



# Evaluation Report: Program Evaluation of USAID/Uganda SUSTAIN Activity - Strengthening Uganda's System for Treating AIDS Nationally

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## TABLE OF CONTENTS

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|                                                                                       |         |
|---------------------------------------------------------------------------------------|---------|
| Executive Summary .....                                                               | 1       |
| Section I. Introduction, Background, And Purpose .....                                | 4       |
| A. SUSTAIN Overview .....                                                             | 4       |
| B. Evaluation Purpose.....                                                            | 5       |
| C. Evaluation Questions .....                                                         | 5       |
| D. Team and Timeline .....                                                            | 5       |
| E. Audience .....                                                                     | 5       |
| Section II. Evaluation Approach, Methods, And Limitations.....                        | 6       |
| A. Approach and Methods of Data Collection.....                                       | 6       |
| B. Sampling .....                                                                     | 6       |
| C. Methods of Data collection .....                                                   | 6       |
| D. Design and Methodology Limitations.....                                            | 7       |
| Section III. Evaluation Findings, Conclusions, and Recommendations .....              | 9       |
| A. Question 1 .....                                                                   | 9       |
| B. Question 2 .....                                                                   | 14      |
| C. Question 3 .....                                                                   | 18      |
| D. Question 4a .....                                                                  | 20      |
| E. Question 4b .....                                                                  | 21      |
| F. Question 4c .....                                                                  | 23      |
| Section IV. Lessons Learned.....                                                      | 25      |
| <br>Annex A. Scope of Work .....                                                      | <br>A-1 |
| Annex B. SUSTAIN-Supported Hubs .....                                                 | B-1     |
| Annex C. Evaluation Tools .....                                                       | C-1     |
| 1. FGD Participant Information Required.....                                          | C-1     |
| 2. FGD Guide for Health Facility Clients .....                                        | C-2     |
| 3. KII Discussion Guide: Other Partners.....                                          | C-4     |
| 4. Key Informants' Topic Guide for National Level .....                               | C-6     |
| 5. Key Informants' Topic Guide for Health Facility In-charges/Regional Directors..... | C-8     |
| 6. Key Informants' Topic Guide for Implementer.....                                   | C-11    |
| 7. Referral Checklist for Regional Referral & Other District Hospitals.....           | C-13    |
| 8. Hospital Observation Checklist.....                                                | C-14    |
| Annex D. SUSTAIN Support History .....                                                | D-1     |
| Annex E. Document List.....                                                           | E-1     |
| A. Documents Consulted during Evaluation of SUSTAIN – Print Copies.....               | E-1     |
| B. Documents on SUSTAIN Website.....                                                  | E-1     |
| C. Documents on Google Drive.....                                                     | E-2     |
| Annex F. Key Informants.....                                                          | F-1     |
| Annex G. Breakdown of Evaluation Interviews .....                                     | G-1     |

|                                                                                     |     |
|-------------------------------------------------------------------------------------|-----|
| Annex H. Indicator Performance Summary: October 2015 – September 2016 .....         | H-1 |
| Annex I. Uganda, MOH, Health Sector Development Plan, 2015/16-2019/20), p. 41 ..... | I-1 |
| Annex J. SUSTAIN’s Results Framework .....                                          | J-1 |
| Annex K. World Health Organization (WHO) Health System Blocks .....                 | K-1 |

## **TABLES**

---

|                                                                                       |
|---------------------------------------------------------------------------------------|
| Table 1. SUSTAIN Program Evaluation Aggregate Respondent Data                         |
| Table 2. Perceived SUSTAIN Contribution to Technical and Leadership Capacity          |
| Table 3. Percentage of Respondents that Noted an Improvement in Knowledge and Skills  |
| Table 4. Health Worker Perception of Areas of Quality Improvement                     |
| Table 5. Trickle Down Effect to LLF: Perception of SUSTAIN as a Capacity Building Hub |
| Table 6. Factors Facilitating or Inhibiting SUSTAIN Implementation                    |
| Table 7. Respondent Perception of SUSTAIN Best Practices                              |
| Table 8. Respondent Feedback by Stakeholder Group on Mentorship and Coaching          |
| Table 9. Respondent Perceptions on Sustainability Without Donor Financing             |

## **FIGURES**

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|                                                                           |
|---------------------------------------------------------------------------|
| Figure 1. Aspects of SUSTAIN Support to Quality Improvement               |
| Figure 2. Comparative Analysis of Referrals Received 2010-2016 – Part 1   |
| Figure 3. Comparative Analysis of Referrals received 2010 – 2016 – Part 2 |

## ACRONYMS

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|              |                                                                                                                                                   |
|--------------|---------------------------------------------------------------------------------------------------------------------------------------------------|
| COP          | Chief of Party                                                                                                                                    |
| DCOP         | Deputy Chief of Party                                                                                                                             |
| DHO          | District Health Officer                                                                                                                           |
| CPHL         | Central Public Health Laboratory                                                                                                                  |
| EMTCT        | Elimination of Mother to Child Transmission of HIV                                                                                                |
| EQA          | External Quality Assessment                                                                                                                       |
| FCR          | Findings, Recommendations, and Conclusions                                                                                                        |
| FGD          | Focus Group Discussion                                                                                                                            |
| GoU          | Government of Uganda                                                                                                                              |
| HCT          | HIV Counseling and Testing                                                                                                                        |
| HCI          | USAID Health Care Improvement Project                                                                                                             |
| HC IV        | Health Clinic IV                                                                                                                                  |
| HCW          | Health care workers                                                                                                                               |
| HIV/AIDS     | Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome                                                                                  |
| HIVQUAL      | Approach to improve the quality of care delivered to persons living with HIV; developed by the New York State Department of Health AIDS Institute |
| HMIS         | Health Management Information System                                                                                                              |
| HSS          | Health Systems Strengthening                                                                                                                      |
| IDEAS        | Innovations for Development, Empowerment and Advancement Strategies                                                                               |
| ICOB         | Integrated Community Based Initiatives                                                                                                            |
| IP           | Implementing Partner                                                                                                                              |
| JCRC         | Joint Clinical Research Centre                                                                                                                    |
| KII          | Key Information Interview                                                                                                                         |
| LLF          | Lower level facilities                                                                                                                            |
| MDR          | Multi-drug resistant                                                                                                                              |
| M&E          | Monitoring and Evaluation                                                                                                                         |
| MJAP         | Makerere University Joint AIDS Program                                                                                                            |
| MoH          | Ministry of Health                                                                                                                                |
| NMS          | National Medical Stores                                                                                                                           |
| NTLP         | National TB & Leprosy Program                                                                                                                     |
| NPHL         | National Public Health Laboratory                                                                                                                 |
| PE           | Performance Evaluation                                                                                                                            |
| PEPFAR       | President's Emergency Plan for AIDS Relief                                                                                                        |
| PLHA         | People Living with HIV/AIDS                                                                                                                       |
| PNFP         | Private Not for Profit                                                                                                                            |
| PMTCT        | Prevention of Mother to Child Transmission of HIV                                                                                                 |
| QA           | Quality Assurance                                                                                                                                 |
| QI           | Quality Improvement                                                                                                                               |
| RRH          | Regional Referral Hospital                                                                                                                        |
| SLMTA        | Strengthening Laboratory Management Toward Accreditation                                                                                          |
| STAR-EC/E/SW | Strengthening HIV&AIDS and Tuberculosis Responses in East Central/East/Southwest Uganda                                                           |
| STD          | Sexually Transmitted Disease                                                                                                                      |
| SUSTAIN      | Strengthening Uganda's Systems for Treating AIDS Nationally                                                                                       |
| TASO         | The AIDS Support Organization                                                                                                                     |
| TB           | Tuberculosis                                                                                                                                      |
| TREAT        | Timetable for Regional Expansion of HIV/AIDS Treatment                                                                                            |
| UAC          | Uganda AIDS Commission                                                                                                                            |

|       |                                                    |
|-------|----------------------------------------------------|
| URC   | University Research Company, LLC                   |
| USAID | United States Agency for International Development |
| UVRI  | Uganda Virus Research Institute                    |
| VHT   | Village Health Team                                |
| VMMC  | Voluntary Medical Male Circumcision                |
| WHO   | World Health Organization                          |

