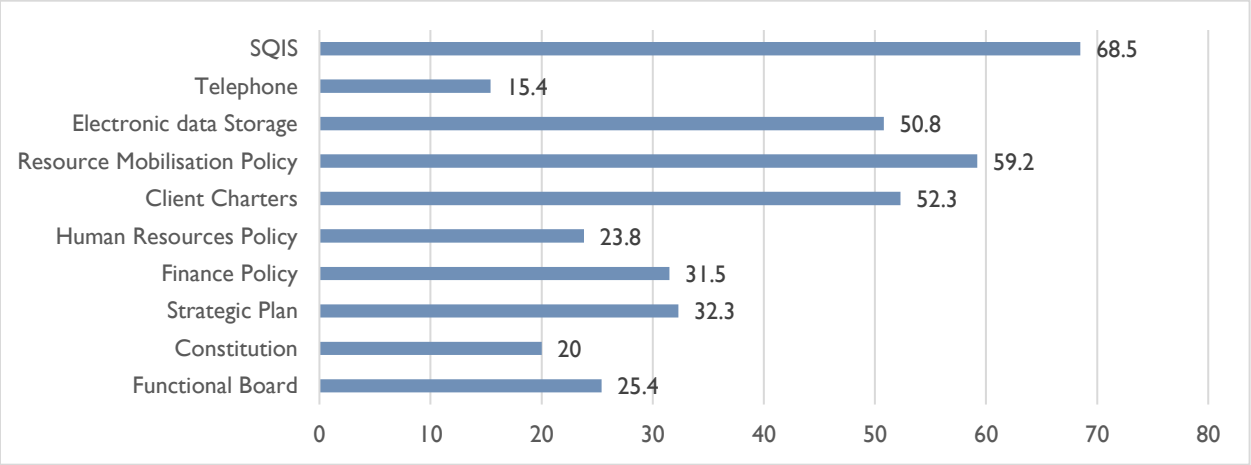
Key recommendations from the PSA included: build government capacity to assure quality in a mixed health delivery system; create financial incentives to harness the private sector; reduce economic barriers to health access; and broker targeted partnerships to increase access to health services. A road map dubbed the "Private Sector Blueprint" was developed to guide public-private interactions and discussions within the sector.

3.7. Strengthened Medical Bureaus and faith-based health networks

Starting in July 2014, the PHS Program provided managerial and technical oversight support to 17 faith-based health facilities, formerly under a program managed by the IRCU. In September 2016, the PHS Program received another contract modification, which expanded its scope to support Medical Bureaus to strengthen their ability to manage 134 health facilities within their networks. The modification specifically mandated the Program to strengthen health systems within the faith-based health sub-sector to build a strong foundation for sustainable scale up of HIV/AIDS services.

The PHS team held extensive consultations with the Medical Bureaus, faith-based health facilities and conducted a Comprehensive Health Systems Needs Assessment for Uganda's faith-based health sub-sector. The assessment included four Medical Bureaus: UCMB, UPMB, UMMB, and UOMB, and their respective health facility networks. This study identified capacity gaps and provided recommendations on best approaches to leverage and harness the sub-sector. Figure 29 indicates the status of selected health system strengthening elements in the 130 PNFP health facilities targeted under the Program.

Figure 29: Status of PNFP Health Facility by Selected HSS elements – March 2017



Source: USAID/PHS PNFP Health System Needs Assessment, 2017.

Informed by the Comprehensive Health Systems Needs Assessment, the Program team developed a plan to strengthen:

- ✓ The knowledge and skills of Medical Bureaus, Hospital Boards, and Health Unit Management Committees (HMUCs) to effectively develop appropriate policies, make strategic decisions and provide appropriate institutional oversight.
- ✓ Strategic planning in the four Medical Bureaus and 31 Hospitals to enable executives to more effectively guide resource planning and execution commitment.
- ✓ Relationships and communication between and among the Medical Bureaus to increase networking, coordination, coherence, and intensity of advocacy efforts aimed at mobilization of both technical and financial resources.
- ✓ The Health Information Systems in Hospitals and Health Units to enable health facility leaders and managers to make evidence-based strategic and operational decisions.
- ✓ Development and review of performance management tools for Medical Bureaus and Health Facilities.
- ✓ Capacity of Medical Bureaus to systematically identify and analyze health workforce needs (size, type, and quality) of health facilities to achieve desirable health outcomes.
- ✓ Business Development Services to institutionalize best business practices, and facilitate good financial management, funding diversification, and resource mobilization.

The Program provided grants and technical assistance to Medical Bureaus and used a Training-of-Trainers (TOT) approach to assist them in transferring the skills and knowledge to facilities in their networks. The PHS Program organized trainings and workshops and facility-level mentorship. Integrated teams of technical advisors from Medical Bureaus conducted supervisory visits to 113 health facilities in all regions of Uganda. Trainings and mentorship covered topics in: HR performance management, HMIS, DHIS 2, resource mobilization, SQIS, HRIS, governance, record management, management of medical stocks, finance management, and internal controls. The Program trained 1,766 staff from FBOs.

With support from the PHS Program, finance management manuals for the four Bureaus were reviewed and updated, and model finance management manuals for Hospitals and for Health units were developed and disseminated. Workload Indicators of Staffing Need (WISN), a human resource management tool, was introduced in the health facilities, which allowed management to optimize use of human resources. In addition, the Program developed Model Customer Care Management Guidelines for hospitals and the health centers.

The PHS Program also supported the Medical Bureaus to conduct six Health Assemblies, bringing together 501 health facility leaders, political figures, district officials, local technical experts and community leaders. These annual health networking meetings served as a platform for transparency and accountability, allowing community members to provide feedback to health facility leadership, and aimed to improve quality of service delivery.

The Program team had a number of consultations with the Medical Bureaus and other religious institutions to increase their readiness in participating in the establishment of a national interfaith body. Two inter-bureau meetings involving 16 bureau leaders were held to build consensus. The bureau leaders observed that a national interfaith body was necessary, given the current coordination challenges within the faith-based sector. The bureaus noted the importance of conducting a benchmarking visit to some African countries (such as Ghana and Zambia) that already have functional inter-faith health bodies at the national level. The bureaus agreed that other issues (such as the governance/management structure, participation of facilities outside of the four medical bureau networks, etc.) would be handled during subsequent consultations. Due to the funding limitation mentioned earlier, the PHS Program was not able to finalize establishment of the national interfaith body. This activity requires continuous external facilitation and assistance and should be supported by future USAID projects.

Grants under Contract

The PHS Program had a significant grants component to support a range of activities for which institutionalization and local capacity building were critical to Program sustainability. The Program worked with 82 grantees and issued 248 grants, delivering USD 13.7 million in funding to local organizations. Some partner organizations received multiple grants as the Program operated on an annual grants cycle. Grants varied in size, with average grant size of USD 60,000 and median grant size of USD 37,000. It should be noted that the PHS Program had 62 active grants on average each month.

Implementation of such a robust grants component required advanced grants management and compliance systems. As an experienced USAID implementing partner, Cardno has established processes, procedures, and best practices to minimize risk, confirm compliance with applicable regulations and policies. The Grant Management team, with support from the M&E team, provided ongoing monitoring of grant recipients by collecting both implementation data and fiscal reports that detail how funds were used. The technical teams provided ongoing technical assistance and mentoring in such areas as financial management; governance; reporting and evaluation; data for decision-making; and quality assurance.

Medical councils. The four medical councils were responsible for licensing and overseeing key provider groups and were essential to the achievement of Program objectives under all three objectives. Grants provided to African Centre for Global Health and Social Transformation (ACHEST) helped build their capacity in governance and regulatory oversight. Grants provided supplementary funding for their activities; for example, to cover the cost of additional staff and travel for supervisory visits.

Private sector federations. The PHS Program provided grants to UHF, FUE and UMA to better organize the private health sector, helping to achieve program objectives under IR3. Grants were used to build the organizations' capacity in governance, policy, and advocacy, and to strengthen their ability to implement workplace health programs, contributing to outcomes under objective 1 and 2.

Medical Bureaus. The PHS Program issued grants to four Medical Bureaus: UCMB, UPMB, UMMB, and UOMB to strengthen their capacity to manage faith-based networks and improve service delivery, contributing to objective 1 and 3.

Ugandan NGOs and CBOs. The PHS Program supported Ugandan NGOs and CBOs in implementing community services, including support to the continuum of care and linkages with facilities, contributing to outcomes under objective 1 and 3. The Program provided grants to NGOs and CBOs to cost-share corporate social responsibility programs with employers, particularly with support to OVC. Over the life

of the Program, we encouraged private sector partners to directly support these organizations as a way to build sustainability in employer-community relations.

Monitoring, Evaluation, and Learning

The PHS Program Monitoring and Evaluation (M&E) system served two critical and overlapping functions. It generated periodic information on Program performance, enabling the accountability requirements to USAID Uganda and other Program stakeholders to be fulfilled. It also generated information as the basis for individual and institutional learning within the Program and among Program stakeholders. In addition to the Performance Management Plan (PMP), the PHS Program incorporated design features to support the Mission's Collaborating, Learning and Adapting (CLA) agenda.

Collaborating. The success of the PHS Program depended heavily on its ability to routinely engage multiple stakeholders in both the public and private health sectors, including implementing partners working with PHPs, GOU and district-level officials, Medical Bureaus, other donors, and CSOs. Another priority was to ensure buy-in from professional councils, the GOU, and private interest groups regarding Ugandan institutions supported by the Program. The PHS Program looked for opportunities to interact with stakeholders in structured activities, such as project-to-project exchanges, communities of practice, and participation in Technical Working Groups.

Learning. The PHS Program fostered a culture of learning and used lessons learned to periodically assess Program design, operations, and results. For example, it aimed to answer questions such as: "Are the causal pathways underpinning project results valid?" or "What are critical knowledge gaps that need to be addressed?" The PHS Program's M&E system combined data collection and analysis with *ad hoc* information gathering to answer questions of interest (See box 2). An ultimate aim of collaborative activities was to position the PHS Program as a "clearinghouse" of knowledge about the private health sector in Uganda.

Box 2. PHS Data collection methods

Patient data collected and reported by facilities through the HMIS:

- Quarterly outlet-based surveys (facilities and drug shops)
- Client satisfaction surveys with patients of Program-assisted healthcare providers
- Annual surveys of stakeholder groups, such as public sector officials, women's groups, industry groups, employees, etc.
- Key informant interviews with stakeholder groups (such as district government, industry groups, CBOs, and other key organizations)
- Focus group discussions with healthcare provider staff, patients, or community representatives

Adapting. Information generated through M&E facilitated planning and decision-making, as well as periodic adaptations of Program strategy and tactics. The PHS Program's M&E system not only generated timely information, but was flexible enough to meet stakeholders' changing information needs. The Program used diverse quantitative and qualitative collection methods to meet information needs in a cost-effective manner. In addition, the PHS Program created internal learning loops by providing opportunities for program management and staff to engage in joint learning activities, such as facilitated staff meetings and annual workshops.

Sustainability

Sustainability was a key consideration in the design and implementation of the PHS Program throughout its entire cycle. The Program team continuously reviewed interventions to determine how they could be further strengthened and determined what could (and should) be brought to scale to ensure sustainability. A participatory process with a strong emphasis on consensus building was adopted as the main approach for the sustainability planning process.

The Program's sustainability and transition plan was prepared to support USAID, the GOU and relevant private health sector actors to ensure continued availability, affordability, and improved quality of critical

health services provided by the private sector in a sustainable manner, and to increase the likelihood of continuation of these efforts beyond the Program's period of performance.

The PHS Program' major investments focused on provision of technical expertise, enhancement of quality standards, improved A2F, support to accreditation, and provision of leadership in the private health sector. To ensure these investments were sustained in the long-term, the Program team focused on three major sustainability approaches:

1. **Program Adaptation—Institutionalization of Services and Systems:** The PHS Program, alongside its partners, developed processes, frameworks and activities, which enhanced the level of coordination, efficiency and effectiveness of the private health sector's performance. To ensure that these processes, frameworks and activities were continually manifested in the behaviors of private health providers, they needed to be institutionalized within the general practices of private sector health providers, the GOU and local umbrella and advocacy organizations.
2. **Organizational Capacity—Local Capacity and Organizational Viability:** The PHS Program made major investments in the development of learning tools and human resources to support PHPs across an array of management systems. The tools and human capital developed by the PHS Program to support the private sector must be organized and sustained within local partner institutions, so that this expertise can continue to be enhanced and delivered.
3. **Environmental Support—Stakeholder Collaboration, Social Cohesion, and Enabling Environment:** The PHS Program's role in coordinating stakeholders to be more engaged in existing health sector systems improved the efficiency and effectiveness of services, as well as transparency and openness across parties. To maintain and scale this momentum, stakeholders must not only be engaged, but mobilized. Ministries, PFPs, PNFPs, CBOs, donors, and district governments must understand the importance and value of engagement between the public and private sectors and advocate for increased coordination, cooperation, and support for the private health sector.

