



**USAID**  
FROM THE AMERICAN PEOPLE

# UGANDA HEALTH INITIATIVES FOR THE PRIVATE SECTOR PROJECT

## FINAL REPORT



*Pictures from various HIPS project activities*

### June 2013

This report is made possible by the support of the American People through the United States Agency for International Development (USAID). The contents of this report are the sole responsibility of Cardno Emerging Markets USA, Ltd. and do not necessarily reflect the views of USAID or the United States Government.



# UGANDA HEALTH INITIATIVES FOR THE PRIVATE SECTOR PROJECT

## FINAL REPORT

**Submitted by:**

Cardno Emerging Markets USA, Ltd.

**Submitted to:**

USAID/Uganda

**Contract No.:**

TASC3 Uganda Health Initiatives for the Private Sector (HIPS)

IQC Contract GHS-I-00-07-00016-00

Task Order GHS-I-02-07-00016-00

**DISCLAIMER**

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

---



## TABLE OF CONTENTS

ACRONYMS.....	II
<b>1 BACKGROUND AND PROJECT METHODOLOGY .....</b>	<b>2</b>
1.1 INTRODUCTION .....	2
1.2 PURPOSE AND SCOPE OF THE HIPS PROJECT .....	2
1.2.1 First phase (October 2007-September 2012).....	2
1.2.2 Second phase (October 2011-March 2013).....	4
<b>2 PROJECT ACHIEVEMENTS .....</b>	<b>5</b>
2.1 TASK 1: EXPAND AND STRENGTHEN ACCESS TO AND UTILIZATION OF HEALTH AND HIV/AIDS SERVICES IN THE PRIVATE SECTOR .....	5
2.1.1 HIV/AIDS prevention.....	5
2.1.2 HIV/AIDS palliative care: basic health care and support .....	8
2.1.3 HIV/AIDS treatment.....	9
2.1.4 Counseling and Testing .....	10
2.1.5 Tuberculosis.....	11
2.1.6 Malaria .....	12
2.1.7 Reproductive health and family planning .....	13
2.2 TASK 2: EXPAND THE NUMBER OF GLOBAL DEVELOPMENT ALLIANCE PARTNERSHIPS .....	14
2.2.1 Partnership building process.....	14
2.2.2 Accomplishments .....	15
2.3 TASK 3: SUPPORT INITIATIVES TO STRENGTHEN PRIVATE SECTOR WORKERS' ORGANIZATIONS .....	16
2.4 TASK 4: DEVELOP INNOVATIVE AND PROVEN APPROACHES TO SUPPORT ORPHANS AND OTHER VULNERABLE CHILDREN.....	17
2.5 PHASE TWO: COMPONENTS.....	18
2.5.1 Quality of care .....	19
2.5.2 Service integration.....	20
2.5.3 Sustainability and exit strategy.....	20
<b>3 CHALLENGES AND LESSONS LEARNED.....</b>	<b>22</b>
3.1 SUSTAINING COMPANY COMMITMENT TO HEALTH PROGRAMS.....	22
3.1.1 HIV/AIDS prevention.....	22
3.1.2 Palliative care.....	22
3.1.3 HIV/AIDS treatment.....	23
3.1.4 Counseling and testing.....	23
3.1.5 Tuberculosis.....	24
3.1.6 Malaria .....	24
3.1.7 Reproductive health .....	25
3.1.8 OVC program .....	25
3.2 MANAGING DEMANDS ON PROJECT AND PUBLIC RESOURCES .....	25
3.3 BUILDING SUSTAINABLE LOCAL ORGANIZATIONS .....	27
<b>4 RECOMMENDATIONS.....</b>	<b>27</b>
4.1 GDA PROGRAMS MUST BE PRIVATE SECTOR-DRIVEN.....	27
4.2 NEW APPROACHES ARE NEEDED TO ENGAGE SMALL COMPANIES AND THE INFORMAL SECTOR .....	29
4.3 GROWING THE PRIVATE HEALTH SECTOR REQUIRES A RANGE OF STRONG LOCAL INSTITUTIONS.....	30
4.4 BETTER INTEGRATION BETWEEN PUBLIC AND PRIVATE HEALTH SECTORS IS CRITICAL .....	30
<b>ANNEX: PROJECT HIGHLIGHTS AND SUCCESS STORIES .....</b>	<b>31</b>



---

## ACRONYMS

AAM	Africa Affordable Medicine
ACP	AIDS Control Program
ACT	Artemisinin Based Combination Therapy
AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-Retroviral Therapy
ARVs	Antiretrovirals
BCC	Behavioral Change Communication
CBO	Community Based Organization
CCP	Centre for Communication Programs
CDC	Centers for Disease Control
CPHL	Central Public Health Laboratory
CSR	Corporate and Social Responsibility
DCA	Development Credit Authority
DED	German Development Agency
EMG	Emerging Markets Group
FPAU	Family Planning Association of Uganda
FUE	Federation of Uganda Employers
GDA	Global Development Alliance
GOU	Government of Uganda
HC	Health Centre
HCT	Home based Counseling and Testing
HIV	Human Immunodeficiency Virus
HIPS	Health Initiatives for the Private Sector
IAA	International Air Ambulance
ICF	Intensified TB Case Finding tool
IEC	Information, Education and Communication
IPT	Intermittent Preventive Treatment
IRS	Indoor Residual Spraying
ITNs	Insecticide Treated Nets
IUD	Intrauterine Device
JCRC	Joint Clinical Research Center
KCCL	Kasese Cobalt Company



---

LLINs	Long Lasting Insecticide Treated Nets
LTPM	Long Term Permanent Methods
MOH	Ministry of Health
MOGLSD	Ministry of Gender, Labor and Social Development
NBL	Nile Breweries Limited
NTLP	National TB and Leprosy Program
OIs	Opportunistic Infections
OGAC	Office of the Global AIDS Coordinator
OVC	Orphans and Vulnerable Children
PE	Peer Education Programs
PEPFAR	President's Emergency Plan for AIDS Relief
PHAs	Persons Living With AIDS
PHS	USAID/Uganda Private Health Support Program
PICT	Provider Initiated Counseling and Testing
PMI	President's Malaria Initiative
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private Not For Profit
PPP	Public Private Partnership
PSFU	Private Sector Foundation-Uganda
RDT	Rapid Diagnostic Tests
RH/FP	Reproductive Health / Family Planning
SCMS	Supply Chain and Management Systems
SMC	Safe Medical Circumcision
SP	Sulfadoxine Pyrimethamine
STD	Sexually Transmitted Diseases
STF	Straight Talk Foundation
TB	Tuberculosis
UAC	Uganda AIDS Commission
UBL	Uganda Breweries Limited
UHF	Uganda Healthcare Federation
UHMG	Uganda Health Marketing Group
UMA	Uganda Manufacturers Association
VCT	Voluntary Counseling and Testing
VSLA	Village Savings and Loan Association



## **1 BACKGROUND AND PROJECT METHODOLOGY**

### **1.1 Introduction**

The private health sector plays a critical role in meeting the health needs of Ugandans, including low-income and hard to reach populations. As in other Sub-Saharan African countries however, this sector is poorly regulated, and often left out of donor-supported programs, government planning, and capacity building efforts. In 2007, no mechanism existed in Uganda for monitoring or enforcing quality of care standards in the private for profit sector, and the majority of private facilities lacked the equipment or financing needed to expand or upgrade services. The absence of a formal coordination framework to support linkages between the private and public sectors also made it difficult for the decentralized Ministry of Health (MOH) to engage with private providers, particularly those in the for profit sector. The Health Sector Strategic Plan II (2005/06 – 2009/10) released by the MOH acknowledged the role of the private health sector, but focused almost exclusively on private not-for-profit (PNFP) providers. Despite these shortcomings, over a third of the population in Uganda reported obtaining health services from private sector facilities.

Recognizing the need to partner with a growing corporate sector, USAID/Uganda was among the first Missions to promote public-private partnerships (PPPs) in the achievement of President's Emergency Plan for AIDS Relief (PEPFAR) goals. From 2004-2007, the Uganda Mission funded the Business Preventing AIDS and Accelerating Access to Anti-Retroviral Treatment (Business PART) project, managed by Cardno Emerging Markets USA, Ltd (formerly Emerging Markets Group). Business PART partnered with over 50 regional and local companies to expand access to voluntary counseling and testing (VCT) services, antiretroviral (ARV) treatment, and AIDS treatment insurance coverage for thousands of employees, family members, and individuals. The follow-on Health Initiatives for the Private Sector (HIPS) project was expected to build on the accomplishments of Business PART to further develop the network of partner companies, and expand the range of health services available to workers and communities.

### **1.2 Purpose and scope of the HIPS project**

The HIPS project was designed to leverage opportunities for partnering with Ugandan businesses to increase access to vital health services for underserved communities. USAID intended to encourage the expansion of company-supported HIV/AIDS services to include new services, and to extend their availability to larger communities. Through partnerships and technical assistance, this initially three-year (2007-2010) project was to support the design and implementation of workplace health programs, with a special focus on HIV/AIDS, tuberculosis (TB) & malaria prevention and treatment services, as well as reproductive health and family planning (RH/FP). The project was to focus on rural areas with underserved populations, such as coffee and cotton outgrowers. To ensure the sustainability of these initiatives, the HIPS project was tasked with building the capacity of private sector employer organizations to manage and support health-focused partnerships with Ugandan companies.

#### **1.2.1 FIRST PHASE (OCTOBER 2007-SEPTEMBER 2012)**

In October 2007, USAID/Uganda extended an \$8.7 million three-year contract to Cardno Emerging Markets USA, Ltd. (Cardno), to implement the HIPS project in Uganda. The contract included an option to extend activities for up to two years, which was exercised in 2010, bringing the HIPS ceiling to \$15.7 million, and extending the period of performance until September 30, 2012. Cardno managed the project in partnership with Johns Hopkins University Bloomberg School of Public Health Center for



Communication Programs (JHUCCP), the Mildmay Centre and O'Brien and Associates International. The scope of the project was structured around the following tasks:

**Task 1: Expand access to and utilization of health services in the private sector.** The project was to increase access to HIV/AIDS, TB, RH/FP and malaria services through mid- and large-size employers within the private sector, and promote utilization of these services, with the explicit goal of helping ensure productivity within the workplace. The following table provides detailed tasks and responsibilities with respect to each health area, as described in the scope of work:

Health Area	Tasks and Responsibilities
HIV/AIDS Prevention	Expand prevention program to stationary and mobile worker and migrant populations at the workplace as well as the surrounding communities. Emphasis was to be placed on alcohol consumption, substance abuse, promotion of responsible behavior to reduce HIV transmission, including couple testing and mutual disclosure within established couples, and consistent and correct condom use within discordant couples, as well as between casual partners.
HIV/AIDS Palliative Care	Facilitate access to comprehensive care and support for people living with HIV/AIDS, including access to preventative care, long lasting insecticide treated nets (LLINs) and psychosocial support, active referral to and follow-up with pain management and treatment programs. The project was to put special emphasis on strengthening support linkages and family-centered approaches through community initiatives as way to improve quality of care and productivity of employees.
HIV/AIDS Treatment	Initiate early treatment to ensure productivity is maintained, train health care staff, facilitate access to ARVs as needed, strengthen linkages to palliative care and support and foster adherence through linkages with other facilities and community-based initiatives. Stigma and discrimination were to be addressed across all program elements.
Counseling and Testing	Build on workplace policies and programs to reduce stigma and increase access and utilization of VCT services. Train peer educators and workplace champions to provide counseling and testing, provide follow up post-test counseling for those who agreed to test and facilitate referrals and linkages to care and treatment services. Promote VCT, including couple counseling, at the workplace and surrounding communities.
Tuberculosis	Support the establishment of a public-private infrastructure for directly observed short course therapy (PPM-DOTS) in Uganda. Strengthen the capacity of community volunteers and facility health workers to ensure implementation and expansion of the community based (CB)-DOTS strategy, and improved management, care and support of TB/HIV patients.
Malaria	Support prevention, diagnosis and treatment of malaria through the involvement of private sector businesses in initiatives such as awareness, clean environments, construction of shallow water wells, protection of springs, and provision of nets at reduced prices.
Reproductive Health	RH services focused on strengthening the delivery of facility-based family planning services including commodities, provider skills, and client satisfaction. Community outreach services were to be strengthened and expanded to minimize myths and misinformation, strengthen community advocacy, and strengthen family planning referrals to facilities.

**Task 2: Establish Global Development Alliance (GDA) partnerships to leverage company-sponsored health services.** The HIPS project was expected to engage private sector companies and partner with them to implement HIV/AIDS and health activities, according to USAID's GDA principles. These included working with companies to define development problems and solutions, using innovative approaches, sharing resources, risk and rewards through joint efforts, and leveraging significant levels of non-USG resources.

**Task 3: Strengthen private sector employer organizations to support health initiatives.** An important aspect of the HIPS project was to build the capacity of the Federation of Uganda Employers (FUE) and the Ugandan Manufacturers Association (UMA) to provide support to local employers in developing or strengthening HIV/AIDS and health workplace programs. This task included developing a sustainability



plan for FUE and UMA, and strengthening their ability to effectively manage and report on their activities.

***Task 4: Implement innovative approaches to support orphans and vulnerable children through the private sector.*** HIPS support to orphans and vulnerable children (OVC) programs through the private sector was to build on experiences from similar programs in Sub-Saharan Africa. Through partnerships with national and multinational corporations, the project was expected to provide support to OVCs in the neediest communities, including strengthening the capacity of families and the community to access services supported by private companies as part of their corporate social responsibility.

### **1.2.2 SECOND PHASE (OCTOBER 2011-MARCH 2013)**

In September 2011, a new six-month extension was provided to the HIPS project, together with \$1.5 million in additional funding to support further expansion of HIV/AIDS, TB, RH/FP and malaria services, as well as several new activities. This extension brought the project end date to March 31, 2013. The revised scope included support for a new Development Credit Authority (DCA) guarantee facility designed to increase access to finance in the private healthcare sector in Uganda. In addition, the HIPS project was to manage the implementation of a PPP with Nile Breweries Limited (NBL), which was jointly funded by USAID/Uganda and the Office of the Global AIDS Coordinator (OGAC). The extension brought the total funding for the HIPS project to \$17.2 million.

Planned activities under the extension period included the following:

- Support supervision and mentoring of antiretroviral therapy (ART) service delivery points, including the monitoring of commodities/logistics buffer supplies
- Continued expansion and scale up Safe Medical Circumcision (SMC), Long Term and Permanent methods (LTPM) programs, and malaria services provision
- Continued support to the FUE and UMA to develop sustainable HIV/AIDS, RH/FP, TB and malaria programs
- Technical Assistance to the forthcoming DCA credit guarantee facility
- Technical assistance to NBL
- Creation and support of a private reference laboratory for use by ART-accredited private clinics
- Scaling up of existing OVC models in partnership with selected private companies
- Sustainability plan to ensure commodity supply to US Government-supported private sector facilities



## 2 PROJECT ACHIEVEMENTS

### 2.1 Task 1: Expand and strengthen access to and utilization of health and HIV/AIDS services in the private sector

The HIPS project used a “menu of services” to engage companies while focusing on USAID strategic priorities. This approach helped develop health services for employees, their dependents, and people living in the communities surrounding company sites. Early on, employers showed particular interest in HIV/AIDS prevention through SMS mobile health messaging, men-only seminars, and community events. Over time, many became highly supportive of health fairs and SMC camps.