## EXECUTIVE SUMMARY

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**Introduction.** USAID/Uganda’s Strengthening Uganda’s Systems for Treating AIDS Nationally (SUSTAIN) activity supports Uganda’s Ministry of Health (MOH) to strengthen quality and comprehensive HIV/AIDS care, prevention, laboratory and tuberculosis (TB) services at selected regional referral and district health care facilities in Uganda, as well as build the capacity of the public health system to sustain these services. SUSTAIN is a six-year USAID-funded activity launched in 2010 and implemented by University Research Co., LLC (URC). SUSTAIN is one of many PEPFAR-funded activities to address the HIV/AIDS epidemic in Uganda. The main objective of the SUSTAIN program evaluation was to examine the activity’s methodology for achieving its objectives in order to inform future USAID design work. USAID noted that URC had performed well on SUSTAIN, as evidenced by its activity reports, but wanted an evaluation of the approach used by SUSTAIN to inform future program designs. SUSTAIN implementation adapted to contextual changes in Government of Uganda (GoU) HIV/AIDS strategy responding to a spike in new infections and people living with HIV, and major shifts in PEPFAR policy.

**Key evaluation questions.** We examined four key questions for the SUSTAIN program evaluation:

1. How did SUSTAIN’s specific strategy and technical approach contribute to: a) Strengthening technical and leadership capacity at partner regional referral hospitals (RRHs); b) Strengthening technical and leadership capacity at partner district hospitals; c) Enhancing MOH (and consequently government of Uganda (GOU)) stewardship and ownership of HIV/AIDS service delivery in partner hospitals and regions; and d) Improving quality of services.
2. What was the SUSTAIN activity’s contribution to positioning the RRHs as hubs for capacity building and oversight to lower facilities?
3. What issues emerged from SUSTAIN activity’s context that facilitated or inhibited its performance? Issues could include political, economic, management, social, and cultural factors. How were these issues managed?
4. Drawing from SUSTAIN activity’s experience: a) What are the best practices that need to be consolidated to achieve sustainable delivery of HIV/AIDS services? b) To what extent did the systems approach succeed in engendering quality and sustainability of HIV/AIDS services? and, c) What key issues must be considered if USAID were to design a new program to deliver and sustain HIV/AIDS services within the public-sector context?

**Methodology.** We used a predominantly qualitative and analytical evaluation approach based on multiple data sources, including document review, semi-structured key informant interviews (KIIs), observation at activity sites, and focus group discussions (FGDs). Over a three-week data collection period, we held a total of 109 interviews and collected data from all 12 regional referral hospitals (RRHs), and 6 lower-level facilities (LLF) within the hub network, and selected HIV/AIDS partners in each region. We also interviewed key informants from the MoH, USAID, and SUSTAIN. Following the data collection period, we tabulated all respondent data to quantify key issues from the KIIs and FGDs responses by stakeholder groups and all respondents (See table 1, Aggregate Respondent Data). We triangulated and analyzed this data with observations and other reviews to develop our findings, recommendations, and conclusions.

**Evaluation Findings, Recommendations, and Conclusions (FCRs).** A brief summary of our FCRs is provided below, with the detailed supporting data provided in the body of the report. As indicated early on by USAID, and corroborated by respondents and our own observations, SUSTAIN had contributed to improved health care services at the RRHs and other partner hospitals, especially in HIV/AIDS and TB.

**Question 1.** Respondents generally believe that SUSTAIN strengthened technical and leadership capacity at RRHs and district health facilities. Strengthened supervision was most reported across respondents (78%), followed by strengthened leadership (75%), and then improved facility management (69%),

despite a substantial disparity between the perception of RRH directors and RRH HIV Clinic In-Charges in all areas (average 95% versus 56%). Both providers and patients reported improved knowledge and skills through SUSTAIN's contributions via their training and mentorship strategy. Over half of respondents reported that infrastructure improvements enhanced the technical capacity of hospitals. A majority of respondents believe that SUSTAIN has enhanced MoH program ownership and stewardship; some respondents, however, noted that real stewardship requires a higher level of MoH resource investments. Respondents noted a number of SUSTAIN-supported improvements that positively affected service quality at RRHs such as health worker skills and knowledge, improved lab equipment, improved HIV testing & counseling, improved infrastructure, and service turnaround time. Clients also reported many improvements in service delivery.

*Recommendations:* Establish stewardship indicators at the MoH level to better gauge ownership. Involve the MOH in dialogues with local government to improve supervision of lower-level facilities (LLFs) by RRHs. Utilize the WHO Six Building Blocks (holistic health system) approach in future activity designs.

**Question 2.** Respondents generally perceived limited trickledown effects of SUSTAIN support. Just over 50% of respondents reported that SUSTAIN improved referral rates to RRHs from LLFs, an important indicator regarding the degree of interaction between the two levels of healthcare facilities. SUSTAIN's major contribution to further positioning RRHs as hubs was bolstering the existing hub network via hub riders, including motorcycles, fuel and maintenance, and advanced testing.

*Recommendations:* Future programs should be circumspect about relying on trickle-down effects that do include specific strategies for strengthening lower level facilities. Follow-on programming to SUSTAIN, if it includes strengthening district facilities as part of the health system, should include specific strengthening measures so those facilities can play their intended role, relieve pressure on over-burdened RRHs, and reduce client travel costs. The health referral system should be mapped and documented. Maintenance and repair services should be provided regionally to further support RRHs as hubs.

**Question 3.** RRH directors, in-charges of HIV clinics and labs, DHOs, and SUSTAIN staff were the main respondents to this question. The top facilitating factor cited by 60% of respondents was the SUSTAIN-provided, fully-deployed human resources working as part of the health system. Three additional factors cited by about one-third of respondents were financial support, good attitudes by RRH staff, and political leadership and ownership. Key challenges (inhibiting factors) cited by respondents were: need for additional financial resources; policy changes (e.g., GoU and PEPFAR, all handled); lack of direct support to districts; the limiting effect of poverty and stigma on access, and serving refugee clients.