Program Management

Successful implementation of the PHS Program can be attributed to the right technical and management leadership in place from Day One. The team benefited from strong technical expertise, established key relationships with private sector stakeholders, intimate knowledge of the full range of issues within both the public and private health sectors, and demonstrated success managing previous programs of similar scope and size. The team of all-Ugandan key and long-term experts were passionate about and committed to ensuring Program success. The Key Personnel (including COP, DCOP and Finance Director) were with the Program from the beginning until its closure, ensuring strong and consistent management of Program activities.

The PHS Program's management approach was grounded in Cardno's corporate experience in private sector programming, and 20 years of experience working with Uganda's public and private health sectors. Cardno empowered the PHS Program's Chief of Party and field staff with primary responsibility for implementation, and drew from our team of local and international partners to integrate international best practices into program activities. To ensure country ownership and sustainability, we established working relationships with the GOU and other implementing partners, as well as Ugandan organizations and local stakeholders, from the very outset of the PHS Program.

Field Management. The PHS Program was led and managed by our field team and office in Kampala. Dr. Dithan Kiragga, Chief of Party (COP), served as the primary point of contact with USAID on all programmatic and contractual matters, and was responsible for achieving the Program's goals. The coordination of technical activities and STTA was the primary responsibility of Deputy COP, Ms. Joy Batusa. Each technical Team Lead was responsible for implementing planned activities in collaboration with subcontractors, ensuring regular data collection and participating in CLA activities. Technical support

and implementation was led by the Service Delivery Capacity, Business Strengthening, and Private Sector Engagement teams, supported by senior-level STTA advisors from Cardno, IHA, and Banyan Global. The performance-based grants program was managed by the Grants & Subcontracts Manager, who worked closely with the DCOP, technical team leads, and M&E Specialist to develop scopes of work, craft measurable deliverables and indicators, and ensure compliance with grant terms.

Home Office Support. Cardno's Home Office team provided technical, management, and contractual support to our COP, DCOP, and technical staff. The Home Office team ensured technical oversight of USAID deliverables, subcontractor liaison, international technical assistance coordination, and expenditure tracking.

Subcontractors. Our consortium included highly-skilled Ugandan and international organizations with proven track records and expertise in all key program areas. Each organization, including Cardno, contributed technical expertise and collaborated with other partners to achieve shared program targets. Cardno provided overall strategic direction for the program, coordinated all partners and activities, and led private sector engagement activities. A small, U.S. woman-owned business, **Banyan Global**, led business strengthening activities, including A2F, business training, and utilization of the DCA facility. A part of Makerere University's College of Health Sciences, **IDI** provided expertise in clinical services and quality assurance, and trained service providers. **IHA**, a Kenya-based, small business consulting firm, contributed international expertise and lessons learned in the East Africa region in the areas of policy, institutional strengthening and provided significant support for the stakeholder analysis.

Constraints and Challenges

The PHS Program conducted a number of participatory consultation sessions to identify and document the key constraints and challenges faced by the PHS team and implementing partners/stakeholders. This revealed that the most important long-term challenge for sustainable access and availability of health services in the private sector was the high cost of services. The cost was further compounded by high operational costs, low profit levels in the facilities, and limited (or no) public funds allocations (or other sources) to subsidize or finance private health services.

The stakeholders voiced their concerns about the low attraction of health workers in the private health sector, followed by poor retention rates among facilities, and high attrition of staff. Workforce issues were exacerbated with challenges in absorption of staff (who were trained and supported under the PHS Program) onto government payrolls.

According to the Assessment's findings, around half (47%) of the health workforce were employed in the private health sector (within PFP and PNFP facilities). The Assessment further pointed to considerable movement between sectors for a variety of reasons, with job preference being first in public sector, second with PNFPs, and third with PFPs. Working conditions were considered better in PNFP and PFP facilities (compared to the public sector), while salaries and job security were better in the public sector. Out of all health cadres, only clinical officers (83%) and laboratory staff (84%) positions were filled to acceptable levels.

With the exception of web-based digital platforms supported by the PHS Program, very few private facilities had access to comprehensive in-house information and communications technology (ICT) platforms, and proper resources and inventory tracking tools.

Access to and administration of TB medicines and commodities is not yet streamlined in the private sector. Stock outs of isoniazid, and health workers' unfamiliarity with the administration of IPT remain a serious challenge. At the same time, FP products are not yet streamlined in the national system. Stakeholders also voiced their concern about frequent breakdowns and stock-outs in the supply system for specific essential medicines at national and district levels.

Participant feedback related to local organizational capacity and viability revealed that the most important challenges to the continual availability of critical health services in the private sector are weak leadership and weak governance structures, which ultimately affect attrition of critical health staff.

Stakeholders also pointed to the high cost of inputs and unfavorable taxation policies for the private health sector: PFP facilities experienced the double burden of income and other taxes (e.g. VAT and import tax), while both PFP and PNFP facilities suffered from the high costs of inputs (e.g. land, power, water, and infrastructure).

Recognizing the negative impact that gender norms and roles can have on the well-being of OVC, the PHS Program continued to ensure active participation and involvement of men in OVC activities, sensitized men about their role in supporting and protecting the rights of women and girls, and sensitized women and girls about their sexual reproductive health and rights.

PHPs require continuous and improved regulatory oversight to assure quality of services. Many have yet to achieve the required standards of care. The lack of private sector capacity necessitates increased access to training (including CPD and CME) and updated internal quality control systems. At the same time, the capacity of umbrella organizations serving and representing the private sector need to engage MOH senior leadership and influence national-level processes, as well as support its membership in attaining the desired capacity to accomplish accreditation. Achievement of required standards of care enhances opportunities to access health financing and PPP ventures.

Per stakeholder feedback and the Private Health Sector Assessment study, many PFPs reported having multiple clients who cannot afford to pay, presenting a major challenge to the overall sustainability of their facilities. Many PFPs are serving target populations, yet they do not enjoy many benefits that PNFPs receive for serving the same target population. PFPs are subject to VAT, pay import taxes on equipment and medicines, and pay income tax.

The Costing and Pricing Study showed that donor subsidies for key services (HIV/AIDS, TB and FP) crowded out PFPs in the provision of these services, because they could not compete with PNFPs or MOH facilities offering the same services at lower (or no) cost.

The District Health Information System (DHIS 2) forms are voluminous, yet photocopying in most Program sites is very expensive or not available. Thus, collecting DHIS 2 data from all HCBs could not be achieved.

For most of the duration of the DCA, Centenary Bank did not have the capacity to track non-DCA health sector loans, making it impossible to track the evolution of the bank's total private health sector portfolio. This was due to a limitation in Centenary's previous computer system, which did not provide a specific code for the health sector. The bank migrated to a new system in 2017 that allowed it to track health sector loans. Unfortunately, due to data clean-up issues, the bank was not able to evaluate historical health lending levels or the changes in the portfolio during the life of the PHS Program—making it impossible to evaluate the total impact of the Program's A2F work on Centenary's health lending.

Centenary Bank loan officers had no specific targets for DCA or health sector loans, and there was no dedicated credit staff to handle this sector. Without specific sectoral targets, the bank's existing lending incentives, rewarding loan officers for volume (and thus larger loans), may have slowed the use of the DCA, with an average of smaller loans given to HCBs.

Ecobank focused on larger, more formal enterprises. The bank's organizational structure was therefore not well-suited to lending to the private health sector in Uganda, especially with the DCA target of 50 percent utilization outside the Central Region. The regional branches did not handle loan requests, and the bank only lent to clients located within a radius of 30 kilometers of a branch. Ecobank did not relax collateral requirements, despite having the DCA guarantee.

Poor initial record organization and filing at the HCBs required significant time with the facilitators to gather the source information needed to even begin coaching them in business skills. Due to heavy

workloads of HCB staff, delays in transferring data to journals, ledgers and financial statements were common. Therefore, the HCB financial management systems and documents were not always up to date at the time of HaaB counseling sessions. Some HCBs, particularly the hospitals under HaaB II, were not willing to release their financial data to HaaB counselors, which affected financial analysis, as well as Program evaluation.

During the final year, USAID informed Cardno that it could not fund the PHS Program beyond the amount already obligated. Our team immediately made the necessary programmatic adjustments and had to effectively suspend implementation. Aside from the reduction in services supported at health facilities, two central activities were particularly impacted: 1) systems strengthening activities with the faith-based PNFP medical bureaus; and 2) technical assistance to the recent DCA Loan Guarantee with DFCU bank.

Lessons Learned

1. **It is feasible to deliver free or subsidized health services in the private sector at affordable quality:** A number of approaches and models employed under the PHS Program attest to this. With appropriate accreditation and linkages to free medicines and supply systems, as well as the introduction of CHI schemes and A2F through DCA, all participating facilities under the PHS Program provided free critical HIV-related health services, as well as other services, at affordable rates and quality.
2. **The national PPPH policy provided a framework for building partnerships:** Collaboration between stakeholders, especially with MOH, regional and district authorities, Medical Bureaus, CBOs and the private sector, was crucial for Program implementation and its strong results. From regional health directors and their staff, to community health workers in remote villages and the district health management teams that support them, partnerships created an environment for improvement. Despite the national PPPH policy's existence, in Uganda's decentralized context, it was not implemented unless District Health Management Teams had the knowledge, tools, and capacity to work with PFPs. There is considerable potential for districts to expand and manage their own PPPs, for example, through contracts with PNFPs or vouchers for safe deliveries.
3. **Strong support from USAID/Uganda was critical for Program success:** The PHS Program enjoyed particularly strong support from USAID/Uganda, including the Health Systems Strengthening Team and Contracts Office staff. Successful implementation of such a complex program with a wide range of activities and the large portfolio of performance-based grants would not have been possible without their consistent programmatic and contracting support.
4. **There is a need to be able to continuously adjust and respond to changes and emerging issues:** A program as complex as the PHS Program must constantly conform its reporting to higher-level programmatic examinations, such as new emerging health quality indicators that need to be incorporated, analyzed, and reported. To address this need, the Program had to sustain continuous change capacity for reporting among supported facilities, sites, and local implementing partners (i.e., instituting a Training-of-Trainers facilities roster). This change capacity is especially important among the Medical Bureaus, given their reporting roles. A cadre able to act as agents of change must be instituted to maintain the needs of the network of 134 faith-based health facilities connected under the PHS Program.
5. **Institutionalization of cross-learning needs to expand and become a major approach:** Moving forward, more emphasis should be paid to information for decision-making. The PHS Program was successful in increasing the reporting capacity among supported facilities, sites, and local implementing partners. Nevertheless, the ability of supported PHPs to critically analyze and use data for management decisions is not yet at the desirable level. Policies, strategies, and formal procedures were established in some facilities, but on the ground, the PHS Program faced implementation challenges with boards, committees, and management.

6. **UHF has a potentially major health Governance role:** UHF proved to be a valuable player in representing the private health sector. Continuous technical assistance, QI guidance and support supervision must be dedicated to UHF to enhance its capacity to manage evidence-based data information and high-level advocacy.
7. **Business TA leads to loans:** The major lesson learned for A2F is that targeted business training, followed by vigorous coaching support to prospective borrowers, is an effective way to build a credit pipeline. The Program's A2F technical assistance was effective in helping PHPs access financing through both DCA and non-DCA loans. The loan proposals of 52 of the 89 Centenary Bank DCA borrowers (58 percent) were a direct result of the PHS Program's A2F team's TA support efforts. The PHS Program's TA was critical to building the DCA credit pipeline.
8. **Partner banks need systems to track all health sector lending over time:** The long-term objective of A2F support was ensuring that health providers had access to finance—even without a DCA guarantee. In order to be able to monitor a bank's performance towards this objective, the bank should be able to track its health sector loan portfolio from before a DCA and TA are received, throughout the life of the program, and beyond. Centenary Bank reported that it has increased its overall health sector lending during the five years of the PHS Program, but its former information system did not provide the data needed to confirm that. After receiving BDS support, HCBs may also have obtained loans from non-DCA banks which did not report to the PHS Program, resulting in underestimating the impact of A2F.
9. **Selection of the right DCA bank partners is crucial:** Although both Centenary Bank and Ecobank received the same TA support from the PHS Program for their health DCA loan guarantees, the results of the two DCAs were very different: Centenary Bank had an 86 percent utilization rate at the end of the Program, while Ecobank's DCA was terminated in early 2018 with only 17.5 percent utilization. Ecobank's centralized structure and limited branch network were not suited to the DCA portfolio's target of 50 percent outside the Central Region, and the bank's inflexible lending criteria did not allow it to work with smaller, rural HCBs.
10. **HCBs value business development services:** There was great appreciation of BDS in most HCBs, which recognized that improved financial management and business planning are crucial to accessing finance. Many HCBs indicated that they would be willing to pay a modest fee for BDS support.
11. **Careful logistical planning and preparation improves the quality and results of BDS:** Holding half-day preliminary regional workshops to introduce Program modules and logistical details to owners could have boosted the commitment and participation rates in business training and counseling activities from the beginning. Issuing the full schedule of mentoring sessions in advance and sending follow-up reminders prevented missed counseling sessions. Maintaining a copy of the mentoring file at both the HCB and the Program office enabled counselors to review compliance and assess the HCB's mentoring coverage/needs. Holding brief pre-counseling meetings the day before the full counseling session was very useful in reviewing the state of each HCB's needs and challenges and in setting priorities for counselors on each visit. Dedicating a business counselor for a full day to each HCB minimized missed mentoring sessions and maximized Client-Counselor contact time.

