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THE HEALTH INITIATIVES FOR THE PRIVATE SECTOR (HIPS) PROJECT

FINAL EVALUATION REPORT

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REEV Consult

FINAL EVALUATION OF THE HEALTH INITIATIVES FOR THE PRIVATE SECTOR (HIPS) PROJECT
AUGUST 2012-JANUARY 2013

Submitted by:

REEV CONSULT INTERNATIONAL

Prof. Augustus Nuwagaba
Dr. Simon Sentumbwe
Charles Rwangoga
Sam Rutahindwa Bamuhiiga

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Acronyms

ACP	AIDS Control Program
AIC	AIDS Information Centre
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Treatment
ARVs	Antiretroviral Drugs
BCC	Behavioral Change Communication
CBOs	Community Based Organizations
CBVs	Community–Based Volunteers
CDC	Centre for Disease Control
CSR	Corporate Social Responsibility
CYP	Couple years of protection
DBFP	District Budget Framework Paper
DCA	Direct Credit Authority
DDP	District Development Plan
DHO	District Health Officer
DHTs	District Health Teams
DOP	District Operational Plan
DOTS	Directly Observed Treatment
EMG	Emerging Markets Group
FGD	Focus Group Discussion
FP	Family Planning
FUE,	Federation of Uganda Employers Association
GDA	Global Development Alliance
HCT	Home based Counseling and Testing
HCT	Home based Counseling and Testing
HIV	Human Immune Virus
HMIS	Health Management Information System
HSSP	Health Sector Strategic Plan
IAA	International Air Ambulance
IEC	Information, Education and Communication
IGAs	Income Generating Activities
IUDs	Intra-Uterine Devices
JCRC	Joint Clinical Research Centre
JHU	Johns Hopkins University
JMS	Joint Medical Stores
KCCL	Kasese Cobalt Company Ltd
LLINs	Long Lasting Insecticide Treated Nets
LTPM	Long Term and Permanent methods
MCP	Malaria Control Program
MGLSD	Ministry of Gender, Labour, Social Development
MIP	Malaria Treatment and Prevention in Pregnant Mothers
MOH	Ministry of Health
MOUs	Memorandum of Understanding
NGOs	Non-Governmental Organizations
NSHS	National Social Health Insurance Scheme
NTLP	National Tuberculosis and Leprosy Program
OGAC	Global AIDS Coordinator

OVC	Orphans and vulnerable children
PACE	Program for Accessible Health, Communication and Education
PLHA	People Living With HIV/AIDS
PMP	Performance management plan
PMTCT	Prevention of Mother to Child Transmission
PNC	Post-Natal Care
PPP	Public Private Partnership
PPPH	Public Private Partnerships for Health
RH	Reproductive Health
RVZ	Royal Van Zanten
SMC	Safe Male Circumcision
STIs	Sexually Transmitted Infections
SURE	Securing Ugandans' Right to Essential Medicines
T&C	Testing and Counseling
TASO	The AIDS Support Organization
TB	Tuberculosis
TEC	Total Estimated Cost
TPC	Technical Planning Committee
UGACOF	Uganda Coffee factory
UGX	Uganda Shillings
UHF	Uganda Health care Federation
UHMG	Uganda Health Marketing Group
UMA	Uganda Manufacturers Association
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

The health sector in Uganda has been overwhelmed by a growing demand for services. Although there are an adequate number of health units, the services provided in the public sector are often of low quality. As a result, the private sector has played a growing role in providing health services. However, the private sector is disjointed and regulatory frameworks for quality are lacking. Further, no coordination framework exists to support linkages between private and public care. Thus, the significant number of patients seeking care in the private sector may also receive inadequate care.

Contrary to the popular belief that the poor are unable to pay for health services, there is evidence showing that when health care is needed, 36% of the population first seek care in private sector facilities (UNHS[1], 2011). To increase the quantity and quality of health care services available, it is critical to incorporate both the public *and* private sector in quality improvement initiatives. It is against this backdrop that USAID made a strategic decision to support strengthening and expansion of services provided by the private sector as a key intervention.

HIPS is a dynamic project designed to be responsive to the unique demands of supporting the private sector in Uganda. Under this project, HIPS aims to increase access to and use of HIV/AIDS, tuberculosis, reproductive health/family planning (FP) and malaria services through mid and large size employers within the private sector. Working in 57 districts across Uganda, HIPS partnered with over 111 companies and 100 clinics (50% company clinics and 50% private clinics).The strategies HIPS adopted to achieve this objective included: expanding the number of global development alliance (GDAs) partnerships; supporting initiatives to strengthen private sector workers' organizations to support health initiatives; and to implement innovative approaches to support orphans and other vulnerable children through the private sector.

USAID/Uganda commissioned the HIPS project final evaluation in August 2012 to assess the effectiveness of the approaches implemented under the project and identify factors for success.

The final evaluation was designed as a cross-sectional descriptive assessment using mixed methods. Qualitative data was collected through the use of in-depth interviews (106[2]) and focus group discussions with beneficiary groups. Observable findings were recorded. Quantitative data was collected through exit poll interviews with randomly selected facility clients (343).

Findings of this evaluation indicate that HIPS has largely achieved its overall objective of expanding access to key services, including: HIV/AIDS, Tuberculosis (TB) and malaria; as well as reproductive health/family planning by increasing the number of clinics, improving the quality and expanding the menu of services provided.

- As a result of increased number of HIPS supported private sector facilities providing HIV/AIDS testing and counseling services (from 29 in 2008 to 100 in 2012) and increased outreach, over 90,824 clients were counseled, tested and received their results in 2012, a significant increase from 11,441 people tested in 2008.

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[1]Uganda National Household Survey (UNHS), 2010; conducted by the Uganda Bureau of Statistics (UBOS)

[2]The distribution of key informants was as follows: Companies (60); Private Clinics (30); DHOs (8); Ministry of Health (4) and Collaborating Institutions (4). Collaborating institutions included: Federation of Uganda Employers (FUE), Uganda manufacturers Association (UMA); Uganda Health marketing Group (UHMG); Johns Hopkins University and Mildmay

- Through the provision of technical assistance, equipment and brokering partnerships with service providers, HIPS has supported 88 companies to get accredited to provide ART services and 45 companies to provide TB treatment, a service area previously dominated by the public service. HIPS partners have registered a 150% increase in the number of clients *currently* receiving ART services; from 2,363 in 2008 to 5,916 in 2012. HIPS facilitated referrals to clinics where employees could be treated through insurance schemes or direct fee-for-service referral arrangements. The TB case detection rate increased from 30 TB cases in 2008 to 393 TB cases in 2012, reflecting increased screening of patients among HIPS trained providers.
- The number of clients who utilized family planning for the first time increased from 500 in 2008 to 12,137 in 2012. Couple Years Protection (CYP) during that period increased from 934 in 2008 to 43,868 in 2012.
- Through the HIPS partner outlets, 17,986 insecticide treated nets have been distributed to citizens' especially pregnant women and children under 5 years. Free *intermittent presumptive treatment (IPTp) for malaria was provided to* all pregnant women, including company employees, dependents and surrounding communities by HIPS partners.

Peer education and behavioral change communication led by the beneficiary companies and facilities were effectively used to create demand for utilization of services within the companies and neighboring communities. Overall, set targets for the expansion of the different health services were achieved and in many instances exceeded. The absence of comprehensive and up to date data on the scope and operations of the health private sector and a project specific baseline assessment to inform planning may have affected the establishment of ambitious project targets. There were missed opportunities during the two program extensions in 2010 and 2011 to strategically review progress, synthesize emerging lessons to inform adjustments in the program targets. More could have been achieved if these targets had been revised.

To protect the health and productivity of their employees, businesses need to address the continuum between the workplace and surrounding communities. HIPS leveraged private resources to address the needs of Orphans and Vulnerable Children (OVCs) resident in the surrounding communities. By the end of the HIPS program, 4,260 OVCs were exposed to opportunities to strengthen skills and explore improved livelihoods through corporate sponsorship programs (donations to OVC support organizations to support education and nutrition), supply chain out-grower programs (companies purchase crops from OVC households), and market access programs (including formation of grower associations and training to improve quality).

From this evaluation, it is apparent that private companies can and will contribute resources towards private health care initiatives, when presented with clear and compelling evidence. Using evidence from a study on costs of ill health on the productivity of companies, HIPS demonstrated to companies the profitability of investing in health care of their employees. With HIPS support, companies have developed a clear way of assessing the unit cost of providing health services and are now more aware of the impact of health on employee productivity. This was coupled with the use of Global Development Alliance (GDA) as a mechanism for leveraging private sector resources for workplace health programs. GDA partnerships entailed a 1:1 financial and in kind contribution from USAID and the company towards mutual objectives. HIPS increased the number of GDA partnerships from 5 to 52 by 2012 mobilizing over $1.9 million from the companies, 90% more funds than had been anticipated. To date, 83% of these GDAs are currently active. Anecdotal evidence showed that the minimum requirement of $5000 locked out some potential partners.

Umbrella organizations like Uganda Manufacturers Association (UMA) and the Federation of Uganda Employees (FUE) are strategic entry points towards mobilizing affiliate companies to commit resources

and sustain health initiatives in the private sector.These organizations represent important sustainability mechanisms. HIPS has worked with these organizations to build their capacity as lead providers of workplace health programs to their member organizations. Through their newly established health business development units, UMA and FUE are mobilizing resources from affiliate companies and other development partners. These resources will facilitate continuous capacity building for health programs within the affiliate companies even after the close of HIPS. By 2012, 63% of HIPS active partners were receiving support formerly provided by HIPS. 30 partners are already paying for services directly from UMA and FUE which is an indication of their demand for their services. The noted challenge has been the ability of UMA and FUE to attract long term funding for the workplace activities. FUE and UMA membership is only limited to companies and excludes some of the private health facilities. This means that these facilities will not be able to access the support including the capacity building initiatives being provided by UMA and FUE after the close of HIPS.

Private sector capacity to provide services has been improved as demonstrated by the increase in services provided to different target groups and the satisfaction of clients with the quality of these services. This has been achieved through targeted training and mentoring of staff, provision of critical equipment, brokering of partnerships with service providers and increasing partnerships with the key service providers. 82% of HIPS supported companies have developed and are implementing HIV workplace policies that provide a framework and resources for companies to implement workplace health programs and protect employees against discrimination. Improved reporting of private sector contribution towards health outcomes is being achieved through a mobile technology platform to report performance information, monitor stock outs and share health information. New equipment provided by HIPS on a cost share basis in 57 companies has created ownership and supported the expansion of menu of services provided and improved quality and utilization of services. 95%of clients interviewed in the exit polls said they were satisfied with the quality of services received in the company clinics and private facilities. Only 5% reported dis-satisfaction. Clients of private clinics were more satisfied (65%) as compared 29% of clients at company clinics. This is evidence of the increasing role of the private clinics in providing quality health services and justifies the need for continued support.

Staff attrition, irregular supplies of key commodities like ARVs and costs of services are still key constraints to ensuring a sustained provision and use of services provided by the private sector. Nearly 2 of every 3 company clinics and private facility staff members trained under the HIPS program has left the job. Drug stock outs of ARVs and TB policy restrictions in 2010-2011 and still occurring irregularities in drug supply affect service provision and long time commitment of the private sector facilities to provide some of these critical services. 45% of the accredited companies to provide ARTs are not doing so partly due to staffing problems and drug shortages. Over 28.5% of clients in the exit polls determined that cost was one of the barriers to using the services provided by these facilities.

With the support of HIPS, the Public Private Partnerships for Health (PPP-H) policy was passed in 2012 to create a more conducive environment for the private sector to contribute significantly to health service delivery. The newly created PPP unit in the MoH will need ongoing support to ensure successful operationalization of the PPP-H policy at various levels.

Within the private sector itself, important strides have been made in establishing a coordinating body and a voice for the sector. HIPS supported the creation of the Uganda Health Federation (UHF) in 2011 bringing together existing private sector health entities under one umbrella recognized by government. UHF is now working together with different stakeholders to develop a sound regulatory framework and standards for quality of care in the private sector. UHF is expected to play a critical role in the roll out of these standards amongst its members once the process is completed. Sustainability of HIPS supported initiatives in improving the quality of services in the private sector will be dependent on the capacity of

the UHF. UHF will continue to need support in expanding its membership and rolling out the self-regulatory mechanism once completed.

Several important factors facilitated HIPS' success. First, there was a strong project design from the outset, which made it easier to secure buy-in from key stakeholders. The design promoted a model where each party contributes according to their resources and market leverage. Secondly, HIPS supported existing MoH policies and plans, working to help government achieve goals already outlined in the national strategic plans. Finally, HIPS had a strong operational focus, working to broker partnerships as a key strategy, ensuring partners worked together to achieve important project goals.

Key recommendations for future private sector strengthening initiatives in Uganda include:

1. USAID and other developing partners should continue to support both company clinics and private clinics because of their different, yet synergistic approaches to service delivery. For example, private clinics largely serve paying clients, mainly in the more urban settings. Company clinics, on the other hand, mainly serve employees, their dependents, and lower income members of the surrounding communities, often in rural areas.

2. GDA partnerships to leverage private sector resources were very successful and should be scaled up in related future programming by USAID.

3. Performance based grants should be introduced for private clinics to ensure full utilization of the capacity built by programs like HIPS. Within a regulatory structure that promotes quality, performance based grants ensure that providers continue to expand services while maintaining national standards for care. In addition, incentives for quality performance can be used to motivate staff and mitigate staff attrition.

4. To facilitate stronger public-private partnerships at the national level, the MoH together with USAID and other development partners should strengthen the PPP Unit in the roll-out of the PPP-H policy at both national and district levels over the coming years.

5. Future programming in health for the private sector should continue to support UHF as a critical platform to improve coordination and build on current efforts in improving regulation and quality of care within the private sector.

6. Future projects implemented by USAID should invest in conducting an inventory of private health facilities and a detailed baseline assessment to establish better the scope and depth of their interventions to inform more realistic project benchmarks. A cost-benefit analysis (CBA) / cost effectiveness analysis to establish value for money and return on investment for similar initiatives would be instrumental in mobilizing support for investments in the health private sector.

1. BACKGROUND, EVALUATION PURPOSE, EVALUATION QUESTIONS

1.1 Project Background

The health sector in Uganda has been overwhelmed by a growing demand for services. Health service delivery has been dominated by a strained public sector. Although there are an adequate number of health units, the services provided in the public sector are often of low quality. As a result, the private sector has played a growing role in providing health services. However, the private sector is disjointed and regulatory frameworks for standardizing quality of care are lacking. The situation is exacerbated by the diverse nature of private sector establishments and weak country systems for enforcing standards of practice. There is no formal coordination framework to support linkages between private and public care. Thus, the significant number of patients seeking care in the private sector may also receive inadequate care.

A Survey of Private Health Facilities in Uganda (2005) reported 2,156 registered private clinics, excluding drug shops, whereby 68 percent of them are in the central region and Kampala alone, which accounts for 45 percent of all private clinics in the country. Over 90 percent of private clinics provide outpatient curative services. Although health infrastructure in the private sector has expanded, the vast majority of health facilities is not fully functional, lack equipment and staff, and is poorly maintained.

Contrary to the popular belief that the poor are unable to pay for health services, there is evidence showing that when health care is needed, 36% of the population first seek care in private sector facilities (UNHS[3], 2011). Clearly, the private sector is filling an important gap in provision of health services. To increase the quantity and quality of health care services available, it is critical to incorporate both the public *and* private sector in quality improvement initiatives.

The Ministry of Health (MOH) in Uganda has recognized the significance of the private sector. MOH acknowledges the role of private sector as a major partner in national health development and service delivery in the Health Sector Strategic Plan (HSSP) III.

It is against this backdrop that USAID made a strategic decision to support strengthening and expansion of services provided by the private sector as a key intervention point. USAID interventions in the private sector were first piloted under the BUSINESS PART program (November 2004 to September 2007) partnering with five companies to provide HIV/AIDS services. On October 1, 2007, the USAID Uganda Mission signed a $8,689,764 three year contract, with Emerging Markets Group (EMG) Limited to engage the private sector through a new Health Initiatives for Private Sector program (HIPS) with the option of two additional years. This project has since been extended twice to now end on March 31, 2013 bringing the Total Estimated cost (TEC) to $17,189,764.

The goal of the HIPS project is to improve access and utilization of health services. HIPS is a dynamic project designed to be responsive to the unique demands of supporting the private sector in Uganda. Under this project, HIPS aims to increase access to and use of HIV/AIDS, tuberculosis, reproductive health/family planning (FP) and malaria services through mid and large size employers within the private sector targeting company employees, their dependents and surrounding communities.

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[3]Uganda National Household Survey (UNHS), 2010; conducted by the Uganda Bureau of Statistics (UBOS)

HIPS works in 57 districts across Uganda, partnering with over 111 companies and 100 clinics (50% company clinics and 50% private clinics). The detailed coverage map is attached as part of Annex 1.

As the first comprehensive health private sector program in USAID/Uganda, HIPS provides valuable lessons on best practices and approaches that can be integrated in future programming within the Mission and the Ministry of Health to support national efforts in strengthening the health private sector to provide accessible and quality health services to the citizens of Uganda.

1.2 Purpose of the Evaluation

USAID/Uganda commissioned the HIPS project final evaluation in August 2012 to assess the effectiveness of the approaches implemented under the project and identify factors for success. Specifically, the evaluation aimed to:

a) Assess the effectiveness of approaches implemented under HIPS and factors for success;
b) Document what worked well and what could have been done better, as well as limitations and challenges;
c) Establish lessons learned and good practices that can be adopted and scaled up; and
d) Generate information to inform the design of future programs by USAID and the Government of Uganda.

1.3 Evaluation Questions

The final evaluation of the HIPS project answered the following questions:

1. Have the desired results been achieved?
2. Has HIPS effectively addressed the capacity building and service delivery needs of a challenging private sector environment?
3. How effective has HIPS been in strengthening existing private sector coordination structures and partnerships between the public sector and government bodies at the national and district level?
4. What are the most effective approaches and innovations that should be scaled up? What factors will contribute to the success of these approaches?
5. What factors have contributed to success or failure of the project – what worked or did not work?
6. To what extent has HIPS strengthened the sustainability of private companies/entities and their ability to continue to provide health services after the close of the program?

A detailed SOW is contained in Annex 2.

1.4 Evaluation Methods and Limitations

1.4.1 Evaluation Design

The final evaluation study was designed as a cross-sectional descriptive assessment, analyzing inter-linkages between program processes, outputs and outcomes.

1.4.2 Methods of Data Collection

The study used mixed methods to collect data. The use of mixed methods was to enable triangulation of data from different sources hence validating the authenticity of the data.

Qualitative data was collected through the use of in-depth interviews (106) and focus group discussions (6). Key informants included: the HIPS implementation team, In-Charges of the health facilities (head

staff); District Health Officers; Ministry of Health Officials; Human Resource Managers of beneficiary companies; officials of Uganda Manufacturers Association (UMA) and Federation of Uganda Employers (FUE); and training officers at Mildmay Uganda. Interviews were also conducted with the relevant USAID staff.

The evaluation team conducted focus group discussions with several groups representing women, men and youth at the Kakira Sugar Works sites in Jinja and at the Farmers Centre in Lira. Observable findings were also recorded.

Qualitative data was augmented with quantitative data collected through exit polls with facility clients. Three hundred forty three (343) interviews were conducted with randomly selected clients at facilities visited. Primary data from the field was triangulated with information from secondary sources for comparison purposes and validation. Relevant documents were accessed from the various stakeholders and reviewed for this purpose.

A purposive sample of 60 facilities involved in the project (30 company clinics and 30 private clinics) was drawn for collection of facility level data. The main criteria for selection included: location of facilities (rural/urban), service delivery mix (prevention, treatment, care and support for HIV, TB, malaria & reproductive health services); and type of health facility (company/private clinics).

Detailed information on the participants in the in depth interviews and focus group discussions, list of documents reviewed, summary of health facilities sampled can be found in Annex 3-7.

1.4.4 Data Management and Analysis

Different methods of data analysis were used. These included: content analysis (for secondary sources); thematic analysis (for key informant interviews and focus group discussions); and descriptive analysis (for client exit interviews).

1.4.5 Limitations of the Evaluation

- Busy schedule of key informants at the health service delivery points
  Key informants interviewed as part of this evaluation were often the in-charges of the health facility or service point. The health facilities had a backlog of patients waiting to be seen. As a result, health workers divided their available time between the patient and our interviewer. This limited the interview time available. To address this limitation, the evaluation team followed-up by phone when interviews could not be completed at a single sitting.
- High staff turnover, resulting in difficulty in tracing health workers that were trained under HIPS
  Two out of three health workers trained under HIPS had changed employers by the time the project was complete. The turnover was reportedly due to better opportunities elsewhere. The consulting team endeavored to locate the respondents who had changed work places, but this was not always possible, as contact information (such as cell phone numbers and primary residence) had changed.
- Stigma related to HIV and TB led many clients to decline interviews or limit their responses.
  Consequently, 343 clients out of the originally planned 480 clients were interviewed. To address this challenge, the team worked to build a stronger rapport with clients before asking sensitive questions.

These limitations notwithstanding, the consulting team obtained sufficient information for the evaluation.