*Recommendations:* SUSTAIN would have been more effective if it had also worked with the districts in addition to the regional referral system. For district-level services, activity design needs to acknowledge and integrate the Ministry of Local Government. Different strategies need to be developed for regions and districts dealing with special circumstances such as refugees. HIV&AIDS service delivery programs need to straightforwardly address poverty and continuing stigma around HIV&AIDS to ensure access and use of services. Adaptation to policy changes throughout implementation should continue to be encouraged by USAID/Uganda as part of future activity designs, as there will always be unanticipated policy and context changes that can otherwise compromise activity success.

**Question 4.** Mentorship, capacity building for human resources and laboratory improvements were the top two most noted best practices of SUSTAIN support to the RRHs cited by respondents. Given the number of unfilled positions country-wide, SUSTAIN's HRH support made a visible difference. Respondents also valued equipment, hub, infrastructure, and HMIS support. Respondents valued quality improvements (QI) and the system introduced for continuous QI. Respondents generally doubt that the MoH would be able to sustain HIV&AIDS and TB service delivery in the RRHs following the end of SUSTAIN, if another activity/IP is not in place.

*Recommendations for future programming:*

- **Model for capacity building.** Emphasize the importance of on-the-job mentoring and coaching in the acquisition and consolidation of new information and skills.
- **Systems approach.** Fold SUSTAIN's adaption of the WHO Six Building Blocks approach to effective and efficient health systems strengthening, which helps ensure that inter-related elements of the health system are addressed, thus maximizing the return on any investment.
- **Trickle-down theory of change.** Given effective capacity building cannot be achieved without a planned intervention, future programming should include specific objectives and activities directed at strengthening lower level health facilities.
- **Promoting ownership, stewardship, and sustainability.** Given MoH reservations regarding ownership/stewardship of SUSTAIN activities, and the little progress in sustainability in terms of additional GoU financing, future health programming should further emphasize ways to advance these inter-related goals of ownership, stewardship, and sustainability; with financing dependent on meeting agreed upon metrics showing progress in achieving goals.
- **Integrating district and regional support.** Because LLFs are under Local Government and RRHs under the MoH, LLF benefits from SUSTAIN improvements were curtailed. Future health programs integrate both central and local government into the design.
- **Alignment of HR policies.** SUSTAIN and MoH HR policies were eventually aligned but this posed more of an implementation issue than ideal. In a future design, we recommend USAID require alignment with MoH HR policies from the start with any personnel that will transition eventually into the MoH. This is especially important for salary scales.
- **Stigma around HIV&AIDS.** Although the HIV&AIDS epidemic is in its fourth decade, stigma and discrimination continue to be determining factors in accessing and using services. Ways to address stigma and discrimination should be woven into all health programs so that every health activity is pulling in the same direction in changing these entrenched and unconstructive beliefs and attitudes.
- **Health referral and transport network.** The increased functionality of the health referral network achieved through SUSTAIN were widely appreciated and should continue into future health programming, with an emphasis on mapping and documenting so that functionality improvements can be better measured and the most beneficial interventions identified, e.g., hub riders.
- **Refugee areas.** Areas attracting refugees from nearby conflict areas require different strategies to help facilities deal with the influx of clients needing services.
- **CLA.** Adaptation to policy changes throughout implementation should continue to be encouraged by USAID/Uganda as part of future activity designs, as there will always be unanticipated policy and context changes that can otherwise compromise activity success. Similarly, future designs should continue to create focus around the benefits of learning from other health workers engaged in similar work at the district, regional, and national level.
- **Laboratory strengthening.** Future designs should ensure continuation of the highly-regarded regional-level laboratory system, which is considered a special achievement and a linchpin in the HIV&AIDS and overall health services delivery system.
- **TB/HIV in isolation.** Addressing TB separately from its MDR form or from its relationship to HIV&AIDS was viewed as problematic by in-charges of TB wards, who encouraged the activity to look at all forms of TB. The NTLP Program Manager also expressed a need for educating and engaging local communities about the interaction of TB with HIV.

## SECTION I. INTRODUCTION, BACKGROUND, AND PURPOSE

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### A. SUSTAIN Overview

Despite an impressive response to the HIV&AIDS epidemic in Uganda over the past two decades, the disease continues to be a major socio-economic challenge for the country and is among the leading causes of morbidity and mortality. Initiated in 2010 and currently in its sixth and final year, SUSTAIN is one of many activities supported under PEPFAR II to build systems to address the on-going HIV&AIDS epidemic in Uganda. The main purpose of SUSTAIN is to support Uganda's MoH to strengthen quality and comprehensive HIV&AIDS care, prevention, laboratory, and TB services in selected regions and district health care facilities (17 hospitals and two health centers), as well as build the capacity of the public health system to sustain these services. SUSTAIN was a follow-on to the USAID Timetable for Regional Expansion of HIV&AIDS Treatment (TREAT) activity, implemented by the Joint Clinical Research Centre (JCRC).

**Theory of Change.** The SUSTAIN model is based on a diffusion or 'trickle down' theory of change. Referenced in URC's SUSTAIN Technical Proposal (April 2010), this approach assumes that by strengthening management and enhancing efficiency and quality of health service delivery at RRHs, the wider health sector network would benefit. Specifically, the RRHs - 'hubs' - would stimulate the lower level facilities (LLFs) (district hospitals and health center IVs (HC IVs)) to adopt improved management and service provision. SUSTAIN expended much effort to develop and improve relationships among RRHs and the network of district hospitals and HC IVs. This approach is explained in SUSTAIN's Results Framework (Annex J).

**Approach.** SUSTAIN's guiding principles include: focus on measurable results and active involvement in monitoring and improvement by stakeholders at all levels of care; build strong partnerships between providers and communities; integrate into existing MoH activities and structures to ensure sustainability. SUSTAIN represents an important shift in health care provision in Uganda, emphasizing HIV&AIDS integration into existing health services and shifting from an acute to a chronic care model. SUSTAIN's approach to supporting sustainable service delivery originates from a health systems strengthening perspective, which focuses on ensuring access to quality services that meet the beneficiary needs along a continuum of care; strengthening health information systems; supporting a skilled and expanded health work force; improving a supply chain management system that enables optimum leveraging of resources; and improving the quality of laboratory services. SUSTAIN's integration of a health systems strengthening approach focused on achieving adequate quantities of HIV related medicines and supplies; modern, quality laboratory services; well-maintained patient medical records; integrated HIV treatment, care, and prevention; and strong leadership for well-managed HIV service delivery.

**Quality Improvement (QI) a Major Focus.** URC used their expertise in QI to support health facilities, complementing the existing MoH Quality of Care Initiative approach. Working with the MoH quality assurance (QA) department and USAID, SUSTAIN applied QI methods in the 18 beneficiary hospitals to improve and measure performance of selected service delivery processes and outcome indicators. The QI approach used on-site training and coaching by SUSTAIN, while individual hospital QI committees monitored QI activities. Conversely, multi-disciplinary QI teams consisting of MoH mentors, SUSTAIN technical staff, and hospital representatives, focused on improving processes along the continuum of care for HIV&AIDS/TB patients, routinely reporting their findings to hospital management.

**Integration with the MoH.** SUSTAIN support was not parallel, but integrated in the MoH activities routine structures and processes to ensure that improvements were an integral part of the care process. Consequently, SUSTAIN placed considerable emphasis on nurturing and mentoring stewardship capability among medical and non-medical agents managing Ugandan health structures. To this end, SUSTAIN mostly worked with MoH technical departments, autonomous bodies (i.e., the National Medical Stores (NMS), Central Public Health Laboratories (CPHL), districts, hospitals, and other partners

to develop and strengthen HIV&AIDS services delivery systems. SUSTAIN also provided additional clinical staff to the facilities, with the intent of gradually transferring those staff to the MoH.