The Way Forward

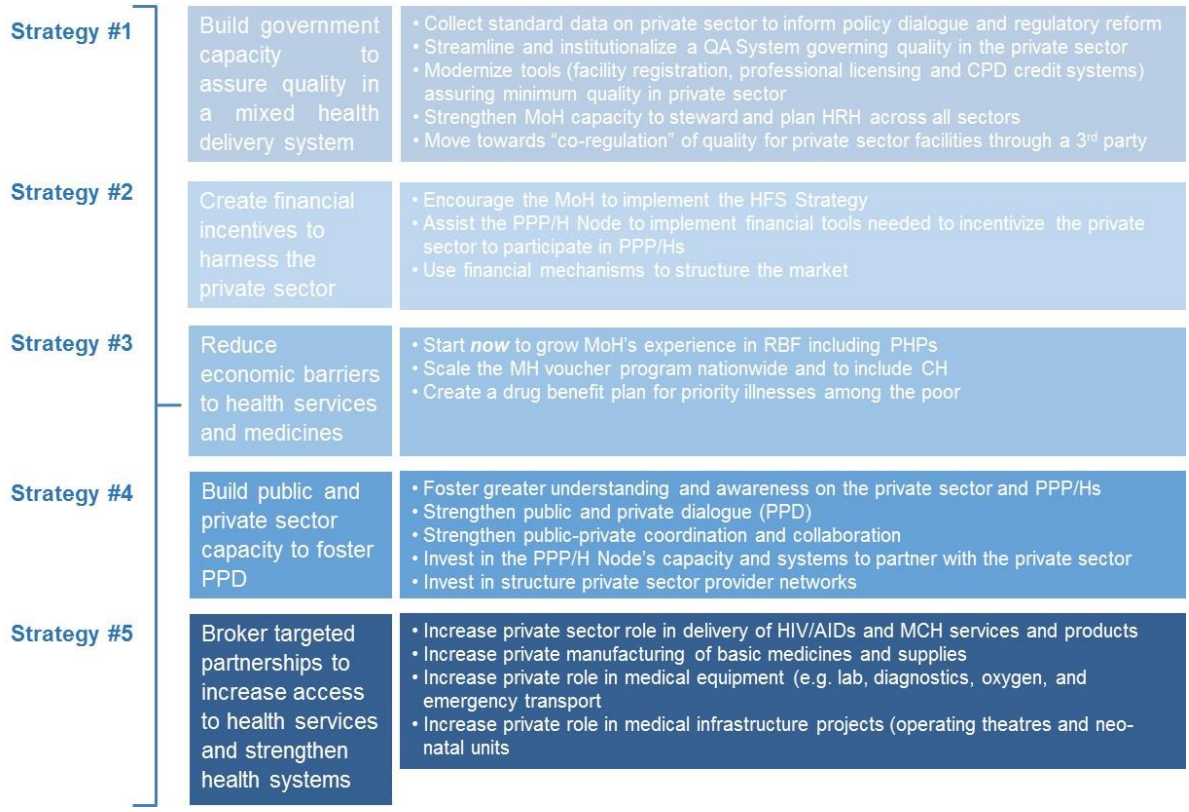
Recommendations for future programming are based on planned activities that the PHS Program was not able to realize, due to funding constraints and on findings of the Private Health Sector Assessment—which provided key recommendations to help harness the private sector to improve access to basic health services and essential medicines, as well as mitigate critical health system constraints.

The Uganda Private Health Sector Assessment found a strong commitment to partnerships from stakeholders in both the public and private sectors and a strong policy foundation to enable public-private

collaboration. To help the Ugandan public and private stakeholders in health think through and prioritize the long list of possible interventions, the Assessment proposed a strategy that prioritizes the wide array of recommendations and suggests timing to implement them – an Implementation Road Map.

Figure 30 below presents a strategic framework to implement priority recommendations. The 5-pronged framework is ambitious and will require that all stakeholders come together to deliberate and further prioritize activities outlined in each strategy. Many recommendations are cross-cutting and will require strategic action and cooperative engagement between the public and private sector stakeholders.

Figure 30: Private Sector Strategy for Mixed Health Delivery System



There are several critical interventions which require continuous support to ensure sustainability and solidify Program gains. In particular, support to four faith-based Medical Bureaus, establishment of an interfaith body, capacity strengthening of UHF, institutionalization of SQIS, and technical assistance to DFSU should be sustained. Those interventions were most impacted by the funding limitation during the final year of the Program. The Program team hopes that USAID and other development partners will continue supporting the private sector to harness its potential for achieving UHC in Uganda.

At the end of the PHS Program five years later, Cardno is proud of the work that led to measurable improvements in numerous areas discussed herein. Systems were improved, PFPs and PNFPs provided higher-quality care, and the correct drugs and equipment were available more often. OVC and their caregivers received comprehensive support. Rigorous research was conducted. But most importantly, the overall health of individuals and families in Uganda improved.

Appendices

Appendix 1: Performance Indicators Data Table (PMP)

Indicators	Year 1 [Oct 13-Sept 14]		Year 2 [Oct 14-Sept 15]		Year3 [Oct 15-Sept 16]		Year4 [Oct 16-Sept 17]		Year5 [Oct 17-Mar 18]		EOP Achievement
	T	A	T	A	T	A	T	A	T	A	
IR1: Expanded availability of health services by program supported private service providers											
HCT											
Indicator 1: Number of individuals who received testing and counselling services and received their test results	100,000	77,393	285,000	384,081	156,858	271,852	352,704	376,254	31,208	44,333	**1,153,913**
Indicator 2: Total number of individuals who received HCT services for HIV and were found HIV Positive	6,000	3,811	15,840	13,804	11,915	9,218	12,536	10,228	1,934	950	**38,011**
Indicator 3: Number of individuals who received testing and counselling services and received their test results as couples.	2,000	5,400	5,650	20,026	3,000	12,332	7,054	21,352	624	7,411	**66,521**
Indicator 4 : Number of service outlets providing Testing and Counseling services	109	67	132	112	93	93	71	71	12	12	**112**
VMMC											
Indicator 5: Number of clients counselled, tested and received HIV results as part of SMC package	9,000	8,450	33,780	35,621	13,324	15,520	43,176	50,658	2,090	2,409	**112,658**
Indicator 6: Number of males circumcised as part of the minimum package of SMC for HIV prevention services disaggregated by age (quality indicator)	10,000	9,274	34,800	32,274	12,500	16,696	45,448	51,730	2,200	2,424	**112,398**
PMTCT											
Indicator 13: Number of women attending 1st ANC visit at service outlets	20,000	12,827	50,500	37,932	21,000	33,334	N/A	35,016	N/A	3,817	**122,926**

Indicators	Year 1 [Oct 13-Sept 14]		Year 2 [Oct 14-Sept 15]		Year3 [Oct 15-Sept 16]		Year4 [Oct 16-Sept 17]		Year5 [Oct 17-Mar 18]		EOP Achievement
	T	A	T	A	T	A	T	A	T	A	
Indicator 14 Percentage of mothers attending at least four antenatal care (ANC) visits during pregnancy	25%	22%	30%	20%	25%	18%	70%	16%	60%	26%	**26%**
Indicator 15a: Number of pregnant women with known HIV status (includes women who tested for HIV and received their results)	18,720	20,485	49,280	17,637	29,707	48,849	N/A	39,356	N/A	7761	**134,088**
Indicator 18a: Number of HIV+ women receiving ARVs to reduce MTCT	1,123	1,492	2,657	2,141	2,768	1,076	98%	2,273	100%	92	**7,074**
Indicator 18b: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	100%	74.6%	100%	48.0%	100%	94.2%	98%	79.7%	100%	86%	**67%**
Indicator 25: Percentage of infants born to HIV-positive pregnant women who were started on Cotrimoxazole (CTX) prophylaxis within two months of birth	N/A	39%	N/A	84%	N/A	79%	80%	72%	90%	75%	**78%**
Clinical Care											
Indicator 26: Number of HIV+ clients newly enrolled in care receiving a minimum of one clinical service	2,105	2,754	9,604	10,897	5,503	7,197	5,491	5,818	1,000	725	**27,391**
Indicator 27: Number of service outlets supported with clinical care	N/A	44	N/A	61	N/A	74	71	71	12	12	**74**
Indicator 28: Number of HIV positive adults and children receiving a minimum of one clinical service	9,000	7,880	53,702	48,743	64,559	39,669	64,445	39,919	11,270	11,602	**11,602***
Indicator 29:# of HIV positive persons receiving cotrimoxazole prophylaxis	N/A	6,580	51,017	44,767	64,559	39,438	64,445	38,563	11,270	11,590	**11,590***
Indicator 30: Number of PLHIV who were nutritionally assessed via anthropometric measurement	N/A	N/A	42,961	30,804	51,647	36,313	59,289	37,032	10,377	11,289	**37,757**

Indicators	Year 1 [Oct 13-Sept 14]		Year 2 [Oct 14-Sept 15]		Year3 [Oct 15-Sept 16]		Year4 [Oct 16-Sept 17]		Year5 [Oct 17-Mar 18]		EOP Achievement
	T	A	T	A	T	A	T	A	T	A	
Nutrition											
Indicator 32: Percentage of People Living with HIV (PLHIV) in care and treatment who were nutritionally assessed via anthropometric measurement	N/A	N/A	N/A	64%	N/A	92%	100%	92%	100%	97.1%	**97%**
Indicator 33: Proportion of clinically undernourished PLHIV who received therapeutic or supplementary food	N/A	N/A	N/A	81%	N/A	33%	80%	52.6%	60%	42%	**70%**
Tuberculosis											
Indicator 34: Number of HIV positive patients who were screened for TB in HIV care or treatment setting	N/A	6,754	53,702	39,950	64,559	35,274	64,445	38,082	11,270	11,309	**39,950**
Indicator 40: Percentage of HIV TB co-infected patients in HIV care or treatment (pre-ART or ART) who started TB treatment	85%	81%	88%	83%	100%	84%	100%	95%	100%	88%	**93%**
Indicator 41: TB treatment success rate at USAID/Uganda Private Health Support Program supported private health service providers	70%	84%	85%	80%	87%	72%	90%	69%	90%	73%	**71%**
Indicator 42: Percentage of registered new and relapsed TB cases with documented HIV status	N/A	N/A	N/A	N/A	N/A	N/A	90%	81.0%	100%	89%	**85%**
Indicator 43: Percentage of HIV-positive new and relapsed registered TB cases on ART during TB treatment	N/A	N/A	N/A	N/A	N/A	N/A	100%	95.0%	95%	99%	**99%**
Indicator 44: Percentage of PLHIV newly enrolled in HIV clinical care who start isoniazid preventative therapy (IPT)	N/A	N/A	N/A	2%	N/A	9%	30%	6%	20%	11%	**11%**
Indicator 45: TB treatment outcomes among registered new and relapsed TB cases who are HIV-positive	N/A	N/A	100%	72%	100%	70%	100%	72%	100%	65%	**69%**
Indicator 46: Percentage of PLHIV in HIV clinical care who were screened	85%	86%	87%	82%	90%	89%	90%	95%	100%	99.0%	**99%**