#### 2.1.1 HIV/AIDS PREVENTION

Prevention activities were typically the first step in collaborating with private companies. HIPS initially built on approaches and materials developed under the Business PART project, and partnered with companies to develop the following programs:

##### Peer education program

Peer education capacity building and refresher training were dominant activities throughout the life of the HIPS project. Demand for these services from partners kept increasing, in part driven by geographical expansion by companies such as Tullow Oil, Kasese Cobalt Company (KCCL), and NBL. Starting in Year 1, HIPS worked with partner companies to identify and train peer educators tasked with creating demand for health services that were made available to employees and community members. When selecting peer educators, the project looked for individuals with leadership skills, enthusiasm, a positive attitude, and personal experience in dealing with persons affected by HIV/AIDS. Many educators worked for partner companies but others were selected from the surrounding community, with a view to achieving gender balance and expanding programs into the company catchment area.

The peer educator training curriculum was designed to provide companies with the flexibility to choose topics of highest relevance to their operations. The project used an entertainment education format adapted from Uganda Health Marketing Group (UHMG)’s established *Good Life* communication platform, branding it the *Good Life at Work*. The training module included employee education seminars, video shows, interactive community drama, and live game show events. This communications platform was embraced by Ugandan companies and demand for the program grew quickly over the life of the project. The *Good Life at Work* model was revised in Year 3 to incorporate new topics and activities, such as discussions of multiple concurrent sexual partners, and a school HIV program. Modifications were also made to comply with Monitoring and Evaluation of Emergency Plan Progress quality assurance guidelines and build self-efficacy skills and risk perception levels among participants.

HIPS staff worked closely with FUE and UMA from the onset of the project to build their capacity to take over the peer education program. Many partner companies eventually developed their own educator training programs and hired FUE/UMA to provide training services. To recruit and incentivize peer educators in the workplace, companies provided certificates of recognition and rewards such as mosquito nets, water treatment products, chargeable solar lamps, lanterns, and hoes.

#### HIPS Sample Menu of Services

- Workplace Policy Development
- Peer Education
- Health Fairs
- AIDS Cost Calculation
- Voluntary Counseling & Testing
- Health Communication Materials
- Low Cost Health Commodities
- Private Clinic MOH Accreditation
- Access to free ARVs/TB Drugs/IPT2
- Lab Equipment/Training
- Clinicians & Community Based Training
- Corporate Social Responsibility Advisory Services
- Referral Linkages for Testing and Treatment

### HIV workplace policy development

HIV/AIDS is both a workplace issue and a development challenge. It is a major threat to employers and workers. HIV/AIDS imposes huge costs on enterprises and organizations in all sectors through increased absenteeism, increased turnover, loss of skills, loss of knowledge and declining morale. The impact is also manifested by increases in insurance cover, retirement funds, health and safety, medical assistance/bills, testing and counseling, and funeral costs. Other costs include increasing demands for training, recruitment and liability.

Consequently, the HIPS project supported partner companies to develop an elaborate and systematic approach of managing HIV/AIDS issues through HIV policy development at the workplace.

### IEC/BCC program

The project produced a wide range of Information, Education, Communication (IEC)/Behavior Change Communication (BCC) materials for company staff, facilities patients, and community members, in collaboration with other organizations working in the field of HIV/AIDS prevention, care and treatment in Uganda. Most of the materials were printed in at least four local languages and included counseling flipcharts, service delivery guidelines, posters, brochures and fliers. Materials were distributed through peer educators, health facilities, men-only seminars, and health fairs. Videos of moderated discussions were adapted from material developed by JHU (Health Centre IV) and UHMG (Good Life Game Shows), and shown at community halls and health centers. In late 2009, HIPS provided a grant to Text to Change, a Dutch organization specialized in mHealth technology, to disseminate health education messages through an interactive SMS mobile network. The TTC technology proved very useful in capturing baseline data and disseminating basic prevention messages. Only four companies, however, supported the program, which ended in 2012.

The HIPS project also adapted communication approaches to the needs of companies with large supply chains. Having identified community radio as an effective communication channel for reaching out growers, the project trained peer educators in the production of pre-recorded discussions in partnership with the Straight Talk Foundation. The programs focused on community perceptions of health prevention practices, including family planning, condom use, HIV testing and counseling, and the use of insecticide treated mosquito nets (ITNs). Over 20,000 individuals were reached through this approach in Year 2.

To meet the needs of hard-to-reach groups, HIPS organized seminars for hospitality workers employed in bars, lodges and restaurants along the NBL supply chain. The project also partnered with KCCL in Kasese District, and the Long Distance Truck Drivers Association to implement HIV prevention activities targeting fishermen and truck drivers. Fishermen from seven landing sites in Uganda were reached through men-only seminars, while truck drivers were reached through peer educators, and pre-recorded audio messages.

#### **Integrated Outreach in Remote Communities of Kasese District**

In partnership with KCCL located in Kasese district, HIPS carried out integrated outreach activities to increase FP uptake. Six outreach events were conducted on cost sharing basis, including the following: health education, VCT, immunization, treatment of sexually transmitted infections and minor illnesses, FP counseling, and commodity distribution (including contraceptives, safe delivery kits and LLINs) and referral of complicated cases. During these outreaches, couple counseling and testing, SMC, birth spacing and sexual RH have been emphasized. This outreach effort resulted in 220 new acceptors of FP methods, including condoms, oral, and injectable contraceptives, and intrauterine device (IUD) insertions.





In its 4<sup>th</sup> year of operation, the project conducted a study of the BCC program among 10 partner companies to establish the extent to which the HIPS communication model influenced client behaviors. The study revealed a strong correlation between peer education, client motivation, and service utilization.

### Health fairs

In Year 1, HIPS introduced the concept of health fairs in partnership with companies and the following organizations:

- UHMG: to provide information and products related to malaria and FP/RH
- Straight Talk Foundation: to educate youths through friendly educational material in the areas of HIV/AIDS prevention, malaria, and FP/RH
- AIDS Information Centre (AIC): to provide counselors and laboratory technicians for VCT
- PULSE: to organize and conduct fairs

Health fairs were designed to provide integrated entertainment education to encourage employees and community members to utilize health services. The fairs were conducted using the “four tent” model, which included discussion platforms for HIV prevention, palliative care, VCT, malaria and family planning. Services provided during the fairs included home based counseling and testing (HCT) (including couples HIV testing), FP and malaria prevention (mosquito nets). In addition, SMC and sexually transmitted infection diagnosis and treatment services were provided through referrals to facilities. The use of locally available human resources (peer educators and local drama groups) helped keep the cost of health fairs low. In the HIPS BCC survey, health fairs were found to be most popular among community members, followed by small group discussions.

**Table 1: Number of Individuals Reached through Community Outreach Prevention Activities**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL
Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required (ABC clients)	174,405	193,584	109,171	61,407	50,220	11,703	600,490

### Safe male circumcision

In its second year of operation, the HIPS project worked with its partners to make SMC services available to employees and community members. Interest in this program quickly grew among partner companies, and demand for SMC services remained high throughout the project life. The most effective way to deliver this service was in the context of “SMC camps,” which were made possible through close collaboration with the Water Reed Project, the Rakai Health Services Program, and Makerere University School of Public Health, which provided training, quality assurance, and promotional materials. The project used men-only seminars to mobilize and register workers and community members before the onset of the camps. HIPS procured SMC kits and theater equipment to support the SMC program, while companies contributed clinical supplies, tent rental, fuel for generators, and transportation for surgeons and community members. This collaborative approach greatly contributed to the rapid uptake in SMC procedures. By Year 5, the program was supporting an average of three surgical camps per week.

**Table 2: Safe Male Circumcision**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL
Number of locations for SMC	0	0	15	32	44	47	47
Total number of males circumcised as part of the minimum package of SMC for HIV prevention service	0	0	1,449	2,514	20,178	8,432	32,573
Number of health workers trained in SMC	0	0	36	42	141	3	222

### School program

HIPS worked with six partner companies to introduce HIV prevention activities in 48 secondary schools supported by those companies. In consultation with the Ministry of Education and Sports, the project developed and supported a peer education program, the *Good Life at School*, designed to provide health and life skills education to young people aged 12-19. HIPS trained 87 teachers in peer education and life skills training, including youth sexuality and adult-child communication skills in select schools. The program framework received praised from the Ministry of Education and Sports, and was recommended for replication at the district level. In addition, the Civil Society Fund endorsed the use of HIPS-developed training materials and data collection tools for in-school youth programs, and funded its replication in 7 schools in Wakiso district, with technical support from HIPS project staff.



In addition, the Civil Society Fund endorsed the use of HIPS-developed training materials and data collection tools for in-school youth programs, and funded its replication in 7 schools in Wakiso district, with technical support from HIPS project staff.

### **2.1.2 HIV/AIDS PALLIATIVE CARE: BASIC HEALTH CARE AND SUPPORT**

The HIPS project worked with 28 private facilities to increase access to quality palliative care services in targeted communities. To help make these services available, the project partnered with Mildmay to provide comprehensive palliative care training to company health workers. The project also contributed IEC materials, psychosocial training, water treatment products, LLINs, job aids, guidelines for pain management, and referral information. By the end of the first year, partner company clinics had provided nearly 3,000 patients with at least one palliative care service. HIPS was also tasked with training community caregivers in company catchment areas in home-based care and psychosocial support. Working with trained peer educators supported by partner companies, the project trained an increasing number of caregivers, typically adults caring for an HIV positive family member, relative, friend or OVC.

#### **HIPS Palliative Care Program**

- Development of a basic care package for use by partner companies
- Capacity building of health workers and community care givers
- Logistical support for partner facilities



**Table 3: HIV/AIDS and Palliative Care Training**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL
Total trained	354	504	563	380	328	0	2,129

**Table 4: Clinical Care Services**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL*
Number of service outlets	28	35	77	80	100	70	N/A
Clients receiving at least one HIV clinical care and support service	2,946	11,756	28,161	29,669	9,262	9,551	N/A

\*Indicators do not measure unique figures, therefore not measured cumulatively

### 2.1.3 HIV/AIDS TREATMENT

The HIV/AIDS treatment program focused on building the capacity of private facilities to provide ART services, and developing sustainable supply chains for ARVs, other health supplies, and needed equipment. The project provided technical assistance and guidance to companies in setting up AIDS treatment programs, including clinical protocols, ART accreditation, and the hiring and training of appropriate staff. In its first year of operation, the HIPS project added 30 new partner clinics to the network developed by Business PART, bringing the total number of accredited private facilities in Uganda to 58.

HIPS was successful in convincing companies to expand HIV/AIDS services for both employees and community members. To achieve ART accreditation and become eligible for free ARVs supplied by the MOH, companies built new clinics or invested in upgrades, including facility renovations, and the hiring of additional staff. To support these efforts, the HIPS project donated or cost-shared medical and laboratory equipment and supplies, including two CD4 count machines, and supported supervision visits from HIPS staff, UMA, FUE, MOH and local district officials. The project also supported on-the-job mentorship programs focused on pediatric care, prevention of mother to child transmission (PMTCT), ART monitoring and cohort analysis. The project used a combination of classroom and placement programs for health workers to improve their skills. Clinicians were placed at Mildmay to receive classroom training and learn practical skills in HIV/AIDS management.

In order to increase access to HIV treatment services beyond accredited facilities, HIPS facilitated linkages between companies with limited service delivery capacity, and organizations able to manage or provide these services. HIPS helped companies identify clinics to which companies could refer their employees, sometimes involving insurance schemes or direct fee-for-service referral arrangements. Some companies (KCCL, RVZ, Hima Cement, and UGACOF), contracted insurance agencies such as IAA and Microcare to manage the provision of health services. In 2012, together with the MOH, the project

#### HIPS HIV/AIDS Capacity Building Program

- Development of job aids for HIV treatment providers
- Training of private practitioners in AIDS treatment (use of ART in resource limited settings)
- Training of private practitioners in pediatric AIDS treatment
- Training in PMTCT, nutritional care and clinical care products to practitioners
- Assistance with ART accreditation of clinics in selected companies and private clinics
- Patients' Adherence Calendar for practitioners
- Training of laboratory technicians, dispensers and record-keeping personnel in ART logistics and Health Management Information Systems (HMIS)
- Facilitation of linkages between smaller companies with no on-site clinics, and organizations that provide these services
- Support referral system for CD4 tests and other tests necessary for patient follow-up



partnered with a private company (SIMS Medical Centre) to develop and help equip an HIV reference laboratory able to provide quality diagnostics and other testing for private sector ART facilities in Uganda.



#### Expanding Access to HIV Treatment through Company Clinics

In 2010, the AIDS treatment program funded by Kinyara Sugar Works Limited opened a new AIDS treatment center, complete with a CD4 count machine. Kinyara had 660 individuals in HIV care and prophylaxis and 151 on ARVs. Before the opening of the center, the company sent samples for CD4 testing to Gulu district, more than 400 km away from the company's operations. HIPS provided training and regular supervision to Kinyara staff through Mildmay, and cost-shared basic equipment for the center. The company now provides a wide range of services to staff, dependents and neighboring communities. These include peer education, health fairs, SMC, and FP as well as support for OVC programs.

In 2011, the HIPS project in partnership with the MOH and Boston University School of Public Health presented a study that examined the cost effectiveness of ART programs in both private (three sites) and public (three sites) health facilities in Uganda. The study was a cost-outcome analysis using unlinked, retrospective medical record data to ascertain total resources used in the first year on treatment, and patient outcomes at the end of the first 12 months. Patient outcomes at all six sites were very good, with total retention rates of 87 to 98% after the first year on treatment, with no clear trend or difference in outcomes between the public and private sector sites. (A second phase of this study was carried out in Years 5-6.)

**Table 5: Adult and Child Clients Receiving ART from Clinics Supported by USAID/HIPS**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL*
Current clients	3,150	4,125	4,326	5,265	5,916	6,157	N/A
New clients receiving ART during the reporting period	1,371	1,445	1,319	1,531	1,037	253	N/A
Cumulative clients	2,931	5,585	6,943	7,731	8,210	8,482	N/A

*\*Indicators do not measure unique figures, therefore not measured cumulatively*

#### 2.1.4 COUNSELING AND TESTING

To increase access to counseling and testing, the HIPS project provided VCT training for health care workers at selected company sites and private health facilities through the AIC. In partnership with the MOH and staff from Central Public Health Laboratory (CPHL), HIPS also supported on-the-job training for records staff and laboratory technicians in VCT inventory. Emphasis during the training was on data quality, logistics, district and national reporting. Facilities were provided with VCT registers, cards and forms and received regular support supervision visits, with a focus on integrating VCT, maternal/child health, and other services. Partner companies initially received free HIV test kits and accessories donated by the Centers for Disease Control (CDC)/USAID, and delivered through the Joint Medical Stores (JMS). Starting in Year 4, however, the project encouraged partners to procure their own test kits.

HIPS engaged staff from the MOH, Supply Chain Management System (SCMS)/CPHL to visit partner sites and provide instructions in VCT register record keeping, forecasting and reporting. HIPS also worked with the AIC to train private sector health workers in VCT, and developed a referral system to link workers and community members to facilities offering these services. HIPS staff developed and



distributed a referral guide, in collaboration with the MOH and other stakeholders, including AIC, Mildmay, Straight Talk Foundation, and partner companies.