**Contextual Changes.** During the period of activity implementation, the context changed considerably. The GoU modified its strategy to address a troubling spike in new infections and number of people living with HIV. PEPFAR adopted major policy changes under its new leadership, specifically 1) moving from prevention to elimination of mother to child transmission (PMTCT to EMTCT), 2) the inclusion of Voluntary Medical Male Circumcision (VMMC) and, somewhat later, MDR TB, and 3) the shift to ‘Test and Treat’ for HIV regardless of the CD4 count. To adapt to these mid-contract policy changes, SUSTAIN swiftly mobilized additional technical staff to better enable the activity to cover the adjusted technical scope. SUSTAIN staff also reported that they received support from URC headquarters, the MoH, and from USAID in the form of prompt approvals.

## **B. Evaluation Purpose**

The principal purpose of this evaluation was to examine the methods used to achieve SUSTAIN’s objectives and draw out lessons learned on the implementation approach and its effectiveness. We do not focus on achievement of targets, but rather on understanding how the approach used affected outcomes.

## **C. Evaluation Questions**

1. How did SUSTAIN’s specific strategy and technical approach contribute to:
  - a) Strengthening technical and leadership capacity at partner RRHs
  - b) Strengthening technical and leadership capacity at partner district hospitals
  - c) Enhancing MoH (and consequently GoU) stewardship and ownership of HIV/AIDS service delivery in partner hospitals and regions
  - d) Improving quality of services
2. What was the SUSTAIN activity’s contribution to positioning the RRHs as hubs for capacity building and oversight to LLFs? While not a discrete performance objective, it was theorized that investments in improving quality and leadership at the RRHs would naturally result in improved capacity at LLFs within their referral zones.
3. What issues emerged from SUSTAIN activity’s context that facilitated or inhibited its performance? Issues could include political, economic, management, social and cultural factors. How were these issues managed? Drawing from SUSTAIN activity’s experience:
  - a) What are the best practices that need to be consolidated to achieve sustainable delivery of HIV&AIDS services?
  - b) To what extent did the systems approach succeed in engendering quality and sustainability of HIV&AIDS services?
  - c) What key issues must be considered if USAID were to design a new program to deliver and sustain HIV&AIDS services within the public-sector context?

Question four relates to a central purpose of the evaluation, i.e., to examine the model used by SUSTAIN for possible future application to health systems strengthening activities supported by USAID/Uganda.

## **D. Team and Timeline**

A multi-disciplinary team carried out the evaluation, led by HSS Expert, Dr. Maryinez Lyons, with QI Expert Dr. David Kyaddondo, and HIV&AIDS Specialist Ms. Josephine Kasaija. A local research group, IDEAS, collected field data and supported data analysis, led by M&E Specialist Jonathan Magoola. Following team planning meetings in Kampala in Sept. 2016, data was collected from Oct. 17 – Nov. 9, followed by data analysis and report drafting. The evaluation team presented initial results and an early draft of the report to USAID on Nov. 15 and 17. USAID comments are integrated into this draft report.

## **E. Audience**

The primary user of the evaluation results is USAID/Uganda, to be utilized as a guide to future program design in this area. Additional users include other U.S. government agencies, donors, IPs, the MoH, and national and international stakeholders with interest in sustainable HIV&AIDS programming.

## SECTION II. EVALUATION APPROACH, METHODS, AND LIMITATIONS

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### A. Approach and Methods of Data Collection

This is a cross-sectional, descriptive, and analytical evaluation that employed primarily qualitative methods of data collection. However, some quantifiable information was obtained from reviewed records and reports, and some of the responses from the key informants were tallied to get an impression of the most common experiences and opinions about SUSTAIN support to RRHs.

### B. Sampling

We employed a purposive sampling strategy. We selected facilities that had directly benefited from SUSTAIN support, including all 12 RRHs. In addition, we selected six other health facilities that did not receive direct support to examine the trickledown effect, including 1 district hospitals and 5 HCIVs. In each health facility, we interviewed technical staff relevant to SUSTAIN, particularly Directors of the RRHs, staff in HIV clinics, laboratories, and human resources. A total of 109 interviews were conducted at the facility level (Annex G). We held 24 FGDs (two FGDs per RRH) with clients who had accessed HIV services for a minimum of two years. HIV clinic staff helped identify interviewees. At the national level, we purposively selected Eight key informants from different MoH departments, including human resources, clinical services, the national laboratory services, planning, policy, and development, pharmacy, and central mechanical workshop. We also interviewed SUSTAIN staff and USAID.

### C. Methods of Data collection

For purposes of triangulation, a range of data collection methods were employed including the following:

**Document Review.** We reviewed policy and activity documents (see list in Annex E) to obtain background information, assess relevance of SUSTAIN to MoH policy, ascertain documented lessons learned, and obtain other factual data. This information was important for triangulation purposes.

**Key Informant In-depth (KIIs) Interviews.** Using semi-structured guides, the evaluation team conducted in-depth interviews with respondents from USAID, MoH, local government, non-government stakeholders implementing HIV&AIDS activities, health facility managers, and service providers in SUSTAIN's implementation area. Six teams of data collectors, each composed of one supervisor and two research assistants conducted a total of 77 KIIs over a two-week period (Annex F). Each team spent one week per hospital, and supervisors interviewed the more senior informants at the district level.

The central Government-level key informants provided information regarding their knowledge, perception, and experience with the systems approach and whether it succeeded in engendering quality and sustainability of HIV&AIDS services, enhancing MoH (and consequently GoU) stewardship and ownership of HIV&AIDS service delivery, and their views on the future of SUSTAIN supported activities. Eight government level national KIIs were conducted including MoH Assistant Commissioner of Clinical Services, MoH Planning Unit, CPHL, National TB & Leprosy Program (NTLP), Pharmacy Division, MoH Senior HR Officer, and Principal Electrical Engineer, Central Mechanical Workshop.

In addition, KIIs were held with USAID COR Dan Wamanya; the SUSTAIN implementation team, including the Chief of Party (COP) and Vice President of URC; and RRH senior staff (Regional Director, HIV Clinic in-charge, Laboratory in-charge, and hospital administrator). KIIs with IPs included TASO, Star-E, Baylor, Nurture Uganda, and Uganda Cares.

**Focus Group Discussions.** Twenty-four FGDs were conducted with HIV+ clients at RRHs, to assess their experiences and opinion on reach, quality, and benefits of SUSTAIN-supported activities. Discussions focused on clients' experiences of service quality and observed changes in the past five years

that could be attributed to SUSTAIN-supported activities. Such changes include availability of competent staff and resources (including lab tests, drugs, etc.) to provide services, and turn-around time in receiving services at supported facilities. Clients also gave recommendations for activity and overall program design improvement. Given demographic and client need variations among the RRHs, the evaluation team sought three categories of participants, each in separate FGDs: adolescents, women, and men.