2. FINDINGS

2.1. Were the Desired Results Achieved?

The core objective of the HIPS project was to increase access and uptake of key health services, HIV, tuberculosis, reproductive health, family planning (RH/FP) and malaria)through medium and large size employers within the private sector. To achieve this objective, HIPS project sought to undertake the following tasks:

i) Expand and strengthen access to and utilization of health and HIV/AIDS services in the private sector;
ii) Expand the number of Global Development Alliance (GDA) partnerships;
iii) Support initiatives to strengthen the capacity of private sector organizations to support health initiatives;
iv) Implement innovative approaches to support orphans and other vulnerable children through the private sector

2.1.1 Expanding and strengthening access to and utilization of health and HIV/AIDS services in the private sector.

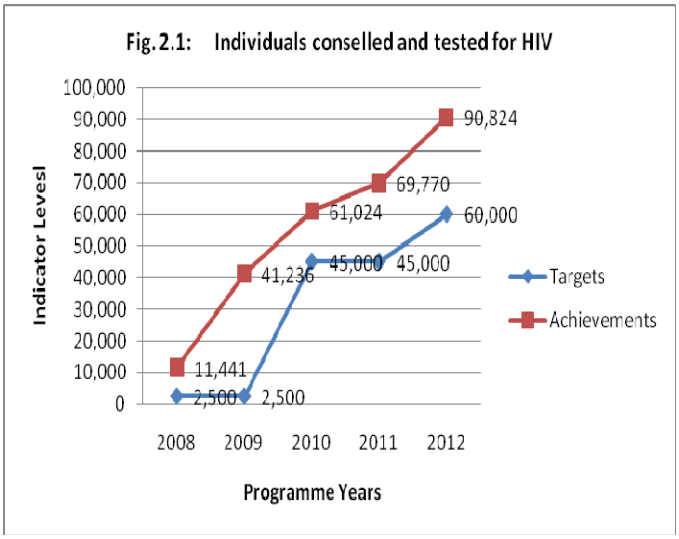
Unlike the previous Business PART program that focused on only HIV/AIDS, the HIPS approach towards expanding access of services provided by private sector was to enable them provide a holistic package of preventive and curative care (including palliative care)centered around HIV, TB, malaria and RH/ FP. By 2012, over 80% of the supported health facilities were providing an integrated health care package comprising: HIV treatment and care services; TB screening and/or treatment; malaria prevention and treatment for pregnant mothers; and RH/family planning services. HIPS provided a combination of training and capacity building support, equipment, brokering of partnerships and linkages with relevant service providers all geared at enabling the partner company clinics and private for profit facilities provide accessible and quality health services.

a) HIV/AIDS

HIV Testing and Counseling

By 2012, 100 of the HIPS supported facilities were providing testing and counseling services, up from 29 sites in 2008. Over 90,824 clients have been counseled, tested and received their results, a significant increase from 11,441 people tested in 2008. 51% of the clients were male, 49 % female. Over 90% off the clients were over 18 years. Some focus has been made over the years to target most at risk populations like fishing communities, truck drivers and bar workers. These results are reflective of similar improvements in HCT from the 2011 Uganda Aids Indicator Survey that showed that the proportion of women age 15-49 that have ever been tested for HIV and received results has increased from 13% in 2004/5 to 66% in 2011 and for men from 11% to 45%. Counseling and testing achievements exceeded the performance management plan

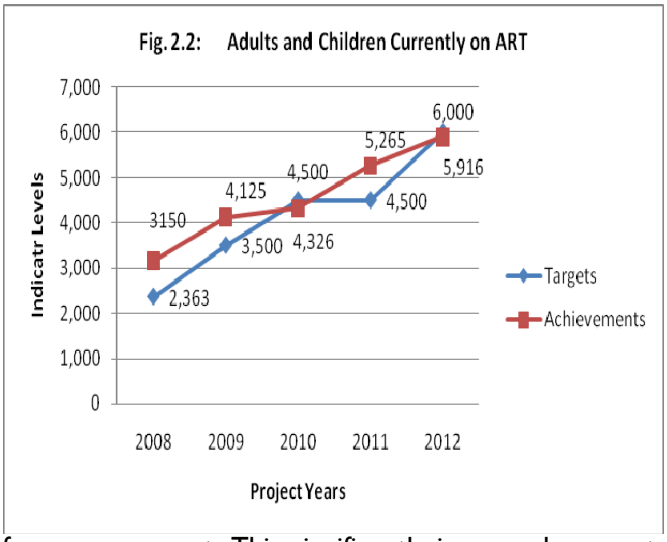
Fig. 2.1: Individuals conselled and tested for HIV



targets annually. The HIPS project facilitated the training of 289 counselors by the AIDS Information Centre. The high level of achievement was also enabled by VCT outreaches in the surrounding communities conducted by company supported clinics.

HIV treatment

Uganda has experienced high HIV prevalence levels over the past twenty years, increasing from 6.4 percent in 2004/5 to 7.3 percent in 2011. This heavy burden demands substantial investment in ART treatment to reduce the HIV related mortalities. Prior to 2008, provision of ART services was the domain of the public sector. With the MoH already accrediting private facilities to provide HIV/AIDS services, USAID has invested in strengthening capacities of the private companies to build their eligibility for accreditation and thereby ability to provide services. HIPS trained staff and supported clinics to secure equipment and infrastructure necessary for provision of quality services in accordance with the national standards. By 2012, HIPS had expanded the number of accredited facilities to 100 (63% company clinics, 37% private clinics) from 19 achieved by BUSINESS PART to provide ART. Accreditation also implies access to free drugs from government. This significantly increased access to quality HIV/AIDS treatment services that meet national standards. ART sites accredited with HIPS support are located across 57 districts of Uganda. These initiatives supported existing MoH plans to accredit private clinics.

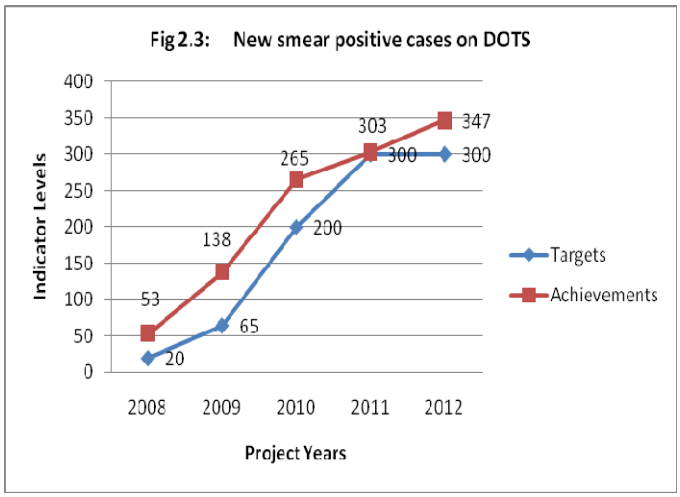


HIPS-supported facilities registered 134.5% increase in the number of adults and children who had *ever started* on ART over the course of the program. The number currently on ART increased from 2,363 in 2008 to 5,916 in 2012 including HIV positive women who received ARVs for Prevention of Mother to Child Transmission (PMTCT) services. This reflects a 150% increase in the number of clients *currently* receiving these services among HIPS partner clinics over the course of the project. In order to increase access to HIV treatment services, HIPS facilitated linkages between companies with small or no on-site treatment clinics to organizations that could manage or provide these services. Insurance agencies like IAA and Microcare took over management of health services of selected companies i.e. KCCL, RVZ, Hima Cement, and UGACOF. Similarly, HIPS has helped companies identify clinics for companies to refer their employees to, sometimes involving insurance schemes or direct fee-for-service referral arrangements.

Currently, only 55% of the accredited company clinics / private facilities are providing ART due to the unreliability of ARVs and loss of trained staff. This has affected the availability of services. More on these issues is discussed in subsequent sections.

b) Tuberculosis (TB)

In Uganda, the authority to approve facilities to dispense TB drugs is provided by the National Tuberculosis and Leprosy Program of the MOH (NTLP) and thus the need for accreditation. Between 2008 and 2012, HIPS supported accreditation of 45 private and company clinics to offer TB-DOTS services in accordance with national standards. The program experienced challenges during some periods (2009-2011) in achieving its targets due to policy restrictions from the NTLP that affected the supply of TB drugs to private sector facilities and thus affecting the pace of accreditation. To date, only the 45 facilities are accessing drugs from the public sector. Nevertheless, during the period 2008-2012, 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 as illustrated in Fig.2.3. TB case detection increased from 30 TB cases in 2008 to 393 TB cases in 2012, reflecting increased screening of patients among HIPS trained providers.



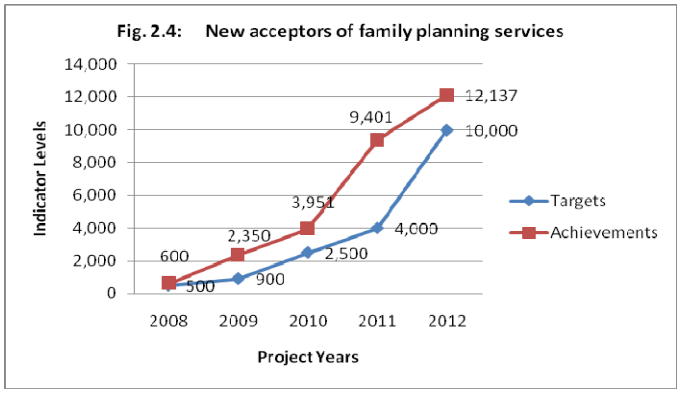
c) Malaria

HIPS partnered with the Presidential Malaria Initiative to provide intermittent preventive therapy (IPT); rapid diagnostic tests (RDT); and insecticide treated mosquito nets (ITNs). HIPS linked partner companies to UHMG and PACE, for procurement of subsidized ITNs that were then either distributed or sold to company employees. The number of ITNs distributed increased from 685 in 2008 to 17,986 in 2012 (. Pregnant women and children under 5 years were targeted to receive ITNs.

Additionally, in partnership with the MoH and district government, HIPS scaled up intermittent presumptive treatment (IPTp) for malaria among partner ANC clinics. The clinics provided free IPTp services to all pregnant women, including partner company employees, dependents and surrounding communities. HIPS also procured commodities for IPT Program including Fansidar tablets, disposable cups, water vessels and aqua safe tablets that were used at the ANC clinics. Further, partner facilities were monitored to ensure presence of sufficient stocks. The number of women who received 2 or more doses of IPTp increased from 685 in 2008 to 17,986 among clients in partner clinics**.**

d) Reproductive Health/Family Planning

The number of clients who attended family planning sessions at HIPS partner clinics and received information on birth spacing, 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 500 in 2008 to 12,137 in 2012. This huge shift confirms the large unmet need for family planning and reproductive health services in Uganda, estimated at (41%) in 2011 (Reproductive



Health Uganda, 2011). Couple Years Protection (CYP[4]) during that period increased from 934 in 2008 to 43,868 in 2012.

Achievements in service utilization have greatly been affected by the peer education. Company clinics provided peer education which created demand among surrounding communities. Peer education was done through community volunteers and company peer educators to sensitize employees and communities to:

i) seek services
ii) reduce HIV/AIDS and TB related stigma;
iii) accept VCT and TB treatment.

The demand created by peer education for services was evidenced during in-depth interviews among clients. For example:

> *At first, I did not want to be identified as a PLWHIV until I was helped by my colleague at work, who encouraged me to test and be able to receive treatment (ART) in case I was found HIV positive. – employee of Kakira Sugar Works Clinic, September 2012*

> *For me, I contracted TB but had not known of my status. I was advised to undertake TB screening which I did after a long time of denial. I was tested and that is when I found that had contracted TB. I am very happy that I received treatment. I now encourage people to test and know their status since they will receive free treatment. –client of Mpanga Growers' Tea Factory Clinic*

The peer education strategy was very effective because it was cheaper for the companies as the peers were workers who acted as volunteers. Workers opened up more easily to their friends/peers about their health than they would, to unknown people. The peer educators convincingly advised their affected colleagues to seek services. Peer education, therefore in most cases, led to increased utilization of services. A study[5] conducted by HIPS in 2011 among ten (10) partner companies found a strong correlation between peer education and service utilization.

To further increase demand for services, HIPS worked with the companies and clinics to provide employee and community sensitization on HIV/AIDS, TB, malaria and RH/FP. Recipient companies predominantly paid for printing of materials while HIPS provided technical assistance. An analysis of project reports shows that estimated 60,000-170,000 community members were reached annually through health fairs and exposure to health messages promoting behavior change.

Overall, set targets for the expansion of the different health services were achieved and in many instances exceeded. The absence of comprehensive and up to date data on the scope and operations of the health private sector and a project specific baseline assessment to inform planning may have affected the establishment of ambitious project targets. There were missed opportunities during the two program extensions in 2010 and 2011 to strategically review progress, synthesize emerging lessons to inform adjustments in the program targets. This challenge could also have been mitigated through a

[4]Couple years of protection (CYP), estimated as protection provided by contraceptive methods during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients

[5] Behavioral Change Communication (BCC) Best Practices Study, 2011

more in-depth participatory planning process with stakeholders at project inception and a formal mid-term review to revise targets.

2.1.2 Expanding the Number of Global Development Alliance (GDA) Partnerships.

The Global Development Alliance (GDA) is a market-based business model for partnerships between the public and private sectors to address jointly defined business and development objectives. Alliances are co-designed, co-funded, and co-managed by partners so that the risks, responsibilities, and rewards of partnership are equally shared.

A well-constructed GDA furthers the objectives of the USAID mission while benefiting the business interests of the resource partner. A partnership is considered a GDA when it meets the following criteria:

- At least 1:1 leverage (in cash and in-kind) of USAID resources;
- Common goals defined for all partners;
- Jointly-defined solution to a social or economic development problem;
- Non-traditional resource partners (companies, foundations, etc.);
- Shared resources, risks and results, with a preference for increased scale of impact; and
- Innovative, sustainable approaches to development.

HIPS GDA partnerships were governed by MOUs and/or subcontracting agreements that clearly articulated each partner's roles and responsibilities and outlined a cost structure for services, including each partner's financial and in kind contribution—with a minimum of 1:1 resource matching.

The GDA partnerships approach was modeled on Business PART[6] that had MoUs with five private companies. The GDA approach was essentially a way to leverage private sector resources (in addition to donor funds) for health initiatives targeting not only employees, but also their dependents and the surrounding communities.

The number of GDA partnerships increased from 5 under Business PART to 55 through HIPS by 2012. Currently 46 (83%) of the GDA partnerships are currently active[7]. Through HIPS, $1 million USD was used to leverage $1.9 million USD from the private sector. However, anecdotal evidence showed that the minimum requirement of contributing $5,000 (1:1 cost sharing requirement) could have locked out some potential partners who were unable to meet this criterion. Other partnerships have fallen out along way due to failure to meet the requirements set out in the MoUs.

Using the disease cost calculator, HIPS was able to demonstrate to private companies that it was more profitable to invest in health care for their employees, rather than incur financial losses associated with prolonged absenteeism, death, low productivity and attrition; culminating in constant recruitment and training of new staff.

[7] GDA partnerships are renewed annually based on extent to which mutual obligations are being met including the investing the minimum requirement of USD 5000

HIPS conducted research[8] to establish the actual cost of ill-health to company productivity. The outcomes suggested that companies with larger numbers of employees were more vulnerable to costs associated with ill-health, particularly those with many low-cadre workers. In addition, some companies had stronger ties with the community that made community health a higher priority. For example, most companies in the agricultural sector had important linkages with communities through out-grower schemes. Based on the evidence that ill-health among employees leads to higher costs for the company, businesses were convinced to commit more resources and engage with the HIPS project to improve the health of employees, their dependents and the community. Through the GDAs, HIPS was able to leverage 1.9 million from the private sector; 90% more than anticipated.

CEOs and Business Leader days were instrumental in exposing the specific organization leaders to the array of services their companies could benefit from if part of a GDA and helping them to appreciate the benefits that would accrue to their organizations. 94 CEOs and 136 members of companies' top managements were involved in these events over the years. Indeed, the consulting team found that CEOs who participated in these days appreciated the role of VCT and supported their organizations to benefit from HIPS project.

HIPS worked with the Uganda Manufacturers Association (UMA) and the Federation of Uganda Employees (FUE) to broker alliances with their member organizations and encourage them to enlist for the GDA partnerships. Both these organizations are extremely strategic as they bring together a wide membership of private sector organizations and employees in Uganda.

2.1.3 Supporting Initiatives to Strengthen the Private Sector Workers' Organizations to Support Health Initiatives

HIPS worked through the Uganda Manufacturers Association (UMA) and the Federation of Uganda Employees (FUE), the lead employment organizations to build their capacity as lead providers of workplace health programs to their member organizations. UMA and FUE were seen as strategic entry points to their affiliate companies. HIPS encouraged partners to affiliate to UMA or and FUE regardless the companies' capacity to raise the $ 5,000 contribution to become GDAs.

Under this arrangement, companies affiliated to UMA (22) and FUE (40) joined the partnership[9]. (see Annex 10 for details). The HIPS project emphasized strengthening the institutional, financial and programmatic capacities of partner organizations for efficient delivery and sustainability of services.

UMA and FUE were strengthened to support workplace health programs in their member organizations. This has included provision of training in non-clinical services including health promotion and preventive services for HIV, TB, malaria and RH/FP and other health services. With HIPS support, both organizations have now established health business development units to mobilize resources for continued capacity building of member organizations and service delivery after the close of HIPS project.

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[8]A study (The Impact of ART on Employer Costs Related to AIDS) by Paul Bukuluki, 2009found that the average annual cost of ART to a partner company is 0.13% % of the total annual cost of labour, compared to 0.14% (of the total annual cost of labour) attributable to worker attrition

[9] Note that a partner company was free to affiliate to either UMA or FUE or both.

As indicated in Table 2.1, both FUE and UMA have generated USD 63,056 and 42,504 respectively from workplace health activities throughout the project life. HIPS also built capacity of partner organizations to attract funding from other development partners for health activities. For instance, FUE generated USD 141,280 in grants over the final 3 years of the project; GTZ (7,680); Uganda AIDS Commission (46,880); Respond (62,400); and ILO (26,400). The developed capacity of FUE and UMA helps build sustainability beyond the life of the HIPS project.

Table 2.1: Revenue from FUE and UMA Workplace Health Activities

Year	Organizations Revenue (US $)	
	FUE	**UMA**
2008		
2009		5,292
2010	12,240	6,080
2011	24,426	7,738
2012	26,390	23,394
Total	**63,056**	**42,504**

However, the FUE and UMA membership is only limited to companies and excludes some of the private health facilities. This means that these facilities will not be able to access the support including the capacity building initiatives being implemented by UMA and FUE after the close of HIPS. The Uganda Health Federation (UHF) described later becomes an entry point then to rolling out support to the private for profit facilities.

2.1.4 Innovative Approaches to Support Orphans and other Vulnerable Children through the Private Sector

To protect the health and ensure productivity of their employees, businesses need to address the continuum between the workplace and surrounding communities. Recognizing the value in this comprehensive view of corporate citizenship, HIPS engaged companies to sponsor disease awareness, prevention, testing and treatment activities in the surrounding communities. Further, HIPS extended OVC programs to the communities where employees and their families live. Since companies source their labor from these surrounding communities, better health for the community means better health for employees and their dependents.

HIPS involvement in care and support for OVCs focused on using partnerships with private companies to leverage resources through Corporate Social Responsibility (CSR) strategies. 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, ensuring that appropriate strategies were used to reach beneficiaries.

HIPS provided matching grants to corporate donations for implementation of OVC activities. In addition HIPS provided technical direction and capacity building for implementing organizations. HIPS monitored the activities to ensure quality service delivery and compliance with the National Strategic Program/ Plan of Interventions for OVC.

By 2012, 4,260 OVCs have been exposed to opportunities to strengthen skills and explore improved livelihoods. With increased household incomes, OVCs may be better able to access services from private health facilities and improve household nutrition. Each of the models is described in more detail below.

a) The Corporate Sponsorship Model

The private sector partners provide cash and in-kind support to OVC implementing organizations as part of their corporate social responsibility (CSR) program. HIPS then provides matching grants to leverage the private sector resources. HIPS matched those corporate contributions 1:1. This arrangement enhanced access to education and nutrition services for 3,273 children, of whom 1,599 were male, while 1,674 were female. Education assistance included the purchase and distribution of scholastic materials, and follow up of OVC at school to ensure regular school attendance and to minimize school dropout, hence improving children's access to education. Food and nutrition interventions focused on enhancing access to food, improved farming methods, school feeding programs and setting up demonstration gardens at school and in the community. In addition, OVC were provided with psychosocial support, health care services, and apprenticeship skills training.

Partners used sports, debates, poems and one–to-one peer support to reach vulnerable children. Through these approaches, the children were able to develop their communication skills, learn more about sexual and reproductive health, decision making, and HIV and AIDS.

HIPS built the capacity of 11 partners in basic financial management, resource mobilization and project planning and management among others: Kakira Sugar Works (KORD), Cornerstone Development (African Children' Mission), Kinyara Sugar Ltd (Kinyara Client Group), Bead for Life, Caring Hands, Mpongo Company Ltd (Fishing Communities Health Initiatives), and Farmers' Center. Capacity building for organizations supporting OVC helps build sustainability beyond the life of the HIPS project.

b) Supply Chain Out-growers Model

The supply chain out-growers model worked well for smallholder farmers who produce raw materials for industries. The company worked through established infrastructure, such as farmer associations and out grower associations to help identify OVC households. The model links individual farmers who produce raw materials into the company's supply chain, thereby keeping more small-scale farmers in business while supplying needed materials to companies. Out growers associations (544 members, 261 males/283 females) supported by KORD earned USD 511,094 from sales over the project life as indicated in Table 2.2. Farmers also received key information on income generating activities to improve their livelihoods.

Table 2.2: Revenue earned by Out growers through KORD

Year	Revenue (USD)
2008	88,113
2009	123,585
2010	137,283
2011	136,679
2012	113,547
Total	**511,094**

To further improve the economic independence and livelihoods of OVC families, HIPs has through the farmer and out grower associations' encourgaed OVC caretakers to form Village Savings and Loan Associations (VSLA) to increase access to credit for income generating activities and addressing other socio-economic needs. By 2012, 42 VSLA have been established under the program. These groups have managed to mobilize total savings of Uganda Shillings 18, 68,600 (HIPS Annual Report 2012). At the KORD, an out-growers youth group acquired a jaggery mill and a maize mill; while the women out growers group bought a 6-acre piece of land with profits from the village savings and loans association (VSLA).Box 2.1 narrates the success story of Kyabaja Tobona group that benefited from OVC programs implemented Kakira Out-growers Rural Development (KORD).