Indicators	Year 1 [Oct 13-Sept 14]		Year 2 [Oct 14-Sept 15]		Year3 [Oct 15-Sept 16]		Year4 [Oct 16-Sept 17]		Year5 [Oct 17-Mar 18]		EOP Achievement
	T	A	T	A	T	A	T	A	T	A	
for TB symptoms at the last clinical visit											
HIV/AIDS Treatment											
Indicator 47:Number of service outlets providing antiretroviral therapy (includes PMTCT+ sites)	70	50	91	61	73	74	71	71	12	12	**74**
Indicator 48: Number of adults and children newly enrolled on antiretroviral therapy (ART)	2,300	2,089	6,500	8,230	8,054	5,860	10,385	6,861	1,000	722	**23,762**
Indicator 49:Number of adults and children currently receiving antiretroviral therapy (ART)	6,937	25,364	30,419	29,371	60,628	33,909	43,224	38,422	11,270	11,593	**39,144**
Indicator 50: Percent of adults and children known to be alive and on treatment 12 months after initiation of ART (Quality Indicator)	65%	92%	80%	55%	85%	86%	89%	82.0%	90%	90%	**80%**
Indicator 51: Percentage of ART patients with a non-detectable viral load result (<1000 copies/ml)documented in the medical record within the past 12 months	90%	90%	90%	85%	90%	89%	90%	91%	95%	90%	**88%**
OVC											
Indicator 52: # of eligible children (OVC) provided services in 3 or more OVC core program areas beyond psychosocial/spiritual support during the reporting period	N/A	N/A	41,793	40,440	44,357	33,096	N/A	27,275	N/A	32,485	**40,440**
Indicator 53: # of eligible children (OVC) provided with education and or vocational training	N/A	N/A	38,787	41,846	39,882	33,845	N/A	15,386	N/A	9,095	**41846**
Indicator 54: Number of OVC who completed vocational/apprenticeship training and provided with startup kits	N/A	N/A	1,850	2,297	2,038	1,177	N/A	1,965	N/A	176	**5,615**

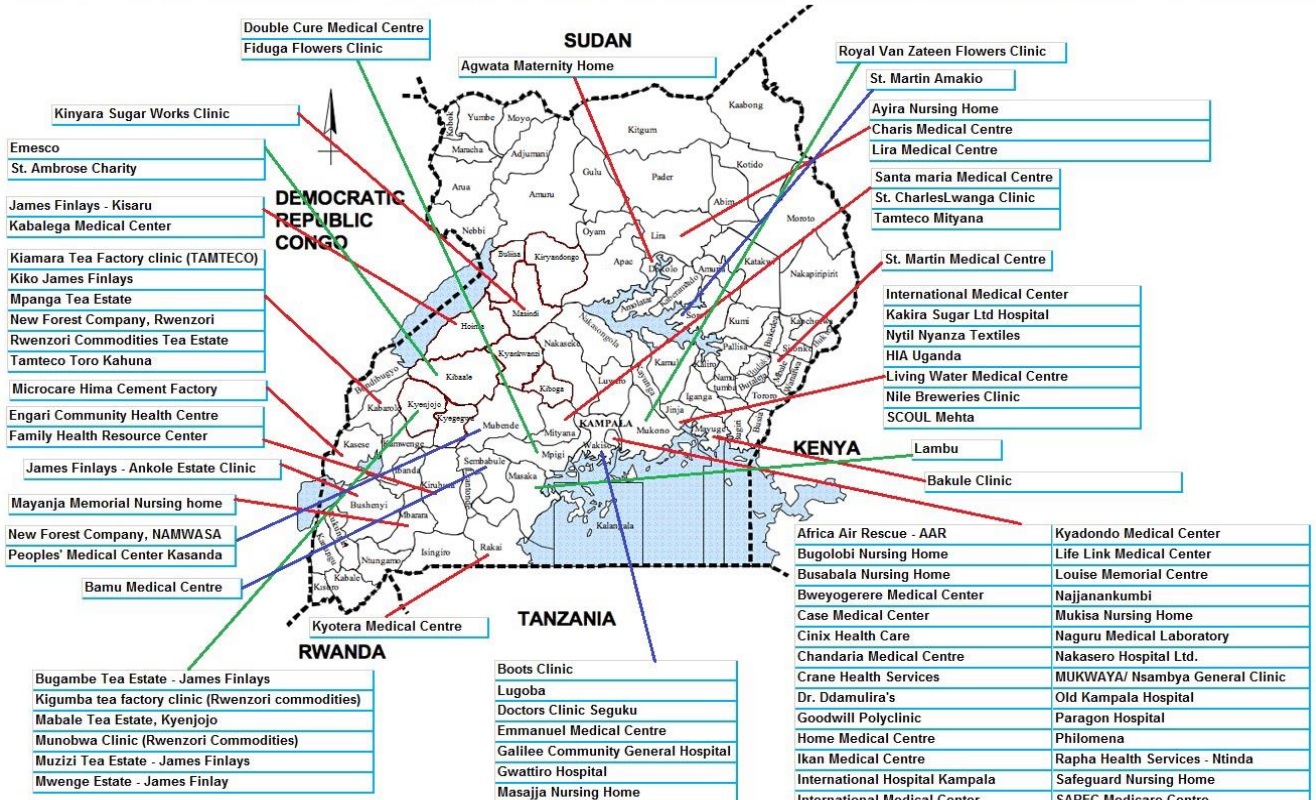
Indicators	Year 1 [Oct 13-Sept 14]		Year 2 [Oct 14-Sept 15]		Year3 [Oct 15-Sept 16]		Year4 [Oct 16-Sept 17]		Year5 [Oct 17-Mar 18]		EOP Achievement
	T	A	T	A	T	A	T	A	T	A	
Indicator 55: Number of caregivers trained in community based nutrition and food security	N/A	N/A	3,000	3,204	3,000	4,680	3,000	3,049	12,000	12,003	**22,936**
Indicator 56: Number of orphans and caregivers trained in income generation using locally available resources	N/A	N/A	2,000	1,944	3,500	3,396	2,500	2,216	N/A	3,968	**11,524**
Indicator 58: Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS	2,820	41,793	44,433	45,676	45,707	59,987	45,707	46,572	36,079	35,076	**60,359**
Indicator 59: Number of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services	1,128		15,551	5,127	24,754	35,170	23,490	29,120	14,700	14,696	**42,593**
Indicator 60:Number of OVC graduating from external support	N/A	N/A	500	403	N/A	1,459	N/A	2,648	N/A	28,543	**33,053**
Malaria											
Indicator 61: Number of pregnant women receiving two or more doses of IPT for malaria	14,000	6,604	14,200	19,292	5,000	16,611	24,600	19,197	3,000	2,928	**64,632**
Family Planning											
Indicator 62: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services	100%	0%	100%	62%	100%	60%	95%	73.6%	100%	85%	**85%**
Indicator 63: Number of new acceptors to FP registered at health service outlets	10,000	0	10,100	4,616	10,200	87,203	30,000	38,645	2,000	4,537	**135,001**
Indicator 64: Couple Years Protection (CYP) in USG supported programs	20,065	30,990	20,467	12,259	21,081	58,208	14,000	43,019		9,110	**153,586**

Indicators	Year 1 [Oct 13-Sept 14]		Year 2 [Oct 14-Sept 15]		Year3 [Oct 15-Sept 16]		Year4 [Oct 16-Sept 17]		Year5 [Oct 17-Mar 18]		EOP Achievement
	T	A	T	A	T	A	T	A	T	A	
Health Systems Strengthening [HSS]											
Indicator 65: Number of healthcare workers who successfully completed an in-service training program during the reporting period	220	228	400	364	350	483	1,514	1438	535	582	**3,095**
Indicator 66: Percentage of supported private facilities reporting on time in the DHIS2	40%	62%	100%	90%	100%	95%	80%	100%	100%	100%	**100%**
IR2: Increased affordability of private health services and products											
Indicator 73: Reduction in sales price of essential health medicines, services, and commodities	N/A	N/A	3%	N/D	N/A	N/A	6%	10%	N/A	N/A	**10%**
Indicator 74: Number of groups (such as VSLAs) providing health service products	N/A	N/A	2	0	3	0	120	70	150	299	**369**
Access to Finance											
Indicator 75: Percentage of Development Credit Authority (DCA) bank loan portfolio held by first time new private health provider borrowers with the DCA bank	30%	24%	35%	29%	**30%**	32%	40%	21%	46%	21.3%	
Indicator 76: Overall utilization of the DCAs for Centenary Bank	70%	46%	100%	59%	70%	73%	100%	83.2%	90%	85.8%	**86%**
Indicator 77: Overall utilization of the DCAs for Ecobank	10%	7%	12%	7%	22%	7%	40%	17.5%	25%	17.5%	**18%**
Indicator 78: Number of relationships established with banks (DCA & non DCA)	10	10	12	51	14	9	16	11	18	3	**84**
Indicator 79: Percentage of successful loan applications from rural private health providers outside the central region with both DCA banks	50%	37%	52%	44%	35%	43%	58%	44.5%	40%	49%	**49%**

**This figure indicates the number of individuals served at the Program's end, when it was working with only 12 private facilities; therefore, this does not represent the Program's overall achievement.*

Appendix 2: Map of PHS Program Interventions and Districts Supported

USAID/UGANDA PRIVATE HEALTH SUPPORT PROGRAM'S PRIVATE PARTNER HEALTH FACILITIES



Appendix 3: List of Implementing Partners

List of Partner Health Facilities

HEALTH FACILITY	YR 1	YR2	YR3	YR4	YR5
AAR Acacia Clinic HC II					
Ankole Tea Factory HC II					
AOET HC II					
Ayira Health Services					
Bamu HOSPITAL					
Boots Medical Centre Clinic					
Bugambe Tea HC III					
Bugolobi Medical Centre HC II					
Buluba HOSPITAL					
Busabala Nursing Home HC II					
Buzirasagama HC II					
Bweyogerere Medical Centre					
Case Medical Centre					
Chandaria Medical Clinic					
Charis HC III					
COMMUNITY HEALTH PLAN UGANDA					
Crane Health Services HC II					
Doctors Clinic Seguku Maternity And Dental CLINIC					
Double Cure Med Center CLINIC					
Dr.Ddamulira'S Clinic HC II					
EMESCO HC III					
Engari Community HC III					
Family Health Resource Centre CLINIC					
Fiduga HC III					
Galilee Community General HOSPITAL					
Ggwatiro Nursing Home HC III					
Good Will Polyclinic & Nursing Home CLINIC					
Health Initiative Association Uganda					
Hiima Iaa (Uci) HC IV					
Iganga Islamic Medical Center HC III					
Ikan Medical Center HC II					
International Hospital Kampala (IHK)					
International Medical Centre-KPC,Watoto					
Ishaka Adventist HOSPITAL					

HEALTH FACILITY	YR 1	YR2	YR3	YR4	YR5
Jinja International Medical					
Jumbo Medical Clinic HC II					
Kabalega Medical Centre HC III					
Kadic Clinic HC II					
Kairos Medical Centre HC II					
Kakira Worker's HOSPITAL					
Kampala Family Clinic HC II					
Kampala Medical Chambers HC II					
Kiamara HC II					
Kigumba Tea Factory HC II					
Kiko HC III					
Kim's Medical Centre HC II					
Kinyara Sugar Works HC III					
Kireka SDA HC III					
Kisaaru Tea HC II					
Kisiizi NGO HOSPITAL					
Kitante Medical Center HC II					
Kiwoko HOSPITAL					
Kololo HOSPITAL					
Kuluva HOSPITAL					
Kumi NGO HOSPITAL					
Kyadondo Medical Centre HC II					
Kyetume CBHC HC III					
Kyotera Med. Centre HC II					
Lambu HC II					
Life Link Medical Centre- Wakiso CLINIC					
Lira Medical Centre Ltd HC III					
Living Water Community Medical Centre CLINIC					
Lugazi Scoul HOSPITAL					
Lyantonde Muslim HC III					
Mabale Tea Factory HC II					
Masajja Nursing Home CLINIC					
Mayanja Memorial HOSPITAL					
Meeting Point Kampala HC II					
Mengo HOSPITAL					
Mirembe Medical Centre- Najja HC II					
Mityana Tea Estate HC II					

HEALTH FACILITY	YR 1	YR2	YR3	YR4	YR5
Mpanga Tea Estate HC II					
Mukisa Nursing Home HC II					
Mukwaya General Hospital					
Munobwa-Hiima Tea Factory Clinic					
Muzizi					
Mwenge Clinic HC III					
Naguru Medical Laboratory Ltd (Namela) HC II					
Nakasero HOSPITAL					
Namungoona Orthodox Hospital HC III					
Nile Breweries Company Clinic HC III					
Nyapea HOSPITAL					
Nytil Southern Range Nyanza Clinic					
Old Kampala Hospital HC IV					
Paragon HOSPITAL Kampala					
Peoples' Medical Center HC III					
Philomena Health Centre HC III					
Qudrah Medical Clinic					
Rapha Health Services HC II					
Royal Van Zanten Clinic					
Safeguard Nursing Home Clinic HC II					
Saidina Abubakar Islamic HOSPITAL					
Santa Maria Medical Centre HC III					
SAS Clinic – Bugolobi					
Sim's Medical Centre HC II					
Span Medicare Centre					
St Martin's Clinic					
St. Ambrose Charity HC IV					
St. Apolo HC III					
St. Catherine HOSPITAL					
St. Francis Health Care Services HC III					
St. Joseph's Clinic- Wandegeya HC II					
St. Luke Namaliga HC III					
St. Martins Amakio HC III					
St. Marys Medical Services CLINIC					
The Surgery CLINIC					
Toro Kahuna HC III					
Touch Clinic - Namuwongo HC II					