**Table 6: HIV Counseling and Testing Results for Health Fairs and Private Facilities**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL
Number of service outlets for VCT	29	88	85	80	100	90	N/A*
Individuals who receive Testing and Counseling	11,441	41,236	61,024	69,770	90,824	17,571	291,866

*\*Indicator does not measure unique figures, therefore not measured cumulatively*

To build demand for VCT services, HIPS used various communication strategies, including the training of peer educators, and community mobilization through health fairs, videos and outreaches. By the end of the first year, 11,441 people had received VCT services at a HIPS-supported facility or through a company sponsored health fair. Data reported from this activity indicated an 8.5% HIV prevalence rate among company workers and in surrounding communities.

Migrant workers presented a challenge for the project because they spend time in the workplace in episodic fashion and are highly susceptible to service interruptions. The referral system developed by the HIPS project aimed to improve the continuity of health services for these workers.

In 2012, the project, in partnership with MOH and technical specialists, conducted a Provider Initiated Counseling and Training (PICT) program for 48 health workers. The course was designed to equip health service providers with knowledge, skills and attitudes needed to provide quality PICT services in a hospital or any health care setting. The following year, HIPS helped extend program services to truck drivers, bar workers and smallholder farmers, with a focus on couples counseling.

#### The Nile Breweries Limited/HIPS Home-Based HIV/AIDS Program

In Year 4, the HIPS project in partnership with Nile Breweries and the Katakwi district health services team implemented a Home Based Testing and Counseling program in Katakwi district, Usuk parish, targeted at sorghum farmers. During the 12-month initial phase of the program, 4,400 people received VCT services. Out of those, 170 were found HIV positive, representing a 3.9% prevalence rate (lower than the national average of 6.7%). All those who tested positive were referred to Katakwi Health Center IV for further diagnosis (CD4 tests), care and treatment. All 170 received Septrin prophylaxis through Usuk Health Center III, and 21 were enrolled on ARV treatment at Katakwi Health Centre IV. The program was expanded in Year 5 to provide a comprehensive package of services to HIV positive people identified through the program.

### 2.1.5 TUBERCULOSIS

Sustained advocacy by the HIPS project in its first year succeeded in increasing the role and contribution of the private sector to the national TB response. The project collaborated with the National TB and Leprosy Program (NTLP) to carry out assessments and eventually accredit 45 private facilities for TB diagnosis and treatment. HIPS worked with Mildmay to design a curriculum and train private clinicians in TB diagnostic and treatment.

In its 5<sup>th</sup> year, HIPS supported the training of private providers in the use of an Intensified TB Case Finding (ICF) tool to increase TB detection among patients seeking care, particularly those living with HIV/AIDS.



Between 2008 and 2012, 20,773 HIV positive clients were screened for TB in HIPS partner clinics, and 1,057 clients who tested smear positive for TB received treatment through DOTS. TB case detection increased from 30 cases in 2008 to 393 in 2012, reflecting expanded screening of patients by trained providers.

HIPS also carried out an evaluation of treatment outcomes of new pulmonary smear-positive patients initiated on TB treatment from 12 partner accredited units. The aim of the study was to assess the quality of TB treatment services among the partner accredited private sector sites. The results showed a TB treatment success rate of 86% which is above the national target of 85%. The Defaulter/Loss to follow up rate was 9%, which was less than 10% as expected per the Uganda NTLP TB DOTS Guidelines of 2002.

#### TB Capacity Building Program

- Assess interest in and needs for TB treatment among company and private clinic facilities
- Prepare, pilot test and finalize TB training curriculum
- Conduct training of clinical personnel on TB diagnostics and treatment
- Assist with accreditation of companies and PFP clinics for TB care and treatment
- Assist selected companies with diagnostic equipment and supply needs
- Conduct peer educator training under Good Life I Module at selected companies
- Open discussions with the NTLP for a public-private mix referral system

**Table 7: TB Performance Indicators**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL
Number of workplace sites accredited by NTLP to participate in PPM – DOTS	10	27	38	45	50	0	50
Number of workplace healthcare providers trained in PPM DOTS with USAID funding	62	98	102	102	105	0	105
Number of TB cases reported to NTLP by USAID–assisted private workplace providers	62	566	1,038	1,243	1,637	161	4,707
Number of new smear -positive cases diagnosed by non–NTLP providers	57	176	423	374	393	23	1,446
Number of new smear positive cases who receive DOTS from non–NTLP providers	53	138	265	254	347	15	1,072

#### 2.1.6 MALARIA

Beginning in 2008, HIPS supported malaria prevention services for pregnant women (IPT2), with funding from the President’s Malaria Initiative (PMI). To this end, the project partnered with 40 companies, and facilitated the procurement of LLINs for distribution at company sites. Companies were very instrumental in increasing access to LLINs in communities. For example, in Year 3, Dominion Oil Uganda purchased and donated 1,300 LLINs to all households in Kikarara, Rwesigiro, Nyakabungo A & B villages in Bwambara sub county of Rukungiri District. HIPS also linked partner companies to UHMG and PACE as sources of subsidized ITNs that were then either distributed or sold to company employees. The number of ITNs distributed by partner companies increased from 685 in 2008 to 17,986 in 2012.

In 2011, HIPS supported a pilot program to introduce Rapid Diagnostic Tests (RDTs) for malaria in the private sector. The project facilitated the distribution of more than 21, 650 RDTs to 25 companies under a cost sharing arrangement, provided training to providers in the use of RDTs through the IDI Joint Malaria



Project, and conducted a cost-benefit analysis of using RDTs at 10 selected company facilities. The use of RDTs improved the accuracy and reliability of diagnosis, particularly in the absence of skilled personnel, as well as rational drug usage for malaria treatment. The study however showed that, at prevailing market prices, no significant cost savings could be achieved from the use of RDTs prior to ACT treatment of patients presenting with fever. As a general rule, private facilities purchased artemisinin-combination therapies (ACTs) and RDTs from local pharmacies. Efforts to link facilities to the Africa Affordable Medicines program had limited success in lowering the cost of these products for private facilities.

Additionally, HIPS introduced and scaled up intermittent presumptive treatment (IPTp) for malaria among partner clinics providing ANC services, in partnership with the MoH and district government. The clinics provided free IPTp services to all pregnant women, including company workers, dependents and surrounding communities. HIPS also procured commodities for the IPT program including Fansidar tablets, disposable cups, water vessels, and aqua safe tablets for use at the ANC clinics.

**Table 8: Performance Indicators for Malaria**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL
Number of SP tablets purchased	15,000	19,800	150,100	80,000	70,000	0	334,900
Number of women receiving IPT2 doses at existing and new workplace sites	648	7,310	19,789	17,606	13,452	3,672	62,477
Number of health facilities with water vessels and cups for IPTp DOTS	3	16	40	50	51	52	52
Number of ANC health workers trained in IPTp, IPTp3	60	128	152	55	55	0	450
Number of people reached with prevention messages on malaria	45,450	53,748	171,773	120,734	100,734	30,921	523,360
Number of subsidized LLIN distributed to pregnant women	685	9,380	19,450	18,583	17,986	3,859	69,943

### 2.1.7 REPRODUCTIVE HEALTH AND FAMILY PLANNING

HIPS partnered with UHMG to build the capacity of private facilities to provide RH/FP services, and facilitated the sale of subsidized FP commodities to partner companies. Because of the large unmet need for family planning in Uganda, demand for family planning grew very quickly. By Year 2, 80% of HIPS-supported private clinics were providing integrated RH/FP services, including LTPMs in 27 facilities. In Year 5, HIPS partners were trained in the MOH plan to shift from PMTCT Option A to B+, and inclusion of at-risk groups (HIV positive adolescents) in FP service provision as well as LTPMs.

The number of clients who attended family planning sessions at HIPS partner clinics and received information on birth spacing and method choices, and available products with proper instructions for use increased from 850 in 2008 to 35,270 by 2012. The number of clients who utilized family planning for the first time increased from 600 in 2008 to 12,137 in 2012. Couple Years Protection (CYP) during that period increased from 934 in 2008 to 43,868 in 2012.

**Table 9: Family Planning and Reproductive Health Indicators**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL
Peer educators trained	1,502	2,174	2,507	2,387	1,568	0	10,138



Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL
Number of health workers trained in FP/HR	0	86	90	183	97	0	456
Number of new acceptors	600	2,350	3,951	9,401	12,137	553	28,992
Number of counseling visits	850	3,059	8,087	25,088	35,270	3,081	75,435
Regularity of contraceptive supply	80%	90%	90%	91%	92%	0	92%
Number of community outreach activities	97	492	350	656	760	8	2,363
CYPs	934	2,703	11,559	34,730	43,868	0	93,794
Number of USG-assisted service delivery points providing FP counseling or services	22	88	88	81	111	0	111
The number of clients using FP/HP services	0	0	0	52,628	48,133	2,649	103,410

## 2.2 Task 2: Expand the number of Global Development Alliance partnerships

In developing the scope of the HIPS project, USAID/Uganda expected that not every business would spontaneously support an expansion of services. The project would need to make the “business case” that increased access to services could improve employee productivity. The HIPS project staff first conducted an initial assessment of existing GDAs to determine the level of current commitment by partner companies, and their interest in expanding health services.

### 2.2.1 PARTNERSHIP BUILDING PROCESS

HIPS initially set out to renegotiate expired MOUs with companies that had previously partnered with the Business PART project. All partnership activities were led by a PPP team, comprised of a Team Leader, a Partnerships Program Specialist, and a Program Assistant, all working in tandem with the Chief of Party.

The HIPS project aimed to encourage companies to expand the scope of their services beyond HIV/AIDS but was willing to tailor programs in order to respond to the needs of each employer. To develop new alliances, the PPP team adopted a process that included market segmentation, needs assessments, and presentations. The team presented companies with a “menu of services” that companies might want to choose from. HIPS also used studies to bolster the “business case” for company investment in employee and community health. For example, using data from a large manufacturing company and private clinics treating AIDS patients, the project was able to quantify the “cost lost per worker to HIV/AIDS,” and compare it with estimated prevention and treatment costs.

Using this process, the project renewed agreements with former partners and developed new partnerships, expanding services to communities, and adding new health services to company benefits programs. Within

#### Approach to GDA Expansion

To expand GDAs under the HIPS project, the Cardno team capitalized on relationships developed by the Business PART project, and applied the following principles:

- Leveraging significant resources from companies with access to large and vulnerable populations
- Understanding companies’ core business, priorities and interests
- Ensuring the quality of health services
- Exploring multi-party partnerships to increase scope and impact
- Brokering linkages with local organizations
- Using capacity building and sustainable models to foster corporate ownership of social programs



its first year, the HIPS project had partnered with 35 companies, and created nine GDAs, leveraging \$900,000 compared to the project's \$300,000 GDA investments. The project's success in setting up partnerships within a short time can be attributed to the systematic approach described above, including needs assessments, developing an evidence-based business case, and the use of the proposed "menu of services." This approach succeeded in strengthening and expanding strong existing relationships with the employer sector.

The project's ability to tailor its programs to respond to companies' specific needs was also largely responsible for the rapid scale up of GDAs. The table below illustrates the scale and diversity of alliances built by the project.

Mobile Technologies	Facilities Construction and Management	Workplace to Community
<p><i>Partners:</i> Kinyara Sugar Works Limited, Kasese Cobalt Company Limited, Kakira Sugar Works; Text to Change</p> <p><i>Program scope:</i> Promote behavior change via innovative text messaging</p>	<p><i>Partner:</i> Tullow Oil</p> <p><i>Program scope:</i> Finalize and transfer maternity clinics to the district's local government health office</p>	<p><i>Partner:</i> Hima Cement</p> <p><i>Program scope:</i> Open up company clinics to the community. Has over 1,500 people on ARVs at project end</p>
<p><i>Partner:</i> Uganda Telecom, Nile Breweries, McLeod Russel Tea, Wagagai Flowers</p> <p><i>Program scope:</i> Strengthen health referrals via mobile user group network</p>	<p><i>Partner:</i> UGACOF</p> <p><i>Program scope:</i> Set up MOH accredited modern container clinic with outpatient services including HIV screening, malaria treatment, and ART</p>	<p><i>Partner:</i> Nile Breweries</p> <p><i>Program scope:</i> Provide health services along the company supply chain – from farmers and raw material producers to bar attendants serving company beer</p>
<p><i>Partner:</i> 70 private and company owned clinics; Access.Mobile</p> <p><i>Program scope:</i> Improve reporting at remote private clinics using a mobile phone based platform</p>	<p><i>Partner:</i> Rwenzori Tea Company</p> <p><i>Program scope:</i> Build a health facility with guidance from HIPS on building design, staffing, and location.</p>	<p><i>Partner:</i> Charis Medical Centre</p> <p><i>Program scope:</i> Cost share to purchase first CD4 machine in Lira district</p>
<p><i>Partners:</i> Wagagai Flowers, Nile Breweries, McLeod Russel Tea; AIDS Treatment Information Center</p> <p><i>Program scope:</i> Provide a hotline to private clinic health workers for ART client management support</p>	<p><i>Partner:</i> Tororo Cement</p> <p><i>Program scope:</i> Set up a treatment aide post in Moroto district, Karamoja region to provide health services to workers in remote limestone-producing quarries</p>	<p><i>Partner:</i> McLeod Russel Tea</p> <p><i>Program scope:</i> Provide community members with access to its six estate clinic states for HIV treatment and SMC</p>

### 2.2.2 ACCOMPLISHMENTS

By the end of 2009, all partner companies with clinics had extended HIV/AIDS treatment to community members and integrated at least two additional services, such as TB, malaria and/or FP/RH. Four companies in particular had made significant advances: the Tullow Oil company, in partnership with the district health team, added an outpatient clinic to the existing maternity center, and obtained ARV accreditation; UGACOF Ltd, a coffee processing company, converted a container into an outpatient facility for the community and was also accredited for ARV provision; the Rwenzori Tea Company began the construction of a health facility; and the Tororo Cement Company set up a treatment aid post in Moroto, Karamoja for workers at remote limestone quarries. By Year 5, the total number of active GDA partnerships managed by the project had reached 46, and the overall number of HIPS partners was 111. Company contributions for that year were \$1,908,809 with a project contribution of \$1,059,231, a 2:1 leverage.



**Table 10: Indicators for Global Development Partnerships**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL
Number of workplace sites collaborating with USAID to offer expanded HIV/AIDS (treatment) services to include the community	13	38	44	55	60	60	60
Number of existing and new workplace sites (clinics) with integrated health services RH/FP, TB or malaria	28	44	42	53	58	58	58
Number of GDA partnerships developed according to USAID principles	9	20	41	51	46	46	46

### 2.3 Task 3: Support initiatives to strengthen private sector workers' organizations

FUE and UMA played a significant role as entry points to a large employer population that enabled quick mobilization of companies and resource commitments. HIPS worked with these organizations to build their capacity to design and support workplace health programs for member companies. From the onset of the project, FUE and UMA agreed to implement the following tasks:

- Work with their members to expand the scope of workplace interventions and integrate TB, FP/RH and malaria to existing HIV/AIDS services
- Support companies in applying best practices in HIV/AIDS and health programing
- Calculate disease-related “loss costs” to convince companies of the need to provide HIV/AIDS and health services to their employees
- Broker relationships with key partners such as the Global Fund, NTLP and UHMG to facilitate access to low-cost or no-cost commodities
- Collaborate with the Ministry of Gender, Labour and Social Development to roll out and operationalize the new HIV/AIDS in the Workplace Policy
- Facilitate private sector support of the National Social Health Insurance Scheme (NSHIS)

In addition to supporting project objectives, FUE and UMA were expected to become nationally recognized leaders in health workplace programs. With technical assistance from the HIPS project team, the two organizations increasingly took responsibility for project activities. In the 1<sup>st</sup> year, over 1,500 peer educators from 13 companies were trained by HIPS, FUE and UMA staff. By Year 4, FUE/UMA were the main providers of health communication services to partner companies and supported 90% of peer educator trainings. By the end of 2012, 63% of HIPS active partners were receiving support formerly provided by HIPS and many partner companies were paying for services provided by UMA and FUE.