Kyabaja Tobona' group was supported under the Kakira Sugar Works/KORD Partnership. With 30 members, the group began its first round of activities in April 2010 after receiving training in VSLA. During weekly meetings, members contribute UGX 200 for to the welfare fund and UGX 1,000 as mandatory savings with a maximum of UGX 5,000, which is counted as shares. Each share of UGX 1,000 is stamped into the pass book with a total of five shares maximum per member.

By the end of the 1st cycle, the group had collected UGX 320,000 as welfare funds and UGX 6,426,750 as savings. With support from the Community Development Officer, the shares due to each group member were calculated and recorded, and the members decided not to share out, but to use the savings to buy a younsel mill worth Ushs 4,500,000. The younsel mill was to be used to add value to the sugar cane they produce by making molasses. The group decided to use the balance of the funds to rent 10 acres of land for six years - an undertaking that cost them UGX 3,000,000. The group had planted sugarcane and intercropped it with maize on this land.

The group was in the process of registering a CBO under the name "Busalaama Sugarcane Growers Association". This, they said, would enable them access funding and support as a group. The group commenced the second cycle of saving and loans in June 2011, and had saved UGX 1,487,700. The group's future plans included buying a lorry to transport their sugar cane and production of molasses for which they had ready market in Lira. The group also nurtured two other groups - "Tibakwina" and "Kibike Kiryamugenzi" - each with 30 members, who were also engaged in VSLA activities.

These achievements (jaggery mill, maize mill, land and an established VSLA) will be sources of financial sustenance for their programs. In addition, to economic empowerment, HIPS used these groups to disseminate health messages. These included messages on prevention of HIV/AIDS, VCT, prevention and mitigation of child labor.

c) The Market Access Model

The market access model was focused on helping OVC households develop capability to produce for the markets as a way of strengthening the social economic security of the household. Over the 5-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. The implementing partner, in turn, worked directly with OVC households to build their capacity to produce for the market including training and monitoring. 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 the OVC activities.

Through the Market Access Model, Bead for Life has doubled the price paid for shea nuts collected by women in Otuke County from USD 0.24 (UGX 600) to USD 0.48 (UGX 1,200) and this has increased the amount purchased and thereby improving sales and incomes of OVC households

Caring Hands has also supported OVC households to improve on the quality of beads produced by the OVC's which they sell on the international market. The quality and quantity of beads bought from the bead makers improved and the OVC caretakers realized an increase in average take home in sales from USD 96 (UGX 240,000) to USD 104 (UGX 260,000).

The effectiveness of these models is highly dependent on the organizational capacity of the implementing organization, the extent to which the members of the community (target beneficiaries) felt ownership and confidence and trust in it. This may partly explain why some implementing organisations like KORD which is fully owned by the sugar cane out-growers were apparently more successful than others. Other challenges to the supply chain and market access model are on the capacity and thereby long term sustainability of the groups and associations, as is common with many community based groups.

2.2 Effectiveness of HIPS in Addressing Capacity Building and Service Delivery Needs in a Challenging Private Sector Environment

2.2.1 Introduction

The HIPS project was designed to develop the organizational and institutional capacities of the company clinics and private providers to expand access and availability of quality health services. Capacity building needs were identified at the company and facility level to enable provision of HIV, TB, malaria and RH/FP services to employees, their dependents and the surrounding communities. Umbrella organizations (UMA and FUE) facilitated the identification of needs among their affiliate companies. The institutional, programmatic and financial capacity needs are presented in Table 2.1.

Table 2.1: Capacity Gaps Identified, Interventions to close the gaps and the results realized

Capacity Gaps	Interventions to close the gaps and the results realized
Institutional	
• Companies did not have workplace HIV/AIDS policies, which affected employee comfort level in accessing services • Weak / absence of a regulatory framework for enforcement of standards for quality care in the private sector • Many clinics had weak internal record keeping systems • Private clinics' contribution to health sector indicators was not captured by the HMIS; yet, studies (UDHS, 2011) have indicated increasing utilization of private health facilities • Limited opportunities for staff professional development in the private sector • Government gives low priority to accreditation of the private sector to	• 82% of HIPS supported partner company clinics have developed HIV/AIDS workplace polices. These have helped to protect employees against discrimination. Records show that no employee has been dismissed on health grounds since the policies came into effect. • HIPS supported creation of the Uganda Health Federation (UHF) to advocate for recognition of private health sector contribution. UHF was established in 2011 to bring together existing private sector health entities under one umbrella recognized by government[10]. HIPS is now supporting UHF and the Ministry to develop a sound regulatory framework and standards for quality of care in the private sector. UHF is expected to play a critical role in the roll out of these standards amongst its members once the process is completed. • Provision of mobile access, training and roll out of use of the national Health Management Information System (HMIS) have improved reporting[11] of private sector contribution toward national health performance indicators. • HIPS built capacity of partner clinics to meet accreditation

[10]In the past two years, UHF has experienced substantial growth rate, both in organization, membership and reach. It hosted the inaugural East Africa Healthcare Federation in Uganda, which has further propelled its reach in the private health sector, not only nationally but regionally. Activities on a local and regional basis for instance include representation on the PIRT (Presidential Investor's Round Table) and continues to have sustained and direct communication path with top level government officials in the ministry of health.

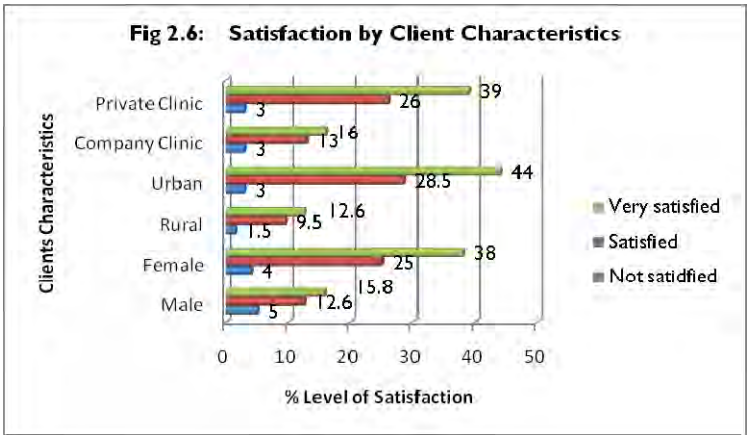
[11]Partner clinics sent data to HIPS and the latter relayed it to MoH.

Capacity Gaps	Interventions to close the gaps and the results realized
provide ART and TB services.	criteria. 88 clinics are now accredited to provide ART services and 45 clinics to provide TB treatment.
Programmatic	
• Partner clinics lacked staff with specialized skills in delivery of ART and TB services, including safe male circumcision for HIV prevention • Private clinics were not allowed dispense ARVs and provide TB services • Private clinics lacked important medical and diagnostic equipment, affecting its ability to provide specialized services.	• HIPS has trained and equipped private sector health workers with skills to provide specialized services including delivery of ART (929) and TB services (363) in accordance with the national standards. • 57 HIPS supported facilities were equipped with necessary medical and diagnostic equipment to enable them provide quality services. Equipment included CD4 machines, hematology analyzers and others. (See Annex 11 for details). Partner clinics are meeting the operational and routine maintenance costs of the equipment. The equipment has expanded the menu of services and improved quality and subsequent utilization of services.
Financial	
• Company clinics did not have long-term commitment of resources for health care of employees. • Private clinics did not have sufficient resources to invest in: medical and diagnostic equipment such as CD4 machines, hematology analyzers. • Limited access to low interest credit by private health facilities to finance investment in health infrastructure and equipment.	• Companies have made long-term commitments to finance health programs for employees, their dependents and surrounding communities through annual budgets. For example, Rwenzori Commodities in Kabarole had an average budgetary provision of USD 2,400 (UGX 6 million) per month. • HIPS provided equipment and appropriate infrastructure using a 50:50 cost sharing model. • HIPS has brokered access to credit for private health facilities through Centenary Rural Development bank though clinics are yet to receive the funding. HIPS is providing technical assistance to potential loan beneficiaries within the private sector using the USAID loan guarantee through the Direct Credit Authority (DCA) mechanism.

Improvements in the capacity of the private sector health service providers has resulted into improved quality[12] of HIV, TB, RH, and malaria services for pregnant women. The majority (96%) of clients interviewed in the exit polls (comprising of very satisfied and satisfied) said they were satisfied with the quality of services received. Only 4% reported non-satisfaction.

[12]Quality of services comprised availability and utilization of diagnostic equipment, shorter time for diagnosis and care as revealed by clients interviewed, observed national standards and guidelines in diagnosis and treatment in the visited facilities. Other quality indicators included: lead time from arriving at clinic to receiving sought service; privacy during diagnosis and treatment; counseling or guidance accorded to the client

Further analysis of these results revealed differences in the perceptions of quality of health care among different types of clients. Clients of private clinics were more satisfied (65%) as compared 29% of clients at company clinics. This is evidence of the increasing role of the private clinics in providing quality health services and justifies the need for continued support. Indeed majority of clients (68.5%) in urban settings (predominantly private clinics) also expressed high satisfaction level. On gender, females (63%) more than the males (28.4%) were satisfied with the services received. This underscores the relevance of the HIPS menu of services to women particularly malaria and family planning services.

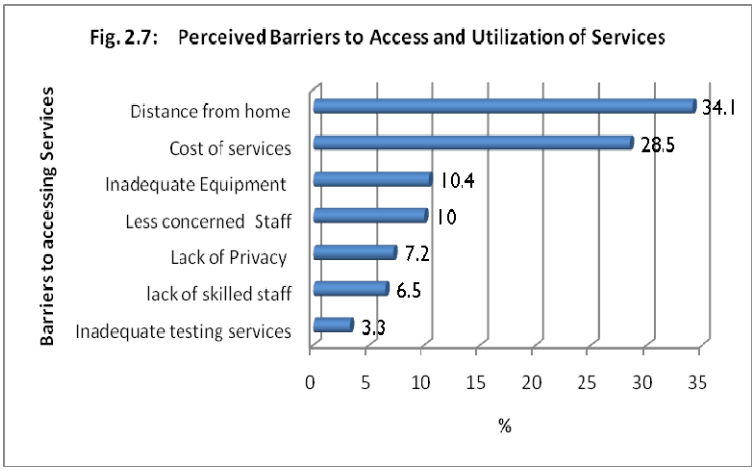


The reported improvement in quality of services is consistent with the findings of the Afro barometer Survey Round 5 in which 78% of the population acknowledged improvements in services provided by private sector facilities (Afrobarometer Survey, March 2012).

2.2.2 Continued Challenges

Despite the investments and results of the capacity building interventions, high staff attrition remains a major deterrent to ensuring sustained access and provision of quality services at private health facilities. On average, 2 out of 3 employees at the 60 partner clinics visited who had benefitted from HIPS training had left organizations under which they were trained[13]. This issue is not surprising given that wages are not regulated in the Uganda health sector, resulting in significant differences in remuneration for the same set of skills. It is likely that health workers that trained under HIPS found opportunities with other clinics that offered better pay and benefits.

It was reported that despite the capacity built with HIPS assistance to provide quality services and scale-up, there still existed low demand for their services due to lack of ability or willingness to pay for the services at private clinics. This information is confirmed in the exit polls that determined that the major barrier to use of private facilities is cost and distance to the facility.



While HIV/AIDS workplace policies have been developed in most of the GDA partners, these policies have not been translated into appropriate dialects (to reach the majority of the

[13]The scope of this study did not allow the team to establish the whereabouts of the trained staff that had left the organizations under which they were trained.

workers). This has limited employee participation in operationalization of the HIV workplace policies in some companies.

2.3 Effectiveness in Strengthening Coordination and Partnerships.

HIPS used a public private partnership model to strengthen coordination and partnerships between the private health sector and government. HIPS sought to strengthen health systems in the private sector and improve coordination with government by focusing on improving provider performance within the core components of Health Systems Strengthening (HSS) including: healthcare delivery system; health workforce; health information system; procurement, supply chain management and logistics system; health financing system; leadership and governance system.

a) Leadership and Governance

Recognizing that private providers play an important role in raising the quality of health care in Uganda, HIPS worked closely with government to develop a clear policy around public-private partnerships for health (PPP-H). The aim of the PPP-H policy was to formalize and streamline the relationship between government and private sector health providers. To address this gap, HIPS partnered with the PPP-H unit at the MoH to advocate for full development of the policy that was eventually adopted in 2012, the final year of the HIPS project. Currently, implementation of the PPP-H policy is still underway, with key players working to drive the private sector health agenda at both national and district levels.

b) Service Delivery

Among private sector providers, quality of care was variable and in some settings, access to key services was limited. To address this, HIPS facilitated the accreditation of 88 private sector clinics to offer ART and 45 clinics to offer TB services. Regular joint monitoring and supervision of the newly accredited facilities by the MoH, the District Health Officer and HIPS helps improve the visibility of the private sector and is also a positive step towards harmonization of the private and public sector.

HIPS also helped establish the health umbrella organization UHF to develop private sector regulatory standards and framework. These standards are expected to be rolled out among the private sector health providers, to establish a way to evaluate the quality of private sector care. Sustainability of HIPS supported initiatives in the roll out of the standards is dependent on the capacity of the UHF, which is still a relatively new organization.

c) Medicines and Technologies: Procurement, Supply Chain Management and Logistics System, Diagnostics

One barrier to quality care in both the private and public sectors is lack of access to drugs and other health commodities. Additionally, lack of robust drug logistics management systems led to stock outs of ARVs and other important drugs. Some providers in the private sector lacked critical laboratory services for quality diagnosis of HIV/AIDS, opportunistic infections and HIV treatment monitoring. To address these gaps HIPS brokered partnerships between the private sector and several key

organizations, including: Securing Ugandans Right to Essential Medicines (SURE)[14], a USAID project; Joint Medical Stores (JMS); Africa Affordable Medicine (AAM); Uganda Health Marketing Group (UHMG); MoH/GF and PACE to improve the supply chain of ARVs, HIV test kits, FP supplies and other health commodities. The HIPS accredited facilities are now on the government's master list to receive free ARVs. This has improved access to ARVs and other commodities in HIPS partner clinics (more analysis on access to ARVs is contained in Section 2.4.1). Under a partnership between the SIMS medical center and Central Public Health Laboratory (CPHL), HIPS funded the establishment of the private sector HIV reference laboratory[15]which is expected to be operational by early 2013.

d) Health Information Systems

There was inadequate reporting by the private sector on key health service provision performance indicators to the district and national HMIS. As a result, the MoH was not able to quantify the private sector contribution to health performance. In January 2012, HIPS piloted Mhealth partnerships[16]: a platform to collect and analyze data using cost effective smart phone-like devices (Mi-Fones) and user friendly tailored SMS based platforms to report patient data, program results and commodity inventory. Results of the pilot indicated significant improvements in reporting of all key indicators—70 partners were able to share timely and complete data within eight months of introducing the system. This has improved accuracy, efficiency and cost effectiveness in reporting data to HIPS and eventually to MoH. It is not clear how this information will continue to be relayed to MoH after the close of HIPS. Mobile technology is also being used by 8 HIPS supported partners under a pilot phone referral program to facilitate critical health information exchange between community-based peer educators, private health clinics, and the AIDS Treatment Information Center (ATIC). The challenge is going to be around meeting the costs of this system after the close of HIPS.

e) Health work force

Private sector had limited skilled and motivated staffs that were responsive, fair and efficient in providing HIV/AIDS, TB, malaria and RH/FP health services. Health workers in the private sector lacked specialized training in management of ART and TB according to national standards. HIPS, in partnership with Mildmay and AIC has provided training to health workers in the private sector in HIV and TB management. In order to ensure that partners continue accessing services, HIPS and Mildmay designed a training package for the private sector and HIPS disseminated it to partners. Furthermore, in partnership with UHMG and PACE, private sector providers were trained in family planning and reproductive health. As noted in earlier sections, issues of attrition especially where people are moving into the public sector or other forms of employment affects the capacity of the private sector work force.

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[14] The overall goal of the SURE project is to ensure that the population of Uganda has access to adequate quantities of good quality essential medicines and health supplies (EMHS) by strengthening the national supply chain for essential health commodities

[15]Once the HIV reference laboratory is complete and operational, it will undertake the following activities i) providing HIV laboratory diagnosis and treatment monitoring among private sector ART clinics; ii) training in laboratory skills and management among laboratory staff in private sector and iii) conduct operational, laboratory and clinical research, and surveillance of HIV Drug Resistance.(HIVDR) in private sector clinics.

[16]The pilot demonstrated that private sector health actors can overcome obstacles to data flow of health indicator data on time and help clinics, donors and MoH monitor potential drugs stock outs in the private sector

f) Health Financing

Prior to HIPS, accessing funds for development was a major challenge to private health providers. This was because of high financing requirements for health related investments. These financing gaps manifested differently depending on the nature of the private health facility:

- Company clinics were reluctant to provide long term HIV and TB services which were expensive and yet with no direct returns. On the other hand, companies perceived reproductive health services as mandate of the public sector or a personal issue. HIPS used the disease cost calculator to demonstrate the relevance a comprehensive health care package for company staff.
- Private clinics lacked sufficient resources to invest in expensive medical and diagnostic equipment. To address these gaps, HIPS advocated for insurance companies to list HIV/AIDS on their health premium. Furthermore, HIPS brokered a partnership with Centenary Bank to provide long term credit[17] to private health providers and secured USAID guarantee.

2.4 Most Effective Approaches and Innovations for Scale Up

The evaluation identified the following as the most effective approaches and innovations under HIPS for replication and scale up.

2.4.1 Accreditation

Accreditation of private sector health facilities for ART and TB related services was the most effective approach for expanding access and utilization of services. Before HIPS, only few private sector clinics were accredited to provide ART and TB care. With accreditation, there has been increased access and utilization of health services (HIV/AIDS, TB, Malaria and RH/FP) as indicated in Figures 2.1-2.4. Accredited facilities are entitled to free ARVs from government stores thereby improving availability of drugs for clients at free or minimal costs. Accreditation provides a good standard platform for ensuring quality services as it makes provisions for regular supervision visits by the MoH and the DHO.

Unfortunately the over-reliance on drugs from the public sector has caused disruptions in service delivery since 2010 when there was a breakdown in supplies. Findings of a study conducted by the HIPS program on frequency of stock outs in 2012 revealed that only 13.3% of companies reported that they have never experienced stock outs. 50% have borrowed drugs from neighboring hospitals or government health centers when stocks are low. These clinics also refer clients to government health centers. 28.5% have purchased drugs during stock outs from 2010 to date amounting to USD 7,317 (UGX 18,292,376). Though companies are establishing own mechanisms for dealing with stock outs in the short run, a long term solution is required to ensure regular provision of ART in the private sector for all kinds of clients and thereby enable a regular provision of services.

2.4.2 Use of the Disease Cost Calculator in Expanding GDA partnerships

The most effective approach used in expansion of GDA partnerships was the use of the disease cost calculator[18] in helping private companies understand the cost implications of employee illness on their business. With HIPS support, companies have developed a clear way of assessing the unit cost of

[17]The program for accessing credit facilities by private sector health providers is yet to be launched.
[18] In terms of determining the losses incurred by the company due to poor health of employee

providing health services and are now more aware of the impact of health on employee productivity. The disease cost calculator empowered private companies to appreciate health of employees as an economic commodity. Since HIPS began, 46 companies established GDA partnerships and now have annual budgets that include their contributions to health service provision to employees.

2.4.3 Support to Existing MOH Policies aand Plans

The project was in line with the national Health Sector Strategic Plan (HSSP), strategic plans for HIV, tuberculosis and laboratory development. The project supported the development of the national PPP-H policy and made important contributions to national health indicators. Subsequently, the MoH was willing to embrace private sector initiatives under the HIPS project. The National AIDS Control Program (ACP) and the National Leprosy and Tuberculosis Programme (NLTP) offered support for ART and TB accreditation and participated in joint supervision of private sector facilities.

2.4.4 The Supply Chain /Out growers model

HIPS rolled out three models to support OVC i.e. corporate sponsorship, supply chain/out-growers model and market access models. Within the project, the most widely recognized and appreciated model (by companies and OVC alike) was the supply chain/out-growers model. This model benefited smallholder farmers who produced raw materials for industries. For instance, at Kakira Sugar Works the company encouraged and supported OVC and their households to produce cane as out-growers and in return, companies bought the cane. The company provided additional support including: training and key inputs such as improved seed through the farmers associations. Under this approach, a total of 935 OVCs benefitted (HIPS Final OVC Report, 2012). For example, HIPS supported the formation of the Kakira Out-growers Rural Development (KORD) group to organize OVC households involved in outgrowing. To leverage their new-found income from outgrowing, the KORD women's group started a Village Savings and Lending Association (VSLA), and then used their pooled savings to buy a six acre piece of land which they are using for income generating activities. Similarly, the KORD youth group has acquired a jaggery mill and a maize mill which create an ongoing source of income for group members.

2.5 Sustainability of Health Service Provision through Companies

2.5.1 HIPS Sustainability Goals

The main objective of HIPS was to build the capacity of partner originations to expand access and utilization of health services *and* carry on the provision of those services beyond the close of the HIPS program. In the context of this evaluation, sustainability was assessed at the following levels institutional; programmatic and financial management.