**Data Analysis.** All KIIs and FGDs were digitally voice recorded. Each day after data collection, the interviews were transcribed. We conducted all FGDs in local dialects and then transcribed and translated them into English. Transcripts were filed based on key variables (interview type and location). After filing, we analyzed the data to identify themes related to each evaluation question. We carefully constructed frequency tables that relate stakeholder responses and themes to interview questions related to each evaluation question. Our frequency tables include data by individual stakeholder, stakeholder groups, and all respondents. In this way, we can express the frequency of responses by individuals, stakeholder groupings, and all respondents; in both total numbers and percentages. These numbers give a sense of the magnitude of different ideas from respondents. By triangulating and analyzing this data with our other reviews, we developed a table with our findings, conclusions, and recommendations. In drafting this report, we draw upon the frequency tables, quotes from interviews, and other analyses to support the logic of the conclusions and recommendations. For a summary of all respondent data to survey questions related to the key evaluation questions, see Table 1 on the following page, Aggregate Respondent Data. We will draw on this data and the supporting data on which it is based throughout this report.

**Contribution Analysis.** Using the theory of change in activity planning documents, the team sought to validate the causal logic of SUSTAIN; identifying and analyzing what are the most pertinent contributors to observed among activity outcomes including factors directly related to activity design, implementation, and management, as well as contextual factors (political, economic, cultural, etc.) beyond SUSTAIN's control that may have influenced activity outcomes.

#### **D. Design and Methodology Limitations**

The evaluation relied on informants' memories which might contain biases, selective memory, telescoping (recalling events that occurred one time as if they were a pattern), attribution, and exaggeration. However, with the triangulation of data sources and methods, we counteracted this limitation. By drawing on data from records and by comparing information from FGDs, KIIs, and our expert observations, we were able to identify trends and validate data. As our evaluation schedule only provided brief advance notice to national respondents whose access is often difficult due to their busy schedules, we offset this challenge by continuing to interview while analyzing already collected data.

While our sample of 12 RRHs, six health facilities, and national respondents from the MoH, USAID, SUSTAIN, and IPs is strong, it presents some limitations on the degree to which the findings can be generalized. We offset this potential limitation through purposeful sampling and extensive triangulation of data sources from informants who regularly interact with large numbers of health care workers (HCWs) and patients exposed to SUSTAIN-supported services. The results provide in-depth and rich information that could lead to new hypotheses, theory, and directions in programming. Overall, this program evaluation provided significant insights on how the SUSTAIN model can be used to influence future programming efforts more broadly.

Even with explanations that this evaluation was for learning purposes, expectations and anxieties among respondents were high, e.g., RRH staff expecting to be integrated into the civil service, clients regarding services, etc. This however did not significantly affect responses and discussions of evaluation issues.

| <b>Evaluation Questions</b>                                            | <b>Response parameters</b>                                                      | <b>Number of responses</b> | <b>Total number of respondents</b> | <b>%</b> |
|------------------------------------------------------------------------|---------------------------------------------------------------------------------|----------------------------|------------------------------------|----------|
| <b>Q1a. Technical &amp; Leadership capacity at RRHs</b>                | <i>Strengthened supervision of RRHs</i>                                         | 26                         | 38                                 | 68%      |
|                                                                        | <i>Strengthened capacity of leaders of RRHs</i>                                 | 26                         | 38                                 | 68%      |
|                                                                        | <i>Improved management of facilities of RRHs</i>                                | 23                         | 38                                 | 61%      |
| <b>Q1b. Technical &amp; Leadership capacity at district hospitals</b>  | <i>Strengthened supervision of district hospitals</i>                           | 24                         | 64                                 | 38%      |
|                                                                        | <i>Strengthened capacity of district hospitals</i>                              | 25                         | 64                                 | 39%      |
|                                                                        | <i>Improved management of district hospitals</i>                                | 20                         | 64                                 | 31%      |
| <b>Q1c. Enhanced MoH/GoU stewardship &amp; ownership</b>               | <i>Enhanced MOH stewardship at RRHs</i>                                         | 9                          | 11                                 | 82%      |
|                                                                        | <i>Enhanced MOH ownership at partner hospitals</i>                              | 9                          | 11                                 | 82%      |
| <b>Q1d. Improved quality of services</b>                               | <i>Improved lab services</i>                                                    | 63                         | 77                                 | 82%      |
|                                                                        | <i>Improved lab equipment</i>                                                   | 53                         | 77                                 | 69%      |
|                                                                        | <i>Improved HIV/AIDS counseling and testing services</i>                        | 63                         | 77                                 | 82%      |
|                                                                        | <i>Improved testing services</i>                                                | 63                         | 77                                 | 82%      |
|                                                                        | <i>Improved health worker skills and knowledge</i>                              | 56                         | 77                                 | 73%      |
|                                                                        | <i>Improved turn around time for services</i>                                   | 36                         | 77                                 | 47%      |
|                                                                        | <i>Infrastructure/working space</i>                                             | 39                         | 77                                 | 51%      |
| <b>Q2. RRHs positioned as hubs for capacity building and oversight</b> | <i>Improved HIV/AIDS testing services at LLFs</i>                               | 40                         | 84                                 | 48%      |
|                                                                        | <i>Improved hub and related capacity</i>                                        | 50                         | 84                                 | 60%      |
|                                                                        | <i>Improved referral system/increased referrals</i>                             | 43                         | 84                                 | 51%      |
|                                                                        | <i>Improved lab services at LLFs</i>                                            | 26                         | 84                                 | 31%      |
|                                                                        | <i>Improved lab equipment at LLFs</i>                                           | 18                         | 84                                 | 21%      |
|                                                                        | <i>Improved HIV/AIDS counseling and testing services at LLFs</i>                | 36                         | 84                                 | 43%      |
|                                                                        | <i>Improved testing services</i>                                                | 39                         | 84                                 | 46%      |
|                                                                        | <i>Improved health worker laboratory skills and knowledge</i>                   | 47                         | 84                                 | 56%      |
|                                                                        | <i>Improved turn around time for laboratory services</i>                        | 26                         | 84                                 | 31%      |
| <b>Q3a. Issues in SUSTAIN context that facilitated performance</b>     | <i>Financial resources available by SUSTAIN</i>                                 | 14                         | 45                                 | 31%      |
|                                                                        | <i>Fully-fledged human resources by SUSTAIN</i>                                 | 27                         | 45                                 | 60%      |
|                                                                        | <i>Improved attitude of RRH staff</i>                                           | 13                         | 45                                 | 29%      |
|                                                                        | <i>RRH direct reporting to MoH</i>                                              | 1                          | 45                                 | 2%       |
|                                                                        | <i>MoH leadership support</i>                                                   | 4                          | 45                                 | 9%       |
| <b>Q3b. Issues in SUSTAIN context that limited performance</b>         | <i>Political leadership/ownership</i>                                           | 12                         | 45                                 | 27%      |
|                                                                        | <i>RRH vs MoH reporting line system</i>                                         | 2                          | 45                                 | 4%       |
|                                                                        | <i>Limited ownership by MoH and or districts</i>                                | 3                          | 45                                 | 7%       |
|                                                                        | <i>Economic/financial support</i>                                               | 11                         | 45                                 | 24%      |
| <b>Q4a. SUSTAIN best practices identified</b>                          | <i>Laboratory improvements</i>                                                  | 44                         | 74                                 | 59%      |
|                                                                        | <i>Equipment support</i>                                                        | 40                         | 74                                 | 54%      |
|                                                                        | <i>Mentorship, capacity building &amp; HRH recruitment</i>                      | 46                         | 74                                 | 62%      |
|                                                                        | <i>Hub</i>                                                                      | 39                         | 74                                 | 53%      |
|                                                                        | <i>HMIS</i>                                                                     | 29                         | 74                                 | 39%      |
|                                                                        | <i>Infrastructure</i>                                                           | 29                         | 74                                 | 39%      |
| <b>Q4b. Practices that did not work well</b>                           | <i>Partnerships/collaborations with district health leaders &amp; other IPs</i> | 12                         | 74                                 | 16%      |
|                                                                        | <i>MoH leadership engagement</i>                                                | 11                         | 74                                 | 15%      |
|                                                                        | <i>Community efforts for TB management</i>                                      | 4                          | 74                                 | 5%       |
|                                                                        | <i>SUSTAIN staff recruitment &amp; aligning salaries to RRH/MoH standards</i>   | 18                         | 74                                 | 24%      |
| <b>Q4e. Sustainability</b>                                             | <i>Continue providing HIV/AIDS services delivery</i>                            | 50                         | 93                                 | 54%      |
|                                                                        | <i>Maintain the human resources recruited by SUSTAIN</i>                        | 20                         | 93                                 | 22%      |
|                                                                        | <i>Maintain HMIS efforts and/or support</i>                                     | 18                         | 93                                 | 19%      |
|                                                                        | <i>Sustain infrastructure set-up</i>                                            | 19                         | 93                                 | 20%      |
|                                                                        | <i>Maintain equipment provided and its servicing</i>                            | 17                         | 93                                 | 18%      |
|                                                                        | <i>Identify required financial support currently provided by SUSTAIN</i>        | 8                          | 93                                 | 21%      |