FUE and UMA made great strides in their capacity to design and market health services to their members. The organizations developed a menu of fee-based services, and used dedicated teams to carry out health workplace activities. Their combined efforts resulted in the creation of 30 HIV workplace policies, 839 trained peer educators and eight health fairs, including the UMA first-ever National Nutrition Fair. In Year 2, FUE was selected to lead the national chapter of the UN Global Compact and to be the focal point for the East Africa Business Coalition.

To help them sustain their activities, HIPS assisted FUE and UMA in developing proposals for grants. UMA was initially awarded \$143,000 by the USAID-funded STRIDES for Family Health project to implement FP/RH activities at company sites, including three HIPS partner companies. In a vote of



confidence in UMA's capabilities, the association was awarded another STRIDES grant worth \$131,200 to expand its activities, this time including antenatal care and other child survival services. During the 4<sup>th</sup> year, both FUE and UMA were awarded an initial \$70,000 grant each from the USAID-funded RESPOND project, followed by \$141,000 and \$139,000 respectively in Year 5 to provide services related to Private Sector Disease Outbreak Training. Funding for association services also came from the public sector. In Year 5, FUE was awarded \$39,200 in 2011 by the Uganda AIDS Commission (UAC) to coordinate HIV/AIDS activities in the private sector, followed by another grant worth \$32,800 in 2012 to support the private sector in contributing to the national response and management of the HIV/AIDS pandemic. FUE and UMA saw a significant increase in income generated from workplace health programs over the life of the project.

In March 2012, the Executive Director of FUE, Ms. Rosemary Ssenabulya, was elected as the vice chairperson of the Global Fund's Country Co-ordination Mechanism. This appointment presented a unique opportunity for the private sector to increase its visibility and influence in Global Fund activities. Furthermore, Mr. Joseph Kyalimpa, UMA's Manager of the Health and Business Unit, was elected on the Global Fund CCM's Sub Committee for resource mobilization and proposal writing.

## **2.4 Task 4: Develop innovative and proven approaches to support orphans and other vulnerable children**

The HIPS project team initially set out to understand OVC needs in priority areas, research best practices, and develop innovative corporate engagement models for OVC programs.

HIPS developed three models for implementing OVC programs: corporate sponsorship, supply chain and market access models. In each model, HIPS identified community-based organizations to implement the planned OVC activities. The children received education support, food and nutrition, psychosocial support, and health care services. Their households also received skills training to improve their economic security. Finally, the project supported interventions to mitigate child abuse, especially for children living in violent situations.

During Year 1, a small grant funding mechanism was established to cost-share support to the OVC programs with private companies. Within the first year, the project signed agreements with several companies to implement OVC programs in their catchment areas and along their supply chains, leveraging a 3:1 contribution. The project used three basic models to partner with companies:

***Corporate Sponsorship Model:*** Under this model, partner companies provided cash and in-kind support to OVC implementing organizations as part of their corporate social responsibility program. HIPS then provided matching grants (on a 1:1 basis) to complement private sector resources. This arrangement resulted in increased access to education and nutrition services for 3,273 children. Education assistance included the purchase and distribution of scholastic materials, and follow up of OVC to ensure regular school attendance and minimize school dropout. The project also supported efforts to improve food and nutrition status among OVCs through improved farming methods, school feeding programs and demonstration gardens at school and in the community. In addition, OVC were provided with psychosocial support, health care services, and apprenticeship skills training.

***Supply Chain Out growers Model:*** The supply chain out growers model was particularly suitable as a way to reach smallholder farmers who produce raw materials for industries. Partner companies worked with farmer associations and out grower associations to identify OVC households and enable them to produce raw materials for the company's supply chain. Out growers associations including 544 members (including 283 female-owned small businesses) supported by Kakira Sugar Works (KORD) under this initiative earned \$511,094 and received assistance in developing further income generating activities.

To further improve the economic independence and livelihoods of OVC families, HIPS encouraged OVC caretakers to form Village Savings and Loan Associations (VSLA) to access credit for income generating



activities. By 2012, 42 VSLA had been established under the program, allowing out growers to acquire land and equipment.

**Market Access Model:** This model focused on building the capacity of OVC households to produce marketable goods as a way to strengthen their economic security. Over the five-year grant, 1,458 OVCs formed associations which negotiated for higher prices for their goods. The role of the private sector companies was to provide technical assistance, training in quality standards, and link OVC households to local and international markets including the companies themselves. HIPS provided technical direction and capacity building for the implementing organizations, monitored the activities to ensure quality services delivery, ensured compliance with the National Strategic Program/Plan of Interventions for OVC and provided a matching grant to implement OVC activities.

In Year 4, HIPS focused on assessing how the technical and financial support provided under this task had helped transform the lives of OVC and their families. The project conducted a review of the programs of KCCL and NBL, KORD, Kinyara Sugar and Farmers' Center Ltd. to assess gaps, successes and lessons learned. HIPS and its partners focused on building the capacity of OVC support organizations in financial management, project planning and management, and resource mobilization.

**Table 11: OVC indicators**

Indicator	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	PROJECT TOTAL
Number of OVC served	1,468	3,090	4,010	3273	3,310	0	3,310*
Number of OVC caregivers trained in comprehensive HIV management	143	458	748	395	465	0	2,209

*\*Indicator does not measure unique figures*

## 2.5 Phase Two: Components

In Year 4, the HIPS project began to focus on legacy activities and strategies to solidify and sustain accomplishments from the previous three years. In addition to continuing to expand access to and use of services, the HIPS team emphasized the following aspects:

**Quality of Services:** In conjunction with the MOH, District Health Teams, NGOs/CBOs and other USAID projects, HIPS facilitated regular and comprehensive support supervision to partner facilities, and worked to ensure appropriate supplies, equipment and referral networks for proper diagnosis and treatment. Direct participation in support supervision was gradually phased out as companies and private clinic partners established solid relationships with District Health Teams/MOH and linked up with established clinic networks such as the Good Life Network.

**Integration of Services:** In Year 4, HIPS aimed to have 80% of partner clinics providing HIV, TB, malaria, and FP/RH services. The project continued to link private facilities to training programs, facilitate access to needed drugs/commodities (free or subsidized when possible), and encourage collaboration with District Health Teams for appropriate referral and reporting.

**Sustainability of Services and Exit Strategy:** HIPS had built the capacity of FUE and UMA to take on all prevention activities with HIPS partners. In Year 4, HIPS aimed to migrate 75% of its partners to FUE/UMA for prevention activities. HIPS also endeavored to work closely with the Ministry of Health and District Health Teams to conduct support supervision at private clinics and to establish functional relationships between the sectors.

### 2.5.1 QUALITY OF CARE

The HIPS project used a combination of methods ranging from placement programs, classroom training, on-the-job mentorship and regular support supervision to improve provider skills and promote service integration. To build clinical capacity, the project organized technical support visits on pediatric care, HMIS, SMC, laboratory inventory and logistics, LTPM and safe motherhood to partner clinics. The planned outcome was to assess service quality and gaps and ensure full integration of programs to minimize missed opportunities. The HIPS technical team was joined by a member of the MOH/AIDS Control Program(ACP) department as well as proficient trainers from Mildmay. While in the field the team was joined by the District Health Team, who was responsible for follow up of the action plan. HIPS also collaborated with the MOH to conduct integrated support supervision visits at partner clinics, using a HIPS Quality Assurance tool, with the goal of harmonizing service delivery across sectors. Technical visits were also conducted to assess the need for PMTCT with a view to gradually migrating partners programs to the PMTCT Option B+ adopted by the MOH. All (100%) reporting and active partner sites received a minimum of two yearly support supervision visits from members of the project, UMA, FUE, local districts and MOH with the goal of ensuring quality service provision.

#### Quality of Care at the Wagagai Clinic

Wagagai Limited is a flower exporting company with a work force of 1,100 employees, situated about 25km from the Kampala city center. It is primarily owned and managed by a Dutch family and produces chrysanthemums and pot plant cuttings on 20 hectares of greenhouses.

Through technical support from the HIPS project, the company transformed its workplace program into a comprehensive health workplace program including HIV/AIDS TB, malaria and RH/FP services. The facility opened a maternity ward fully equipped with an operational theatre and blood transfusion services. The Wagagai clinic has become a model facility in the central region, providing high quality services to communities as far as Entebbe. In 2012, the clinic provided ART to 85 patients, and administered Septrin prophylaxis to over 100 HIV positive clients.



*Deputy Secretary and Ambassador Burns (far right) during a visit to Wagagai Flower Farm in 2012*

HIPS focused on strengthening mechanisms for ensuring sustained access to and utilization of quality health services and information. These included continued external and on-the-job trainings as well as technical support supervision visits all geared towards improvement in quality of services. In addition, focus was placed on dissemination of standard guidelines for quality of care and reporting to ensure harmonization with MOH reporting tools. To further improve service delivery, HIPS partnered with the Uganda Healthcare Federation and Medical Councils to develop quality assurance standards, and pilot a voluntary self-regulation initiative in the private health sector.

The project put special emphasis on linking partner clinics to training/mentoring programs and sustainable sources of low-cost drugs and commodities needed to provide quality services in HIV, TB, SMC, malaria, and RH/FP. To this end, HIPS linked partner facilities to local donor-supported suppliers, such as, JMS, Africa Affordable Medicines, and UHMG to prevent future stock outs of critical medicines.

Finally, HIPS spearheaded the development of the first private sector HIV reference laboratory, a public-private partnership designed to make high quality, reliable and affordable HIV laboratory services available to private providers. In partnership with SIMS Medical Centre and the MOH, HIPS assessed the feasibility of providing HIV laboratory services to accredited private sector HIV/ART clinics. The project



secured overwhelming support and HIPS developed a management advisory board for the reference laboratory comprised of MOH and CPHL staff, private sector clinicians, laboratory experts and a lawyer. In early 2013, HIPS supported the procurement of equipment needed for the private sector reference laboratory to be operational.

### 2.5.2 SERVICE INTEGRATION

Providing comprehensive health care packages at partner clinics and achieving greater integration of services became a key focus area during the extension period of the HIPS project. By the end of Year 5, 90% of HIPS partners had successfully integrated comprehensive services, extending beyond HIV services to the adoption of TB, malaria, FP/RH. Through HIPS training and support supervision, partner clinics also integrated critical services such as SMC, IPT2, and LTPM.

Integration was facilitated by improving the availability of commodities. HIPS received 13,000 SMC kits, allowing for the scaling up of this service with partner companies. HIPS, in partnership with the NTLP also successfully supported the accreditation and functioning of five private sector TB diagnosis and treatment centers.

### 2.5.3 SUSTAINABILITY AND EXIT STRATEGY

The strategy adopted by the HIPS project to increase the sustainability of US Government-supported health partnerships included four main approaches: building the capacity of local organizations to partner with companies and provide health services (programmatic sustainability); improving program coordination between the public and private sectors; building more adequate representation for the private health sector in Uganda; and supporting mechanisms to increase access to financing in the private sector.

HIPS increased its support to FUE and UMA during the extension period, helping the associations take more responsibility for HIPS-supported programs and increase their fundraising and income generating capacity. In Year 5, FUE and UMA won four new awards for workplace health activities, including PPP coordination, HIV/AIDS mainstreaming, and workplace policy development. FUE and UMA experienced significant demand for their services in the form of fees for services and grants from new donors, including the German Society for International Cooperation (GIZ). With HIPS support, FUE and UMA also successfully held various regional conferences aimed at marketing workplace health programs and recruiting new members.

#### The Uganda Healthcare Federation: Providing a Voice for the Private Sector

Before 2010, the Ugandan private healthcare sector lacked a platform for effective representation and advocacy. The Ugandan Healthcare Federation (UHF) was created by a prominent group of health professionals as an umbrella organization to bring cohesion and credibility to the private healthcare sector. The HIPS project helped UHF create a board, constitution and bylaws, provided support for an office, intern and administrator, and co-financed selected activities.

Today, UHF's membership base includes professional and regulatory bodies (national councils and societies) associations representing special interest (medical, dental, nurse, midwife, insurance, pharmaceuticals) and corporate members (large private and no-profit hospital and clinics). The Federation is accredited by the MOH and affiliated to the East African Healthcare Federation. It is mandated to research issues affecting various private health sector players and lobby government for action, including through representation on the PIRT (Presidential Investor's Round Table).

Having attracted a broad membership of 31 associations and corporate organizations within its first year of existence, UHF has demonstrated its credibility and influence in the healthcare sector. Examples of UHF achievements include creating working groups to improve standards and quality in the private health sector, bringing together regulatory councils and the KCCA (Kampala City Council Authority) to develop a regulation and accreditation program in Kampala, and hosting the East Africa Health Federation (EAHF) inaugural conference in May 2012.

Through its involvement with the MOH Private Sector Technical Working Group, the HIPS project contributed to the formulation the Health Sector Strategic Plan III (HSSP III), and participated in the final



---

draft and rollout of the MOH PPP for Health Policy, which outlines a framework for engagement between the public and private sector in the delivery of health services.

HIPS continued its technical assistance support of the NBL/USAID/OGAC partnership, further described in the annex. At the end of the HIPS project, it was agreed that NBL/SAB Miller would retain the services of the project coordinator and assistant from the HIPS initiative, who would continue implementation of the project. Technical assistance is expected to be provided by the follow-on project to HIPS, the USAID/Uganda Private Health Support (PHS) program.

Phase 2 of the HIPS study on the costs and outcomes of ART therapy was also completed in early 2013. This study builds on the work of the first phase and analyzes months 12 through 36 of ART for patients at the same public and private clinics as in Phase 1. See the annex for more information on study outcomes.

HIPS led the way in launching several key support mechanisms to bolster and sustain the private health industry. UHF provided a cohesive voice for the private sector and advocated for industry improvements, such as quality of care standards. In 2011 and 2012, UHF experienced substantial growth, both in organization membership and activities scope. In May 2012, UHF hosted the inaugural East Africa Healthcare Federation in Uganda, which gave it regional exposure and increased credibility.

HIPS also substantially contributed to supporting the Development Credit Authority (DCA) guarantee facility for the health sector, which was signed on September 2012 by USAID in partnership with SIDA, and Centenary Bank, a local bank. HIPS held workshops to prepare health providers and Centenary Bank staff for the launch of the DCA. In addition, HIPS provided limited direct technical assistance to potential borrowers to increase their financial and business skills. The project deployed various strategies to support the DCA facility including raising awareness of access to finance opportunities among potential borrowers, providing business training to private clinic owners, facilitating workshops and mini-fairs for private sector associations and bank staff, and using the network of UHF, UHMG and Marie Stopes Uganda members. The project also supported the development of marketing materials, and initiated dialogue with equipment wholesalers to explore leasing partnerships and buy-back options.