HEALTH FACILITY	YR 1	YR2	YR3	YR4	YR5
Triam Medical Centre CLINIC-NR					
Tropical Clinic					
Uganda Railways HC II					
Wagagai HC III					

Implementing Partners for OVC Services

District	Partner/Facility
Alebtong	Lango COU Diocese
Arua	CARITAS NEBBI-
Buikwe	International Needs Network
Bushenyi	Bweranyangi Parish OVC Project
Gulu	Comboni Samaritans of Gulu
Hoima	(ECO-AGRIC)
Iganga	Family Concepts Center
	Kiwanyi Muslim Support Initiative (KIMOSI)
Jinja	Jinja Diocese-Management
	Kakira Outgrowers Rural Development Fund
Kamuli	Al-Qudus Centre-
Kampala	Masanafu child & family support Project
Kampala/ Wakiso	Meeting point Kampala
	Namungoona Christian Care Initiative
Kasese	South Rwenzori Diocese/ Bishop Masereka Christian Foundation
Kabarole	Ngombe Community Health Project
Kumi/ Bukedea	Islamic outreach center-Kumi
Kumi	Kumi COU Diocese
Kyenjojo	Bringing Hope To the Family
Lira	AMUCA SDA OVC Project
	AOET Lira
Luwero	Nankyama Foundation
Masaka	CARITAS MADDO
	Fishing Community Health Initiative
Masaka/ Lwengo	Buddu Social Development Association
Masindi	Family Spirit Children Centre (FSCC)
Mbarara/ Ntungamo	Mbarara Archdiocese
Mityana	Kireku Health Program
	Kiyinda Mityana Diocese
Mukono	Chain Foundation
	Katente Child Care

District	Partner/Facility
Nakasongola	Kasana Luwero Diocese
Nebbi	Nebbi COU Diocese-
Rukungiri	Agape Nyakibale
	Kakinga Child Development Center
Sheema	Karera Ecumenical Development Organization (KEDO)
Tororo	Action for Behavioral Change Tororo
Tororo/ Busia	Bukedi Diocese Mobile Farm School-
Wakiso	Friends of Canon Gideon Foundation-
	FXB
	Kampala Archdiocese
	KIFAD Kiira
	Kiyita Family Alliance for Development Mende
	Mary Muke Solidarity Fund-
	Namirembe diocese-
	SOS Children's Village Uganda Kakira

Business Development Service Partner Institutions

District	Partner Facility
Abim	Rhema Hospital/Medical Group
	Defa Medical Care Clinic
Adjumani	Safesoul Medical Clinic
Amuria	Zion Medical Clinic
Amuru	Goli Health Centre III
	Paidha Medical And Maternity Clinic
Arua	Got Kamba Clinic
	Tropical Medical Care
	Mola Medical Centre
	Charity Medical Centre
Bugiri	Pikwo Medical Centre
Bukedea	Kony-kwo Clinic
Busia	Patochi Clinic
Gulu	Pabo Medical Clinic
	Keyo Medical Centre
	Hope Community Health Care Centre
	Labora Clinic
	Pearl Medical Centre
	Anzoa Medical Bureau
Hoima	Lira Medical Centre Ltd

District	Partner Facility
Ibanda	Charis Medical Centre
Iganga	Ayira Health Services
Isingiro	Alleluyah Medical Clinic And Lab Services
	Good Hope Joint Medical Clinic And Lab Services
Kabarole	Kanginima Hospital
Kampala	Soroti Medical Associates Nursing Home
	Kona Clinic
	Community Clinic And Imaging Centre
	Community Clinic And Imaging Centre
	St. Martin's H/C III Amakio
	Divine Health Centre
	St. Ann Domiciliary
	Kamuli HealthCare Emergency
	Bachi Medical Clinic
	St..Mary's Domiciliary
	Luhaire Life Care
	St. Martin's Health Center, Mbale
	St. Martha Maternity Home
	Gloria Health Center
	Kabarole Hospital Church of Uganda
	Rwamanja health centre
	MBH Maternity Centre
	Rwebisengo Maternity and child care centre
	Bufunjo medical centre
	St.Edward health centre
	People Medical Centre
Kamuli	Ibanda Medical clinic
Kamwenge	John Medical Centre
Kasese	Zam Zam health centre
Kiruhura	Sanga human diagnostic centre
	Family Health Resource Centre
	Engari Community health centre
Kumi	Mayanja Memorial Hospital
Kyenjojo	Diisi Medical Center
	Kathel medical care
Lamwo	Polly care medical center
Lira	Kyotera Medical Centre
	Ssanje Domicilliary clinic
	Mugume Clinic
Mayuge	Bamu Hospital

District	Partner Facility
Mbale	Ashock Health Centre
Mbarara	Goodwill Polyclinic
	Mirembe medical centre
	Sarec medical Limited
Mubende	Span medicare
Nebbi	Devine Ortho Care
Ntoroko	Kireka SDA Health Centre
Ntungamo	Masajja Nursing Home
Nwoya	Qudrah medical centre
Pader	St. Apolo Health Centre
Pallisa	St.Marys medical services
Rakai	Abii Clinic
	Ikan Medical Centre
Rukungiri	Case Hospital
Sembabule	Galilee Community General Hosipital
Serere	kairos Medical Centre
Sironko	Kampala family clinic
Soroti	Life Link Medical Centre
	Paragon Hospital Kampala limited
Zombo	St. Catherine clinic
	Gwatiro Hospital

Appendix 4: Disaggregated DCA Loan data

Table 1: Disaggregation of Centenary Bank DCA Loans

Total Number of Borrowers = 89, Total Amount of Loans Disbursed = UGX 6,592,000		
	% of Total Borrowers (n=89)	% of Total Amount Disbursed
By Gender		
Female	16%	13%
Male	84%	87%
Total	**100%**	**100%**
By Rural/Urban Location		
Rural	69%	51%
Urban	31%	49%
Total	**100%**	**100%**
By New/Repeat Borrower		
New	40%	35%
Repeat	60%	65%
Total	**100%**	**100%**
By Region		
Central	40%	54%
East	15%	21%
North	7%	4%
West	38%	21%
Total	**100%**	**100%**
By Type of Facility		
Clinic	78%	68%
Dentist	3%	2%
Drug Store/ Pharmacy	16%	12%
Medical Equipment Vendor	1%	12%
Medical Training School	2%	6%
Total	**100%**	**100%**
By Loan Purpose		
Equipment	33%	43%
Construction/Expansion	30%	29%
Working Capital	33%	25%
Multiple Purposes	4%	3%
Total	**100%**	**100%**

Table 2: Disaggregation of Ecobank Bank DCA Loans

Total Number of Borrowers =4, Total Amount of Loans Disbursed = UGX 3,120,000		
	% of Total Borrowers	% of Total Amount Disbursed
By Gender		
Female	0%	0%
Male	100%	100%
Total	**100%**	**100%**
By Rural/Urban Location		
Rural	25%	40%
Urban	75%	60%
Total	**100%**	**100%**
By New/Repeat Borrower		
New	100%	100%
Repeat	0%	0%
Total	**100%**	**100%**
By Region		
Central	75%	60%
East	0%	0%
North	25%	40%
West	0%	0%
Total	**100%**	**100%**
By Type of Facility		
Clinic	25%	1%
Dentist	0%	0%
Drug Store/ Pharmacy	50%	59%
Medical Equipment Vendor	0%	0%
Medical Training School	25%	40%
Total	**100%**	**100%**
By Loan Purpose		
Equipment	25%	1%
Construction/Expansion	25%	40%
Working Capital	50%	59%
Multiple Purposes	0%	0%
Total	**100%**	**100%**

Appendix 5: List of Reports and Documents Developed Under the PHS Program

PROGRAM STUDIES, TECHNICAL REPORTS, ASSESSMENTS AND POLICY BRIEFS

1. 2016 Uganda Private Health Sector Assessment
2. A Case for Reform of the Three Health Proffessionals Councils
3. A Case for Reform of the Three Health Proffessional Statutes _ Report of Legal Consultants Activities for the Month of August
4. A Comprehensive Health Systems Needs Assessmentt Report for All Faith Based Medical Beaureus and Health Facility
5. A Situation Analysis of Legal and Regulatory Frame Works of Health Proffessionals Councils in the East African Community
6. Actuarial Services Product Development Report
7. Acturial Study for Private Health Insurers and HMOs
8. Analysis of Existing Structure of the Private Partnership for Health Set Out in the Public Private Partnership Policy
9. Assessing Outcomes and Impact of Material and Child Health Vouchers Programe at Family Health Resource Centre
10. Baseline Capacity Assessment USAID Uganda Private Health Support
11. Baseline Survey Report of DCA Borrowers
12. Cost And Pricing Study _An Assessment of Private Health Facilities in Uganda
13. Guidelines on Continuing Proffessional Development for the Allied Health Proffessionals
14. Health as a Business (HAAB) _ Technical Guide
15. Health Facility Census in the Kampala Capital City Authority Division
16. Implementation Guidelines for PPP for Health
17. Medicine Consumer Awareness _ Campaign Report
18. National Refferal Guidelines
19. Proffessional Fee Guidelines for Medical and Dental Practitioners
20. Provision of Actuarial Consultancy Services to Select Private Health Insurers in Uganda _Literature Review
21. Provision of Acturial Consultancy Services to Select Private Health Insurers in Uganda _ Road Map Report
22. Provision of Consultancy Services for the Development of an Implementation Plan to Operationalize the Five Year PPPH Strategy (2017- 2022)
23. Report and Recommendation on Allignment of the PPPH Structure and TWG to the PPP Act
24. Report on the Existing Medicine _ Price Monitoring Policies
25. Review of the Composition and the Terms of Refference for the Technical Working Group on the Public Private Partnership Policy
26. Self- Regulatory Quality Tool for Quality Improvement in the Private Sector Uganda
27. The Kampala Capital City Authority Health Facility Census Report
28. The Kampala Capital City Authority Pharmacy and Drug Shops Facility Census

29. The Uganda Nurses and Midwives Council _ Continuing Proffessional Development Frame Work for Nurses and Midwives in Uganda
30. Uganda Medical and Dental Practioners Council (UMDPC) Continuing Proffessional Development (CPD) Accreditation and Certification Guidelines
31. Uganda Private Health Sector Assesment (Abridged Version)
32. Uganda Private Health Sector Assesment Report
33. Ugandas National Strategy for Public Private Partnership in the Health 2016 – 2020
34. UMMB – Comprehensive Health Systems Needs Assessment
35. UOMB – Comprehensive Health Systems Needs Assessment
36. UPMB – Comprehensive Health Systems Needs Assessment
37. UCMB – Comprehensive Health Systems Needs Assessment

WORK PLANS

38. PHS Program Year 1 Workplan
39. PHS Program Year 2 Workplan – PFP Activities
40. PHS Program Year 2 Workplan – PNFP Activities
41. PHS Program Year 3 Workplan
42. PHS Program Year 4 Workplan
43. PHS Program Year 5 Workplan

ANNUAL AND FINAL REPORTS

44. Year 1 Q 4 And Annual Report
45. Year 2 Q 4 And Annual Report
46. Year 3 Q 4 And Annual Report
47. Year 4 Q 4 And Annual Repirt
48. PNFP Activity Report April – June 2015
49. PNFP Activity Report Aug – Sept 2014
50. Final Report