Ultimately, sustainability was also measured by the level of ownership of interventions and ability to carry them on without HIPS support

a) Institutional

i. HIPS facilitated partner companies to develop HIV/AIDS workplace policies. These policies are operational in 82% of the companies surveyed. The work place policies lay out commitments from the employer in the form of health services and benefits and financial resources that will be allocated to health programs within the company. The HIV/AIDS workplace policies have helped to protect employees against discrimination.

ii. HIPS strongly supported the completion of the PPP-H policy, which had been in the process of approval for more than 10 years. The policy provides a regulatory framework through which the private and public sectors collaborate in the provision of health services. The MoH has established a

unit to effectively coordinate private sector health activities. The PPP desk at the MoH has limited capacity to support private sector activities independently. This MoH body will need ongoing support to ensure successful operationalization of the PPP-H policy at various levels.

iii. HIPS built the capacity of partner clinics to meet accreditation criteria through provision of medical training for staff, mentoring, provision of equipment and tools. Subsequently, 88 partner clinics were accredited to offer ART and TB services. The accredited partner clinics have expanded access and utilization of services and are expected to continue to provide these services after the HIPS program.

iv. HIPS-supported umbrella entities like UMA, FUE, and UHF are key sustainability platforms.

HIPS made a strategic decision to work with and strengthen *UMA and FUE*, local membership organizations to provide health services to their respective members. UMA and FUE already have large memberships and appropriate mechanisms for continuing to mobilize members and provide ongoing support. Both organizations have benefitted from technical, institutional and organizational development support to become leaders in provision of workplace health programs. Through their newly established health business development units, UMA and FUE are mobilizing resources from affiliate companies and other development partners. These resources will facilitate continuous capacity building for health programs within the affiliate companies. By 2012, 63% of HIPS active partners were receiving support formerly provided by HIPS from the two organizations. 30 partners are already paying for services directly from UMA and FUE which is an indication of their demand for their services. The noted challenge has been the ability of UMA and FUE to attract long term funding for the workplace activities and thereby affecting income flow and long term financial standing of the associations. Most of the grants received so far support implementation of initiatives of activities for no more than 12 months.

HIPS supported the formation of Uganda Health Federation (UHF) as a key cornerstone of private sector sustainability and the organization is already serving a significant group of stakeholders. HIPS support of UHF initiatives in developing a self-regulatory mechanism for the private sector signifies an investment in ensuring standards of quality care even after the close of HIPS. There is need to recognize that UHF is still a new organization and will continue to need support in expanding its membership and rolling out the self-regulatory mechanism once completed.

b) Programmatic Strengthening

Sustainability created through HIPS was analyzed at two levels: company clinics and private provider clinics, as the two types of clinics provided services under different arrangements. Whereas company clinics provided services to employees, their dependents and the surrounding communities; private clinics were open to any member of the public willing to pay for services.

i) Company Clinics

HIPS supported companies to train staff and provided equipment to raise the quality and scope of services provided. Additionally, HIPS supported companies to develop HIV/AIDS workplace policies which link with the National HIV/AIDS Policy and Strategic Plan. Further, HIPS brokered partnerships between private companies and umbrella organizations (UMA and FUE) and other collaborating institutions (JMS, MoH, UHMG, Mildmay and PACE). These partnerships are key for sustainability of health-related activities. HIPS brokered additional collaborations between partner clinics and the Central Public Health Laboratory for quality assurance, quality control and training of laboratory technicians. This is an ongoing relationship that will continue to grow after the HIPS project has closed.

ii) Private Provider Clinics

HIPS initiated a collaborative arrangement with private clinics on a 50:50 cost-sharing basis. Because private providers were expected to match HIPS funds, a greater sense of ownership was created while allowing clinics to purchase needed equipment they could not afford on their own. All 30 private clinics visited had undertaken service maintenance and met operational costs of equipment—for example, partners like Wagagai clinic and Sims Medical Centre that acquired hematology analyzers were meeting the operational and maintenance costs. Due to the 50:50 cost sharing, the beneficiary clinics provided the HIPS menu of services at subsidized rates.

c) Financial Management Strengthening

Establishment of health business development units within UMA and FUE will help to sustain resource mobilization for planned health initiatives in the coming years. These organizations have already had success in mobilizing resources and are poised to continue raising funds to cover ongoing costs needed to sustain programs.

HIPS has also provided initial support to the roll out of a Direct Credit Authority (DCA) facility that will improve access of finances for private sector facilities. Under this arrangement, partner clinics will receive funding from Centenary Rural Development Bank. HIPS will provide technical assistance to potential loan beneficiaries within the private sector using the USAID loan guarantee. Subsequent reviews on investments in the private sector should assess the effectiveness of this facility in strengthening access to finance and improving access to services provided by the private sector.

3. CONCLUSIONS

The main objective of the HIPS project was to improve access and utilization of HIV/AIDS, TB, malaria, and reproductive health/family planning services within the private sector. The strategies HIPS adopted to achieve this objective included: expanding the number of global development alliance (GDAs) partnerships; supporting initiatives to strengthen private sector workers' organizations to support health initiatives; and to implement innovative approaches to support orphans and other vulnerable children through the private sector.

From the findings of this evaluation, HIPS has largely achieved its overall objective. The initiative has expanded access to key services, including: HIV/AIDS, TB and malaria; as well as reproductive health/family planning by increasing the number of clinics and expanding the menu of services provided. Further, services were being utilized by the intended beneficiaries. More could have been achieved in the expansion of services if more realistic targets had been set and or re-adjusted over the course of the program.

Accreditation of company and private clinics has increased access to health services amongst employees and surrounding communities.

Private companies can and will contribute resources towards private health care initiatives, when presented with clear and compelling evidence. Coupled with a renewed positive attitude towards staff health, GDAs have proved to be an important mechanism for the leveraging of private sector resources to provide workplace health programs

Umbrella organizations like UMA and the FUE are strategic entry points towards mobilizing affiliate companies to commit resources and sustain health initiatives in the private sector. Capacity building

services and work health program support provided by these organizations will be critical in sustaining initiatives started by HIPS. Mechanisms for ensuring long term financial independence of these organizations need to be identified.

Private sector capacity to provide services has been improved as demonstrated by the increase in services provided to different target groups and the satisfaction of clients with the quality of these services. Staff attrition, irregular supplies of key commodities like ARVs and costs of services are still key constraints to ensuring a sustained provision and use of services provided by the private sector.

Peer education was an effective strategy for creating demand for use of services among company employees. The use of company employees as peers and the willingness of workers to open up to their peers made it easier and cheaper to mobilise employees to utilise services.

The PPP-H policy has been rolled out and this creates a conducive environment for the private sector to contribute significantly to health service delivery. The capacity of the newly created PPP unit needs to be strengthened to ensure successful operationalization of the PPP-H policy at various levels.

Further, the UHF provides a regulatory framework to ensure provision of quality health services within the private sector. UHF will continue to need support in expanding its membership and rolling out the self-regulatory mechanism once completed

The rationale of the OVC component was to empower the OVCs to improve their livelihoods. This proved true as the former OVCs had established income generating activities and are now able to even access health services from the private sector.

4. RECOMMENDATIONS

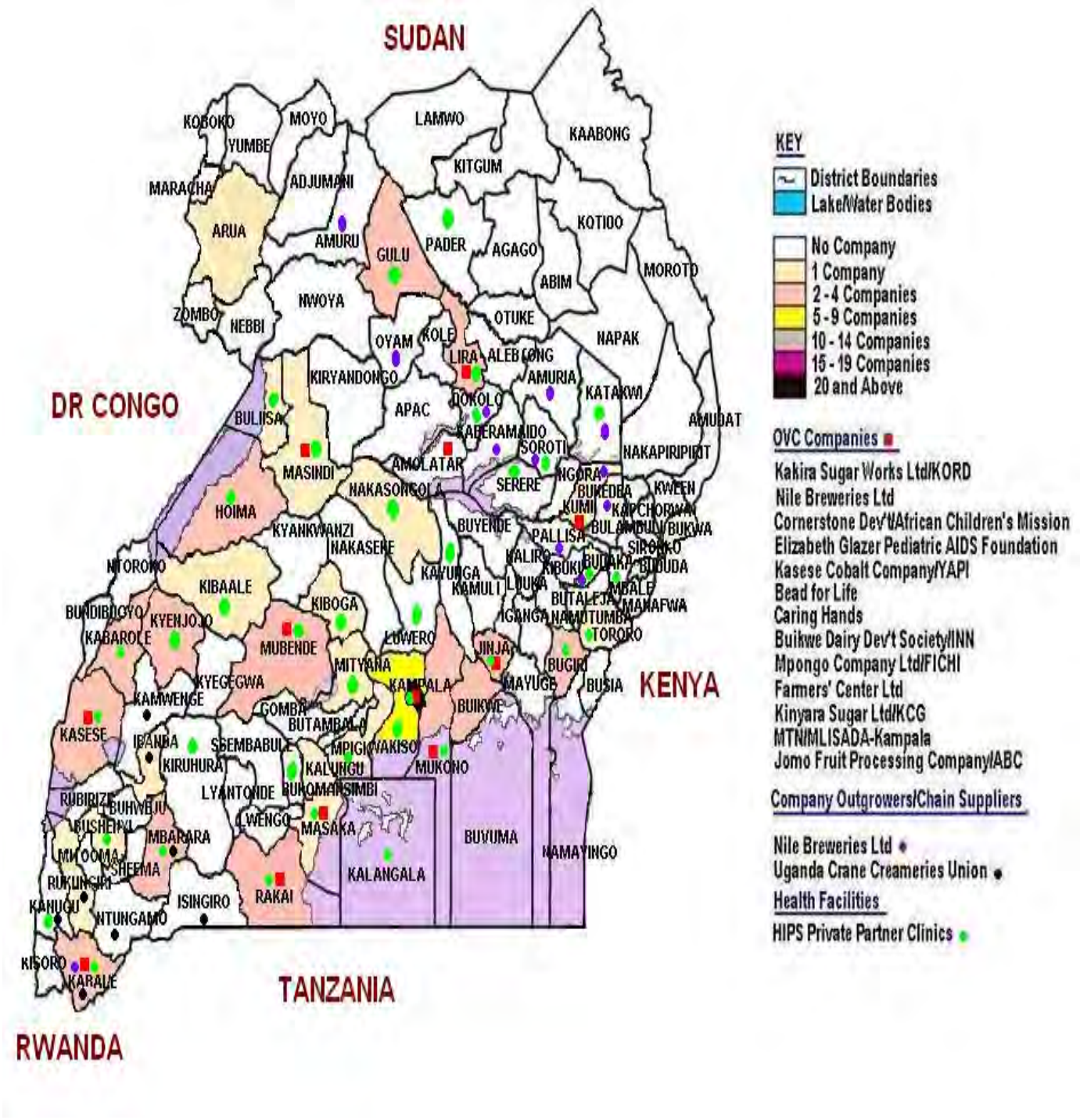
On the basis of conclusions drawn from the evaluation and the lessons learned; the following recommendations are made to guide the designing of similar programs in future.

ACTION		RESPONSIBLE PARTY
1.	Brokering partnerships to improve service delivery is an excellent model that should be adopted and scaled up by programs aiming to expand service delivery in the private sector. As a platform for implementation, the partnerships created confidence, interest, commitment, and improved coordination among partner organizations.	USAID, MOH, other development partners
2.	Continue to support both company clinics and private clinics because of their different, yet synergistic approaches to service delivery. For example, private clinics largely serve paying clients, mainly in urban settings. Company clinics, on the other hand, mainly serve employees, their dependents, and lower income members of the surrounding communities, often in rural areas.	USAID, other development partners
3.	GDA partnerships to leverage private sector resources were very successful and should be scaled up in related future programming.	USAID
4.	Performance based grants should be introduced for private clinics to ensure full utilization of the capacity built by programs like HIPS. Within a regulatory structure that promotes quality, performance based grants	USAID, other development

ACTION		RESPONSIBLE PARTY
	ensure that providers continue to expand services while maintaining national standards for care. In addition, incentives for quality performance can be used to motivate staff and mitigate staff attrition.	partners
5.	To facilitate stronger public-private partnerships at the national level, the PPP-H Unit should be strengthened. This unit is an important entity to drive the public-private partnerships agenda in health and promote continued national development in this area. The PPP-H Unit is also essential to completing the roll-out of the PPP-H policy at both national and district levels over the coming years.	MOH, USAID, Development partners
6.	Future programming should also focus on strong joint planning, monitoring and support supervision between the private sector and the MoH and District Health Offices.	
7.	Scale up use of the disease cost calculator in the private sector to further promote the evidence that addressing employee health is important for companies' bottom line.	UMA, FUE
8.	Future programming in health for the private sector should continue to support UHF as a critical platform to improve coordination and build on current efforts in improving regulation and quality of care within the private sector.	USAID
9.	Future projects should invest in conducting an inventory of private health facilities and a detailed baseline assessment to establish better the scope and depth of their interventions to inform more realistic project benchmarks. A cost-benefit analysis (CBA) / cost effectiveness analysis to establish value for money and return on investment for similar initiatives would be instrumental in mobilizing support for investments in the health private sector.	USAID

ANNEXES

ANNEX 1: HIPS COVERAGE



ANNEX 2: STATEMENT OF WORK FOR EVALUATION OF THE HEALTH INITIATIVES FOR THE PRIVATE SECTOR (HIPS) PROGRAM

I. BACKGROUND

The private sector plays a very important role in many developing countries where health is considered a public good with services provided either free or at minimal charge. Contrary to popular belief that the poor are unable to pay for health services, there is evidence showing that they do. In Africa, 50% of total health expenditures go to private providers, and 60% of health care financing comes from private sources. This shows that the private sector is filling an important gap in public sector provision of health services and people are paying out of pocket for these services. Furthermore, the market for healthcare is expected to increase by more than double by 2016, up to $35 billion. In Uganda, out of every four shillings spent on health care, three shillings are private outlays, mostly out-of-pocket payments direct to providers. To increase the quantity and quality of health care services, one must not ignore the private sector.

The Ministry of Health (MOH) in Uganda has for some time now recognized the significant importance of the private sector. In the draft Health Sector Strategic Plan (HSSP) III, the MOH acknowledges the role of private sector as a major partner in national health development and service delivery. The private sector is increasingly becoming a major source of health services to the populace. A study conducted in 2005 on "Understanding the Impact of Eliminating User Fees; Utilization and Catastrophic Health Expenditure in Uganda" reported that when sick, 53% of the people turn to the private sector for treatment, 24% to the public sector, 4% to others and 19% do not seek care. The MOH further identifies the biggest challenge to strengthening public-private partnerships as the fact that the Public-Private-Partnership in Health (PPPH) policy is still in draft form. In the absence of a concrete policy, the MOH has tended to provide more support to the private not-for-profit sub-sector as compared to the private for profit sub-sector. A Survey of Private Health Facilities in Uganda (2005) reported 2,156 registered private clinics, excluding drug shops, whereby 68 percent of them are in the central region and Kampala alone, which accounts for 45 percent of all private facilities in the country. Over 90 percent of private facilities are clinics that provide outpatient curative services. Although health infrastructure in the private sector has expanded, the vast majorities of health facilities are not fully functional, lack equipment and staff, and are poorly maintained.

As part of the US Government (USG) efforts to support the private sector, on October 1, 2007, the Mission signed a $8,689,764 three year contract, with an option to extend for two years with Emerging Markets Group (EMG) Limited to engage the private sector. The option to extend for two years with CardnoEM was approved on June 15, 2010 bringing the new ceiling to $15,689,764. Effective September 26 2011, the Health Initiatives for the Private Sector (HIPS) project was extended for six additional months from September 30, 2011 to March 31, 2013 bringing the Total Estimated cost (TEC) to $17,189,764.

The goal of the HIPS project is to improve access and utilization of health services. The project provides support to the private sector company employees, their dependents and surrounding communities at both medium and large size levels.

HIPS is a dynamic project designed to be responsive to the unique demands of supporting the private sector in Uganda. Under this project, HIPS aims at increasing access to and use of HIV/AIDS, tuberculosis, reproductive health/family planning (FP) and malaria services through mid and large size employers within the private sector.

Specific components of the HIPS program are to:

- Expand and strengthen access to and utilization of health and HIV/AIDS services in the private sector;
- Expand the number of Global Development Alliance (GDA) partnerships;
- Support initiatives to strengthen the private sector workers' organizations to support health initiatives;
- Implement innovative approaches to support orphans and other vulnerable children through the private sector;

HIPs works in 57 districts spread across Uganda. The program HIPS works with over 100 companies on a cost sharing basis and 100 clinics (50% company clinic and 50% private clinics). The detailed coverage map is attached as Annex 1.

As the HIPS program draws to a close, USAID/Uganda is interested in conducting an evaluation that will establish the effectiveness of the intervention and a documentation of what has worked or not. HIPS', being the first fully fledged health private sector program in USAID/Uganda, is expected to provide lessons on best practices and approaches that can be integrated in future programming within the Mission and the Ministry of Health to support national efforts in strengthening the health private sector to provide accessible and quality health services to the citizens of Uganda.

II. PURPOSE OF THE EVALUATION

USAID/Uganda is commissioning HIPS project final evaluation to assess the effectiveness of the approaches implemented under the project and identify factors for success. The evaluation will document major achievements (what has worked well) and opportunities (what could have been done better), limitations and challenges; and establish lessons learned and good practices. Information from this evaluation will be used to inform designs of future program work by USAID and the Government of Uganda.

III. KEY EVALUATION QUESTIONS

The evaluation should answer the following specific questions:

- Have the desired results been achieved?
- Is HIPS effectively addressing capacity building and service delivery needs in a challenging private sector environment?
- How effective has HIPS been in strengthening existing private sector coordination structures and partnerships with the public sector at the national and district level (private sector companies, Government of Uganda – GOU, etc.)?
- What are the most effective approaches and innovations that should be scaled up? What factors will contribute to the success of the effective approaches?
- What factors have contributed to success or failure of the project – what is working / not working?
- To what extent has HIPs strengthened the sustainability of the private companies/entities and their ability to continue to provide health services after close of the program?

IV. PROJECT INFORMATION AND DOCUMENTS

The following information documents and sources are available and relevant to the evaluation:
USAID:

- Original Request for Proposal for the HIPs program
- USAID program and financial reporting requirements
- USAID Country Development Cooperation Strategy 2011-2015

HIPS:

- Program Description
- Annual and quarterly reports
- Annual work plans
- Performance Management Plan
- Baseline survey report
- Other surveys and assessments undertaken.

Other information documents outside USAID and program: Health Sector Strategic Investment Plan/ Heath Sector Performance reports, Private Sector reports/policies/guidelines from GOU and other Development Partners, and updated private sector assessment report.

V. EVALUATION METHODOLOGY

The Offerer may propose a mix of qualitative and quantitative methods to conduct an evaluation that meets the stated purpose and responds to all the evaluation questions listed above. Proposed methodology should bear in mind the wide coverage and diverse group of stakeholders and show clearly how reliable and meaningful information will be collected in an efficient manner.

The submitted proposal should include a detailed evaluation design that looks at each question, defines the methodology to be used, main features of the data collection instruments, sampling methodology where necessary and the data analysis plan. Where possible gender disaggregated information should be collected and analyzed. A sample design matrix is attached as Annex 2.

With regard to data quality, the evaluation team is expected to be familiar with USAID data quality standards for objectivity, validity, reliability, precision, utility and integrity and be able to apply them in the final report, by identifying such data limitations as may exist with respect to these standards (ADS 78.3.4.2 – http://www.usaid.gov/policy/ads//500/578.pdf) and ADS 203.3.5.1- http://www.usaid.gov/policy/ads/200/203.pdf).

Initial findings of the evaluation will be shared within the Mission and with the Implementing Partners. The final report will be shared with the Government of Uganda and other development partners. The Contractor is expected to submit the final approved report to the USAID's Development Experience Clearing House (DEC) within three months of approval of the final report.

VI. DELIVERABLES

1. In Briefing: Introduction of the evaluation team, discussion of the SOW and initial presentation of the proposed evaluation work plan.
2. An Inception report detailing the Contractor's interpretations of the assignment, an evaluation design and methodology, analytical plans, sampling, tools and work schedule to be submitted within 7 working days of the in briefing.
3. Weekly Progress Reports: Brief informal reports summarizing progress, challenges and constraints and describing evaluation team's response.
4. Oral Presentation: Power Point presentation (including hand outs). The oral presentation should, at a minimum, cover the major findings, conclusions, recommendations, and key lessons. The

evaluation team will liaise with the mission to agree on the dates, audience, venue and other logistical arrangements for this briefing. The presentation shall be held within 35 days after the in briefing.

5. Draft Evaluation Report: The report should comply with the USAID's Evaluation Report standards set out in Annex 3. The report is expected within 7 days after the oral presentation.
6. Final Draft Report: Complete report incorporating comments from USAID and other stakeholders submitted within 5 days of receipt of the comments.
7. Final Report: The contractor will submit a final report incorporating final edits for wider sharing within two days. The approved final report should be cleared by USAID before submission to the DEC.

* Draft and Final Evaluation Reports should be provided in four (4) hard copies and one (1) electronic copy.

VII. DURATION OF THE ASSIGNMENT

The evaluation will begin on or about 05/29/2012 and end by or about 08/13/2012. The offeror shall propose a work plan based on their interpretation of the statement of work.

VIII. LOCATION OF ASSIGNMENT

HIPS office(s), USAID/Uganda and site visits conducted in the private sector facilities. There may be need to visit public sector organizations and health facilities for information and comparison purposes.

IX. EVALUATION TEAM COMPOSITION

The offeror is expected to propose a multi-disciplinary team of evaluators, health, HIV/AIDS and private sector programming and research expertise to conduct the evaluation. The following are required members of the team;

- **Team Leader/Lead Evaluator:** Consultant with demonstrated professional experience in the design, management and implementation of evaluation studies over the past 10 years. Additional expertise in health and HIV/AIDS development work is required. S/he must possess good writing skills. Knowledge of key USAID policies and procedures is desirable. S/he will be responsible for leading the team in the design of the methodology, execution, reporting and have overall responsibility for preparation of the final product and presentation to the Mission.
- **Health Private Sector Expert:** consultant with demonstrated international experience in health private sector design, management or evaluation in developing countries, particularly sub Saharan Africa is required. The offeror may propose other members as they deem fit to execute the job.