By the end of the project, 10 private clients/institutions had borrowed funds through the DCA. Another 15 private institutions had submitted proposals and were under consideration. The total amount of loans in the pipeline was \$380,000.



### 3 CHALLENGES AND LESSONS LEARNED

The challenges encountered by the HIPS project were in large part the by-product of its successes. The peer education and health fairs programs in particular were very well received by employers, but demanded extensive investments in time and resources from the project. The following are cross cutting challenges that were observed in the delivery of services through private providers in all health areas:

#### 3.1 Sustaining company commitment to health programs

The services promoted by the HIPS project were generally met with positive responses from existing and potential partners. Most large companies in Uganda were concerned with the impact of HIV/AIDS, TB and malaria on their workforce, and were willing to invest in the health of communities in their catchment area. Many companies also agreed to add new services, such as FP/RH, to their benefits programs, and cost-shared community health fairs and SMC camps. Adding new health services to company-supported workplace and community health benefits however required substantial investments in human resources, training, facility upgrades, clinical supervision, equipment and commodities, and data reporting systems. Company perceptions of reasonable commitments in time and resources for these programs were sometimes at odds with project requirements, as described below:

##### 3.1.1 HIV/AIDS PREVENTION

- Peer education, which was popular among companies because it leverages their own workforce for health promotion and education, requires careful selection, training and supervision in order to be effective. Some partners requested lower-cost approaches to the selection and training of peer educators, as well as more streamlined reporting requirements. Additionally, the requirement to limit group discussions to no more than 25 participants proved difficult in a business environment. Companies as a rule favored the use of lunch breaks for video and radio shows, because dining rooms can accommodate large groups.
- In response to these challenges, the project increased its support for more integrated outreach services, for example by promoting and supporting SMC camps. HIPS project staff worked closely with company managers to minimize the drawbacks of the peer education programs while advocating for sustained corporate support. Sponsoring community health fairs also proved to be a practical way for companies to fund health programs with broad appeal in their catchment area. As for the peer education program, high costs initially raised concerns about the sustainability of this approach. In the early years of the project life, a local entertainment company was contracted to develop material and support activities at an estimated average cost of \$3,750 per fair. Subsequently, HIPS developed an approach that leveraged peer educators and local drama groups to mobilize communities, eventually bringing the cost of the program down to \$1,100 per health fair.

##### 3.1.2 PALLIATIVE CARE

- At the onset of the project, demand for *palliative care* was already high in targeted communities, raising concerns at the cost of care and treatment services other than ART. Companies were especially reluctant (or in some cases set ceilings) to extend support to community members for drugs used in pain management and the treatment of opportunistic infections. In response, the project actively lobbied partner companies to support the procurement of vital medicines and drugs for community patients on palliative care, but also worked to link company clinics with free drug programs for the management of opportunistic infections. HIPS provided extensive on-the-job support to private health providers, and enlisted the support of other implementing partners, local NGOs and CBOs working in the company catchment areas.



### 3.1.3 HIV/AIDS TREATMENT

- Because of considerable latent demand for HIV/AIDS treatment in Uganda, some companies had expressed concerns about the significant costs involved in running community ART programs. Hima Cement Company, for example, had over 400 patients on ART. Though ARVs were free to accredited clinics, the costs associated with opportunistic infection treatment, and tests required for patient follow up had to be borne by the company. Over the life of the project, staff attrition, irregular commodity supply, and high service costs frequently tested the commitment of partner companies to the HIV/AIDS treatment program. HIPS also noted that by the end of the project ART public sites were currently congested with regular stock outs of drugs, as well as other quality concerns at these sites expressed by many patients visiting private sites. Some partners set up patient caps to reduce congestion at their facilities. This issue is expected to be explored further by the follow on program to HIPS, the PHS Program.
- ARV drugs provided free of charge to accredited private providers were initially donated by the Global Fund and made available through the National Medical Stores, the main MOH commodity supplier. The portion of ARV stock set aside for private facilities (20%), however, proved to be insufficient, and frequent stock-outs threatened the viability of the ART program. A study conducted by the HIPS project in 2012 revealed that 86% of companies had reported having experienced stock outs of ART related drugs. Post-test clubs created by People Living with HIV/AIDS (PHAs) experienced ARV stock outs that required the transfer of some clients to other centers, affecting team cohesion and follow-up.
- In response, the HIPS project capped the number of ART accredited clinics at 100, and began to explore alternative supply sources, including Medical Access and Africa Affordable Medicines. After severe ARV shortages occurred at National Medical Stores, and the MOH considered cutting off supply to the private sector, HIPS supported a study of the cost effectiveness of ART programs in private and public health facilities. The study revealed similar outcomes in both categories, and demonstrated savings obtained by leveraging private providers. These findings helped make the case for continued inclusion of the private sector in ARV distribution programs. Subsequently, private facilities were able to access PEPFAR-donated ARVs from JMS with subsequent improvements in commodity supply. By the end of the project, the supply of ARV and other drugs had normalized.
- Although the ART cost effectiveness study showed that private sector facilities had good treatment outcomes, the majority of the sites had poor laboratory capacity, which could adversely affect the monitoring of ART clients. Under a partnership between the SIMS Medical center and CPHL, HIPS funded the establishment of the private sector HIV reference laboratory which became operational in early 2013.

### 3.1.4 COUNSELING AND TESTING

- The project also struggled initially with the cost of VCT and initially low uptake of this service. HIPS experimented with a mobile unit (van) to promote and deliver VCT services but the approach proved both ineffective and too costly, and it was eventually discontinued. In addition, the standard 2-3 week VCT course provided by AIC, though very comprehensive, was quite expensive and required company staff to stay away from their job for long periods of time. To increase attendance, HIPS scaled up couples counseling at health fairs and developed a follow-up mechanism for those who tested positive. VCT services were also promoted at the workplace and provided through partner clinics. To address the demands on staff time, the project worked with AIC to reduce the duration of the training course without sacrificing its quality. As a result of these interventions, the project eventually greatly exceeded its VCT targets.



- Commodity supply issues also affected VCT services. Private facilities were willing to provide these services at no cost to their clients, as long as test kits were provided free of charge. Although the MOH, through JMS, initially supplied the kits to facilities, this free distribution program eventually was discontinued in Year 3, affecting testing services at some sites.

### 3.1.5 TUBERCULOSIS

- Low capacity was particularly noticeable in the TB prevention and treatment area. Private health facilities typically lacked adequate TB infection control systems and trained clinical and laboratory staff. As a result, they reported very low numbers of TB cases detection and treatment, especially in rural areas. The project also found low levels of awareness about TB infection, diagnosis and treatment among both health workers and members of targeted communities.
- In response, HIPS focused on facilitating and supporting the training of private clinicians and laboratory staff, helping accredit private facilities to provide TB treatment, and facilitating the supply of TB drugs from the MOH. HIPS also worked closely with the NTLP to increase support supervision on TB program implementation at facility level. The project helped mainstream the use of the intensified case finding tool among patients in order to identify more cases, and worked with facility staff and district supervisors to ensure the follow-up of TB-positive patients at partner sites.
- Because not all workplace clinics had the capacity to manage/treat TB, the project helped develop a referral system that allowed patients diagnosed with TB at the workplace to be treated at TB treatment facilities where patients received free or subsidized medicines and treatment.

### 3.1.6 MALARIA

- As for other health conditions, the provision of malaria prevention and treatment services at private facilities was highly dependent on the availability of low-cost commodities. Many companies were hesitant to invest in procuring LLINs for the prevention of malaria because they were considered too costly. Companies also lacked access to malaria RDTs and drugs. Ensuring quality malaria treatment services was highly dependent on the availability of anti-malarial medicine, but the treatment recommended and distributed by the MOH (Coartem) was not available to private clinics. As a result, a few clinicians in the private sector were still prescribing chloroquine, monotherapy, or unapproved treatment combinations. This issue was followed up with the Program Manager of ACP/MOH. HIPS and MOH agreed to conduct onsite mentorship for the affected sites and distribute national guidelines on malaria case management.
- Private facilities benefitted from PMI subsidies through support from the HIPS project, which procured LLINs and distributed them on a cost share basis to partner companies. HIPS also assisted partner facilities in accessing low cost commodities for malaria diagnosis and treatment. By Year 3, however, reduced supply of LLINs from PMI affected their availability at the facility level and at the workplace.
- During the 4<sup>th</sup> year, the HIPS project carried out a baseline study among 10 partner company facilities to assess the cost, benefits and savings of using RDTs in malaria case management. The findings of the study suggested that using RDTs would only be cost effective for companies in located in high endemic areas. Unless the costs of RDTs were reduced below the prevailing prices, there would be no savings realized on using RDTs in malaria diagnosis for facilities in the hypo-endemic areas.
- In response, HIPS encouraged the districts to provide free ACTs to project-supported facilities and provided training support to partner clinics to improve laboratory diagnosis prior to administering treatment. The project also worked with UHMG and other suppliers of LLINs to increase the



affordability of nets and developed cost-sharing arrangements with companies, to ensure net supplies to vulnerable groups.

### **3.1.7 REPRODUCTIVE HEALTH**

- The addition of FP/RH services at company facilities resulted in a rapid increase in demand for contraceptive products, especially long term methods. Some partners however were reluctant to allocate budgets for FP commodities, especially implants and IUDs, which are not readily available on the Ugandan market. To address this challenge, the project partnered with social marketing organizations, including PACE and UHMG, to supply partners with FP supplies at affordable prices and linked partners to districts, Africa Affordable Medicines and other NGOs for additional access to FP commodities.

### **3.1.8 OVC PROGRAM**

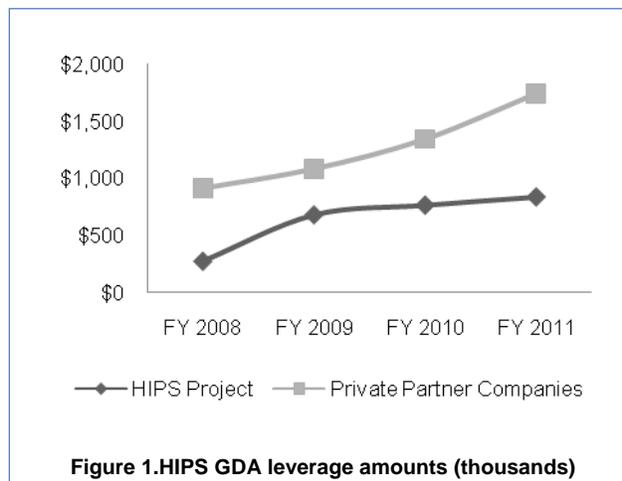
- A 2009 study of 50 companies conducted by the UMA with support from the HIPS project revealed that many companies were providing support to OVCs in their catchment area. Most however were more inclined to provide one-time donations than to support comprehensive OVC programs. In the 1<sup>st</sup> year of the project, as an overwhelming number of OVC registered during the selection process, HIPS encouraged companies to use their funds more effectively, steering them away from one-off activities and towards partnerships with local CBOs capable of implementing comprehensive OVC programs.
- Maintaining the quality of OVC services in the context of company-supported activities proved difficult as more children were being orphaned by the HIV/AIDS epidemic. To address the increase in demand for health care, child protection and food support, HIPS developed a referral mechanism between companies and service providers, including health centers and local CBOs and NGOs. The project also sought to prevent the abuse of OVC by empowering partner organizations and local religious leaders to identify cases of child abuse and report them to District Probation Officers.
- The OVC program also faced challenges that arose from factors beyond the scope of the HIPS program. For example, the reunification of street children with their families was often short-lived in the absence of community involvement, or when child abuse took place. Companies however were unwilling to commit to additional activities to overcome these challenges.

## **3.2 Managing demands on project and public resources**

Many of the HIPS project partners were multinational firms with large workforces, such as NBL, Kinyara Sugar and McLeod Russel Tea, which employed between 1,000 and 10,000 workers. Each year, the HIPS project was expected to sign up new GDA partners while utilizing the same level of resources. Over time, the project had to dedicate more resources to identifying and engaging smaller companies with more limited means. As the GDA indicator targets increased from five in Year 1 to 50 by Year 5, the PPP team also had to ensure that the resources needed to develop new commitments would not negatively affect existing relationships.



- In its first year, HIPS leveraged at least \$900,000 worth of private sector contributions for an investment of \$300,000 GDA - representing a 3:1 leverage ratio. In the 2<sup>nd</sup> year, this ratio reduced to 2:1 as HIPS leveraged only an additional \$180,000. During the same period, however, the project doubled its GDA investments from \$300,000 to \$684,719, and the number of GDA partnerships increased from 9 to 29 in Year 2. By redesigning older GDAs and designing new partnerships that required a lesser commitment, HIPS managed to sign up new partners with the same level of resources (see Figure 1). Furthermore, whereas the project's investments plateaued after 2009, the amount leveraged from the private sector increased.



- As demand for health services grew, HIPS had to ensure that staff, supplies and other resources were available to sustain the delivery of these services. Over time, HIPS had to substantially increase support to companies for peer education and clinical training, SMC camps, commodity and equipment procurement, and data collection and reporting. For example, when IPT was introduced at partner facilities, the project had to stretch resources and hire a malaria advisor to ensure supervision of the large number of new partner facilities expressing interest in the program. By Year 4, over 25% of HIPS supported sites had suffered from high staff turnover, including doctors and clinical officers. To overcome this problem, HIPS stepped up trainings and on-the-job training mentoring, focusing on newly recruited staff at accredited sites.
- As a mitigating strategy, the project sought to build the capability of UMA and FUE to negotiate PPPs and implement workplace programs. In addition to the services they were already providing to their members (such as workplace program design, and occupational health and safety trainings), FUE and UMA were tasked by the HIPS project with supporting companies that were being graduated from direct project support. These associations however, were not always able to provide the same level of support partners had been receiving from the HIPS project staff. Though both associations recruited clinical personnel, their capacity to implement clinical programs and support partners in key areas like ART and TB remained low. Some companies expressed concern over the lack of health expertise at FUE and UMA. To allay these concerns, the HIPS project decided to instead continue to provide health trainings and treatment services directly through the end of the project, while FUE and UMA focused on prevention activities. HIPS also looked to link with other national programs and departments.
- With the OVC program, the HIPS project was faced with challenges that stretched its technical and financial resources. HIPS worked with companies to build the capacity of OVC households to generate income, including through the sale of goods and services along the companies supply chains. In Year 3, HIPS scaled up income generating programs, such as school gardening programs replicable at home, in an effort to reduce this insecurity. The needs of OVC, however, were broad and required the involvement of multiple stakeholders, such as Community Development Officers, who were in short supply in program areas.
- As the peer educator program created demand for services, referrals provided through peer educators began to put pressure on public facilities in rural areas, some of which were ill-equipped to provide services such as SMC. The HIPS project had to invest (mostly by cost-sharing commodities and providing training support) in building the capacity of private facilities to offer integrated primary health care services to communities through companies.