## SECTION III. EVALUATION FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This section presents the evaluation FCRs, organized and presented under each evaluation question.

### A. Question 1

*How did SUSTAIN's specific strategy and technical approach contribute to:*

- Strengthening technical and leadership capacity at partner RRH's*
- Strengthening technical and leadership capacity at partner district hospitals*
- Enhancing MoH stewardship and ownership of HIV&AIDS service delivery in partner hospitals and regions*
- Improving quality of services*

#### A.1 Strengthening technical and leadership capacity at partner RRHs and district hospitals

Respondents generally believe that SUSTAIN made significant progress in strengthening technical and leadership capacity at regional and district facilities. Specifically, per Table 2 below, RRH directors and HIV in-charges, and DHOs reported improvements in supervision, leadership capacity, and facility management.

Table 2. Perceived SUSTAIN Contribution to Technical and Leadership Capacity

| Aspect of Technical and Leadership capacity | RRH Directors (n=12) | HIV Clinic In-charges (n=12) | DHOs (n= 8) | Average all respondents |
|---------------------------------------------|----------------------|------------------------------|-------------|-------------------------|
| Strengthened supervision of RRHs            | 92% (11)             | 67% (8)                      | 75% (6)     | 78%                     |
| Strengthened capacity of leaders            | 92% (11)             | 58% (7)                      | 75% (6)     | 75%                     |
| Improved management of facilities           | 100% (12)            | 42% (5)                      | 63% (5)     | 69%                     |
| Average                                     | 95%                  | 56%                          | 71%         | 74%                     |

Strengthened supervision was most reported across respondents (78%), followed by strengthened leadership (75%), and then improved facility management (69%). There is substantial disparity between the perception of RRH directors and RRH HIV Clinic In-Charges in all areas (average 95% versus 56%), with the DHOs falling at the midway between the two. This may be due to a greater perception of improvements in supervision, leadership, and management among top administrators (RRH Directors) than among the HIV Clinic In-Charges. This might mean (1) top administrators are performing less well than they themselves perceive, i.e., that their direct reports don't experience as much of a positive shift in supervision, leadership, and management; but (2) top administrators are however performing better than before as noted by the DHOs. It may also be that the number of the HIV Clinic In-Charges trained by SUSTAIN were transferred, left for further studies, or on leave, which also may have skewed responses.

**Training and Mentoring of Staff.** Both providers and patients reported improved knowledge and skills through SUSTAIN's contributions via their strategy to transfer and improve technical and functional skills of RRH staff through training and mentorship. SUSTAIN established a training cohort of different experts in each region and, by the end of 2016, 7,514 individuals had received training, including MoH headquarters staff. Overall, 73% (56/77) of respondents report improved knowledge and skills among health workers (see Table 1). Table 3 below shows the breakout among respondent groups, again with some disparity among regional and district staff. Lab staff universally acknowledged improved skills due to the training and orientation that accompanied lab rehabilitation and equipment upgrades. Clients echoed similar findings regarding health worker staff knowledge, per two-thirds (or 16 out of 24) FGDs.

Respondents reported that, as a result of SUSTAIN training and mentorship, health staff had better knowledge and skills, and higher confidence in delivering services. Respondents also noted that through shared training and co-facilitation, links between the RRH staff, district health team, and MoH were strengthened. While we were not able to assess the quality of training, we noted that the training is based

on standard MoH manuals and uses experienced facilitators from SUSTAIN, MoH, and the district health team. Respondents lauded SUSTAIN for ensuring that trainings remained relevant to the Ugandan health system and its policies and focused on skills required at the facility level.

Table 3. Percentage of Respondents that Noted an Improvement in Knowledge and Skills

| Respondent Category  | %    | # of positive respondents | Total # of respondents |
|----------------------|------|---------------------------|------------------------|
| RRH Directors        | 91%  | 11                        | 12                     |
| HIV in-charges       | 75%  | 9                         | 12                     |
| Lab in-charges       | 100% | 12                        | 12                     |
| DHOs                 | 63%  | 5                         | 8                      |
| Lower facility staff | 66%  | 4                         | 6                      |

**Improvement of Technical Infrastructure and Equipment.** Full utilization of technical knowledge and skills requires good infrastructure. Overall, just over half (51%) of respondents reported that infrastructure improvements enhanced technical capacity of hospitals (Table 1). Furthermore, SUSTAIN was reported as one of the few projects that support health infrastructure development, and all the eight MoH headquarter informants reported infrastructure support as one of SUSTAIN best practices.

## A.2 Enhancing MoH Stewardship and Ownership

**Stewardship at RRH level.** SUSTAIN uses a checklist of nine items to monitor the degree of stewardship and ownership achieved in supported RRHs (see text box). Most respondents believe that SUSTAIN enhanced stewardship and ownership of RRHs by the MoH: 78% (7/9) of MoH respondents and 82% (9/11) of all respondents. Based on the SUSTAIN checklist, improved stewardship is evident among RRHs in some of the areas. For example, several SUSTAIN-hired RRH HIV clinic managers were transitioned to MoH employment and supervision by the end of 2013.<sup>1</sup> We noted duty rosters at all supported RRHs showing the allocation of responsibilities among staff as well as well-maintained HR records (checklist items #8 and #9).