X. MANAGEMENT ROLES AND RESPONSIBILITIES

The USAID/Uganda PPD M&E Adviser will have primary administrative and technical responsibility of the evaluation process. This also includes making the necessary arrangements for USAID inputs and briefings. The Contractor will liaise closely with the Contract Officer's Representative (COR) for HIPS and the Senior Strategic Information Advisor (SSIA) for the Health, HIV and Education Team.

Emerging Markets will contribute to the design and planning of the evaluation, provide logistics for implementation (documents, meetings, interviews), participate in the oral presentation and review the draft and final reports.

Emerging Markets and all sub-contractors/sub-awards, USAID and other stakeholders will not interfere with the evaluation team's capability to collect objective information and to conduct independent investigation relevant for this evaluation, analyze data and make inferences, conclusions and recommendations.

XI. EVALUATION CRITERIA

The list below serves as the standard against which all technical information shall be evaluated and serves to identify the significant matters which offerors shall address;

A. Technical approach
B. Key personnel
C. Past Performance

2) Technical Approach

Sub-Criteria in order of importance

1. Extent to which the proposed technical approach is clear, logical, well-conceived, technically sound, reflects an appreciation for the likely problems to be encountered during the evaluation and directly addresses the steps in the Statement of Work.
2. Extent to which the proposed technical approach demonstrates an understanding of the implementation context.

B. Personnel

1. Extent to which the proposed key personnel meet the required qualifications demonstrating the Offeror's ability to effectively conduct the evaluation.

C. Past Performance

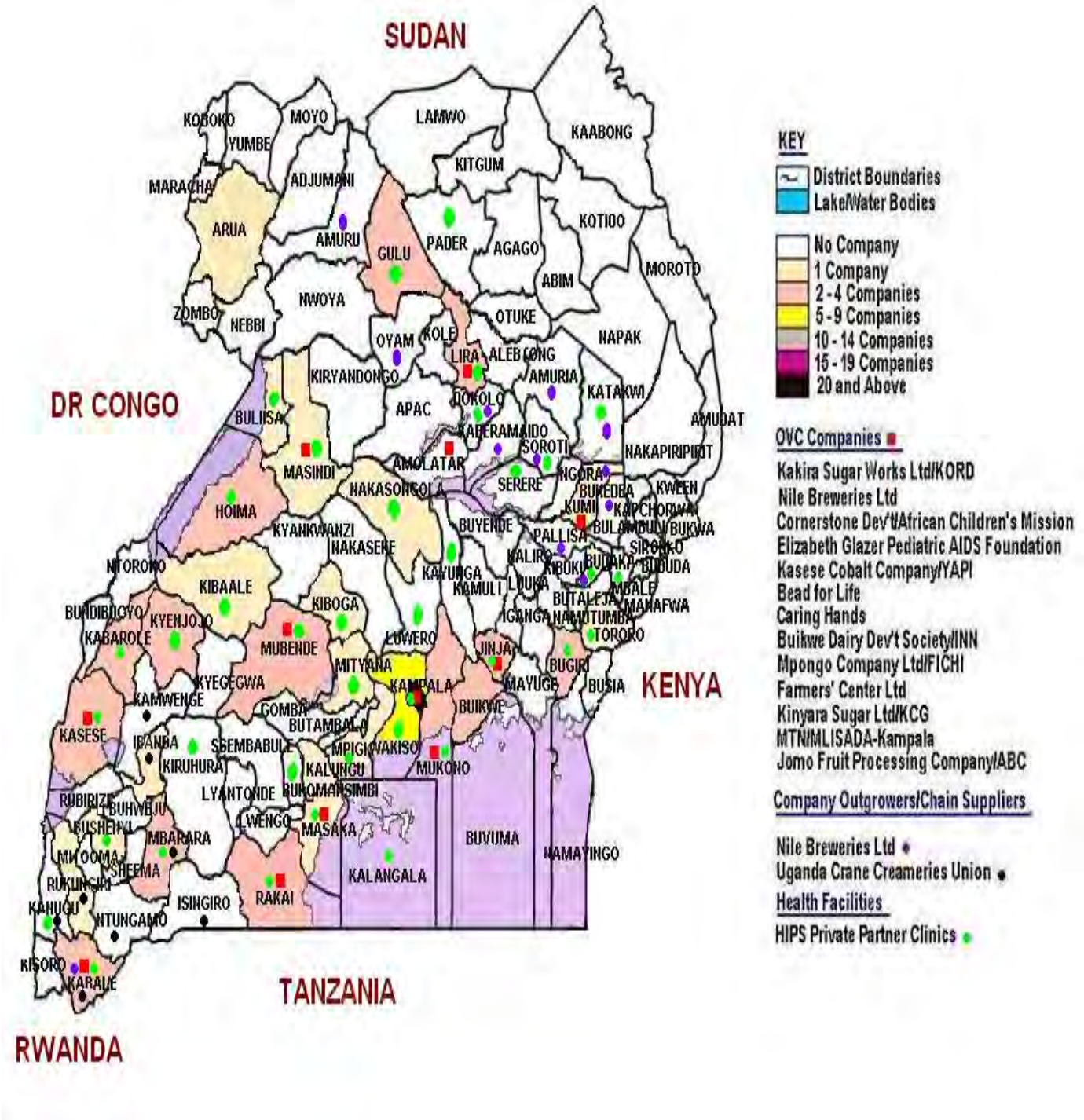
1. The extent to which the offeror demonstrates successful implementation of evaluation of similar health sector programs or similar projects and application of relevant lessons learned to this evaluation.

XII. COST PROPOSAL EVALUATION

The evaluation of the offeror's cost proposal shall deal with cost realism analysis. This shall consist of a review of the cost portion of the offeror's proposal to determine if the overall costs proposed are: 1) realistic for the work to be performed; 2) reflect the offeror's understanding of the requirements; and 3) are consistent with the technical proposal. Evaluation of cost proposals shall consider, but not be limited to the following:

1. Cost realism and completeness of cost proposal and supporting documentation.
2. Overall cost control evidenced by the proposal (such as avoidance of excessive salaries, excessive field visits, and other costs in excess of reasonable requirements).

HIPS Coverage



SAMPLE EVALUATION DESIGN MATRIX

Evaluation Question	Sub question (will help you answer the key evaluation question)	Indicator / Performance Measure (information needed to answer the question	Data Source (primary and or secondary)	Data Collection Instrument	Data Analysis Plan	Comments

Criteria to Check the Quality of the Evaluation Report

- The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not and why.
- Evaluation reports shall address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline need to be agreed upon in writing by the USAID technical officer.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an Annex in the final report.
- Evaluation findings will assess outcomes and impact on males and females.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence and data and not based on anecdotes, hearsay or the compilation of people's opinions. Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

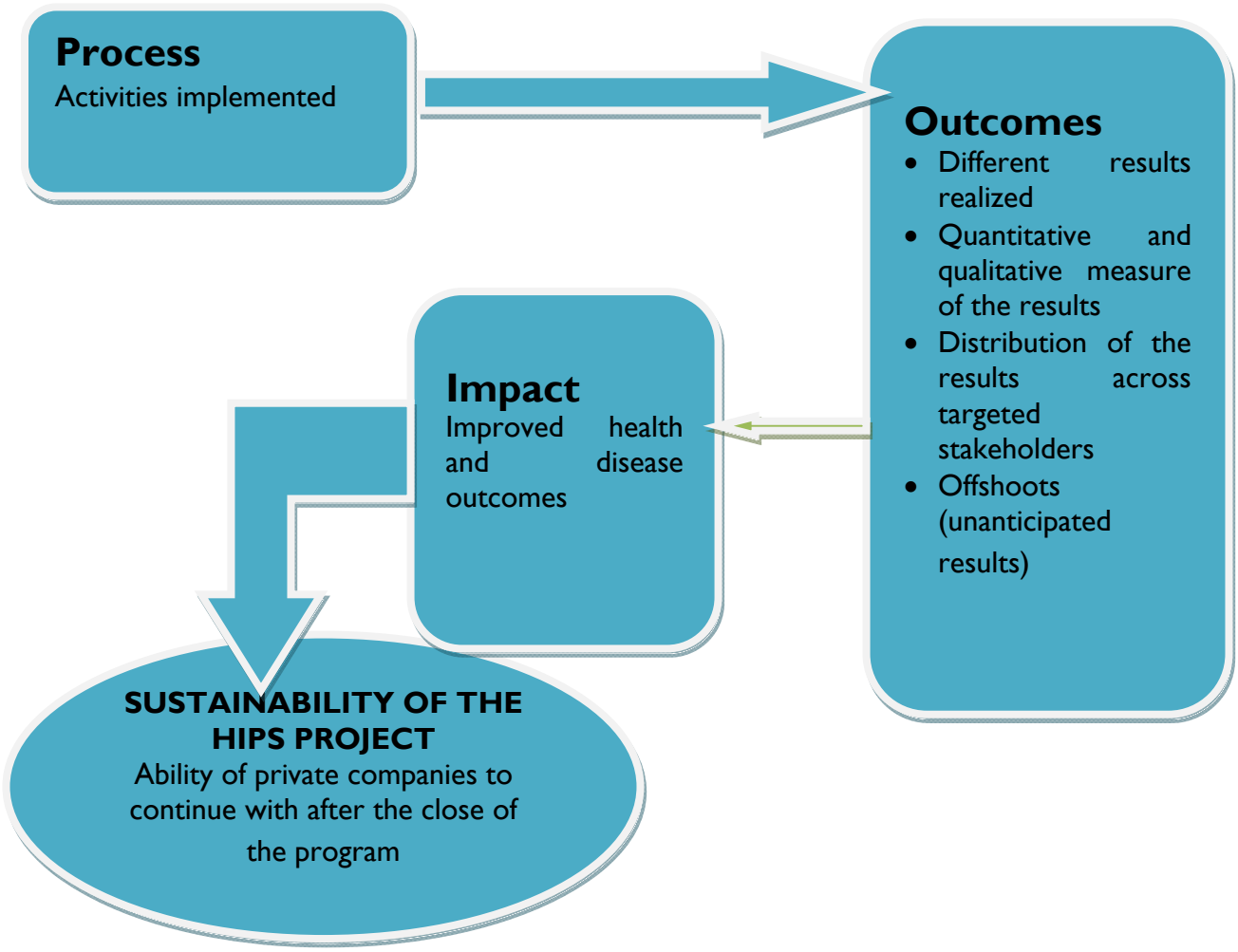
ANNEX 3: EVALUATION METHODS AND TOOLS

APPROACH AND METHODOLOGY

Scope of the Study

The project for conducting an evaluation of the effectiveness of the approaches implemented under the HIPS project and identifying factors for success adopted a systems analysis model for evaluation of the performance of HIPS project. The model comprised the following as indicated Fig.1.1.

Figure 1.1: Systems Analysis Model to be used in Execution of the Assignment.



The model indicated in Fig 1.1 was based on systems analysis. Under this model, the success of HIPS project was measured on the basis of achievements, impact, effectiveness, efficiency and the sustainability of project activities. More importantly, however, was the sustainability of different strategy impacts and outcomes focused on the private sector operators' capacity to continue to provide services after the end of program. They included strengthened private sector coordination and innovations that needed to be scaled up and maintained beyond HIPS support.

1.2 Overview and Approach to the Evaluation Process

The final evaluation of HIPS Project was conducted as a collaborative evaluation process involving a wide range of HIPS project partners; the Ministry of Health; USAID/HIPS staff; and a team of consultants. The assignment was carried out in 4 stages namely:

i) Preparatory phase
ii) Field work
iii) Data analysis report writing
iv) Workshops for validation and debriefing

1.3 The Evaluation Design

The final evaluation study was cross-sectional descriptive assessment focusing on the programme processes, outputs, outcomes and impact using participatory evaluation techniques. Triangulation was used to compare the information from participants (target clinics & population and project staff) in the field evaluation and information from desk review or secondary sources.

1.3 Sampling

1.3.1 Sampling Frame

HIPS project supported private clinics fell into two major categories: i) Company clinics providing services to company staff, their families and/or neighboring communities; ii) Private Clinics providing services to individuals, families, corporate clients and surrounding communities. Therefore, clinics from both strata were enrolled in the study.

Additionally HIPS Project has been collaborating with other institutions and Umbrella organizations of the business community and Private health service providers during project implementation. These were interviewed in the final evaluation study. Multiple methods of data collection were used to meet the TORs. The methods of data collection yielded a plethora of both qualitative and quantitative data required to accomplish the task. A participatory approach involving wide consultations with all stakeholders was emphasized throughout the final evaluation study.

Data collection was done among HIPS project staff; partner company clinics; collaborating institutions; USAID and its partners; and focal persons of Ministry of Health programs and departments. The table below shows the sample of institutions for the evaluation:

Table 1.1: List of Institutions selected for the evaluation

Government Institutions	HIPS and Partner Private Clinics	USAID and Collaborating Institutions
AIDS Control Program (ACP-MoH)	HIPS Project staff	USAID and Partners (Strides, Respond)
Tuberculosis and Leprosy Control Program (TLCP-MoH)	Company clinics	Joint Medical Stores (JMS)
Malaria Control Program (MCP-MoH)	NGO Clinics	Mild May Centre
Department of Reproductive Health (MoH)	Private Hospitals	UHMG
Central Public Health Laboratory (CPHL-MoH)	Private Clinics	John Hopkins Bloomberg
District Health Officer (DHO) of selected districts	OVC Programmes	Uganda Manufacturers' Association

PPP Desk/ TWG (MoH)		Federation of Uganda Employees
		Uganda Health Care Foundation

1.3.2 Selection of Heath Facilities for the Interviews

Altogether, data collection was undertaken in 60 facilities consisting of 30 Company clinics, and 30 Private Clinic (For-Profit health facilities); which were selected through the following steps:

a) The consulting team reviewed the HIPS supported companies and clinics inventory and compiled a list of health facilities that consistently worked with HIPS project to provide services since the project started.

b) The following criteria were used to select health facilities to be interviewed:

Table 1.2: Criteria for Selection of Health Facilities

Criteria	Consideration Criteria
Location	Rural/ urban mix Remote areas
Service delivery site mix	Prevention, treatment, care and support; community outreach services and livelihood/OVC support
Level of care/type of services	Hospital Vs Clinic level services HIV, TB, Malaria & RH services
Type of service provider	Private Clinic Company Clinics
Accreditation status	This will facilitate comparing performance and issues between the accredited clinics with HIPS support; those accredited without HIPS support and currently non-accredited clinics.

1.3.3 Sample Size Estimation for Exit Poll Interviews

A representative sample of clients served by HIPS project partner clinics will be enrolled for client exit interviews. Sample size calculations will be based on the national prevalence rates of the HIV/AIDS based on the following reasons i) HIPS Project used HIV/AIDS disease as an entry point for four main diseases of focus (HIV, Tuberculosis , Malaria and reproductive health problems) of the HIPS project for which it has undertaking health systems strengthening for improved disease outcomes, ii) HIV/AIDS is the least prevalent of the four diseases/conditions mentioned above and estimations based on HIV prevalence would enrol a representative sample of clients who receive services for all the four conditions iii) HIV occurrence takes a longer time to change and thus harder to detect changes.. The Sample size will be calculated to yield 80% power of the study at a level of 99% level of significance (α at 0.01 and β at 0.20). . The occurrence of HIV among clients will be analysed as a dichotomous variable and results expressed as a confidence interval around the estimated proportion (P) of clients with disease. The desired precision or total width (W) of the confidence interval will be 0.1 (0.05+0.05).

Sample size calculations will be based on current prevalence of HIV of 6.7% (AIDS Indicator Survey, 2011-MoH) in the general population. The following formula will be used to estimate the sample size (Stephen. B.et al, 1998):

$$N = 4 Z_{\alpha}^2 P(1-P) \div W^2$$

Where;

P= expected proportion who have the variable of interest = 0.067

(According to the 2011 Uganda AIDS indicator survey 6.7% Ugandan aged 15-49 years are HIV positive)

W= desired total width of the of the confidence interval = 0.1

Z_{α} = the desired normal deviate for a two-tailed α, where $(1-\alpha)$ is the confidence level (for 99% confidence level, $Z_{\alpha} = 2.576$).

Thus, $$N = \frac{4 \times (2.576)^2 \times 0.067 (1-0.067)}{(0.1)^2} = 166$$

Using the above formula, a sample size of 166 clients will be interviewed. However, this will be corrected with the design effect of 2 (there are 2 categories of facilities: Private for profit and Private Not for Profit) Thus 6 clients (3 men and 3 women) exit interviews will conducted at each of the health facilities visited giving a total of 360 client exit respondents.

1.4 Phases of the Evaluation and Data Collection methods

1.4.1: Phase 1. Preparatory Activities:

The first phase of the final evaluation study involved HIPS Project Staff, USAID Staff and the consulting team. The tasks accomplished in the first phase included:

i) Preliminary Meetings

This involved **c**onsultations and debriefing meetings with focal persons of HIPS Project and USAID staff regarding overall process of the project evaluation. The purpose of these meetings was to get consensus on the evaluation methodology and study tools. The meetings were also a forum to finalize on administrative aspects of the assignment.

ii) Desk review,

- HIPS project documents including the Project log-frame and M&E plans; M& E reports; annual and assessment reports; survey reports; feasibility studies; and other documents made available by HIPS, MOH and collaborating institutions. Secondary quantitative data: summary of project quantitative key indicators of HIPS project; quantitative data from partner clinics and collaborating institutions.

iii) Training of the Research Team

Prior to field visits, the consulting team participated in a four day workshop during which they were oriented on the evaluation methodology and data collection tools.

1.4.2 Phase 2: Field based Evaluation

This involved field visits to HIPS partner health facilities and collaborating institutions. Three (3) field teams each headed by a field supervisor were constituted as follows:

Respondent Category	Responsible Person/s	Remarks
Government/Ministry of Health and USAID Technical Working Group	• Augustus Nuwagaba • Simon Ssentumbwe • Sam Rutahindwa	These were high level respondents that held interviews with the consultants in the specialist areas
HIPS staff and Partner companies/clinics and USAID collaborating institutions	• Augustus Nuwagaba • Simon Ssentumbwe • Sam Rutahindwa • Associate Research Staff	These were the major and biggest number of respondents for the study. Therefore the consulting team added associate research staff (highly trained) to beef up the data collection team.
Clients (for client exit interviews)	• Field Staff	These constituted persons trained in data collection that was always engaged by REEV Consult International.

At the end of each day of field work, the supervisors met their respective teams to review the quality of data collected and where gaps existed, the interviewers were requested to go back and fill in missing data gaps. The team leader on daily basis kept contact with the supervisors for feedback and met the

field interviewers at least once every week to get feedback from the field work. The following data collection methods were used:

i) Key informant in-depth interviews:

Key informant interviews were conducted with participants who were purposively chosen for their deep knowledge of the project being evaluated. Interviews were conducted using a set of key informant interview guides for different categories of partners and institutions: Private Sector Partners (Health facilities), Funding and implementing agency (HIPS/USAID), Collaborating institutions and Ministry of Health (relevant programs & PPP-TWG), and OVC programme.

ii) Client Exit Poll interviews

Client exit interviews were conducted among respondents seeking services at the HIPS Project supported Health facilities.

iii) Focus Group Discussions

FGDs were conducted among the following

a) Beneficiaries of the OVC (Orphans and vulnerable children) in Kakira and Lira supported by HIPS Project.
b) Adults Men: these included men aged 20-45 within the OVC programme areas
c) Adult women: these included women aged 18-49 within the OVC programme areas.

The focus group discussions were used to explore the group perceptions on how employees and their families, individuals and community had benefitted from OVC activities supported by the HIPS Project

iv) Case Study:

After key informant interviews, the consulting team conducted a case study of OVC at Kakira Sugar works which was a good performer. This was done alongside the Focus Group Discussions that were conducted on OVC activities.

v) Observation during field visits:

Observational techniques using a check list was used as a data collection method in this evaluation study. Directly observed service provision, infrastructural support and equipment provided was documented with observers marking observations against a checklist.

i) Data Management and Analysis

All completed questionnaires were entered in EPIDATA V.3.1 software which had been fitted with a range and consistency checks. The data was then exported in STATA V9. A team of highly trained and experienced data entrants outsourced by REEV consult International under the supervision of a highly qualified data manager did data entry and analysis. Observation of security and confidentiality of data was at maximum.

Quantitative data from client exit polls was mainly analysed with descriptive analysis. Quantitative data from primary and secondary data sources was presented using graphic representation to show the trends of key indicators over time. The appropriate graphical format was utilized to plot key variables and assess the trend of key program indicators over time.

For qualitative data from Key Informant Interviews, Focus Group Discussions, the case study, and Observation, thematic analysis was done as follows:

a) Textual data was explored using content analysis. Data was read and re-read by the analysts in order to identify emerging themes from the responses.
b) All relevant data to each theme was identified and examined using the process of constant comparison, in which each item was checked or compared with the rest of the data in order to establish the analytical theme findings, conclusions and recommendations were guided by the Agency Evaluation Policy.

ANNEX 4: DATA COLLECTION INSTRUMENTS

KEY INFORMANTS INTERVIEW GUIDE

Ministry of Health

RESPONDENTS IDENTIFICATION NUMBER_____

COMPANY/CLINIC IDENTIFICATION NUMBER_____

DISTRICT _____

SUBCOUNTY / TOWN ___

URBAN	1	RURAL	2

INTERVIEW DATE 2011

LANGUAGE USED DURING THE INTERVIEW (ENGLISH) 01

ENGLISH	LUGBARA
1	4
LUO	NGAKARIMAJONG
2	5
LUGANDA	4 RS
3	6

SUPERVISOR'S APPROVAL……

This tool will be used to interview the key officials at the MoH headquarters and the national level Private sector partners; on:

a) Organization, coordination and management of HIPS Project support to the private sector including plans for sustainability
b) Integration of HIPS Project support to HIV/AIDS/TB/Malaria/ RH/FP and other primary health care services
c) Structures and systems in place to support Private sector activities
d) Involvement of HIPS Project partners in HIV/AIDS/TB/Malaria/ RH/FP and other primary health care services

The key informants will include:

a) Director General of Health Services
b) STD/AIDS Control Programme
c) Tuberculosis and Leprosy program
d) Malaria Control Programme
e) Reproductive Health and Family planning program
f) Central Public Health Laboratory

1. Comment about the level Political commitment at national level

Probe for the following:

a) Status/prioritization of Private sector in the National Health Policy, Health Sector Strategic Plan and National Strategic Plan for HIV/AIDS/TB/Malaria/ RH/FP and Laboratory services
b) Feedback to policy makers on progress HIPS Project support to private sector contribution to Health systems strengthening.
c) Level of involvement of the Minister of Health and high- level officials at MoH in Private sector and HIPS project support to Health sector.