- Because the private health sector is poorly regulated in Uganda, projects involving private facilities must rely on voluntary reporting of data and patient information by facilities. Accredited partners were required by the MOH to report monthly to the sub health district. In the absence of clear incentives, however, privately owned clinics typically resisted requests for detailed and regular reporting because they place demands on staff time. Many sites lacked FP registers, client cards and forms and received little support or feedback from districts regarding data reporting. To address the situation, the project invested in strengthening M&E systems at partner sites with a focus on data collection, analysis, forecasting and reporting to the districts and MOH. HIPS also facilitated visits by district authorities, and stopped supporting sites that were not reporting to the district or the project on a regular basis.

### **3.3 Building sustainable local organizations**

- Both FUE and UMA initially lacked sufficient resources and capacity to deliver high quality health workplace programs on a large scale. Each had fewer than two individuals assigned to the health workplace team and often relied on consultants, which did not contribute to building institutional capacity. In addition, both organizations experienced attrition, requiring additional investment in training and capacity building of new employees. As HIPS began to migrate prevention activities to FUE and UMA, the additional responsibility led to a strain on both organizations.
- Another challenge for the HIPS project was the difficulty of attracting long term funding for workplace programs implemented by UMA and FUE. Some member companies resisted having to pay for health services (such as peer education training offered by FUE and UMA), which they felt should be free as part of their membership benefits. To address this perception, HIPS assisted in conducting a member survey to assess which services companies might be willing to pay for. The survey findings helped repackage services and fees, leading to increased demand from new and existing members.
- Though FUE and UMA were generating revenue from various workplace services, the percentage of revenue assigned to program expenses was unclear. FUE and UMA initially lacked a business model for the health program, or a clear understanding of program costs. By Year 4, the HIPS project engaged a consultant to assist the two associations with the development of a five year strategic plan. Neither FUE nor UMA, however, were able to reach revenue targets set in their business plans, as companies canceled or scale down scheduled workplace health activities, in part due to Uganda's political and business climate. In the last few months of the project, FUE and UMA sought to build a combined portfolio of private client services and donor-funded programs as a way to improve the financial sustainability of their health activities.

## **4 RECOMMENDATIONS**

### **4.1 GDA programs must be private sector-driven**

- Many of the new MOUs signed with companies expected them to support and sustain more health activities, often requiring higher staff commitment. A few partners expressed unease at the increasing amount of time their staff had to dedicate to peer education or health training. Ten of the smaller companies chose not to renew their MOUs for this reason. This setback highlighted the need to continuously ensure that the programs supported by the private sector must be continuously measured against business standards, which demand cost effectiveness and clear benefits over long term social impact. Furthermore, the success of a GDA was typically driven by a champion within the partner company (such as a managing, finance, or human resources director) who was highly engaged during



the partnership-building process. The promotion or departure of a champion in any given company often required another round of meetings and negotiations for the program to be sustained. Managerial changes at Wagagai flowers, Hima cement, and Kakira Sugar Works required renewed efforts by the HIPS staff to make the business case for health programs. In order to mitigate this, it may be more sustainable when partnerships with companies are developed to ensure that the goals of the partnership are written into company policy, either under employee benefits, or as part of the company's corporate responsibility policy. Also, these programs should be strongly linked to the long term business plan of the company, and should be endorsed at various levels of the company's management structure so that they are less dependent on a single champion. Last, keeping note of MOU expiry dates, obtaining regular activity reports, and convening annual meetings with partner companies to renew MOUs may mitigate time lost during any company managerial transitions.

- Unlike the public sector, where each district has a designated number of public institutions, most private sector activity is demand-driven and unevenly distributed across the country. Most businesses in Uganda are concentrated in the central region districts of Kampala, Wakiso, Mukono and Jinja. A 2007 national survey revealed that the central region had the biggest share (65%) of Uganda's business establishments versus 7% (the northern region). Consequently, most of the HIPS project GDAs were developed in the central region, as shown on the map of HIPS' private sector partners (see Figure 2). A 2010 assessment of the private sector in northern Uganda found that it was mostly comprised of small and medium scale enterprises unaffiliated with any industry association. Despite the immense demand for health services in the Northern region, the lack of significant private sector activity and resources prevented the project from replicating its successful model in that area.

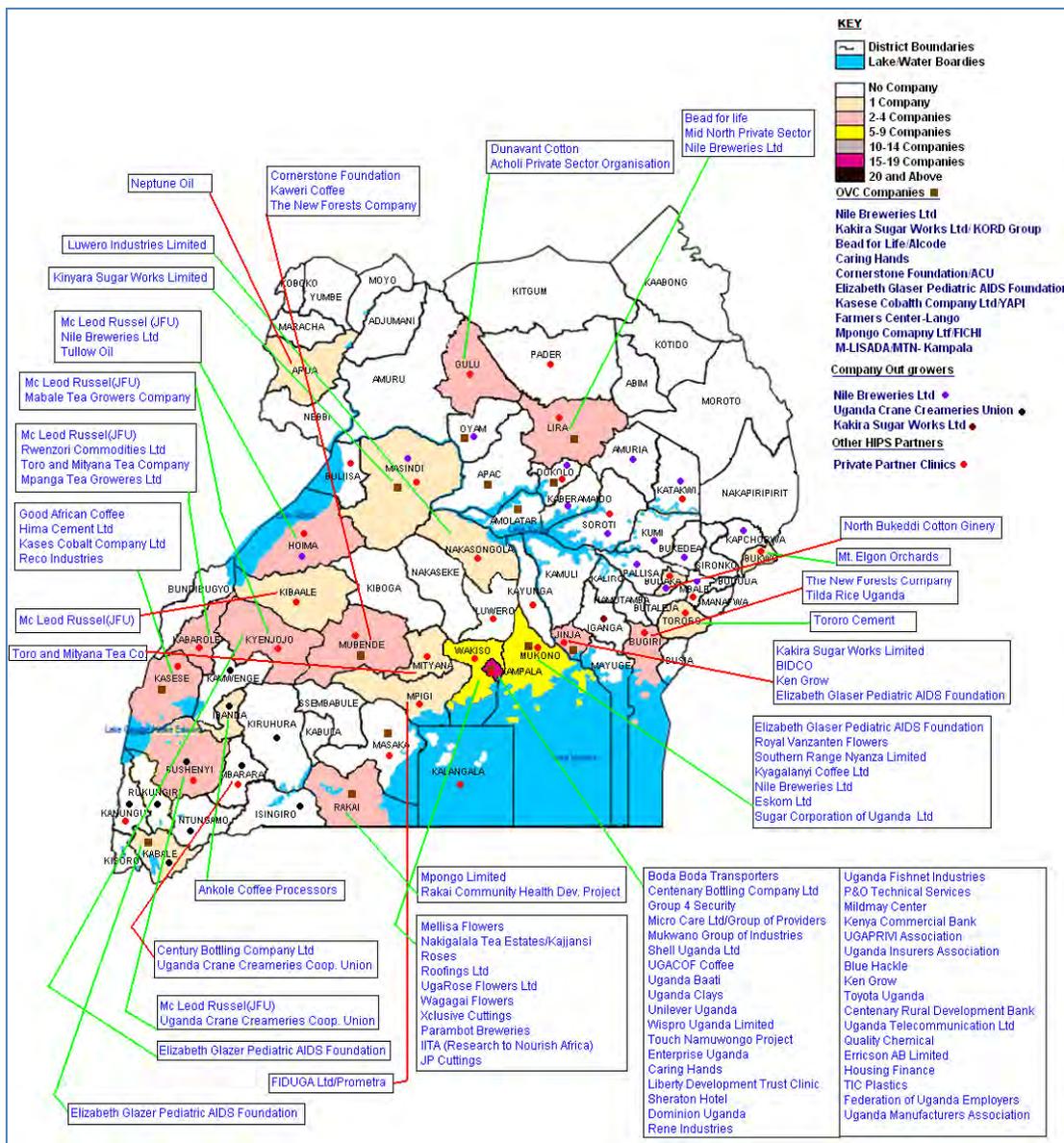


Figure 2: Map of HIPS private sector partners and private clinics

#### 4.2 New approaches are needed to engage small companies and the informal sector

- Many of the smaller firms approached by the HIPS project had a low perception of the benefits of providing health services to their workforce. For companies with 50 to 300 employees, who could be replaced if they got ill, cost savings realized through prevention counseling and health services seemed less impressive than for very large employers. To make business sense for these companies, investments must be cost-effective. Small companies can be encouraged to join FUE or UMA in order to receive health services bundled with other membership benefits. 12 smaller companies, ranging from coffee processors, to the Regional Lorry Drivers and Transporters Association, became FUE and/or UMA members during the life of the project.
- The national household survey revealed that nearly 70 percent of the Ugandan workforce is employed in the informal sector. To engage and leverage this highly fragmented sector, however, the project



would have to spend considerable resources and reach many employers in order to have any impact. As the private sector continues to expand in Uganda, it may be possible to encourage informal employers to form associations that could then be linked to FUE/UMA for a range of services. Both have new satellite associations that seek to engage the informal sector. For instance, FUE and UMA formed an HIV/AIDS coordination committee that includes the Uganda Small Scale Industries Association, the Uganda Fish Processors and Exporters Association, and the Uganda Hotel Owners Association. As a result, a larger proportion of the workforce employed in the informal sector may receive health services offered by FUE or UMA.

#### **4.3 Growing the private health sector requires a range of strong local institutions**

- Building the capacity of FUE and UMA to provide more health services was a key aspect of the program's sustainability strategy. As partner companies were "migrated" from the HIPS GDA family and moved under the responsibility of FUE and UMA, however, they remained dependent on the HIPS project for training and treatment support. To complete the sustainability of privately-supported services, better local capacity for clinical training and quality assurance must be developed. The HIPS project laid the groundwork for several initiatives through UHF that may result in improved standards and a network of service providers for the private healthcare sector.
- It may not be realistic to expect industry associations to sell the full range of services required to implement high quality health programs, or to do so while being financially sustainable. It was difficult for FUE and UMA to negotiate and develop comprehensive, longer term partnerships with most of the new partner companies. Most of the new partners prefer to offer one-off activities such as a workplace policy or a health fair, instead of a full package of community mobilization, peer education, support supervision, etc. Both FUE and UMA realized that donor support would be required to both sustain programs and generate revenue in addition to the membership and service fees they could collect through their marketing efforts.

#### **4.4 Better integration between public and private health sectors is critical**

- When companies first became engaged with the HIPS project, their communications with the district were infrequent or non-existent. The HIPS team facilitated linkages between employers and district health teams as a way to provide oversight of health services. The team organized regular visits involving multidisciplinary teams hailing from various branches of the MOH and local district health officials, many of whom had never visited the private facilities. This approach paved the way for companies to work directly with the districts, yet, these linkages remained tentative as the PPPH policy had not yet been operationalized.
- Any support from the MOH and health districts provided in the early years of the project can be ascribable to goodwill as well as the efforts of the HIPS staff. However, a formalized relationship involving the sharing of information, planning, human resources and commodity supply mechanisms across the public and private sectors can go a long way towards sustaining HIPS programs. Increasing collaboration between the two sectors may require increased advocacy efforts and data gathering, such as the HIPS ART study completed in 2013, which demonstrated that providing donated ARVs to accredited private and company clinics could achieve savings for the public sector.
- The lack of integration, particularly with respect to health information and data reporting, leads to investments in parallel systems that can be short-lived. The HIPS-supported Access.Mobile program proved inadequate in satisfying district reporting requirements and facilities had to report twice, once to the district (through paper forms) and once to the project. The program was eventually phased out and is being substituted by newly introduced DHIS-2, which came into place towards the end of the HIPS project.

## ANNEX: PROJECT HIGHLIGHTS AND SUCCESS STORIES

### Technical Support to the Private Sector: Facilitating ART & TB Accreditation

#### Why the Private Sector in Uganda?

Only 50% of individuals with advanced stages of AIDS in Uganda are currently receiving ART. Under-resourced and over-burdened, the public health sector faces steep challenges in providing healthcare to the community, and is further restrained by limited financial and human resources as well as inefficient systems for managing procurement and service delivery. Many service delivery gaps of the public system are filled by the frequently overlooked and minimally regulated private sector, where 33.5% of health services are delivered countrywide, and where even the poor pay for services through out of pocket expenditures.

#### The Role of HIPS

The USAID/Uganda HIPS project works with the private sector to tap into an exceptional opportunity to expand quality HIV/AIDS care. The project supports private clinics in going through the MOH accreditation process to provide ART and TB treatment. When clinics receive accreditation, they are able to access free ART drugs, and provide services in ART & HIV/AIDS care. All HIPS-supported private clinics provide highly subsidized health services to partner company employees, beneficiaries, and the surrounding community. Because of accreditation support from HIPS, by March 2013, affordable ART was being extended to 5,916 individuals through the private sector.

#### HIPS Accreditation: Affordable, High Quality Services in the Private Sector

HIPS has partnered with 100 private health facilities to facilitate MOH ART accreditation to provide ART. Accreditation activities include:

- Capacity assessment of private sector clinics for staff, equipment, and expertise necessary for accreditation
- Training of clinical personnel on diagnostics and treatment for HIV/AIDS and pediatric HIV/AIDS (how many)
- Provision of key lab equipment such as microscopes, centrifuges, and refrigerators as needed (number or dollar amount of distributed equipment)
- Establishment of VCT & PITC



After a series of illnesses failed to respond to treatment, this 11-year-old was tested for HIV at the Wagagai company clinic. The boy tested positive along with his father, and lab results confirmed that both had advanced stages of AIDS and would need to start on antiretroviral therapy. Within six months of diagnosis, the pair began to receive comprehensive and free treatment from the company clinic, which is close to their home, school, and work. For a person living with HIV/AIDS in Uganda, the shock, hardship, and relief of treatment experienced by the boy and his father during the process may be familiar. What is unique in this case is where they have received their services, and how they have been paid for.

From treatment seeking and diagnosis to the initiation of ART, father and son have received affordable care from the Wagagai company clinic, tapping into a non-traditional source of subsidized care that is nearby their home. Wagagai Flower Company has constructed a new clinic, outside the company gates so that community members can access it. The company pays for all clinical staff, consultations and diagnostic tests. Through the HIPS project, the Wagagai private clinic has received Ministry of Health ART accreditation for provision of ART. Because of this accreditation, the clinic is eligible to receive and disburse free ART drugs to employees and the surrounding community. As a result, father and son are able to access lifesaving ART drugs without spending a full day every month visiting a more distant health center.

- Follow-up training and technical support to clinics in providing ART
- Linkages to the MOH and District Health Teams for accreditations, referrals, reporting, and supervision
- Development of guidelines for private clinics on getting drugs and commodities from the MOH



A technician uses equipment provided by HIPS during the accreditation process. The capability to provide quality diagnostics is necessary for antiretroviral & TB treatments, and is required for MOH accreditation.

By linking private sector clinics with drugs from the MOH, HIPS is breaking down barriers that inhibit private sector clinics to provide quality ART by providing linkages to regulatory frameworks, building the capacity of the private sector health workforce, and strengthening laboratory capacity and access to commodities. As a result of the accreditation process, HIPS has brought to bear combined private sector and MOH resources to provide ART for over 5,916 individuals, palliative care for 9,262 individuals, and counseling and testing for over 90,824 individuals.

The project's starting point of supporting HIV/AIDS treatment in the private sector has expanded to support integrated services for TB, malaria and FP how the private sector, particularly the workplace, can bring significant financial and human resources in prevention and treatment of HIV/AIDS, TB, malaria, and services in RH/FP. Project activities have also proven how effective

partnerships between MOH, District Health Teams and private clinics can ensure quality services, timely referral and accurate reporting.