### SUSTAIN's Stewardship Checklist

1. Evidence of HIV service delivery activities and inputs incorporated in the hospital work plan and budget
2. The head of the HIV Clinic is MOH staff (public servant)
3. PMTCT Focal Person is MOH staff (public servant)
4. HTC Coordinator is MOH staff (public servant)
5. VMMC Focal Person is MOH staff (public servant)
6. Evidence of staff appraisals conducted by senior management
7. Evidence of disciplinary action taken on staff
8. Evidence of allocation of responsibilities, duty rosters in place
9. Presence of well-maintained HR records, staff files in place

**Stewardship at national-level.** 82% (9/11) of respondents believe that SUSTAIN has enhanced MoH program ownership, including USAID and SUSTAIN informants. Most of the MoH leadership interviewed agrees with this (78% or 7/9), including the MoH Director of Planning, Policy, and Development (see quote in text box).

*"Our partnership has been good and strong. I am not sure if this was a design (SUSTAIN working well... or it has been the individuals) but what I know is they have been cooperative. They do not do things that we do not know about and they report to us during the quarterly meetings, which I chair. They are doing interventions that we know and we talk the same language." (Director of Planning, Policy and Development Interview, 26.10.16)*

National-level respondents commended SUSTAIN for keeping the MoH informed of interventions and activities at RRHs through quarterly presentations.

Some respondents, however, noted that real stewardship requires resources which are presently insufficient at the MoH; while others noted that the MoH should be more involved in activity planning and staff recruitment. One respondent stated that, *"We are the ones in charge of hospitals.... MoH active involvement (leadership) for health was ignored largely!"*<sup>2</sup>

<sup>1</sup> SUSTAIN Annual Report, October 1, 2013 – September 30, 2014

<sup>2</sup> Assistant Commissioner Clinical Services, MOH, interview Kampala, 11.09.16

We found it difficult to assess stewardship at the national level, due to a lack of indicators for measuring stewardship and the size and complexity of the MoH. Stewardship in one department did not necessarily represent the entire ministry. The MoH has not yet absorbed a considerable number of program-supported staff, which was originally anticipated to occur before SUSTAIN ends. Overall, it appears that MoH stewardship has increased over the life of SUSTAIN, but is a work in progress.

**Policy direction.** Per MoH respondents, SUSTAIN shared information with the ministry, and facilitated ministry participation in meetings for policy development which strengthened the ministry's mandate for providing and leading policy direction. SUSTAIN collaborated with ASSIST<sup>3</sup> and the MoH Quality Assurance Department to evaluate the previous National Quality Improvement Framework and Strategy Plan 2010-2015; and then helped produce the new National Framework and Strategy Plan 2016-2020, which was officially launched in August 2016.

### A3. Improved quality of service

Respondents noted a number of SUSTAIN-supported improvements that positively affected service quality at RRHs. Most prominently mentioned was improved lab services, reported by 83% of the respondents summarized in Table 4, and 82% (63/77) of all respondents (see Table 1). As expected, the LLFs scored lowest on QI (between 13% and 63%) as they did not receive direct SUSTAIN support. Other SUSTAIN-supported areas of improvement that respondents believe positively influenced quality are, in the following order per average of all respondents:

- Health worker skills and knowledge
- Improved lab equipment
- Improved HIV testing & counseling
- Improved infrastructure
- Service turnaround time

Each of these is discussed in turn below.

Table 4. Health Worker Perception of Areas of Quality Improvement

| Areas of Quality                  | Respondents Category  |                             |                      |           |                      | Average across all health workers |
|-----------------------------------|-----------------------|-----------------------------|----------------------|-----------|----------------------|-----------------------------------|
|                                   | RRH Directors (n= 12) | HIV Clinic in-charge (n=12) | Lab in-charge (n=12) | DHO (n=8) | LLF In-charge (n= 8) |                                   |
| Improved lab services             | 83% (10)              | 83% (10)                    | 100% (12)            | 87% (7)   | 63% (5)              | 83% (44/52)                       |
| Health workers skills & knowledge | 91% (11)              | 75% (9)                     | 100% (12)            | 63% (5)   | 50% (4)              | 76% (41/52)                       |
| Improved lab equipment            | 83% (10)              | 83% (10)                    | 100% (12)            | 63% (5)   | 13% (1)              | 73%(38/52)                        |
| Improved HIV testing & counseling | 17% (2)               | 83% (10)                    | 91% (11)             | 100% (8)  | 63% (5)              | 71% (36/52)                       |
| Improved Infrastructure           | 67% (8)               | 50% (6)                     | 58% (7)              | 50% (4)   | 13% (1)              | 48% (26/52)                       |
| Service turnaround time           | 25% (3)               | 50% (6)                     | 50% (6)              | 63% (5)   | 38% (3)              | 45% (23/52)                       |

Client perception of improvements that most affected service quality are:

- Improved lab services: 100% (10/10)
- Improved HIV testing & counseling: 90% (9/10)
- Health worker skills & knowledge: 70% (7/10)
- Improved lab equipment: 70% (7/10)
- Improved Infrastructure: 60% (6/10)
- Service turnaround time: 60% (6/10)

**Laboratories and testing services.** As indicated by Table 4, QI was most affected by improvements in laboratory services, noted by all lab directors (100%), the majority (83%) of RRH directors and in-charges of HIV clinics, and more than two-thirds (71%) of clients. Reportedly, lab services improved HIV

<sup>3</sup> USAID, Applying Science to Strengthen and Improve Systems

testing, including CD4 count and viral load tests, which are historically a treatment challenge for RRHs and LLFs. SUSTAIN's rehabilitation, expansion, upgrading, and equipping of RRH labs to a higher standard of quality allowed for these tests, which respondents widely noted with positivity. The improved laboratories have also allowed for diagnostic tests beyond HIV, thus more appropriate treatment. Furthermore, lab improvements have motivated patients to undertake more tests and trust the results. During an interview, the Head of the National Health Laboratories reported a visit to a refurbished hospital lab with a member of parliament who was so impressed and proud of what he saw that he exclaimed: *Take my blood now for the test!*

*To me the trainings were [good] quality trainings because those who came to train the staff are skilled people and they know what they are giving and they are people who are doing this work all the time...the mentorships is real mentorship, they don't rush through the facility, they take time in supporting the staff in areas of weakness. (Acting DHO, Kabale)*

*Initially definitely we did mainly classroom trainings but afterwards we found out those mentorships are more important so in the second part of the support we concentrated more on mentorship and support at the place of work and it has a marked improvement. (Hospital Director, Fort Portal RRH)*

**Improved health worker knowledge and skills and QI institutionalization.** As a result of training and mentorship, 76% (56/73) of respondents cited improved HCW skills in improving service quality. RRH directors and Lab-in-charges rated this most highly. Respondents also noted that training activities were an opportunity for trained staff to pass their knowledge and skills to LLFs ("trickle-down" effect); and cited SUSTAIN's practice of having training/technical staff spend six plus days mentoring and coaching staff at a single facility as a best practice.

Almost all 24 health workers interviewed at RRHs noted receiving QI training, including in improved logistical planning, in turn increasing RRH ability to track patients and reduce commodity stock-outs. Availability of commodities is a critical indicator of quality, especially from patients' point of view. Since the uninterrupted supply of drugs and healthcare supplies heavily relies on the National Medical Stores (NMS), many respondents voiced concerns about sustainability in this regard. They noted that SUSTAIN often intervenes when there is danger of a stock-out, not facility staff, which is needed for sustainability.