Appendix 6: Detailed Annual OVC DATA

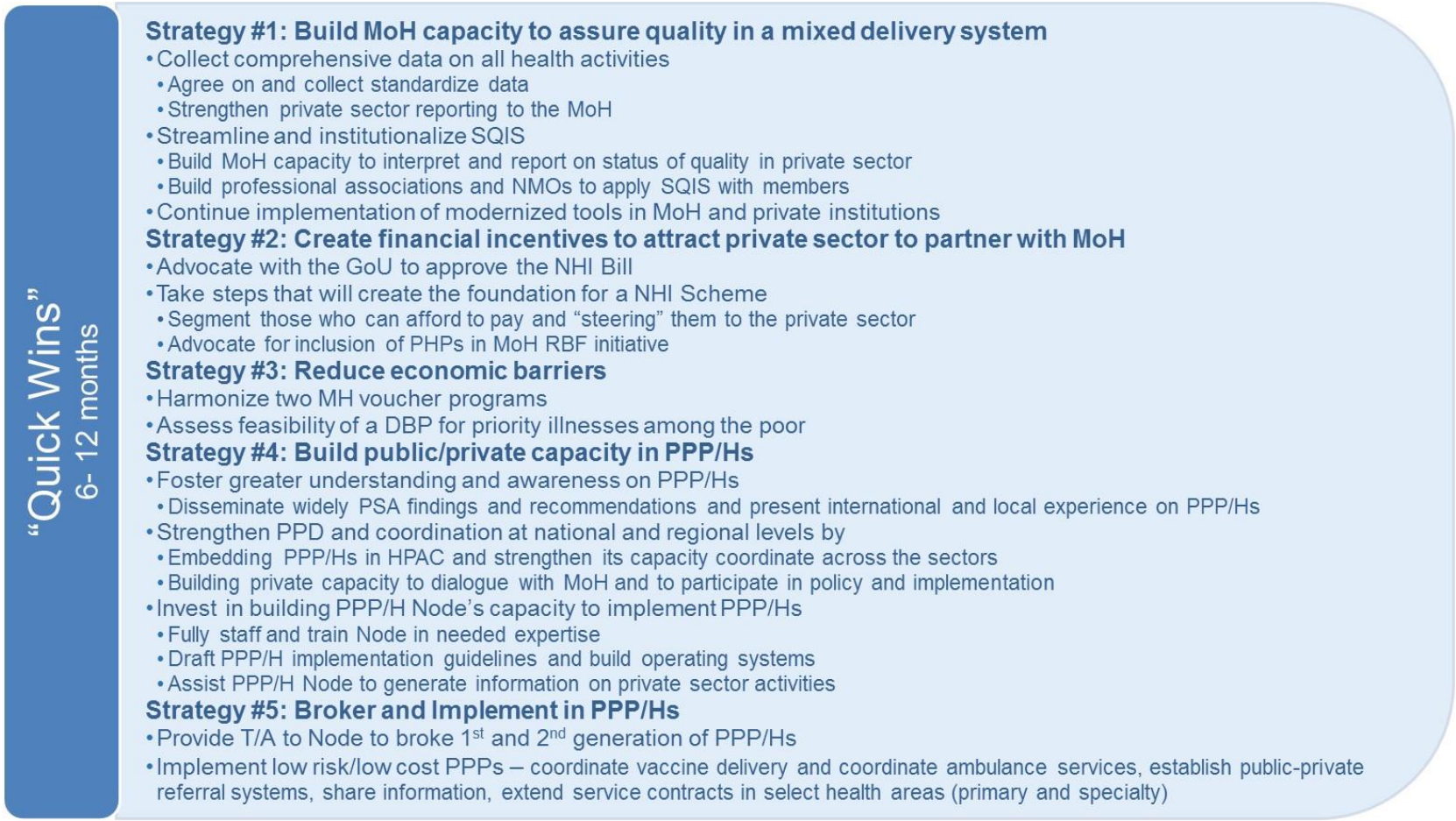
District	Name of CSO	OCT 2014-SEPT 2015			OCT 2015-SEPT 2016			OCT 2016-SEPT 2017			OCT 2017-MAR 2018		
		Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
Buikwe	International Needs Network	213	187	**400**	370	273	**643**	368	278	**646**	368	278	**646**
Bushenyi	BWERANYANGI PARISH OVC PROJECT	498	403	**901**	542	488	**1030**	542	488	**1030**	543	471	**1014**
Gulu	Comboni Samaritans of Gulu	123	134	**257**	71	91	**162**	70	92	**162**	70	92	**162**
Hoima	Environmental Conservation and Agriculture, Enhancement Uganda Ltd	947	724	**1671**	636	654	**1290**	636	663	**1299**	549	579	**1128**
Iganga	FAMILY CONCEPTS CENTRE IGANGA (FCC)	444	297	**741**	452	236	**688**	596	362	**958**	325	268	**593**
	KIWANYI MUSLIM ORPHANS SUPPORT INITIATIVE	836	811	**1647**	886	820	**1706**	886	820	**1706**	553	508	**1061**
Jinja	Jinja Diocese-Management	709	799	**1508**	709	799	**1508**	746	742	**1488**	746	742	**1488**
	KORD KAKIRA OUTGROWERS RURAL DEVELOPMENT	814	641	**1455**	626	557	**1183**	576	501	**1077**	566	505	**1071**
Kabarole	NGOMBE COMMUNITY HEALTH PROGRAMME	430	419	**849**	434	427	**861**	341	357	**698**	377	431	**808**
Kampala	Kampala Archdiocese Acronym	633	489	**1122**	653	489	**1142**	653	489	**1142**	963	489	**1452**
	Mary Muke Solidarity Fund	480	420	**900**	459	441	**900**	459	441	**900**	204	207	**411**
	MASANAFU CHILD AND FAMILY SUPPORT PROJECT	276	292	**568**	306	265	**571**	362	278	**640**	300	160	**460**
	MEETING POINT KAMPALA	600	470	**1070**	679	536	**1215**	679	536	**1215**	423	342	**765**
	Namirembe Diocese	1027	1049	**2076**	1010	1071	**2081**	1010	1071	**2081**	1010	1071	**2081**
	Namungoona Christian Care Initiative (NCCI)	412	374	**786**	259	269	**528**	275	250	**525**	455	435	**890**
Kamuli	AL-QUDUS CENTRE	87	53	**140**	259	228	**487**	310	252	**562**	128	128	**256**
	Busota Parish OVC Project	961	868	**1829**	0	0	**0**	0	0	**0**	0	0	**0**
Kasese	Bishop Masereka Foundation/South Rwenzori Diocese	369	348	**717**	369	348	**717**	405	350	**755**	238	181	**419**
KUMI	Kumi COU Diocese	330	433	**763**	177	195	**372**	177	195	**372**	0	0	**0**
	Islamic outreach center-Kumi	494	575	**1069**	452	506	**958**	502	544	**1046**	0	0	**0**
Kyenjojo	Bringing Hope To The Family	877	902	**1779**	538	450	**988**	537	449	**986**	320	293	**613**
Lira	Amuca SDA OVC Project	779	822	**1601**	298	273	**571**	308	276	**584**	223	228	**451**
	AOET Lira	688	658	**1346**	407	397	**804**	445	434	**879**	342	313	**655**
	Lango COU Diocese	181	239	**420**	194	227	**421**	194	227	**421**	0	0	**0**
Luwero	KASANA LUWEERO DIOCESE / CARITAS	1225	1183	**2408**	704	675	**1379**	704	675	**1379**	0	0	**0**
	Nankyama Foundation	1035	1033	**2068**	973	999	**1972**	973	999	**1972**	295	289	**584**

District	Name of CSO	OCT 2014-SEPT 2015			OCT 2015-SEPT 2016			OCT 2016-SEPT 2017			OCT 2017-MAR 2018		
		Female	Male	Total	Female	Male	Total	Female	Male	Total	Female	Male	Total
Masaka	BUSODA	693	661	**1354**	751	710	**1461**	797	753	**1550**	797	753	**1550**
	CARITAS MADDO	761	698	**1459**	547	490	**1037**	582	507	**1089**	192	136	**328**
	FISHING COMMUNITY HEALTH INITIATIVE	697	550	**1247**	593	488	**1081**	605	504	**1109**	405	341	**746**
Masindi	Family Spirit Children Centre	207	268	**475**	621	690	**1311**	497	563	**1060**	552	621	**1173**
Mbarara	Mbarara Arch Diocese	686	691	**1377**	932	887	**1819**	932	887	**1819**	715	631	**1346**
Mityana	Kireku Health Programme	597	513	**1110**	588	516	**1104**	588	516	**1104**	403	383	**786**
	Kiyinda Mityana Dioceses	391	357	**748**	337	388	**725**	367	427	**794**	310	282	**592**
Mukono	CHAIN FOUNDATION UGANDA	471	517	**988**	453	530	**983**	453	530	**983**	163	212	**375**
	Katente child care project	578	565	**1143**	607	575	**1182**	611	576	**1187**	932	974	**1906**
Nebbi	Caritas Nebbi	428	440	**868**	408	467	**875**	408	467	**875**	154	189	**343**
	Nebbi COU Diocese	311	361	**672**	146	184	**330**	164	188	**352**	126	162	**288**
Rukungiri	Agape Nyakibale	867	697	**1564**	867	697	**1564**	867	697	**1564**	653	750	**1403**
	Kakinga Child Development Center	537	516	**1053**	607	588	**1195**	623	599	**1222**	607	588	**1195**
Sheema	Kakarera Educational Development Organization	526	488	**1014**	478	468	**946**	483	472	**955**	338	292	**630**
Tororo	Bukedi Dioces Mobil Farm School	1037	935	**1972**	1013	896	**1909**	1053	941	**1994**	1053	941	**1994**
	Action for Behavioral Change	460	397	**857**	451	479	**930**	452	479	**931**	390	404	**794**
Wakiso	FRIENDS OF CANON GIDEON FOUNDATION	299	243	**542**	327	241	**568**	196	158	**354**	87	99	**186**
	Caring Hands	0	0	**0**	308	305	**613**	308	305	**613**	0	0	**0**
	FXB Uganda	251	76	**327**	733	711	**1444**	739	708	**1447**	705	662	**1367**
	Kiyita Family Alliance for Development	1305	845	**2150**	1007	1014	**2021**	1261	1245	**2506**	1060	1060	**2120**
	SOS Childrens Village	470	374	**844**	678	660	**1338**	553	490	**1043**	525	451	**976**
	Grand Total	**27040**	**24815**	**51855**	**24915**	**23698**	**48613**	**25293**	**23781**	**49074**	**19165**	**17941**	**37106**

Appendix 7: Private Sector Strategy

Abstract from "Exploring Partnership Opportunities to Achieve Universal Health Coverage: Uganda PSA 2016"

Private Sector Assessment provides a roadmap for optimizing private sector inputs within the context of the overall mixed health delivery system. The road map is organized by "quick wins" (6 to 12 months), "low hanging fruit" (12 to 24 months) and "long-term gains" requiring investments in system and capacity building that finally bear fruit in four to five years.



"Low Hanging Fruit"
1 - 2 Years

Strategy #1: Build MoH capacity to assure quality in a mixed delivery system

- Collect comprehensive data on all health activities
  - Strengthen private sector reporting to the MoH
  - Assist MoH and professional associations/NMOs use data to inform policy, programs
- Streamline and institutionalize SQIS
  - Build MoH capacity to interpret and report on status of quality in private sector
  - Assist MoH and professional associations/NMOs to use data to improve quality
- Separate and build HRH policy and planning function in the MoH
  - Improve HRIS
  - Strengthen and harmonize professional associations
  - Streamline and strengthen regulatory agencies and councils
- Move towards 3rd party co-regulation of quality
  - Convey legal authority to NMOs
  - MoH and NMOs work together to establish roles/responsibilities and operating systems; conduct joint visits

Strategy #2: Create financial incentives to attract private sector to partner with MoH

- Create institutional arrangements/operating systems for provider payment mechanisms
  - Build Node's capacity to apply tools (e.g. contracting, RBF, vouchers, etc.) in various PPP/Hs