2. Private Public Partnership (PPP) Portfolio at MoH

Probe for the following:

a) Status of PPP Health policy and how it impacts on PPP support activities and initiatives including HIPS Project.
b) Staff assigned to the PPP Unit and PPP focal persons HIV/AIDS/TB/Malaria/ RH/FP and laboratory services programs at the national and district level
c) The chain of supervision of PPP focal persons and linkages with HIPS Project partners from the national to the health facility level.
d) Plans for capacity building to support PPP activities.
e) Functionality of PPP technical committee (TWG), strengths and weaknesses? How can it be improved?

3. HIPS Project support to PPP Activities, coordination and integration into HIV/AIDS/TB/Malaria/ RH/FP services

Probe for the following:

a) Effectiveness of HIPS Project support to the management and coordination of private sector contribution in HIV/AIDS/TB/Malaria/ RH/FP and laboratory services in Uganda

b) Mechanisms for coordination and linkages between PPP unit, HIPS Project and HIV/AIDS/TB/Malaria/ RH/FP and laboratory programs

c) Innovations and approaches in which the HIPS Project has impacted on the PPP activities country wide. How effective have these been?, How can they be scaled up?

d) For innovations and approaches by HIPS project that are considered successful in delivery of HIV/AIDS/TB/Malaria/ RH/FP and laboratory services; probe for the following:

- What worked well and why?
- What was key in achieving project results?
- What didn't work well and why?
- What was key in hindering project results?
- If you had to replicate the process which aspect would you retain?
- If you were to replicate the process which aspect would you exclude?
- If you were to replicate the process which process would you change?
- How would you change it?
- What other improvements are necessary?

KEY INFORMANTS INTERVIEW GUIDE

District Level (District Health Officer)

RESPONDENTS IDENTIFICATION NUMBER_____

COMPANY/CLINIC IDENTIFICATION NUMBER_____

DISTRICT _____

SUBCOUNTY / TOWN ___

URBAN	1	RURAL	2

INTERVIEW DATE 2011

LANGUAGE USED DURING THE INTERVIEW (ENGLISH) 01

ENGLISH	LUGBARA
1	4
LUO	NGAKARIMAJONG
2	5
LUGANDA	4 RS
3	6

SUPERVISOR'S APPROVAL……

1. **HIPS Project support to the Private sector in the provision of HIV/AIDS/TB/Malaria/ RH/FP and Laboratory services (Partnerships) at the district level**

Probe for the following:

a) Partnerships that have been developed in implementing the HIPS project at the district level; with private sector/practitioners, NGOs, CBOs, other groups,

b) Involvement of HIPS Project staff, partners/ private sector in the planning for HIV/AIDS/TB/Malaria/ RH/FP and Laboratory services at the district level.

c) Involvement in direct implementation at the district and health facility level.

d) Involvement of HIPS Project staff and partners in Monitoring and evaluation HIV/AIDS/TB/Malaria/ RH/FP and Laboratory activities.

d) Compliance of HIPS staff and partners with national standards.

e) Challenges/constraints and successes.

f) For the HIPS project partners that are considered successful in delivery of HIV/AIDS/TB/Malaria/ RH/FP and Laboratory services at the district level; probe for the following:

- What worked well and why?
- What was key in achieving project results?
- What didn't work well and why?
- What was key in hindering project results?
- If you had to replicate the process which aspect would you retain?
- If you were to replicate the process which aspect would you exclude?
- If you were to replicate the process which process would you change?
- How would you change it?
- What other improvements are necessary

2) What are the key private health sector issues in the district and how has the HIPS project helped to address them (Probe: district awareness of the role of the private sector; regulation; private sector mandate; access to information on private sector activities; existence of and effectiveness of district level coordination mechanisms)

2) Feedback on HIPS project approaches and innovations in private health sector support?

KEY INFORMANTS INTERVIEW GUIDE

HIPS Project Staff

RESPONDENTS IDENTIFICATION NUMBER_____

COMPANY/CLINIC IDENTIFICATION NUMBER_____

DISTRICT _____

SUBCOUNTY / TOWN ___

URBAN	1	RURAL	2

INTERVIEW DATE 2011

LANGUAGE USED DURING THE INTERVIEW (ENGLISH) 01

ENGLISH	LUGBARA
1	4
LUO	NGAKARIMAJONG
2	5
LUGANDA	4 RS
3	6

SUPERVISOR'S APPROVAL……

This tool will be used to interview the key staff at the HIPS Project on the following issues:

a) Organization, coordination and management of HIPS Project support to the private sector including plans for sustainability
b) Integration of HIPS Project support to HIV/AIDS/TB/Malaria/ RH/FP and other primary health care services
c) Structures and systems in place to support Private sector activities
d) Involvement of HIPS Project partners in HIV/AIDS/TB/Malaria/ RH/FP and other primary health care services

The key informants will include the following:

i. Chief of Party, HIPS Project
ii. Team Leader Health Services
iii. Team leader OVC Program

1. Comment about the level of Political commitment at national level.

Probe for the following:

a) Status/prioritization of support to Private Sector Health facilities in the National Health Policy (vertical or integrated programme) and National Health Sector Strategic Plan and National Strategic Plan for HIV/AIDS/TB/Malaria/ RH/FP/OVC.
b) Resource allocation by HIPS Project/ USAID to Private sector support in HIV/TB/Malaria/RH/FP and the health sector in general, (proportion of HIV/AIDS/TB/Malaria/ RH/FP/OVC funds allocated to Private sector).
c) Feedback to policy makers on progress in private sector contribution in implementation of HIV/AIDS/TB/Malaria/ RH/OVC interventions.
d) Level of involvement of the Government (MoH of Health) in private health sector support and in service delivery.

2. HIPS Project Support to Partner companies/ private clinics in Health Service provision for HIV/AIDS/TB/Malaria/ RH/FP/OVC services

Probe for the following

a) Specific annual targets for private sector (GDA/ clinics/OVC) expansion and achievements to date.
b) Number of GDAs/Partner company/ private clinic sites and proportion of these facilities providing HIV/AIDS/TB/Malaria/ RH/FP/OVC services.
c) Successes, Challenges/constraints in overall HIPS project support to GDAs/companies/ private clinics.
f) For the HIPS project support to GDAs/companies/ clinics that are considered successful/not successful in enhancing service delivery to target communities; probe for the following:
    - What worked well and why?
    - What was key in achieving project results?
    - What didn't work well and why?
    - What was key in hindering project results?
    - If you had to replicate the process which aspect would you retain?
    - If you were to replicate the process which aspect would you exclude?
    - If you were to replicate the process which process would you change?
    - How would you change it?
    - What other improvements are necessary?

3. HIPS Project support to Capacity building in Private sector companies and clinics:

Probe for the following:

HIPS project achievements in training and provision of human resources for service delivery for HIV/AIDS/TB/Malaria/ RH/FP/OVC services in private sector health facilities against its project plan.

a) Number of Health workers trained to provide quality HIV/AIDS/TB/Malaria/ RH/FP/OVC services among partner companies and clinics.
b) Adequacy of training given to Health workers to provide HIV/AIDS/TB/Malaria/ RH/FP/OVC services among private sector health facilities.
c) The chain and quality of supervision of HIPS supported private sector clinics from the national to the health facility level.
d) Availability of tools (policy guidelines, treatment guidelines, job aides, manuals, algorithms and HMIS registers at the private sector partner sites.

4. Coordination and integration into Ministry of Health programs (HIV/AIDS/TB/Malaria/ RH/FP) and other primary health care services

Probe for the following:

a) Comment on the roles and functionality of the of HIPS Project as an IP responsible for management and coordination of USAID support to private sector clinics in HIV/AIDS/TB/Malaria/ RH/FP/OVC interventions in Uganda.

b) Appropriateness of the current organizational structure of HIPS project support to private sector clinics for the successful implementation of the HIV/AIDS/TB/Malaria/RH/FP/OVC programmes? Explain. (Probe for the umbrella [UFE, UMA, UPPA, UHF, PSF, Direct support to clinics] organization is most appropriate).
c) Mechanisms for coordination and linkages between HIPS supported private sector companies/clinics and Ministry of Health (PPP unit, AIDS Control Program, National Tuberculosis & Leprosy program, Malaria Control Pragram, RH/FP, Central Public Health Laboratory/OVC) at the national level.
d) Other ways in which the HIPS Project support to private sector has impacted on the HIV/AIDS/TB/Malaria/ RH/FP/OVC and other primary health care services in Uganda.

5. Partnership development (Public- Private Partnerships, International partnerships)

Probe for the following:

a) Partnerships that have been developed by HIPS Project in implementing the programme with private sector/practitioners, MoH, NGOs, CBOs, other groups international or bilateral agencies.
b) HIPS project support to partners in the planning and policy formulation for private sector activities.
c) HIPS project support to partners in direct implementation at the district and health facility level.
d) HIPS project support to partners involvement in Monitoring and evaluation of the private sector activities.
e) Compliance of private sector partners with national standards/policies/guidelines.

6. HIPS Project Approaches and Innovations in Health Systems Strengthening among Partners (GDAs/Companies/Clinics/OVC)

Health system component	HIPS support and Achievements	Innovation among Partners
Leadership and governance (Coordination, partnerships, accountability etc)		
Service delivery (increasing access and equity of services)		
Health financing (Medical schemes, insurance schemes, provider fees, grants, co-financing, contracting out services etc)		
Health information (HMIS, M&E)		
Vaccines and technologies (Drug & commodity logistics, Laboratories and diagnostics)		
Health workforce (Human resource)		

7. HIPS Project successes and Failures

a) Successes, Challenges/constraints in partnerships

b) For the partnerships that are considered successful in delivery of HIV/AIDS/TB/Malaria/ RH/FP/OVC activities; probe for the following:

- What worked well and why?
- What was key in achieving project results?
- What didn't work well and why?
- What was key in hindering project results?
- If you had to replicate the process which aspect would you retain?
- If you were to replicate the process which aspect would you exclude?
- If you were to replicate the process which process would you change?
- How would you change it?
- What other improvements are necessary?

8. Sustainability of partnerships and service delivery after HIPS Project

Sustainability of HIPS project approaches/innovations and plans (institutional/financial/programmatic) and potential for continuity of HIV/AIDS/TB/Malaria/ RH/FP/OVC service provision after end of USAID/HIPS project support to private sector clinics/comp

KEY INFORMANTS INTERVIEW GUIDE

HIPS Project Partner Companies and Clinics (Health Facility Level)

RESPONDENTS IDENTIFICATION NUMBER_____

COMPANY/CLINIC IDENTIFICATION NUMBER_____

DISTRICT _____

SUBCOUNTY / TOWN ___

URBAN	1	RURAL	2

INTERVIEW DATE 2011

LANGUAGE USED DURING THE INTERVIEW (ENGLISH) 01

ENGLISH	LUGBARA
1	4
LUO	NGAKARIMAJONG
2	5
LUGANDA	4 RS
3	6

SUPERVISOR'S APPROVAL……

This tool will be used to interview the key staffs at HIPS Project Partners (GDAs/Companies/Clinics) on the following issues:

i) Improving quality and access to HIV/AIDS/TB/Malaria/ RH/FP/Laboratory and other primary health care services
ii) Capacity building for HIV/AIDS/TB/Malaria/ RH/FP/Laboratory and other primary health care services
iii) Partnerships/collaborations.
iv) Creative approaches and innovation in HIV/AIDS/TB/Malaria/ RH/FP/Laboratory service delivery.
v) Sustainability of services HIV/AIDS/TB/Malaria/ RH/FP/Laboratory service delivery.

The key informant interviewees will include the following:

- Health Facility In –Charges.
- Heads of HIV/AIDS/TB/Malaria/ RH/FP/ Laboratory units.
- Staff Providing HIV/AIDS/TB/Malaria/ RH/FP/Laboratory units

A. HIPS Support to Quality and Access to Service delivery

1. Quality Service delivery of HIV/AIDS/TB/Malaria/ RH/FP/Laboratory services

Probe for the following:

a) Capacity building needs among partner clinics
b) HIPS Project support in availing and utilization of the national HIV/AIDS/TB/Malaria/ RH/FP/Laboratory guidelines and protocols at the site; Are the guidelines used at this site? If not why not?
c) HIPS project support of training of staff involved in HIV/AIDS/TB/Malaria/ RH/FP/Laboratory activities.
d) List the cadre of staff who provide HIV/AIDS/TB/Malaria/ RH/FP/Laboratory services

Title	Background	HIPS Training

Background – Dr, Clinical officer, nurse, lab technician, counselor etc
HIPS Training – subject areas in which has received training

e) Provide details on laboratory capacity at the partner facility (CD4, PCR, hematology, clinical chemistry, OI diagnostics, other) and training in use of these equipments. Which tests are sources out and where?

2. HIPS support to Monitoring, evaluations and quality for the HIV /TB/Malaria/RH/FP services at the health facility level

Probe for the following:

a) Collection, analysis and reporting of data at the partner site. Describe how this is done. Are forms and other logistics available at the site? Are staffs trained to do this?
b) Integration of HIV /TB/Malaria/RH/FP in the HMIS
c) Data quality; How does the site ensure quality of data collection?

d) Data flow: describe the data flow from the facility to the national level. How often is this data provided and how often is feedback received?
e) Utilization of programme data to inform management decisions. How is the data utilized at site level? By whom? How often?
f) Is regular feedback received from the HIPS Project, district and national level concerning implementation data?
g) Information sharing: How is relevant information shared? What kind of information is shared
h) Support supervision by HIPS/MoH and frequency

3. Community Support and involvement in HIPS Project activities

a) Community initiatives and availability of support groups: Are there HIV /TB/Malaria/RH/FP support groups at the facility? Are there community networks available to:
b) Provide psychosocial support to clients?
c) Provide food and nutrition support to clients?
d) Provide livelihood Support (Income generating activities [IGA], Village Saving and Loan Association [VSLA])
e) Are there micro-credit interventions available to clients or their families /communities?
f) Communication with the communities: What regular communication is there between the HIPS project partner and the local support groups
g) Community mobilization for HIPS Project supported services: What community mobilization activities are implemented at facilities ; Are they isolated events or sustained programmes at selected or all facilities?
h) Ways in which the communities contribute to the HIPS projected supported services.
i) What are the constraints to/gaps in support for HIV-infected women in this area?
j) For the community support activities that are considered successful/not successful; probe for the following:
k) What worked well and why?
l) What was key in achieving project results?
m) What didn't work well and why?
n) What was key in hindering project results?
o) If you had to replicate the process which aspect would you retain?
p) If you were to replicate the process which aspect would you exclude?
q) If you were to replicate the process which process would you change?
r) How would you change it?
s) What other improvements are necessary?

4) HIPS support to Management of essential HIV /TB/Malaria/RH/FP/laboratory commodities at the HIPS partner health facility

Probe for the following:

a) Procedures followed in the selection and procurement of commodities test kits, consumables, ARVs and discuss successes and constraints).
b) Availability of ARVs in the health facility; availability of HAART, ARV prophylaxis for PMTCT, FP supplies (LTPM), test kits/lab reagents, condoms etc.
c) Availability of drugs for opportunistic infections at the health facility.
d) Availability of pediatric ARV formulations at the health facility.
e) Frequency of stock outs (for ARVs, cotrimoxazole, test kits, other logistics) and contributory factors.
f) Cost for delivery of supplies; cost recovery mechanisms; payment for services and supplies by the PMTCT clients.

g) Storage and distribution of supplies; use of stock cards; tracking data around reception and distribution and it use for supply planning.

h) Challenges/constraints/successes which the program is currently facing in logistics management of the PMTCT commodities at the health facility level.

5) HIPS Support to Integration of HIV/AIDS/TB/Malaria/ RH/FP/Laboratory services and impact on other primary healthcare services

Probe for the following:

a) Accommodation of the HIPS Project supported HIV/AIDS/TB/Malaria/ RH/FP/Laboratory services regarding space in existing facilities (has additional space been provided, have other services displaced, has there been space sharing, Was space already available).

b) Other ways in which HIPS project supported activities have impacted onother primary healthcare services provided by the company/clinic .

6) HIPS Support to Partnerships/collaborations

Probe for the following:

a) Presence of linkages to other Public sector /Ministry of health

b) Strategic partnerships that have been developed in HIPS project activities with NGOs, CBOs, private sector/practitioners, international and bilateral agencies

c) For the partnerships that are considered successful in delivery of HIV/AIDS/TB/Malaria/ RH/FP, Laboratory and other primary health care services ; probe for the following:

- What worked well and why?
- What was key in achieving project results?
- What didn't work well and why?
- What was key in hindering project results?
- If you had to replicate the process which aspect would you retain?
- If you were to replicate the process which aspect would you exclude?
- If you were to replicate the process which process would you change?
- How would you change it?
- What other improvements are necessary?
- Innovations that have evolved during implementation?
- Plans for sustainability?

7). Sustainability Plans for HIPS partners at end HIPS Project

Sustainability plans (institutional/ financial/programmatic) and potential for continuity of HIV/AIDS/TB/Malaria/ RH/FP service provision after end of USAID/HIPS project support to private sector clinics/companies.

KEY INFORMANTS INTERVIEW GUIDE

Client Exit Questionnaire

1 RESPONDENTS IDENTIFICATION NUMBER_____

2 TYPE OF FACILTY (FP/NFP) _____

3 COMPANY/CLINIC IDENTIFICATION NUMBER _____

4 NAME OF INVESTIGATOR ___

_____

URBAN	1	RURAL	2

5 INTERVIEW DATE 2011

6 LANGUAGE USED DURING THE INTERVIEW (ENGLISH) 01

ENGLISH	LUGBARA
1	4
LUO	NGAKARIMAJONG
2	5
LUGANDA	4 RS
3	6

SUPERVISOR'S APPROVAL……...……

Respondent is a client exiting a service at a HIPS partner Clinic health facility

Dear Participant,
You have been randomly selected to be part of this study and we would therefore like to ask you some questions The study is being conducted by REEV Consult International and the information you provide will only be used to understand quality of HIV/AIDS/TB/Malaria/RH/FP services offered in this facility; and how clients view these services. This information is necessary for the effective planning of improved health care delivery in private clinics Uganda.

You are kindly requested to provide the information required as sincerely as possible. The interview will take approximately 30 minutes. You will be asked questions about:

- Background information
- Health seeking practice
- Perceptions about HIV/AIDS/TB/Malaria/RH/FP services

The information you provide is totally confidential and will not be disclosed to anyone. It will only be used for research purposes. Your name is not required.
Your participation is voluntary and you can withdraw from the study at any time of your choice even after having agreed to participate. You are free to opt not to answer any question that is asked in the questionnaire.

Ask respondent if he/she consents, if the answer is yes then proceed with interview (Saying yes indicates respondent understands what will be expected of them and their willingness to participate in the survey).

100: Respondent's Background Characteristics

N°	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
	Sex	Male.....1 Female.....2	
101	Age (write the block age)	.....Years	
102	Religious Affiliation	Protestant/Anglican.....1 Catholic.....2 Muslim.....3 Other (specify).....4	
103	Marital Status	Married.....1 Single.....2 Separated.....3 Widowed.....4 Others (specify).....5	
104	Main Occupation	Teacher.....1 Driver.....2 Peasant Farmer.....3 Trader.....4 Waiter/waitress.....5 Artisan .....6 Others (Specify).....7	
105	Level of education of respondent	Never went to School .....1 Primary .....2 Secondary.....3 Post-Secondary.....4 Other.....5	

Nº	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
106	Level of education of the spouse	Never went to School ……...……1 Primary .....……...……..…….. 2 Secondary……...…… …..……..3 Post-Secondary……...……...… …….4 Other.....……...…… ...…….5	
107	Can you read and write? *(Give a respondent something to read)*	Yes.....……...…… ……...……..1 No.....…….. …...…….2	

200: Health care Practice

N°	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
201	Nature of service received	Malaria Services ……..…..…..……1 HIV/AIDS /PMTCT services ….……..2 TB services ...……..……..…..……..3 Reproductive health/Family planning services .....…..…..……...……4. Laboratory services.....5 Other.....…..…..…...……..… ……...6	
102	Were you given a referral to come to this facility?	Yes.....……..…… ……..……..1 No.....…….. …..…….2	
103	How much time did you spend for your visit at this clinic today?	_____ minutes	
104	What is your view about the time you spent to get the service?	Too Much..…..……..…… ……1 Just Right…….……..…… ……2 Too Short….....…..…… …….3	
105	Upon your arrival at the clinic did the staff offer you HIV/AIDS/TB/Malaria/RH/FP counseling?	Yes.....……..…… ……..……..1 No.....…….. …..…….2 N/A….....…..…… …….3	
106	How long did the Health provider (or other staff) take talking to you during counseling/treatment?	_____ minutes	
107	Is there anything you did not like during the treatment/provision of the services?	Yes.....……..…… ……..……..1 No.....…….. …..…….2	
108	If yes, please explain more about it	....	