## Family Planning: Supporting Women in the Workforce

As a nation, Uganda has experienced consistent economic growth, with a growth rate of 6.4% in 2011. Nevertheless, much of the country remains in deep poverty, and rapid population growth – estimated at 3.3% in 2012 - is placing increasingly strenuous demands on household and environmental resources. Family planning plays a pivotal role in mitigating these challenges, saves maternal and child lives through birth spacing, and reduces unintended pregnancies and abortions. However, rates of use are still low, with a 24% contraceptive prevalence rate, and a 41% unmet need for family planning among married women - a rate which increases for rural areas. Rural areas also face a higher household burden, with a total fertility rate of 7.0, compared to a 4.3 rate found in urban areas. As public sector health services struggle to meet health demands in hard to reach locations, alternative means of accessing family planning through the private sector and NGOs is essential.



At the Wagagai Clinic near Entebbe, a health provider counsels a young woman. The clinic is supported by Wagagai Chrysanthemums Ltd, and provides long term family planning methods, ART, and laboratory services to employees and the surrounding community. The Wagagai Clinic also offers antenatal and maternity care.

### Family Planning in the Private Sector

In response to the powerful evidence and the need to support family planning and LTPMs in hard-to-reach rural areas, HIPS initiated a pilot intervention with private sector partners to provide affordable and high quality family planning through the workplace. More than 50% of the employees from HIPS partner companies are women. However, 80% of these partners were not providing long term methods to their employees, and a recent study by UMA and FUE showed that only 34% of employers provide family planning and reproductive health services. As a result of this initiative, the following was achieved in 2011-2012:

- 70 partner clinics were providing integrated RH services
- 12,137 new acceptors and 43,868 couple years of protection were provided
- 1,568 peer educators were trained
- 760 community outreach activities have been conducted

HIPS preselected partners for the LTPM initiative based on certain characteristics: a workforce of between 300- 10,000 people, a commitment of a 1:1 match with project resources, and a company clinic for the provision of free health services to employees and the community. Activities included:

- A survey of knowledge, attitudes, and practices on family planning, as well as staff capacity in company health facilities
- Provision of training of at least 50 clinical staff on long term and permanent methods
- Provision of basic supplies such as tubal ligation sets, insertion kits and other start up materials
- Ongoing support supervision to health facilities and assessment of method up-take among clients
- Training of peer educators to build awareness of family planning and reproductive health options
- Community outreach activities to raise awareness on family planning.

## FUE and UMA: Leading Providers of Workplace Health Services

The HIPS project made great strides in strengthening the institutional, programmatic and financial capacity of FUE and UMA. FUE and UMA are the two premier employer associations in the country with a combined corporate membership of over 1,000. FUE and UMA were positioned to increasingly take responsibility for HIPS-initiated activities throughout the life of the project.

FUE and UMA were supported through the HIPS project to deliver comprehensive prevention workplace programs, provide HIV workplace policies, use communication strategies such as health fairs, peer education, and men-only seminars, assess sites for possible ART accreditation, and conduct support supervision of partners to check on quality and strengthen service delivery. By the end of the project, both organizations were supporting 36 companies. Companies being supported by the associations have been directly recruited through their corporate membership while others have been migrated from HIPS project.

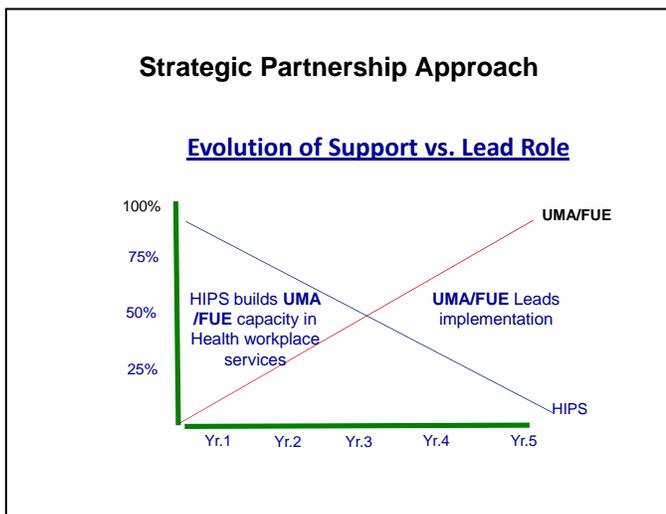
Financially, FUE and UMA health workplace programs are becoming sustainable. Both associations have a menu of services with professional fees charged to companies for services offered. In 2012, both associations raised a total of \$43,266 from professional fees; representing a 37% increase from fees earned in 2011.

The HIPS project also built the capacity of FUE and UMA to develop a business plan, write winning proposals, mobilize resources and diversify their portfolio.

FUE and UMA successfully responded to requests for proposals for grants. In 2010, FUE was granted \$7,500 from the UAC to mobilize and represent the private sector. In the same year, UMA won \$143,000 from the USAID STRIDES project to implement family planning and reproductive health activities at workplaces, in partnership with TAMTECO, SCOUT, Mpanga Tea Growers and Mabale Tea Growers Company.

The two organizations are taking national leadership roles in health at the workplace. FUE was selected to be the national focal point for the East Africa Business Coalition and the UN Global Compact while UMA successfully hosted the first and second annual National Nutrition, Safety and Health Fair.

The continued growth and strengthening of the two associations is a key indicator to the continued involvement of the private sector in partnering with the public sector in the delivery of health services.



The Prime Minister, Professor Apollo Nsubambi at 2<sup>nd</sup> Annual National Nutrition, Safety and Health Fair at UMA. The marketing events organized increased UMA visibility as Health Service and Program providers at the Workplace.

## USAID/HIPS Project Supports the Dissemination of the National Policy on Public Private Partnerships in Health

---

In 2011, HIPS, in collaboration with the Italian Cooperation supported the MOH to disseminate the National PPPH Policy. The policy aimed to provide guidance, to mainstream and promote recognition, as well as, to value the role and contribution of the private sector in the health development. The policy provides an institutional framework within which to coordinate, implement, monitor, evaluate and enrich PPPs.

In an effort to operationalize this policy, HIPS together with the Italian Cooperation conducted four regional dissemination workshops, from September to December 2011. HIPS organized and sponsored two well-attended workshops; one in Mbarara on November 16<sup>th</sup>, 2011 and one in Fort Portal on November 30<sup>th</sup>, 2011. The workshop in Mbarara was attended by 88 of 100 participants invited from the targeted districts, namely; Mbarara, Kabale, Ibanda, Bushenyi, Kanungu and Rukungiri. The workshop in Fort portal attracted 85 of 100 targeted participants from Kabarole, Kasese, Kyenjonjo, Kamwenge and Bundibugyo. The Italian Cooperation sponsored other workshops in Jinja and Moroto. Participants included stakeholders from both the public and private health sectors at national and district levels. The stakeholders' profile included:-

**At national level:** MOH officials including the Commissioner Health Planning, PPPH desk officer and representation from the Policy Analysis Unit, Representatives from the Private Health Providers (PHPs) Umbrella Organizations, PNFP Medical Bureaus, NGOs implementing health and representatives from the Traditional & Complimentary Medical Practitioners' sub sector (TCMP).

**At district level:** District Health Officers, Chief Accounting Officers, Secretaries for Health, District PPPH Desk Officers, District Drug Inspectors, representatives of Heads of Health Sub District, Private Health Providers' district representatives, members from the Facility & Non Facility Based Private-Not-For-Profit subsectors, CSOs and representatives from the TCMP.

Both workshops attained national media coverage as they were featured on the national news channels UBC TV, WBS TV and NBS TV during prime time. The presentations and discussions were lively and informative. It was observed that while the government has collaborated with the PNFP sub sector through the Medical Bureaus, collaboration with the PHPs has been limited. Therefore this policy should help to enhance collaboration between the sectors. Joint planning between the sectors at the district level will be critical to the success of this policy. As part of HIPS' support to this process; an orientation training workshop of the district PPPH desk officers and subsequent joint planning at district level is imperative. Therefore HIPS, in collaboration with the MOH and the Italian Cooperation, is organizing an orientation training workshop for the district PPPH desk officers and District Health Officers from 20 pilot districts. This is to be followed with subsequent district level joint planning amongst key stakeholders (from the Public & Private sectors) as the initial step to kick-start inter-sectoral collaboration at the district level.

## The National Partners Symposium

On April 6<sup>th</sup> 2011, HIPS together with FUE and UMA organized the first ever national partners' symposium. The event, held at the Protea Hotel in Kampala, brought together 158 representatives from HIPS partner companies and clinics, potential partners, MOH, local government and development partners such as Save the Children, Italian Cooperation, USAID and JHUCCP. This event was the first interaction between HIPS and its implementing partners to critically review progress of activities since inception of the project. During the symposium, HIPS highlighted achievements and successes with its partners in the last three and a half years. As a result, outstanding partners who had implemented all activities on the HIPS "menu of services" were recognized with plaques while the rest of the partners received certificates of recognition for their commitment and dedication in improving access to health services at the workplace and community.

During the symposium it was highlighted that between 2007 and 2011, HIPS and its partners, located in up to 57 districts, have positively impacted the lives of many Ugandans. 110,000 people have received HIV/AIDS Counseling and Testing; 2,000 health providers have been trained; 100 clinics have been accredited for HIV and 38 clinics have been accredited for TB - through closely working with the MOH and NTLP; 30,000 women have been reached through the IPT program; 4,500 Ugandans are on ARVs; 4,000 OVCs have been supported; 450,000 people have been reached with health messages; 28,000 people are receiving palliative care and 40,000 people have accessed family planning products.



Mr. David Eckerson, former USAID Mission Director (2<sup>nd</sup> right), Ms. Barbara Addy-HIPS former Chief of Party (right), Dr. Asuman Lukwago, Permanent Secretary MOH (2<sup>nd</sup> left), and Dr. Akol Zainabu (center) former PM-ACP awarding the best partner companies. Receiving the award (1<sup>st</sup> left) is Kenneth Wanyoto, former Human Resources Manager for Nile Breweries.

Through the various presentations made, the contribution of the private sector in improving access to vital health services to Ugandans was strongly recognized. This was reiterated by the Permanent Secretary of the MOH, who acknowledged the contribution of the private sector and pledged the Ministry's continued support to the sector. He also emphasized the benefits of the PPPH Policy framework whose ultimate goal is to contribute to the strengthening of Uganda's national health systems through close collaboration between the public and private health sectors.

HIPS worked closely with the MOH and the Italian Cooperation in piloting the implementation of the National PPPH Policy in the country. Mpanga Tea, one of HIPS' partners, presented a topic on the benefits of providing health services to company employees and community members, encouraging all the partners out there who have not yet extended health services to the community to do so. International Air Ambulance (IAA), also one of HIPS' partners, was given an opportunity to introduce the new HIV managed care product – an insurance product that was developed as a result of a study conducted by HIPS.

The prominence of FUE and UMA during this symposium gave the partners more confidence in working with the two associations once HIPS exits.

## **Orphans and Vulnerable Children: the M-LISADA Program**

---

Music Life Skills and Destitution Alleviation (M-LISADA) is a largely self-supportive organization that is being directed by former street children. Since 1996, M-LISADA has provided a haven for street children. M-LISADA uses music dance and football to entice children off the streets and place them in a reception center at the M-LISADA Home. In partnership with MTN, Beads for Life, HIPS, and Mildmay, M-LISADA has been able to provide emotional and psychosocial support to children who are destitute through music, dance and football. The individual stories of the children that converge at the M-LISADA center demonstrate the remarkable resilience of the children's human spirit.

Starting in 2006, the MTN Foundation provided financial support to children to attend music classes at the Kampala Music School. By 2011, over 40 children had completed training at the school, with 20 of them completing in 2010. Based on the training they received from Kampala Music School and from other instructors, M-LISADA was able to organize musical performances that were then used to fundraise, advocate and lure children off the streets. The brass band is M-LISADA's major fundraising activity. The cultural group also performs during traditional functions and raises funds to support M-LISADA's activities.

As of June 2011, select M-LISADA youths are instructing Rubaga youth brass band as well as practical music lessons at Namagunga girls primary school and Mengo secondary school. The youths were instructed and trained at Kampala Music School courtesy of MTN Foundation and won certificates in the Associated Board of the Royal Schools of Music awards; an award they receive after excellent performance in music classes. To date, another two M-LISADA graduates are instructors of Rubaga Youth brass band.

M-LISADA continues to provide support services to children living on the streets as an approach to meeting some of their basic needs while they considered leaving the streets. M-LISADA provided over 70 children with clean drinking water, soap and water for washing clothes and bathing. M-LISADA also provides porridge and a resting place for the children during the day.

## Collaborating with the MOH to Support Training of Community and Private Clinic Staff in Kampala District on HIV and TB Control

In Uganda and the world over, HIV/AIDS co-infection is a major factor affecting 50% of TB patients.

The MOH recognizes that approximately 50% of TB cases in the country are in Kampala district, hence the need for partners support to intensify integrated HIV/TB diagnosis and treatment within the district for successful and effective TB control.

In 2011, the HIPS project supported Touch Namuwongo which is the community program of International Medical Foundation/International Hospital Kampala to hold a three day training of 20 Community AIDS and TB Treatment Supporters selected from 10 villages in Kiruddu parish, Makindye Division, in the suburbs of Kampala city.

The training was held at Makindye division local administration headquarters while trainers were from the MOH.

The training equipped participants with knowledge and skills to carry out community sensitization, mobilization identification of patients, referral, and follow up of those receiving treatment at Touch Namuwongo and Kiruddu HC III.

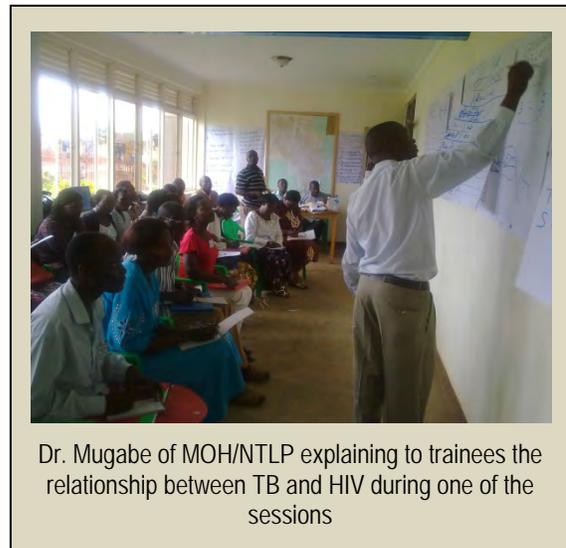
HIPS also facilitated a workshop for the Kampala region private sector facilities offering TB treatment.

The one day workshop was aimed at improving coordination and TB drugs/logistics support among private health facilities by the NTLP of the MOH. The workshop coordinated by the Kampala district/regional TB & Leprosy Supervisor, was attended by 20 TB focal persons representing 20 clinics.

Participants outlined difficulty in accessing TB drugs from the district by the accredited private clinics as their main challenge. The NTLP regional supervisor pointed out failure to adhere to the TB drugs logistics system and non-reporting as the main hindrances for the private facilities to access TB drugs.

The NTLP regional supervisor oriented participants on how to complete the TB drugs request form and promised them assistance whenever contacted.

Participants recommended that NTLP holds quarterly regional meetings to improve coordination, collaboration, follow-up, and continuous education in order to ensure an effective, successful and sustainable TB control program.