Strategy #3: Reduce economic barriers

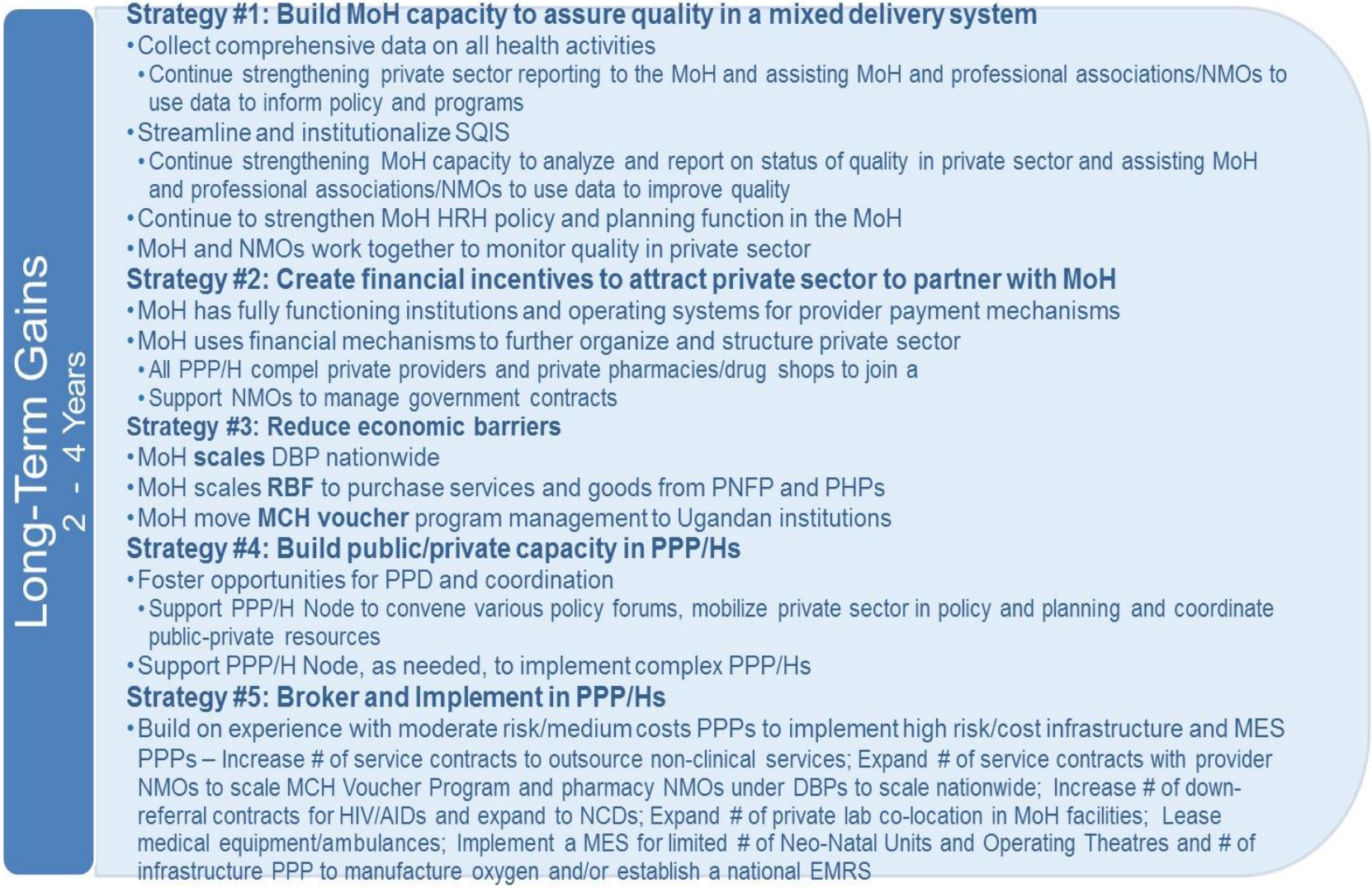
- Design and roll-out **DBP**
- Adapt MH voucher for urban setting, include CH in benefit package s and roll out to urban poor
- Use financial mechanisms to organize and structure private sector in key health markets
  - Compel private providers and private pharmacies/drug shops to join a NMO
  - Provide TA to NMOs to become viable and financially sustainable network managers

Strategy #4: Build public/private capacity in PPP/Hs

- Intensify dialogue and interactions between the sectors
  - Build gov't entities dialogue and partnering skills
  - Build private sector capacity to unify the private health sector voice
  - Establish PPP/H Coordinating Committees at the District Level
- Invest in building PPP/H Node's capacity to implement PPP/Hs
  - Train and mentor Node staff skill areas as they broker PPP/Hs
  - PPP/H Node continues to generate data to inform policy and planning

Strategy #5: Broker and Implement in PPP/Hs

- Implement moderate risk/medium costs PPPs – Service contracts with provider NMOs for Urban Poor MH Voucher and pharmacy NMOs under DBP, Down-referral PPP/H for HIV/AIDs, purchase commitments to locally manufacture ORS/ZINC/fortified food, co-location of private lab, outsource non-clinical services


Long-Term Gains
2 - 4 Years
Strategy #1: Build MoH capacity to assure quality in a mixed delivery system
• Collect comprehensive data on all health activities
• Continue strengthening private sector reporting to the MoH and assisting MoH and professional associations/NMOs to use data to inform policy and programs
• Streamline and institutionalize SQIS
• Continue strengthening MoH capacity to analyze and report on status of quality in private sector and assisting MoH and professional associations/NMOs to use data to improve quality
• Continue to strengthen MoH HRH policy and planning function in the MoH
• MoH and NMOs work together to monitor quality in private sector
Strategy #2: Create financial incentives to attract private sector to partner with MoH
• MoH has fully functioning institutions and operating systems for provider payment mechanisms
• MoH uses financial mechanisms to further organize and structure private sector
• All PPP/H compel private providers and private pharmacies/drug shops to join a
• Support NMOs to manage government contracts
Strategy #3: Reduce economic barriers
• MoH scales DBP nationwide
• MoH scales RBF to purchase services and goods from PNFP and PHPs
• MoH move MCH voucher program management to Ugandan institutions
Strategy #4: Build public/private capacity in PPP/Hs
• Foster opportunities for PPD and coordination
• Support PPP/H Node to convene various policy forums, mobilize private sector in policy and planning and coordinate public-private resources
• Support PPP/H Node, as needed, to implement complex PPP/Hs
Strategy #5: Broker and Implement in PPP/Hs
• Build on experience with moderate risk/medium costs PPPs to implement high risk/cost infrastructure and MES PPPs – Increase # of service contracts to outsource non-clinical services; Expand # of service contracts with provider NMOs to scale MCH Voucher Program and pharmacy NMOs under DBPs to scale nationwide; Increase # of down-referral contracts for HIV/AIDs and expand to NCDs; Expand # of private lab co-location in MoH facilities; Lease medical equipment/ambulances; Implement a MES for limited # of Neo-Natal Units and Operating Theatres and # of infrastructure PPP to manufacture oxygen and/or establish a national EMRS

Appendix 8: Selected PHS Program Success Stories

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SUCCESS STORY

Strengthening the Delivery of Private Health Services through Business Development Support

At least half of Uganda's health care needs are met by the private health care sector through private-for-profit (PFP) health facilities which are particularly popular for their accessibility, medicines, shorter waiting times, and higher perceived quality of service. Improvements in the quality, availability and access to health services will lead to improved health outcomes in Uganda.

The PFP health facilities are small-to-medium enterprises (SMEs) constrained by financial resources, limited service offering which limit their growth and ability to access financing. Most PFPs are managed by doctors with few business skills and rarely maintain financial records or inventory management.

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The USAID/Uganda Private Health Support Program is implementing a *Health as a Business (HaaB)* advisory support effort for the private healthcare sector to expand the availability of services, increase affordability, and improve the quality of private sector health delivery. HaaB is managed and implemented by Banyan Global.

HaaB's goal is to improve the business operations of 150 selected health care businesses throughout Uganda, specifically, providing training and counselling to improve their business and financial management systems/practices.

One of Haab's topics is entitled, "Health Practice as a Business". In this module, health care businesses are guided in assessing their own business growth plans and conceptualizing a future growth strategy. One of the foundational elements of this training is educating owners on the importance of delegating tasks and responsibilities, enabling owners and managers to spend time on higher level decision-making. In addition, this HaaB module reviews different types of administrative organizational systems to maintain effective internal operations.

Paidha Medical and Maternity Clinic recently went through the HaaB training and determined that their healthcare business was poised to expand its operations and become more efficient in the process.

> "At the training, we realized that we need to become more professional! I recognized that my clinic has to become more organized and that I must stop overseeing its day to day management if we are to expand and grow" Mr Wanjala Martin, Director of Paidha Medical and Maternity Clinic

Using lessons from the training, the Clinic is making significant changes to its financial management practices. For example, money for personal use is no longer drawn directly from the clinic without recording this as a transaction and treatments received by staff or their families are recorded (for the first time). The clinic is also applying to be part of two health insurance plans to expand its client pool. With these changes in-place, Mr. Martin hopes to apply for a bank loan to support his clinic's physical expansion and to buy new equipment.

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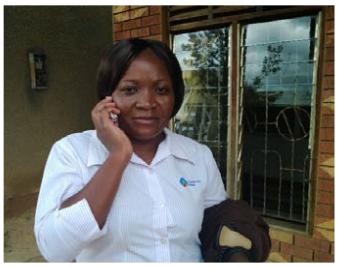
SUCCESS STORY
The Centenary Health DCA

Increased access to finance improving access to health services



USAID/Uganda Private Health Support Program

A Gord Medical Clinic health worker chats with one of her clients

In 2012, USAID partnered with Centenary Bank to develop and market financial products to Ugandan private health facilities. To date, the DCA has had a 100% zero default rate, a 60% utilization rate, and no claims or notices of default. At Gord Medical Clinic, one of the DCA beneficiaries, monthly outpatient and inpatient admissions increased from 20 to 65 clients within nine months of acquiring a loan.

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The recent USAID funded Health Initiatives for the Private Sector (HIPS) Project (2007-2013) supported the health Development Credit Authority (DCA) by assessing the needs of private providers and working with Centenary Bank to develop and market financial products such as loans and leasing agreements. The USAID/Uganda Private Health Support Program (2013-2018) team will further the utilization of the DCA facility through training and technical assistance to banks, providers, and other businesses, and will engage additional financial institutions.

The Centenary Health DCA supported by USAID and SIDA, was officially launched in October 2012 to support lending to the health sector in Uganda. In its first year of implementation, it has been successful in addressing some of the access to finance challenges facing private healthcare service providers. As an incentive to commercial banks, the DCA helps to lower the risk profile of potential borrowers in the health value chain.

The DCA has been successful in yielding additionality to private health lending. The facility has served new clients that would not have accessed bank financing. Even for existing bank customers, additionality has been created by increasing loan amount sizes and loan tenors to borrowers. The average loan period has also increased from 15 to 30 months.

To date, the Centenary Health DCA has a 100% zero default rate and a 60% utilization rate. There have been no claims or notices of default made so far and four loans have been fully paid off.

With the support of the DCA, it is anticipated that Centenary Bank will become more comfortable with lending to the Ugandan health sector so that even when the program ends, the bank will have acquired sufficient skills to continue lending to this sector. It is also common for DCA program beneficiaries

[Continued]

to improve their collateral position over the period of the loan. With a 100% zero default rate to date, it is expected the bank will use this as a cue for more aggressive lending to the sector. Below is an example of a private healthcare business that has accessed finance under the DCA.

Gord Medical Clinic

Gord Medical Clinic

Gord Medical Clinic, a private health center, is a Marie Stopes BlueStar Franchisee outpatient clinic and pharmacy. It is located in Bwizibwera Town council, Rwanyamahembe Sub County in Mbarara district. It offers reproductive healthcare and family planning services. The clinic also implements a Marie Stopes voucher scheme that offers subsdies for expectant mothers. Services such as the "Healthy Baby" voucher entitle the holder to four antenatal care visits, a delivery and one postnatal care visit. The "Healthy Life" voucher provides diagnosis and treatment of sexually transmitted infections sold through the pharmacy. The clinic proprietor, Patrick Muhumuza, (a health inspector professional) assisted by his wife (a clinical officer) established the clinic in 2010. It has four full time staff. The clinic applied for a UGX 12,000,000 (US $4,750) loan in January 2013 under the Centenary Health DCA. The loan was approved and duly disbursed in March 2013 and was used to purchase an ultrasound scan machine. The funds have had a positive impact on the effectiveness, sustainability, and financial performance of the clinic, enabling the clinic to increase the number of rural clients it serves.

The outpatient clinic and inpatient admissions have increased from 20 clients per month to 65 clients per month. In the last five months since the ultrasound scan equipment was purchased, the number of expectant mothers has increased from 30 per month to 65 per month. In the past, the maximum loan amount available to the clinic from microfinance institutions and Savings and Credit Co-operatives (SACCOs) was UGX 4,000,000 (US $1,580) with a loan tenor of only three months.

Gord Medical Clinic reception

Community Based Health Insurance Makes Services More Affordable for Ugandan Women.

A few years ago, having medical insurance in Uganda meant that you came from a wealthy background, or worked for one of the reputable organizations in the city canter. Many Ugandans could not afford medical insurance and did not even remotely think of it as a possibility.

Since 2017, the USAID/Uganda Private Health Support Program worked with various community health strengthening organizations such as Integrated Community Based Initiatives, (ICOBI) and private-for-profit medical facilities to introduce and implement community-based insurance programs in targeted rural areas of Uganda.

These areas were Jinja, Rukungiri, Sheema, and Wakiso in Eastern, Western, and Central Uganda respectively. The Program has seen more and more rural poor joining the Community Based Insurance Programs through their savings' groups. Some personal testimonies give you a glimpse into what might have ended in tragedy but instead brought hope to an individual, a family, or a community.

"As a mother of three, I am so grateful that my children and I can receive decent medical care from a decent facility at a very affordable price. I specifically remember when I had a terrible experience; I had been pregnant and suddenly began to bleed. I went to the hospital, hesitantly, but the young doctor who was at Crescent Medical Centre was not disgusted or afraid of my bleeding.

Instead, he received me well, encouraged me, and attended to me immediately - with gentleness and much care. He made me aware that I was having a spontaneous abortion. He also encouraged me to stay the night in the hospital and only discharged me the next day after I had received all the medical attention I needed. I realized that they cared for me immensely. "After the doctor had attended to me, I was surprised to find that my bill was only UGX 9,000. For all the care and tests conducted, as well as for the medication, that was truly a small amount. I am glad that I joined the health insurance program, and I am ready to renew for myself and my children for the next year."– Margaret Mukoda – Jinja district.