N°	QUESTIONS AND FILTERS	CODING CATEGORIES			SKIP TO
109	What were the good things (that you liked) about the treatment/service that you received?	....			
110	Did you feel comfortable with your Health service provider?	Yes.....……..…… ……..……..1 No.....…….. …..…….2			
111	Do you think there was enough privacy during treatment / service provision?	Yes.....……..…… ……..……..1 No.....…….. …..…….2			
112	Were you comfortable with laboratory services/ other tests done?	Yes.....……..…… ……..……..1 No.....…….. …..…….2			
113	Was the provider friendly to you?	Yes.....……..…… ……..……..1 No.....…….. …..…….2			
114	What barriers do you think affect you or prevent you or other people you know from accessing and utilizing the HIV/AIDS/TB/Malaria/RH/FP services	..... ……..……1 .....……..…… …….……..2 .....……..…… …….…….3 .....……..…… …..…….4 .....……..…… …..…….5			
115	Rank the importance of the following barriers to HIV/AIDS/TB/Malaria/RH/FP services as you or any other people you know experience it in this clinic				
	Barrier	**High**	**Moderate**	**Low**	
a)	Distance & cost from home				
b)	Cost of services				
c)	Lack of privacy in busy clinics				
d)	Perceived lack of skilled health providers				
e)	Perceived lack of concern on the part of health staff				
f)	Inadequate medical equipment				
g)	Inadequate laboratory / other testing services				
h)	Any other barrier				

Nº	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
116	Overall ranking/ assessment of services received	Very Satisfied……..…… ……1 Satisfied...…..……..…… ……2 Not Satisfied.....…..…… ….3 Not Sure.....…..…… …….3	
117	In your opinion, what three major things do you think should be improved?	..... ……...……. .....……...…… …….…….....1 .....……...…… …….……... .....……..…… …..…….2 .....……..…… …..…….... 3	
118	Are you aware of HIPS/USAID support to this clinic to provide quality and subsidized HIV/AIDS/TB/Malaria/RH/FP services to this community?	Yes.....……...…… ……...……..1 No.....…….. …..…….2	

Thank you for your cooperation and time

KEY INFORMANTS INTERVIEW GUIDE

OVC Programs Supported by HIPS Project

RESPONDENTS IDENTIFICATION NUMBER_____

COMPANY/CLINIC IDENTIFICATION NUMBER_____

DISTRICT _____

SUBCOUNTY / TOWN ___

URBAN	1	RURAL	2

INTERVIEW DATE 2011

LANGUAGE USED DURING THE INTERVIEW (ENGLISH) 01

ENGLISH	LUGBARA
1	4
LUO	NGAKARIMAJONG
2	5
LUGANDA	4 RS
3	6

SUPERVISOR'S APPROVAL……

100:	**Organization background of HIPS Project Partner**		
	Name of organization	....	
	Name of respondent	....	
	Position/Responsibility in Organization	....	
	When was the OVC program initiated	....	
	How large is the catchment area of the program	....	
	How many clients are served (Direct/Indirect)	....	
200	**Organization Structure of HIPS Project Partner**		
201	Type of OVC program (NGO,CBO, Company affiliated, Clinic affiliated)		
202	Head of program		
203	Who coordinates OVC program		
300	**Staff Composition**		
301	Permanent staff		
302	Part-time staff		
	Volunteers		
400	**OVC Services and Activities supported by HIPS Project Partners**		
a)	Nature of clients accepted	AIDS orphaned ……....……1 All orphaned…….....…..…… ……2 All vulnerable children (probe).....3 Not Sure.....….…..…… …….3	
b)	Methods of enrolment	Others.....1 From hospital/clinic/health facility.2 From Community.....3 Self referral.....4	

	Name of organization	....	
c)	What is the range of services provided and supported by HIPS project and partners		
d)	Shelter	....	
e)	Food and dressing	....	
f)	Education/ school fees/scholastic materials	....	
g)	OVC Rights protection	....	
h)	Clinical and nursing care	....	
i)	Counseling, psycho-social support	....	
j)	Financial/IGA assistance	....	
k)	Home help	....	
l)	Support groups	....	
m)	AIDS prevention & STI treatment	....	
500	Describe the criteria used for provision on OVC support to those in need	....	
600	**Capacity building in OVC support by HIPS project /Partner**		

	Name of organization	....	
601	HIPS project achievements in training and provision of skilled personnel in OVC support programs.		
a)	Number of people trained in OVC support and care		
b)	Content and adequacy of training given to OVC program providers		
c)	Adequacy of trained OVC providers in program		
d)	The quality of supervision of OVC program		
700	**OVC innovations among HIPS supported programs**		
701	What new innovations / initiatives have you incorporated to improve in your OVC programs that have resulted in high quality impact?	....	
702	For OVC support initiatives/activities that are considered successful/not successful; probe for the following:		
a)	What worked well and why?		
b)	What was key in achieving project results?		
c)	What didn't work well and why?		
d)	What was key in hindering project results?		
e)	If you had to replicate the process which aspect would you retain?		
f)	If you were to replicate the process which aspect would you exclude?		
g)	If you were to replicate the process which process would you change?		
h)	How would you change it?		
i)	What other improvements are necessary?		

703 Partnerships/Collaborations among HIPS supported OVC supported programs

i) Presence of linkages to other Public sector /government department

……
……..

2) Strategic partnerships that have been developed in OVC program with NGOs, CBOs, private sector/practitioners, international and bilateral agencies

……
……..

3) For the partnerships that are considered successful in delivery of OVC care: probe for the following:

- What worked well and why?

……
……..

- What was key in achieving program results?

……
……..

- What didn't work well and why?

……
……..

- What was key in hindering programresults?

……
……..

- If you had to replicate the process which aspect would you retain?

……
……..

- If you were to replicate the process which aspect would you exclude?

……
……..

- If you were to replicate the process which process would you change?

……
……..

- How would you change it?

……
……..

- What other improvements are necessary?

……
……..

- Innovations that have evolved during implementation?

……
……..

- Plans for sustainability?

……
……..

704 Sustainability Plans for HIPS partners at end HIPS Project

Sustainability plans (institutional/ financial/ Programatic) and potential for continuity of HIV/AIDS/TB/Malaria/ RH/FP service provision after end of USAID/HIPS project support to private sector clinics/companies.

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Thank you for your cooperation and time

KEY INFORMANTS INTERVIEW GUIDE

USAID Staff (CTO, Team Leader –HIV/AIDS, Team Leader-Presidential Malaria Initiative)

RESPONDENTS IDENTIFICATION NUMBER_____

COMPANY/CLINIC IDENTIFICATION NUMBER_____

DISTRICT _____

SUBCOUNTY / TOWN ___

URBAN	1	RURAL	2

INTERVIEW DATE 2011

LANGUAGE USED DURING THE INTERVIEW (ENGLISH) 01

ENGLISH 1 LUO 2 LUGANDA 3	LUGBARA 4 NGAKARIMAJONG 5 4 RS 6

SUPERVISOR'S APPROVAL……

1. Partnerships

Probe for the following:

a) Support to the HIPS Project to expand access and increase utilization of HIV/AIDS/TB/Malaria/ RH/FP, Laboratory and other primary health care services among HIPS partner companies /clinics.

b) Support for Capacity building among HIPS project partners in HIV/AIDS/TB/Malaria/ RH/FP, Laboratory and other primary health care services delivery

c) Support to HIPS Project and partners for involvement in the national and district level health planning and policy formulation.

c) Support for direct implementation at the HIPS project partner companies and clinics/facility level.

d) Support in Monitoring and evaluation of the HIPS Project supported activities.

e) Challenges/constraints and successes.

f) For the HIPS Project innovation and partnerships that are considered successful in delivery of HIV/AIDS/TB/Malaria/ RH/FP, Laboratory and other primary health care services ; probe for the following:

- What worked well and why?
- What was key in achieving project results?
- What didn't work well and why?
- What was key in hindering project results?
- If you had to replicate the process which aspect would you retain?
- If you were to replicate the process which aspect would you exclude?
- If you were to replicate the process which process would you change?
- How would you change it?
- What other improvements are necessary?
- Innovations that have evolved during implementation?
- Plans for sustainability?

2. Funding mechanisms for implementation of HIPS Project activities

Probe for the following:

a) Amount of funds provided to HIPS Project and HIPS Partners to implement HIV/AIDS/TB/Malaria/ RH/FP, Laboratory and other primary health care activities.

b) Funding modalities used to support HIPS Project and Partners.

c) Direct support to the HIPS Project partners and challenges faced.

d) Extent of alignment of the various funding mechanisms to HIPS project partners and National strategy (NSP / HSSP).

f) Challenges/constraints/successes.

g) For the funding mechanisms that are considered successful/not successful in supporting HIPS Project activities; probe for the following:

- What worked well and why?
- What was key in achieving project results?
- What didn't work well and why?
- What was key in hindering project results?
- If you had to replicate the process which aspect would you retain?
- If you were to replicate the process which aspect would you exclude?
- If you were to replicate the process which process would you change?
- How would you change it?
- What other improvements are necessary?
- Innovations that have evolved during implementation?

3. Sustainability Plans for HIPS Project partners at end HIPS Project

Sustainability plans (institutional/ financial/programmatic) and potential for continuity of HIV/AIDS/TB/Malaria/ RH/FP service provision after end of USAID/HIPS project support to private sector clinics/companies.

Thank you for your cooperation and time

KEY INFORMANTS INTERVIEW GUIDE

HIPS PROJECT COLLABORATING INSTITUTIONS (UMA; FUE; UHMG; MILD MAY CENTRE, UHF, JHUB

RESPONDENTS IDENTIFICATION NUMBER_____

COMPANY/CLINIC IDENTIFICATION NUMBER_____

DISTRICT _____

SUBCOUNTY / TOWN ___

URBAN	1	RURAL	2

INTERVIEW DATE 2011

LANGUAGE USED DURING THE INTERVIEW (ENGLISH) 01

ENGLISH	LUGBARA
1	4
LUO	NGAKARIMAJONG
2	5
LUGANDA	4 RS
3	6

SUPERVISOR'S APPROVAL……

1. **Partnerships**

Probe for the following:

a) Your involvement HIPS Project activities to expand access and increase utilization of HIV/AIDS/TB/Malaria/ RH/FP, Laboratory/OVC support and other primary health care services among HIPS partner companies /clinics.

b) Your involvement in Capacity building initiatives among HIPS project partners in HIV/AIDS/TB/Malaria/ RH/FP, Laboratory/OVC support and other primary health care services delivery

c) Your involvement in the national and district level health planning and policy formulation among HIPS Project partners.

c) Your involvement in direct implementation by HIPS project partner companies and clinics/facility level.

d) Your involvement in Monitoring and evaluation of the HIPS Project supported activities.

e) Challenges/constraints and successes.

f) For the HIPS Project innovation and partnerships that are considered successful in delivery of HIV/AIDS/TB/Malaria/ RH/FP, Laboratory/OVC support and other primary health care services ; probe for the following:

- What worked well and why?
- What was key in achieving project results?
- What didn't work well and why?
- What was key in hindering project results?
- If you had to replicate the process which aspect would you retain?
- If you were to replicate the process which aspect would you exclude?
- If you were to replicate the process which process would you change?
- How would you change it?
- What other improvements are necessary?
- Innovations that have evolved during implementation?
- Plans for sustainability?

2) Sustainability Plans for HIPS Project partners at end HIPS Project

Sustainability plans (institutional/ financial/programmatic) and potential for continuity of HIV/AIDS/TB/Malaria/ RH/FP service provision and OVC support after end of USAID/HIPS project support among partner private sector clinics/companies.

Thank you for your cooperation and time

ANNEX 5: LIST OF DOCUMENTS REVIEWED

Cassandra Blazer and Meghan Majorowski (2011): The HIPS Project. Extending Healthcare Through the Private Sector in Uganda. AIDSTAR One. Case Study Series. February 2011.

Emerging Markets Group (2007) Company to community treatment partnerships: an evaluation of community AIDS treatment partnerships under the Uganda Business Part project. August 2007.

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Government of the Republic of Uganda (2005); The Uganda Health Sector Strategic Plan. Kampala, Uganda

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Kelly McCoy, Dithan Kiragga, Barbara Addy and Frank G. Feeley (2011); Costs and outcomes of delivering ART in the Private and Public Sectors in Uganda. Kampala, Uganda 2011

Obrien and Associates International (2011); Health Care Franchising in Uganda, Kampala

Paul Bukuluki (2009); Impact of ART on employer costs related to AIDS- Report

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Uganda Health Marketing Group (2011); A Manual for the Training of Trainers of Peer Educators, Kampala, Uganda

Uganda Health Marketing Group (2011); Handbook for Peer Educators, Second Edition, Kampala, Uganda

Uganda Manufacturers Association (2009), Involvement of the Corporate Sector in support for Orphans and Vulnerable Children and Reproductive Health in Uganda.

Wilsken Agencies (2008); Formative Study for HIPS' Good Life Project, HIPS Uganda

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ANNEX 6: SUMMARY OF HEALTH FACILITIES SAMPLED FOR THE EVALUATION

	Health facility	Location
	Private Health Facilities	
1.	Abii Clinic	Wandegeya-Kampala
2.	Busabala Road Nursing Home	Basabara Road-Kampala
3.	Case Clinic	Buganda Road, Kampala
4.	Crane Medical Centre	Kampala Road-Kampala
5.	Double Cure Medical Centre	Mpigi
6.	Good Will Nursing Home	Mutungo-Kampala
7.	Ikan Clinic	Bukoto, Kampala
8.	Kabalega Medical Centre	Hoima
9.	Kadik Health Centre	Nakulabye, Kampala
10.	Kireka SDA Clinic	Kireka, Kampala
11.	Kyaliwajala Clinic	Bweyogerere, Kampala
12.	Lambu Clinic	Masaka
13.	Lukuli Hope Clinic	Makindye, Kampala
14.	Mirembe Medical Centre	Wakiso
15.	Musoke Domicilliary Clinic	Ntinda-Kampala
16.	Norvik Hospital	Bombo Road, Kampala
17.	Old Kampala Hospital	Kampala
18.	Paragon Hospital	Bugolobi, Kampala
19.	Philomena Clinic	Kikoni-Kampala
20.	Safeguard Nursing Home	Makindye-Kampala
21.	SAS Foundation	Bugolobi, Kampala
22.	SEO Clinic	Ntinda-Kampala
23.	Sims Medical Centre	Rubaga, Kampala
24.	St. Catherine Clinic	Buganda Road-Kampala
25.	St. Charles Medical Centre	Mityana
26.	St. Joseph's Clinic	Wandegeya, Kampala
27.	St. Mary's Medical Centre	Entebbe
28.	Touch Namwongo Project	Namwongo-Kampala
29.	Tropical Clinic	Entebbe
30.	Victoria Medical Centre	Buganda Road, Kampala
	Company Clinics /GDAs	
31.	Ankole Growers Tea factory	Bushenyi
32.	Crown Beverages	Kampala
33.	FIDUGA- Nsimbe Estates	Wakiso
34.	Hima Cement Ltd Clinic	Kasese
35.	IAA Royal van Zanten	Mukono
36.	Kakira Sugar Works Ltd. Clinic	Jinja
37.	Kinyara Sugar Works	Masindi
38.	Kitante Medical Centre	Kampala
39.	Luweero Industries	Nakasongola
40.	Mabaale Growers' Tea Estate	Kyenjojo
41.	Makerere University Hospital	Kampala.
42.	Mt. Elgon Orchard	Mbale

43.	Nakigalala Tea Estate Clinic	Entebbe
44.	New Forest Company Ltd. Clinic	Kiboga
45.	Nile Breweries Clinic	Jinja
46.	NYTIL Clinic	Jinja
47.	Reco Industries	Kasese
48.	Roofings Ltd. Clinic	Entebbe
49.	Rwenzori commodities- Buzirasagama	Kyenjojo
50.	SCOUL (Lugazi) Clinic	Lugazi
51.	Tam Teco – Kyamara	Kabarole
52.	Tam Teco- Kijura	Kabarole
53.	Tam Teco Mityana	Mityana
54.	Tilda Rice Ltd Clinic	Bugiri
55.	Tororo Cement Ltd. Clinic	Tororo
56.	Tullow Oil	Hoima
57.	Ugacof	Wakiso
58.	Uganda Clays Ltd. Clinic	Kajjansi (Wakiso)
59.	Uganda Crane Creameries Cooperative Union	Mbarara
60.	Wagagai Flowers Clinic	Kasenyi (Entebbe)

ANNEX 7: LIST OF PERSONS INTERVIEWED AND PARTICIPANTS IN FOCUS GROUP DISCUSSIONS

Ministry of Health	Program Officer, HIV/AIDS	1. Musinguzi Joshua (Dr)
	Coordinator; RH commodities	2. Albert Kalangwa (Dr)
	Head; Family Planning	3. Rose Akol (Dr)
	Malaria Control Program	4. Albert Peter Okui (Dr) 5. Myers Lugemwa (Dr)
Federation of Uganda Employers (FUE),	HIV AIDS Coordinator	6. Asha Nantamu
	Employment Relations Officer	7. Lilian Nyachwo
Uganda Manufacturers Association (UMA	Coordinator Training	8. Joseph Kyalimpa 9. Caxton Mayanja
Uganda Health Marketing Group (UHMG)	Fiona Mahoro	10. Program Officer
Johns Hopkins University (JHUCCP)	Technical Advisor; BCC	11. Lilian Nakato
Mildmay Centre	Training Manager	12. Edith Akankwasa
HIPS	Chief of Party Team Leader; Health Services Program Manager; OVC	13. Dithan Kiragga (Dr) 14. Fred Ntege (Dr) 15. Jarvice Sekajja
USAID	Contract Officers Representative (HIPS) and Deputy Health Team Leader Program Management Specialist / PMI OVC Program Management Specialist Senior youth and OVC Advisor	16. P.A Kyambadde 17. Joel Kisubi 18. Catherine Muwanga 19. Wanican Joyce
HIPS Partner clinics		
Private Clinics		
Abii Clinic	Enrolled Nurse	20. Kulthum Kisaakye
	Nurse	21. Madina Nakigula
	Counsellor	22. Rosette Birungi
Busabala Road Nursing Home	Clinical Officer	23. Dan Bukenya
Case Clinic	General Manager	24. Issa Bulafu
	Coordinator	25. Amina Kabuye
Crane Medical Centre	Clinic In-charge	26. Henry Kimaite
Double Cure Medical Centre	Hospital Administrator	27. Lydia Nakitende (Dr)
Good Will Nursing Home	Director	28. Odong-Kulo (Dr)
Ikan Clinic	Director	29. Karen Ndahura (Dr)

Kabalega Medical Centre	Director	30. Joseph Ruyonga (Dr)
Kadik Health Centre	Nasumba Harriet	31. Midwife/counselor
Kireka SDA Clinic	Clinical Officer	32. Parsis Ndagire
	Clinic In-charge	33. Alex Kambere
Kyaliwajala Clinic	Enrolled Comprehensive Nurse	34. Lamek Waswa
Lambu Clinic	In charge	35. Nkoyoyo.A (Dr).
	Coordinator HIPS Activities	36. Kalule Siraj
Lukuli Hope Clinic	HIV Counselor	37. Zaituni Namusisi
Mirembe Medical Centre	Clinic In-charge	38. Mutebi Bob
Musoke Domicilliary Clinic	Clinic In-charge	39. Imelda Musoke (Mrs)
Norvik Hospital	Doctor	40. Bahauddin
	Operations Manager	41. Babu T.
Old Kampala Hospital	Clinic In-charge	42. Rehemah N
Paragon Hospital	In charge Maternity	43. Juliet Nakawesi
Philomena Clinic	Clinic In-charge	44. Henry Byanaku
Safeguard Nursing Home	Clinic In-charge	45. Rehemah Nabayunga
SAS Foundation	Nursing officer	46. Nabawanuka Betty
SEO Care Clinic	Clinic In-charge	47. Julius Nainywa
Sims Medical Centre	Director	48. Simon Sentumbwe
St. Catherine Clinic	Counselor	49. David Bunjo
	Laboratory Technician	50. Kilama Otika
	Accountant	51. Lutuu
St. Charles Medical Centre		52. Ziwa (Dr)
St. Joseph's Clinic	Director	53. Josephine Birungi
	Clinical Officer	54. David were
	Clinical Officer	55. Samuel Mwamia
St. Mary's Medical Centre	Clinic Administrator	56. May Mbyetsiza
Touch Namwongo Project	Project Administrator	57. Debrah Nanyombi
Tropical Clinic	Director	58. Rogers Amule (Dr)
Victoria Medical Centre	Clinical Officer	59. Okello Newton
Company Clinics		
Ankole Growers Tea factory	Enrolled comprehensive Nurse	60. Pascal Thembo
Crown Beverages	Clinic In-charge	61. Jude Thadeus Sekiswa (Dr)
Farmers Centre	Area operations Manger	62. Scwici Susan
	Project Assistant	63. Atim Sarah
FIDUGA- Nsimbe Estates	In-charge, ART Clinic	64. Aisha Birabwa Kasirye
	In-charge IMC FIDUGA Clinic	65. Kevin Nabuuma
Hima Cement Ltd Clinic	Case Clinic administrator/incharge	66. Nanette P
IAA Royal van Zanten	Clinic In-charge	67. Paul Ngobi