## Representing the Interests of the Private Non-State Healthcare Sector in East Africa

---

In 2012, Uganda, Kenya and Tanzania formed national bodies as umbrella organizations representing the interests of the private non-state healthcare sector in their respective countries. Dr. Ian Clarke, Chairman of UHF, Dr. Amit Thakker, Chief Executive Officer of Kenya Healthcare Federation (KHF), and Dr. Samwel Ogillo, Chief Executive Officer of the Association of Private Health Facilities in Tanzania (APHFTA), jointly organized the first ever East Africa Healthcare Federation Conference in Kampala, Uganda. The theme of the conference *Partnerships: Harnessing Opportunities and Innovation* firmed up proposals on the formation of a substantive body representing the healthcare sector in East Africa. The conference provided a forum for exchanging lessons, experiences, challenges and innovations in the private non state health sector. Case studies were drawn from each of the East African countries; painting a picture of what was happening in the region and what opportunities were available.

UHF, with support from HIPS, also hosted its 2<sup>nd</sup> annual general meeting at the beginning of the conference and attained region-wide input and lessons from the participants and invited guests from elsewhere in East Africa. The objectives of the conference included:

- Presentation of the PPPH policy passed by cabinet
- Pooling of resources and coordinated re-distribution to maximize utilization and the sector's growth
- How healthcare organizations could respond to medical technological advances and data collection recommendations
- Formation and concretization of the East Africa Healthcare Federation
- Provision of a networking base through the plenary and conference sessions with an opportunity to foster responsible and balanced debates on issues that affect healthcare

The conference was well attended, with representation from all over East Africa and top ministry officials in Uganda, including the Minister of Health, Dr. Christine Ondo, the Director General, Dr. Jane Acheng, and the Permanent Secretary, Dr. Asuman Lukwago. During the three-day conference, the Institute of Health Policy Management and Research recognized new innovations in the sector. The greatest achievement of the conference was the launch of the East Africa Healthcare



Federation aimed at regionally engaging with governments and participating in policy formulation with particular regard to the private health sector. This was witnessed by the Minister of East Africa Affairs in Uganda, Honorable Eriya Kategaya. East Africa Healthcare Federation will bring together all non-state sectors and stakeholders under one umbrella body for the sole purpose of advocating for policy change.

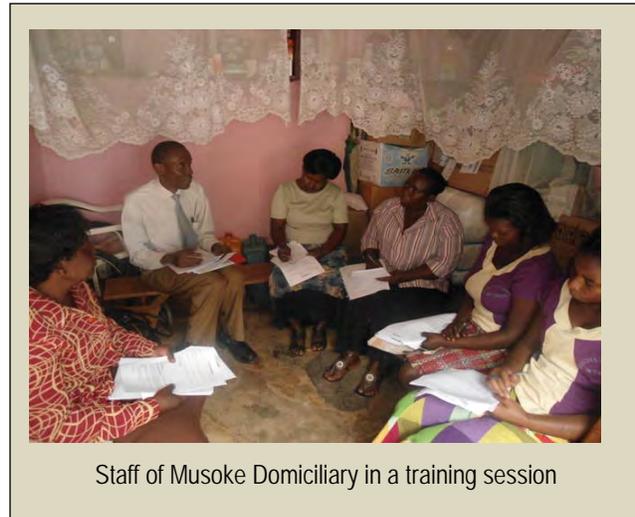
The outcomes of the conference included:

- Greater understanding of the Uganda PPPH policy to be launched this year
- Formation of the East Africa Healthcare Federation
- Recognition of new innovations in the sector
- UHF's 2<sup>nd</sup> annual general meeting
- Regional aligned coordination in the private health sector
- Regional policy exchange, and
- A Conference report

## Supporting the Development Credit Authority

---

In 2012, HIPS undertook a number of activities to aid the startup and smooth progress of the DCA. In January 2012 HIPS held a workshop on Financial Management & Modeling for healthcare providers. This workshop was attended by 35 HIPS clinics represented by clinic owners, accountants and finance officers. The training sought to give the participants a deeper understanding of financial management and an insight on lending from the bank's perspective. In September 2012, another workshop was held for Centenary Bank's lending staff. The bank was chosen to administer loans on behalf of the DCA. The purpose of the bank training was to give lending staff a better understanding of the health sector and point out to them the benefits of lending in the health sector. This would enable the bank view the private health sector as a viable and potential business partner.



Staff of Musoke Domiciliary in a training session

In August 2012, HIPS together with an accounting firm (Finsys Consult) offered training in Financial Management to partner clinics to improve their financial record keeping systems.

The main outcome of the training was to have the accounting firm support the clinics to restructure and guide their financial recording system. The clinics would have to keep records according to the training guidelines to enable them prepare financial statements.

All the clinic owners were eager to receive this training so as to strengthen their systems and controls. At the end, they all agreed it had been helpful in understanding the importance of financial information. As a result of the trainings, the technical capacity of participating clinics had been strengthened as reflected in the improved financial decision making and management skills they acquired.

On December 14<sup>th</sup>, 2012, HIPS together with Centenary Bank held a mini-launch event for the DCA guarantee facility. The goal was to increase publicity for the DCA and link potential beneficiaries to Centenary Bank. A total of 65 people from private clinics, hospitals, USAID and non-US Government implementing partners, medical associations, pharmaceuticals and equipment importers in the private health sector attended. In addition, Centenary Bank gave a presentation on the DCA to the Uganda Medical Practitioners Association during the practitioners' annual Continuous Professional Development Workshop held between December 1<sup>st</sup> and 2<sup>nd</sup>, 2012. A total of 55 medical practitioners attended the workshop. To date, eight private institutions have received loans through the DCA to primarily expand their services. One facility in Kampala borrowed 50 million UGX (\$19,300) and one facility in Arua (Northeast Uganda) borrowed 45 million UGX (\$17,370).

The meetings were a great marketing forum and raised interest from other private health companies, facilities, associations and projects that are not US Government partners. Inquiries about the loan program have been received by both the bank and HIPS. As of 2013, HIPS was working with Centenary Bank to develop marketing materials for the DCA and will participate in health fairs where members of the private health sector fraternity will converge and be guided through the process of applying for a loan.

## **The Nile Breweries Limited/OGAC/HIPS Partnership**

---

*Introduction:* In 2011, HIPS started supporting NBL to implement a three-year program aimed at preventing new HIV infections as well as providing access to care and treatment among vulnerable populations along the NBL supply chain. An incentive fund awarded \$385,000 to NBL for the program. Of this total award value USAID/Uganda contributed \$130,000 while OGAC contributed \$260,000. Through the partnership with HIPS, NBL conducted activities that included training of peer educators, training of hospitality workers, HCT health fairs and support for referral services among other activities. The program supported a broad spectrum of health services in 12 districts across the country where NBL has operations. These districts are Dokolo, Katakwi, Lyantonde, Kapchorwa, Kasese, Hoima, Masindi, Nebbi, Lira, Soroti, Busia and Rakai.

*Beneficiaries:* The program targeted the NBL supply chain which includes smallholder farmers, truck drivers, and bar workers. It supported two clinics in each of the selected districts to provide basic treatment and healthcare services to the target groups. The clinics identified were preferably private clinics operating in areas close to the supply chain; although NBL and HIPS also supported public health center IIs in remote rural areas where there were no private health facilities. Initially, the objectives of the program were:

- To increase access and use of prevention interventions and HCT in the NBL supply chain
- To support the scale up of voluntary home-based couples counseling and testing for smallholder farmers
- To improve clinic capacity and provide training to health workers
- To implement community based peer education programs in support of prevention messages
- To scale up dissemination of anti-alcohol abuse messages for smallholder farmers in remote areas, as well as for bar workers and truckers.

Program activities included:

- Training 600 community based peer educators to provide prevention messages
- Providing HCT to 1,250 truckers, 2,000 bar workers and 3,250 smallholder farmers a year, as well as to their partners
- Conducting health fairs to provide HCT and health information to 15,000 community members through the “four tent” model
- Providing treatment to over 200,000 people in NBL’s catchment population, targeting the most vulnerable groups in NBL’s supply chain
- Providing welfare and nutrition support to PHAs in the program area

*Achievements (as of March 2013):*

**Peer Education:** During the 1<sup>st</sup> year of the program, a total of 390 individuals were trained as peer educators to disseminate health messages and mobilize their communities to access health services. In 2012, 4,775 people were reached with HIV prevention messages and 1,215 people were reached with messages on health topics such as FP/RH, malaria, TB and palliative care.

**HIV Counseling and Testing:** The program has provided VCT/HCT services to a total of 8,580 truckers, bar workers and smallholder farmers. Of these, 4,799 received the service through health fairs while 3,781 were tested through the home-based HCT program in Adok sub county, Dokolo district. The people who tested HIV positive were referred to health facilities which provide HIV care and support services for ongoing support care and case management. During the implementation of these activities NBL distributed a total of 99,400 condoms and 5,000 LLINs.

Through a collaboration arrangement between St. Anne Usuk Health Centre II and Katakwi Hospital, 200 PHAs are now accessing ART services and 80 of these PHAs are receiving welfare and nutrition support through the NBL program.

Treatment and Referral Systems Assessment: Clinical assessments were conducted in Katakwi – Usuk Health Centre, Dokolo – Adok Health Centre, Lira – Loro Health Centre and Amach Health Centre to ascertain the support that the HIPS/NBL program should offer to improve services for their smallholder communities. Support will be given to these health centers in the next program year.

Dissemination of Anti-Alcohol Abuse Messages: Anti-alcohol abuse campaigns were conducted in Katakwi, Dokolo and Kachumbala districts. The campaigns aimed at promoting behavior change for HIV prevention and approximately 3,320 people received the anti-alcohol abuse messages.

## ART Cost and Outcomes Study

Uganda developed a pioneering program under which private clinics accredited by the MOH receive Government or donor funded antiretroviral drugs at no cost, provided that the clinics do not charge for these drugs. The clinics can charge for laboratory tests, consultations or other drugs. Employer based clinics and free standing private providers participate in this program, often receiving technical support from the USAID-funded HIPS project.

This study builds on a previous study of patients during their first 12 months on ART at six selected public and private clinics accredited to provide ART. It analyzes the outcomes and per patient costs at the same clinics in months 12 through 36 of ART. We have estimated the savings to the Government and donors which occur when a patient receives ART at the private clinics.

The study was conducted using a methodology developed by Rosen et al and previously applied to ART facilities in South Africa, Zambia and Kenya. Medical record data were obtained for a sample of patients completing 1-3 years of ART at three public clinics (100 patients per clinic) and three private clinics (50 patients per clinic). This data indicated all drugs dispensed (ARV and non-ARV) as well as lab tests received at these clinics from the 13<sup>th</sup> through the 36<sup>th</sup> month of ART. Unit costs were determined for each drug, test or service, and the fixed costs of the facility allocable to the ART program were added.

Patient outcomes were determined from the medical record, at the end of 24 and 36 months from the start of ART, with patients in the sample classified as:

- No longer in treatment (died or lost to follow up)
- In treatment and not responding (as indicated by CD4 or viral load, or, in the absence of such tests, the presence of a WHO stage 3 or 4 AIDS-defining condition), or in treatment and responding.

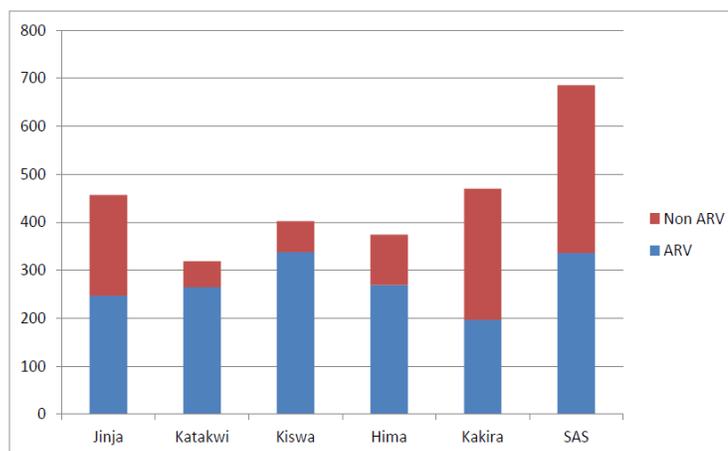
Average treatment costs were determined for each outcome category at each of the six facilities. We calculated the value of the private resources leveraged when patients were treated at private clinics using the publicly supplied ARVs.

The majority of patients had a baseline CD4 count recorded, with the exception of one agricultural employer clinic, where patients were often initiated on ART based on clinical condition alone. Median baseline CD4 count ranged from 109 cells/mm<sup>3</sup> to 209 cells/mm<sup>3</sup>. In our earlier study, patient outcomes in the 1<sup>st</sup> year of treatment were generally good. Between 77% and 88% of patients were in treatment and responding at the end of one year at four clinics. One public clinic had 97% in treatment and responding, and one private clinic had 94%. In this new study, the proportion of patients who started the second year of treatment and finished the third, apparently responding to treatment, varied between 80% and 92%. The annual rate of “attrition” was lower than observed in the first year of treatment.

Treatment regimens were generally similar and consistent with national protocols. Some providers, generally those with higher costs, had a higher percentage of patients on regimens that included efavirenz, tenofovir, or lopinavir. Great variation was observed in the average number of lab tests per patient year.

CD4 tests at all sites were relatively infrequent, with some providers ordering almost none, and all sites in this study ordered less than one per patient year. All clinics had between 10.5 and 13.5 patient visits per year in the first 12 months of ART, but this rate fell to 6.1 to 9.9 visits per patient year in months 12-24

ARV and non-ARV Costs, per Patient, for Care in Months 12-36 of ART (USD)



after treatment initiation, and to 5.4 to 9 visits per year from months 24-36. Employer clinics often had higher visit frequencies than public clinics.

Over the 2<sup>nd</sup> and 3<sup>rd</sup> years of treatment, total cost per patient in treatment and responding varied from a low of \$320 for two years of treatment at the rural public clinic to \$686 at the private urban clinic.

The other two public sites had per patient costs (\$457, \$402) similar to the two employer clinics (\$470, \$374) over the two year period.

The distribution of publicly sourced antiretroviral drugs in Uganda is saving public and donor funds. In the two employer clinics, private resources amounting to \$53 and \$137 per year are expended on the non-ART costs of caring for each patient from months 12 to 36 after treatment initiation. In two public facilities, annual expenditures on items other than ART were lower: \$27 and \$32 per patient-year in this treatment period. But at the 3<sup>rd</sup> public site these costs were \$105 per year. For the 2<sup>nd</sup> and 3<sup>rd</sup> years of ART, the private sector is contributing between 28% and 58% of the total cost of ART when it receives ARVs for free. If the patients were not being treated at these private clinics, the Government would need to expend a minimum of \$27 to \$32 per year to absorb each additional private patient into the public system.

#### Public Sector Savings due to Provision of ART in the Private Sector

Costs per IC patient	Jinja Referral	Katakwi	Kiswa	Hima Cement	Kakira Sugar	SAS Foundation
ARVs	\$247	\$265	\$338	\$269	\$197	\$336
All other costs	\$210	\$54	\$64	\$105	\$273	\$350
Total	\$457	\$320	\$402	\$374	\$470	\$686
% of total cost borne by the private sector				28%	58%	51%