The PHS Program brokered a relationship with Crescent Medical Centre in Jinja, which is managed by Dr. Anjum, to attend to the insured clients. Anjum started the medical center in 1987 as a very small unit which has now grown to see over 40 clients a day. *"Even though we initially thought the [community health insurance] premiums would not be enough, we have found that we have neither made losses nor profits, but the program is helpful for the people especially because they are from villages where they are unlikely to receive good medical care,"* Anjum says.

Most of the people in these villages live below the poverty line and the idea of health insurance for them is difficult to comprehend. However, as more and more beneficiaries share their positive experiences about the kind of treatment they get from Crescent Medical Centre as well as how little they pay given the buffer that the health insurance provides, more people are persuaded to join. They have the option of paying a UGX 40,000 for six months or UGX 80,000 for a full year of health insurance. For Margaret, health insurance was a life saver, at a very small fee.

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SUCCESS STORY

Living Positively: Beyond Commercial Sex Work

A vibrant Nulu Zalwango brings out a stool for us to sit on (above), before she proceeds to roast some fresh cobs of maize from her garden for us (as seen below).

At least half of Uganda's health care needs are met by the private health care sector through private-for-profit (PFP) health facilities which are particularly popular for their accessibility, medicines, shorter waiting times, and higher perceived quality of service. Improvements in the quality, availability and access to health services will lead to improved health outcomes in Uganda.

All Photos by Cynthia Ayeza

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USAID's Uganda Private Health Support Program is contributing toward a viable, cost-effective private sector for health services by strengthening private-for-profit (PFP) and private not for profit (PNFP) providers' ability to contribute to the achievement of Uganda's health goals. The private health sector, which represents half of all health services delivered in Uganda, has an important role to play in the country's development. By strengthening PNFPs as well as the PFPs health systems, the Program is building a strong foundation for sustained scale-up of integrated health and HIV/AIDS services for People Living with HIV/AIDS (PLHIV). Stories such as the one portrayed bellowed affirm the work of the Program in Njeru, Jinja – Uganda.

A hand gently parts the blend of purple and pink curtain that shields the doorway, and a jovial woman emerges. She receives us with a familiar warmth common to Ugandans. She was expecting us, and quickly notices our excitement to see her garden of maize. She is eager to share her yield, so she dashes back into the house to grab a small knife; returning, she proceeds to cut down some cobs of maize from her home garden. A nearby *sigiri* (charcoal stove) was already burning as if sensing it would be needed. As we settle down on the seating she had provided, Nulu goes about roasting some maize for us, as she narrates her story.

My name is Nulu Zalwango and I am 32 years old. I am a single mother of three children. While accompanying a friend of mine to St Francis Health Care Services in Njeru, I learned about the work and support provided at the facility. But it was only in 2008 that I considered joining the program at St Francis, and made the decision to take a blood test. Unfortunately, I tested positive for HIV. At the time, I had been a Commercial Sex Worker, and testing positive was a wake-up call for me. Following the test, I was given Septrine to orally take for two weeks, after which I returned to the facility and was started on ARVs. Prior to testing positive for HIV, I had become very thin but had not known why I was so thin; my health had not been good at all. But as I started on the medication I had been given, together with the guidance from the volunteers/workers at the facility, I began to regain my weight, and my health got better. I chose to turn my life around and opted out of Commercial Sex Work. I also decided to get involved in the work that St Francis was doing, by reaching out to communities and specifically to commercial sex workers, trying to encourage people to get tested.

Through this program, I have learned to care for my health; I bought a small plot of land – where we stand presently – and built a small house and started a small garden growing food to nurture my health. I sought to live differently, learned to develop myself, and I learned to love my children. It is not uncommon to find that most commercial sex workers have little to no affections for their

own children – they hardly know who the fathers of those children are, and it becomes difficult for them to develop a healthy attachment with the children. Even getting CSWs to test for HIV is difficult because of the prevailing stigma in our community.

I learned to love my three children. It is not natural for us, as former commercial sex workers, to love. But I have learned to love my children, and some other CSWs are learning to do the same.

Part of caring for her health means Nulu has to be diligent in taking her medication. She says, "When I have to step out of the house, the first thing I pack in my back is my medication because I know that I need it. It is imperative in my being able to live a healthy life".

Besides her garden where she harvests food for herself and her household of four in total, Nulu volunteers as an Expert Client at St Francis Health Care Services, assisting with medicine counts, and filing. She also runs a small side business selling second hand clothing at a local community market. The second hand clothing business is thriving due to the great demand for good but inexpensive clothing by the majority of Ugandans. From this small business, she has been able to put her children through school. Her daughter completed Form Four and took on a course in hairdressing, her son is in Form Four and the last child is in Primary Three.

The USAID/Uganda Private Health Support Program through St Francis Health Care Services, Njeru, Jinja continues to make a difference in the lives of those living positively. Nulu Zalwango is only one of many beneficiaries of this program.

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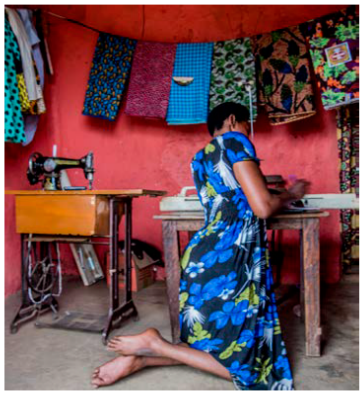
SUCCESS STORY

Orphans and Vulnerable Children: Disability Eased by Skills Empowerment

Jackline captured narrating her story, and below on her knees as she fills out a consent form.

The Program in line with USAID/PEPFAR and Ministry of Gender Labour and Social Development framework and priorities works through 46 community based organizations in 28 Districts to support a total of 40,610 OVC and their families to access a package of comprehensive services.



Despite Uganda's favorable policy framework, children with disabilities (CWDs) deserve special attention. About 2.5 million and youth with disabilities in Uganda face complex challenges in mobility, sight, hearing, learning, emotional violence and are more vulnerable to sexual abuse increasing risks to HIV and unwanted pregnancies. The Program in line with USAID/PEPFAR and Ministry of Gender Labour and Social Development framework and priorities works through 46 community based organizations in 28 Districts to support a total of 40,610 OVC and their families to access a package of comprehensive services.

Jackline Turyasingura, as her last name states, is an overcomer. When she was born, Jackline was a healthy baby, and with functional arms and functional legs. But when she was about 10 years old, she was afflicted by polio. Being from an uneducated background and poor family, her parents did not know better and would not have had the means to take her for immunization against polio.

> *I had been walking for some time. I was about 10 years old, and in primary three. But then I fell sick and it affected my legs. They would swell and were very painful, and this carried on for four years. My parents took me to every hospital they could think of and that they could afford. But it was pointless. There was no help. No one seemed to know or understand my ailment. There was no cure. Desperate and at the end of their wits, my parents bundled me up and we returned home. And so my life as a disabled person began. I painfully learned to walk with my knees because life needed to go on.*

CWDs (Children with Disabilities) have inadequate access to information, resources and limited participation in social-economic development process. Only 5% access education within inclusive regular schools while 10% access education through special schools. With the help of various partnerships, we have seen improvement in CWDs' self-esteem, and improved access to vocational training for older CWDs in shoe making, knitting, and tailoring. As a result, older CWDs' opportunities to self-employment have greatly improved as exemplified by promising individual testimonies.

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Jackline is one among over 1780 Orphans and Vulnerable Children who have benefited from the USAID/Private Health Support Program providing vocational and apprenticeship training for out of school youth/OVC with special focus on adolescent girls. The Program is implemented through Mbarara Archdiocese, located in Mbarara District.

I did not think that I would ever be able to use a sowing machine, even though I had been taught and trained on how to use a crochet machine. But one day, the Program surprised me with a sewing machine especially made for me to use – it only required my hands since my legs were of no use to me. I was very happy. I felt set for life.

Like several OVC in Western Uganda, Jackline was recruited from a school for the deaf and dumb, which also took in children of varied disabilities. It is here that she had first realized and experienced other persons/children living with disabilities. For the first time, she did not feel out of place – she belonged. The Program encourages youth with disabilities to join vocational training and apprenticeship, giving them practical skills from which they forge forward in life. Many of them graduate from the vocational training and return to their home towns to start and run small businesses within their acquired skill set.

Jackline completed primary seven at the age of 24. She has since been trained in tailoring and crocheting, and was given a starter kit entailing a sewing machine and crochet machine. After graduating from the Program, Jackline returned home to live close to her parents, where she also has opened up a small shop making sweaters for school going children and teenagers, as well as other African print clothes for people living within the community. She makes no excuse despite her disability; she says she has been empowered to care for herself and her child.

Below, Jackline shows us her flattened knees that have become feet to take her around.

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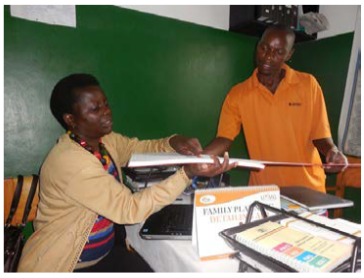
SUCCESS STORY

Improving Private Sector eMTCT Reporting through Mentorship, Coaching and Social Media



Program M&E Specialist Ms. Joyce Achan (seated) conducts on-site mentorship at New Forests Company- Namwasa Health Centre.

Background: Elimination of mother to child transmission (eMTCT) of HIV/AIDS is one of the national priorities for the Ministry of Health in Uganda. According to the Uganda National Health Strategic Plan (2010/11 – 2014/15) only 68% of Uganda's HC-III level centers (which comprise most Program partner clinics) provide prevention of mother to child transmission services for HIV/AIDS. The numbers are undoubtedly lower in the private health sector. In July 2013, the USAID/Uganda Private Health Support Program started working with 110 private health facilities to increase the uptake of eMTCT services for pregnant mothers. At the time, only 40 facilities were registered as providing eMTCT services. Less than 15 of these were reporting monthly through the district (DHIS2) reporting system – a necessary requirement for all private health facilities as of January 2012. An even smaller fraction were reporting through the USAID funded Monitoring and Evaluation of Technical Assistance (META) nationwide program.

A quick assessment of these sites revealed that, many of the staff were providing eMTCT services but few were documenting their support. Although staff had been trained to provide eMTCT, the high staff turnover characteristic of private health sector facilities meant those left behind were not conversant with adequately extending the services. Of those that could ably provide the services, many exhibited a poor attitude towards reporting. Indeed a few staff interviews revealed reporting was not prioritized at many private health facilities. Private health providers did not typically recruit records management staff and even when they did, these staff were usually cross-trained to take up a number of other functions. The lack of updated and easy to use reporting tools such as the health information management system (HMIS) tool further compounded the problem.

Interventions: To increase weekly reporting rates, the Program instituted a plan that took advantage of the existing mobile phone networks. The Program appointed point persons to send

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Success Story: Improving Private Sector eMTCT Reporting through Mentorship, Coaching and Social Media

out weekly SMS reminders to the 40 eMTCT Program partners using regular texts and social media tools such as whatsapp. To facilitate the reports, the Program loaned mobile phones to the eMTCT reporting facilities to mitigate disruptions due to staff turnover – when staff often left with all the institutional memory and new staff had no reporting referral point. The point persons followed up these texts with phone calls every Tuesday morning.

The M&E team also provided onsite support to the facilities through regular eMTCT-focused support supervisions and one-to-one trainings on how to compile the weekly and monthly reports. To support these initiatives, the Program trained 40 partner private health care workers in Option B+ and 80 others in HMIS and comprehensive HIV care and management. The Program also took all 40 health facilities through mentorship sessions in eMTCT and HMIS reporting. In July 2014 the Program started supporting transportation of samples to facilitate the retention of HIV/AIDS positive mothers in care. To ensure no further gaps arose, the Program engaged a consultant to manage all eMTCT related logistics.

Successes: The number of service outlets providing eMTCT services has increased to 51, while reporting rates have increased from under 25% at the start of the year to 63% currently. The number of women recorded to have attended at least one ANC visit at a partner service outlet has increased by 62 % between December 2013 and June 2014. See table below for specific indicator improvement.

Indicator	December 2013	July 2014
Number of service outlets providing eMTCT services	33	48
Number of women attending 1st ANC visit at service outlets	2,706	6,549
Number of pregnant and lactating mothers who were tested for HIV and received their test results	4,525	9,357
Number of HIV positive women identified	381	843
Number of HIV positive women receiving ART for eMTCT	381	550
Number of exposed infants tested for HIV below 18 months	160	372
Percentage of exposed infants testing HIV positive below 18 months	3%	12%

The Program plans to provide continuous mentorship to ensure staff turnover does not affect the gains so far made. The Program will also closely monitor all eMTCT facilities' reporting rates to ensure that their contributions towards eliminating mother to child transmission are properly accounted for at the district and national level. The Program has also hired a Quality and Accreditation Officer to support partner sites improve on the eMTCT care cascade. Particular emphasis has been placed on early infant diagnosis of HIV/AIDS.