	Counselor	68. Zigonzaga Lubega
	Human Resource Manager	69. Juliet Kabaitira
Kakira Sugar Works Ltd. Clinic	Clinical Officer	70. Bukenya Misaki
Kinyara Sugar Works	Clinic In-charge	71. Samuel Nsubuga
Kitante Medical Centre	Doctor	72. Saul B
	Nurse	73. C. Pulkeria
	Counselor	74. Tusiime Christine
Luweero Industries	In-charge	75. John Mwanda
Mabaale Growers' Tea Estate	In-Charge	76. Philemon Ahabwe
Makerere University Hospital	HIV/AIDS Nursing Officer	77. Yahya Ndiwalana
Mpanga Growers' Tea factory	Company Administrator	78. Annah Adong
	Clinic In charge	79. Ahaisibwe Margret
Mt. Elgon Orchard	General Manager	80. Bazaale Kethern
Nakigalala Tea Estate Clinic	Clinic In-charge	81. Ritah Namubiru
New Forest Company Ltd. Clinic	Programmes Manager	82. Alex Kyabawampi
	CSR Manager	83. Kate Sharum
	OVC officer	84. Martin Okello
	Clinical officer	85. M.J. Emma
	Clinical officer	86. Ruth Nalunga
Nile Breweries Clinic	Clinical Officer	87. Koomi George
NYTIL Clinic	Nursing Officer	88. Laker Rosemary
Reco Industries	Human Resource Manager	89. Asiimwe Winnie
Roofings Ltd. Clinic	Clinic In charge	90. Godfrey Busingye
Rwenzori Commodities-	Clinic In charge	91. Patrick Ndyanabo
SCOUL (Lugazi) Clinic	Hospital Superintendent	92. Kigula (Dr)
	Hospital Administrator	93. Annet Nampiima
Tam Teco – Kyamara	Clinic In charge	94. Grace Namugga
Tam Teco- Kijura	Clinic In charge	95. Julius Twesigye
Tam Teco Mityana	Clinic In charge	96. Cleophus Birungi
Tilda Rice Ltd Clinic	Coordinator	97. Mr. Umar Mukose
	Human Resources Manager	98. Mr. Livingston Jushua
Tororo Cement Ltd. Clinic	Coordinator-HIPS project	99. Omeda Arthur
	Chief Marketing Manager	100. Alok. R. Kalo
Tullow Oil	Clinic In charge	101. Vincent Bisobolwa
Ugacof	Enrolled Comprehensive Nurse	102. Winnie Wanyana
Uganda Clays Ltd. Clinic	Clinic In-charge	103. Godfrey Bazaale (Dr)
Uganda Crane Creameries Cooperative Union	Field Coordinator	104. Tukamushaba Pison

Wagagai Flowers Clinic	Manager	105. Kate Ochom
	Administrator	106. Roy Kyabangi
	Laboratory Manager	107. Frederick Emoru
District Health Officers		
Hoima	District Health Officer	108. Joseph Ruyonga (Dr)
Bushenyi	District Health Officer	109. Mwesigye Edward (Dr)
Kabarole	District Health Officer (Ag)	110. Mpuuga Hosea (Dr)
Kasese	District Health Officer	111. Samuel Kasimba (Dr)
Mukono	District Health Officer	112. Elli Muhumuza (Dr)
Focus Group Participants		
Jinja	Youth	113. Michael Kintu
		114. Baleeke Jane
		115. Muwaseka Samuel
		116. Bagaya Peter
		117. Namugere Christine
		118. Kimbowa Paulo
		119. Matwama (Ms)
		120. Kintu Musa
	Women	121. Doreen Nakazibwe
		122. Gladys Balitumye
		123. Peace Ayagalwa
		124. Christine Ayanga
		125. Justine Kwaga
		126. Judith Kaliiza
	Men	127. David Kasaaga
		128. Philemon Kazunghu
		129. Festus Luganga
		130. Timothy Waiduba
		131. Benard Wamimbi
		132. Anold Kirunda
Lira	Youth	133. Martin Ojok
		134. Ronald Ojul
		135. Denis Ocoka
		136. Susan Aroko
		137. Joan Aciro
		138. Bridget Okot
	Women	139. Matilda Ochola (Mrs)
		140. Stella Opio (Mrs)
		141. Susan Owanyi (Mrs)
		142. Juliet Auma
		143. Flavia Anena

		144. Hilda Angom
	Men	145. Paul Oloya
		146. Ronald Okello
		147. Jolly Joe Onen
		148. Henry Komakech
		149. Petros Odongpiny
		150. Geofrey Okeny

ANNEX 8: SUMMARY MATRIX FOR ACHIEVEMENTS OF THE CAPACITY BUILDING COMPONENT OF HIPS

Activities	Expected Results	Achievements	Analysis
Expanding FUE and UMA scope of workplace intervention to integrate TB,FP/RH, and Malaria with HIV/AIDS care	FUE and UMA acquire capacity to take responsibility for project-initiated activities. Leading collaborating organizations (UMA, FUE, Mildmay, UHMG and Straight Talk Foundation) take leadership role in health workplace programs.	• FUE and UMA have successfully brokered partnerships with private companies for implementation of project activities. Currently, active GDA partnerships are 42 and the overall active partners are 95. • In addition, FUE and UMA entered Sub-Agreements with identified local organizations for specific undertakings (SoW) for each organization. • FUE and UMA have demonstrated readiness to take over the full responsibility the HIPS partnerships, evidenced by a significant increase in income generated from HIPS partners (an increase of 67% from Quarter 3 to Quarter 4 alone). • Of the 88 total partnerships eligible for migration to FUE or UMA management, 74% migrated and are now overseen by the associations. • FUE and UMA have established firm partnerships with Mildmay, UHMG and Straight Talk Foundation for both clinical and peer education.	• Using UMA and FUE; the lead employment organizations in the country easily mobilized private companies for project activities as the two easily brokered the companies for partnership • By leveraging private company resources HIPS convinced the companies to expand health services into new areas (HIV/AIDS care TB,FP/RH, and Malaria) as the project offered support in expanding infrastructure and providing equipment and drugs • The trainings provided by the project prepared the health workers to handle new challenges
Supporting Companies to develop and implement HIV/AIDS and health workplace policies and programs building on best practices	All partner implementers have in place, workplace health policies; more so the HIV/AIDS workplace policy	The HIV/AIDS workplace policies have been developed in most of the partner institutions; 18 of the 22 GDAs visited for this evaluation had the policy in place	• The HIV/AIDS workplace policy was one of the main outcomes of the project as it protected workers against discrimination. This gave workers confidence as it recognized their right to work. • The limitation though, was that the policy had not been adequately circulated to all workers; and where available it was not translated in dialects

			most understood by the majority of the workers
Calculating the loss to for companies arising out of the sickness of their employees (absenteeism due to mobility or subsequent death).	Establish cost of disease per partner (on the basis of specific company data) using the disease Cost Calculator model	HIPS conducted research based studies[19] to establish the actual cost of ill-health to company productivity, It was shown that it is cheaper to provide higher health care than lose workers or work hours through prolonged absenteeism	• A scientifically calculated cost of disease (which recommended more services for increased productivity) was instrumental in convincing the mangers of private companies to increase health financing
Brokering linkages with key partners such as Global Fund, to facilitate low cost or no-cost commodities	Private sector partners have firm linkages with Global partners to facilitate access to free or cheaper medicines and other medical commodities	HIPS successfully advocated for the private sector to access ARVs from JMS: and other supplies free or at subsidized rates from other suppliers such as…	• It is pertinent that prior to HIPS, private sector health units were not permitted to provide ART and TB services. With HIPS intervening private clinics and hospitals provide ART and TB services. • This is a great achievement as this as significantly improved access to quality services • Access to free ARVs and other subsidized key health supplies solved the problem of stock outs

[19] A study (The Impact of ART on Employer Costs Related to AIDS) by Paul Bukuluki, 2009found that the average annual cost of ART to a partner company is 0.13% % of the total annual cost of labour, compared to 0.14% (of the total annual cost of labour) attributable to worker attrition

			at service points which was threatening the effectiveness of the project especially when NMS stopped supplies of ARVs to private sector health service providers
Collaborate with Ministry Gender, Labor and Social Development to roll out and operationalize the new HIV/AIDS workplace policy	Have in place functional partnerships with all national stakeholders	HIPS in collaboration with the MGLSD finalized a concept on developing the workplace health policy and the national OVC policy	• Development of HIV/AIDS and other workplace health policies has greatly addressed the issue of discrimination and stigmatization of HIV/AIDS. • Employees were found to be free, confident and outgoing in their workplace due to the policy of non-discrimination. • This had a double edged results- it increased employee confidence but also improved work productivity. • Involvement of the government in project work such as development of the workplace health policy gives the policy legitimacy and increased clout
Facilitate private sector support of the National Social Health Insurance Scheme(NSHS)	A fully developed National Social Health Insurance Scheme(NSHS)	• **The Uganda Healthcare Federation (UHF)** was formed with strong support of HIPS; as a negotiating forum and advocacy body for the private sector initiatives	

ANNEX 9: MAPPING CHANGES ARISING FROM IMPLEMENTATION OF HIPS

Status Prior to HIPS Project	Moderating/intervening variables	Observed Change
1. HIV/AIDS • No elaborate workplace HIV/AIDS policies • No Company had established collaboration with AIDS treatment centers close to them. • No partner clinics were accredited to offer ART and TB services • TB services did not have clear referral centers • Absence of use of standard guidelines from the Ministry of Health	Development of the HIV/AIDS workplace policy; and establishment of functional collaborative partnerships	• More than 80% of the sampled and visited GDAs have HIV/AIDS Workplace policy in place and disseminated to all staff • All sampled companies have established collaboration with AIDS treatment/referral centers close to the companies. • All sampled partner clinics have been accredited by the MoH for ART and TB management Partnerships established under HIPS have enabled the company clinics to refer complicated cases for vital tests (CD4 cell counts, viral load tests) and follow up to more competent facilities; including public health units. • A referral guide was developed and distributed to provide relevant information about the existing optional referral centers to the company health providers and company employees, thereby ensuring continuity of health care services to, the workers irrespective of whether they are at their work places or away. • Use of standard Ministry of Health guidelines and service delivery formats has resulted in better management of health information
2. Healthcare for the workers not among the top priorities of the private sector whose primary concern was making profit	Research and revelations by the Disease Calculator that better health services improve/protect company productivity	• Private companies now value the health of employees and have willingly committed to increased financing of health care for the workers
3. Private sector health facilities were barred from providing TB treatment	Accreditation of private sector health providers (company clinics and private clinics) for ART and TB	• Many private sector health providers now accredited; and do manage HIV/AIDS and TB
4. Training in health care was largely clinical; and only organized and undertaken by specialized health institutions	HIPS capacity building initiatives focusing on the private sector attracted interest of new players led by UMA and FUE; in training for health	• There are many training opportunities for workers both clinical and non-clinical for health management • UMA and FUE have mobilized significant financial resources through training in health care services (focusing on HIV/AIDS, TB, RH/FP services)to sustain project activities • UMA and FUE have developed technical proposals which

		have been funded such funding includes funds secured from ILO to FUE
5. Prior to HIPS, insurance companies were reluctant to accept HIV/AIDS on insurance premium	A positive multi-sectoral policy spearheaded by GoU at the highest political level, with advocacy from HIPS	• Currently, many insurance companies accept HIV/AIDS on insurance premium
6. Private sector contribution to health care of employees was minimal; although many companies provided some of the health services as part of CSR	Existence of CSR with the activity plans of private companies operational framework HIPS has leveraging the private sector towards health programs (to the tune of US$ $1M:$2M)	• Most private companies increased their contributions towards the health care programs of the workers
7. Prior to HIPS, the cost-benefit analysis of providing adequate health care for workers was not known.	Development of the disease calculator and conducting research/studies showing the Unit cost of providing health services such as ART, TB or RH/FP	• It has been established that the cost of providing adequate health care for the workers is lower than the cost of frequent worker attrition
8. Poor health information management. Prior to HIPS, the information collected on health services was often incomplete; and would be submitted late despite the significant resource outlays spent on monitoring activities	• HIPS initiatives such as reporting by mobile phone distributed to clinics	• The data collected using mobile phones is timely, complete and cost effective
9. Availability of ITNs and LLTNs to workers	• Linkages to HIPS partners supplying ITNs/LLNs free or at subsidized rates	• Insecticide treated mosquito nets are purchased and sold at a subsidized rates • Staff and dependents now have access to insecticide treated bed nets • Staff and dependents are well informed about treatment of malaria
10. Availability of information and subsidized reproductive health products	Partnerships established with institutions experienced in that field; including UHMG, Straight Talk Foundation and PACE with expertise in IEC message development	Reproductive health products are more available at all levels either free or at very affordable cost
11. Low sensitization of employers and communities toward OVC	Leveraging corporate resources (by HIPS) for implementing community programs including OVC.	Enhancement of the private sector company CSR programs to include OVC

ANNEX 10: COMPANY AFFILIATION TO UMA/FUE

No.	Name of company	Association Migrated To:	
		FUE	UMA
HIPS Managed 1-2/3 Years; Migrated to FUE and UMA (These are partners that were initially managed by HIPS only and then migrated to FUE and UMA)			
1	Coca Cola	✓	
2	Eskom Uganda		✓
3	Hima Cement	✓	
4	James Finlay's Uganda (Mc Leod Russell)	✓	
5	Kakira		✓
6	KCCL	✓	
7	Kinyara		✓
8	Luwero industries	✓	
9	New Forest Company	✓	
10	Nile Breweries	✓	✓
11	Roofings Uganda Limited		✓
12	Royal Van zanten Flowers	✓	
13	Rwenzori commodities	✓	
14	Shell Uganda	✓	
15	Southern Range Nyanza Limited		✓
16	Tullow oil	✓	
17	UGACOF		✓
18	Uganda Clays		✓
19	Wagagai	✓	
20	Toro And Mityana Tea Company (TAMTECO)		✓
21	Sugar Corporation of Uganda (SCOUL)		✓

No.	Name of company	Association Migrated To:	
		FUE	UMA
22	Xclusive Cuttings	✓	
23	Touch Namuwongo Project		✓
24	Ugarose		✓
		13	12
	Total 24 Companies		
HIPS Initiated; FUE and UMA Managed (These are partnerships that were brokered by HIPS but whose management was immediately transferred to FUE and UMA right from the onset.)			
1	Ankole Coffee Processors		✓
2	Centenary Rural Development Bank	✓	
3	JP Cuttings	✓	
4	Dominion Uganda	✓	
5	IITA (Research to Nourish Africa)/FUE	✓	
6	Reco Industries		✓
7	Kenya Commercial Bank (KCB)	✓	
8	Mpanga Tea growers limited		✓
9	Uganda Crane Creameries Cooperative Union Ltd		✓
10	Uganda Baati		✓
11	Fiduga Flowers Limited	✓	
12	Regional Lorry Drivers and Transporters Association	✓	
13	BM Technical services Mbarara	✓	
	Total 13 companies		
FUE and UMA Initiated and Managed (These are partnerships that have been brokered by FUE and UMA directly.)			
1	Ericson AB Limited	✓	
2	Fish Ways Uganda Limited	✓	
3	Ken group		✓

No.	Name of company	Association Migrated To:	
		FUE	UMA
4	Kengrow		✓
5	Kyagalanyi Coffee Limited		✓
6	Mabale Tea Growers Company		✓
7	Multitech Business School	✓	
8	Quality Chemicals		✓
9	Sadolin		✓
10	SAIL Uganda	✓	
11	TIC Plastics		✓
12	Toyota Uganda	✓	
13	Uganda National Road Authority	✓	
14	Unga Millers		✓
15	Watsila	✓	
16	Wispro		✓
17	Swift	✓	
18	Munyonyo Common Wealth Speke Hotel	✓	
19	Orange Uganda Limited	✓	
20	Comprehensive services ltd	✓	
21	SDC Uganda Ltd	✓	
22	Tropical Heat Uganda Ltd	✓	
23	Uchumi Supermarket (u) Ltd	✓	
24	Emirates Airlines	✓	
25	Esco (U) Ltd	✓	
26	First Insurance Company	✓	
27	Child Fund International	✓	

No.	Name of company	Association Migrated To:	
		FUE	UMA
28	Steel and Tube	✓	✓
		27	10
	Total 28 companies		

Source: HIPS Year 5, Quarter 4 and Annual Report FY 2012

ANNEX II: HIPS PARTNER CLINICS THAT RECEIVED MEDICAL A DIAGNOSTIC EQUIPMENT

No	Name of Health Clinic Beneficiary	Description
1.	Ayiira Nursing Home	Electrical Microscope
2.	Boots Clinic	Microscope Electric
		Laboratory Incubator
		Laboratory Fridge
3.	Buzirasagama	Centrifuge(electric)
		Heamcue with cuvettes
		Incubator
		Refrigerator
		Microscope
4.	Bweyogerere Medical Centre	Refrigerator
		Centrifuge
		Microscope
		Electric sterliser
5.	Case Medical Centre	Microscope Electric
6.	Charis Health	Refrigerator
		Electric Sterliser
		Centrifuge
		Microscope
7.	Crane Health Services	Autoclave Electric
		Laboratory Incubator
		Electric Rotator
		Microscope Electric
8.	Double Cure Clinic	Autoclave
		Binocular Microscope
		Electrical Centrifuge
		Fridge
		Microscope
9.	Emmanuel Medical Centre	Laboratory Rotator
10.	Engari Community Health Care	Binocular Microscope
		Delivery Bed
		Delivery Set- 2
		Centrifuge Elelctrical
		Examination Couch- 2
		Fridge
11.	Family Health Resource Centre	Binocular microscope
		Operation theatre table
		Operation Light
		Delivery bed
		Electrical centrifuge

		Colorimeter
12.	Good Will Poly Clinc	Microscope Electric
		Electric Centrifuge
		Electric Centrifuge
		Fridge
		Auto Clave Bench Top
13.	Hima Cement	Microscope
14.	IAA/Dunavant	CD4 Count Machine
		Centrifuge (electric)
		Microscop Electric
		Hemoglobinometer +cuvvets
		Colorimeter
		Microscope
15.	Kabalega Medical Centre	Chemistry Analyser
16.	Kadic Hospital	Microscope Electric
17.	Kakira Sugar	Auto Urinalysis Machine
		Microscope
		Refrigerator
18.	Kamokya General Clinic	Examination Bed
		Sterilizer Charcoal
		Electrical Microscope
		Centrifuge
19.	Kitetika Marternity Centre-Boots	Electric centrifuge
		Carolimeter
		Binocular Microscope
		Examination Couch- 2
20.	Kikyusa Health Centre	Maternity Bed
		CD4 Machine
21.	Kinyara Sugar	Microscope
		Microscope
		Centrifuge
		Fridge
		Sterliser
22.	Kireka SDA	Delivery Bed
23.	Kitante Medical Centre	Microscope
		Chemistry Analyser(50%)
		Microscope
		Incubator
		Water bath (Van Belgium)
24.	Kyadondo Medical Centre	Cyan Haematology Machine (50%)
25.	Kyaliwajala	Microscpe Electric

		Steam Sterliser
		Centrifuge Electric
		Fatal Heart Detector
		Laboratory Fridge
26.	Kyotera Medical Centre	Electrical Microscope
		Delivery couch
		Refrigerator
		Sterliser-Electric
		Vacuum Extractor
27.	Lambu Health Centre	Electric Microscope
28.	Luweero Industries Clinic	Microscope Electric W Mirror
		Delivery bed
29.	Mabale Tea Clinic	Examination couch
30.	Mehta Hospital	Operation theatre table
31.	Mellisa Flowers	Binocular Microscope
		Microscope
		Chemistry Analyser
		Fridgerator
32.	Mirembe Medical Centre	Centrifuge
		Microscope
33.	Mpanga Tea Clinic	Centrifuge Electric
34.	Munobwa Clinic	Refrigerator
		Microscope
35.	Nakigalala Tea Estate	Refrigerator
		Microscope Electric w mirror
36.	New Forest Company Clinic	Examination Couch
		Microscope Olympus
37.	NFC- Kirinya	Fridge
		Microscope
38.	Nile Breweries	Fridge
		Electric Microscope
		Refrigerator
39.	Nytil Picfare	Centrifuge
		Air condition
		Operation Light
		Electric Microscope
		Chemistry Analyser
40.	Old Kampala Hospital	Water Bath
		Electric Microscope
		Delivery Bed Standard
41.	People's Clinic Kassanda	Electrical Steriliser 40lts

		Mobile Surgical Operating Lamp- 4
		Microscope
		Electrical Calorimeter
42.	Philomena Clinic	Delivery Bed
		Chemistry Analyser
43.	Rakai Community Based Health Project	Electric Centrifuge
		Electrical Microscope
		Centrifuge Electric Bucket
		Autoclave-Charcoal
		Centrifuge
		Sterliser Electric
44.	Safe Guard Nursing Home	Autoclave Electric
45.	SCOUL	Cetrifuge
		Electric Microscope
		Hematoclit Centrifuge
		Haematology Analyser
		Binocular Microscope
		Operational Table Superior
		Operation Light for Reflector
		Autoclave Steriliser/Tuttnauer
		Diathermy Unit Sutron 160W
		Nonin Digital Pulse Oximeter Avant
		Seca digital mother & child column
		Centrifuge -CL008
		Refrigerator
		Incubator CL011
		Generator
		UPS
46.	Sims Medical Centre	Air Conditioner
		Colorimeter
		Sahli's Haemometer
		Binocular Microscope
		Delivery Bed
47.	St. Charles Medical Centre	Autoclave
48.	St. Ambrose	Delivery Bed Imorted
		Fridge
		Delivery Bed
		Fridge Laboratory
		Delivery Bed
		Steriliser Electric with Timer
49.	Tamteco	Centrifuge Electric

		Microscope Electic w Mirror
50.	Teso Community Health	Delivery Bed
		Examination Bed
		Examination Couch
51.	Toro Kahuna	Laboratory Fridge
		Haemocue
52.	Tororo Cement	Serliser-Non Electric
53.	UGACOF	Sterlilizer Electric with Timer
		Refregerator
		Microscope Electric
54.	Uganda Baati	Microscope Olympus
		Water bath (Van Belgium)
55.	Wagagai Clinic	Electric Microscope
		Laboratory Fridge
		Autoclave Bench top Microbiology
		Vacuum Extractor
		Oxygen Concetrator
		Cyanpus ChemistryAnalyser
		Semi Automated Steriliser- 50%
		Heamatology Analyser
56.	White Horse Nursing Home	Electric Centrifuge
		Laboratory Fridge
		Urine strip Analyser
		Incubator
		Electric Sterliser
57.	Xclusive Cuttings LTD	Steriliser Electric with Timer
		Microscope Electric (Humascope)

U.S. Agency for International Development
U.S Mission Compound, South Wing
Plot 1577 Ggaba Road
P.O. Box 7856,
Kampala, Uganda