#### *Client Perception of Improvements in Service Delivery*

- Far shorter turn-around time due to rationalized and streamlined services
- Greatly improved attitudes of HCWs, who were often described as 'attentive'
- Much improved infrastructure, equipment, and performance of laboratories
- Efficient, scheduled transport and testing of blood samples via the web of motorcycle riders
- Improved HMIS/ability to retrieve and track patient tracking
- Well-functioning community referral system, assisted by village health teams (VHTs)
- Improved health care delivery in communities resulting from improvements in the hub system

Respondents lauded the increased personnel resulting from SUSTAIN support, also important for achieving quality. Recognizing that better equipment and laboratories would not be beneficial without requisite supporting staff, SUSTAIN introduced new personnel categories, e.g., bio-medical technicians who were immediately understood as essential personnel and integrated into MoH planning.<sup>4</sup> Again, retention of such new hires creates vulnerabilities for sustainability at program conclusion.

Respondents reported that SUSTAIN supported efforts to institutionalize QI approaches at key functional points of HIV&AIDS prevention, care and treatment including PMTCT, nutrition, VMMC, TB, laboratory, adolescent friendly HIV services, and other HIV-related services. Mbale RRH was ranked the best RRH in Uganda, for which it credits the SUSTAIN activity.<sup>5</sup> We found that setting up QI teams was a sustainable mechanism, as teams at different units, including labs, HIV clinics, and management, regularly meet to set QI targets, evaluation, and re-planning. This URC trademark approach was highly commended by RRH staff and IPs working in the facilities we visited. In support of quality treatment of

<sup>4</sup> MOH (January 2014) Health Infrastructure Division, (December 2013). *Operation Manual for Regional Medical Equipment Maintenance Workshops and Medical Equipment Maintenance Guidelines.*

<sup>5</sup> Quote from the Principal Hospital Administrator, Mbale RRH.

TB and MDR TB, SUSTAIN participated in performance reviews, and previously supported joint technical support supervision. It supported infrastructural remodeling in about six MDR sites and refurbishment of MDR wards. SUSTAIN had effective QI approaches in this regard, bringing all implementers together to share best practices and critical learning on a quarterly basis.<sup>6</sup>

**Infrastructure improvements.** While it did not rank as high as other areas among respondents, half (39/77) reported infrastructure development as an area in which SUSTAIN improved service delivery. Infrastructure and general facility improvements were observable in all RRHs visited. During FGDs, clients noted with appreciation infrastructure improvements such as waiting shelters and additional space which reduced congestion, especially in TB wards.

SUSTAIN helped to empower the MoH to improve its central medical equipment maintenance unit and regional units in the maintenance of microscopes, centrifuges, autoclaves, blood bank refrigerators, air conditioners, infant warmers, power generators, instrument trolleys, stethoscopes, wheel chairs, lighting systems, electric boilers, X-ray machines, Ultrasound machines, ophthalmoscope, operating tables, digital blood pressure machines, weighing scales, suction machines and oxygen concentrators.

**Figure 1. Aspects of SUSTAIN Support to Quality Improvement**



**HMIS.** With improvements to HMIS and access to the DHIS2, records systems are sufficiently monitoring health care improvements across the board at SUSTAIN-supported sites. Equipment and supplies such as registers and paper, along with trainings in MoH systems, has further assisted management of patients. The fact that clients were properly registered and their improvements could be monitored over time resulted in far better treatment outcomes. Printed data has replaced handwritten results, which greatly improves efficiency of service delivery. Kabale RRH lab was proud to inform the evaluation team that they had moved from Star 3 to Star 4 level (categories used to rank HMIS), thanks to the SUSTAIN activity.

**Integration of HIV&AIDS Care.** SUSTAIN support has in part facilitated the integration of HIV care in other clinics. Informants from RRHs and districts acknowledged that with the improved labs and human resources, it is now possible for RRHs to undertake provider-initiated testing and counseling at different points of care, such as dental or eye clinics. The Assistant Commissioner of Clinical Services explained, “*There has been a change in investigative procedures for HIV&AIDS; HIV was looked at as an isolated issue in the past where the hospital would have two labs; one for HIV&AIDS patients and the other for [non-HIV&AIDS] people.*” There are a number of advantages to integration, ranging from diminishing stigma experienced by clients, to renovation of laboratories and other hospital facilities. This integration of HIV&AIDS into the wider hospital system is also in line with MoH policy, and supports the WHO recommended Test and Treat and the 90/90/90 policies for HIV&AIDS.

Other areas of quality of services improvement cited by respondents include:

- **Mother – Baby Points** in maternal, new-born and child health units as a one-stop health center for postnatal HIV-infected mothers and their babies.
- **Adolescent Friendly Services (AFS) clinics** were established at six supported facilities that include Jinja, Mbale, Gulu, Lira, Moroto and Kabale as a response to a baseline survey findings that showed a lack of these services (previously only available in 17% of facilities). Working with

<sup>6</sup> Program Manager, NTLP.

the MoH Reproductive Health Division, there was a review and harmonization of adolescent data collection tools, including an adolescent assessment tool, adolescent register, and the monthly report format that is used to report on selected key indicators.<sup>7</sup>

- **Support with Guidelines and Treatment Standards.** However, there was one noted complaint expressed by MoH/GoU in the National HIV and AIDS 2015/16-2019/20 report, “*The capacity of the UAC to coordinate the national multi-sectoral HIV and AIDS responses was undermined by other players’ limited understanding and adoption of existing policy guidelines.*”

#### A4. Conclusions

1. SUSTAIN activities in strengthening technical and leadership capacity for RRHs and district hospitals translated into improved knowledge and skills among health staff, improved quality of care, and the competencies need to fully benefit from improvements in infrastructure and equipment.
2. SUSTAIN’s strategy of ongoing, standardized approach to mentorship and coaching resulted in over 7,000 health workers in the health system with higher competencies in delivering appropriate HIV&AIDS and TB health services.
3. SUSTAIN enhanced MoH stewardship and ownership of HIV&AIDS delivery in partner hospitals and regions through development and use of a stewardship checklist, mentorship and coaching, and collaboration with MoH officials. However, despite these efforts, MoH respondents expressed reservations about the degree to which they felt ownership or stewardship of SUSTAIN’s activities.
4. SUSTAIN’s strategy improve and integrate HIV&AIDS services in the twelve RRHs, with the laboratories being the outstanding improvement with new equipment and trained technicians.

#### A5. Recommendations

1. Establish a participatory checklist of stewardship and leadership indicators with the MoH, to better measure stewardship and ownership at the ministry level.
2. Supervision of LLFs by RRHs is not mandated currently, and this curtailed the degree to which LLFs benefited from SUSTAIN improvements. To address this, future activities should facilitate MoH dialogues with the Ministry of Local Government to establish RRH supervision of LLFs.
3. Future activities should align HR policies, especially salary scales, with the MoH.
4. Given SUSTAIN’s adaption of the WHO Six Building Blocks approach was an effective and efficient method of health system development (a holistic approach addressing both material and HR capacity), it should continue to be used in future activities.

### B. Question 2

*What was the SUSTAIN activity’s contribution to positioning the RRHs as hubs for capacity building and oversight to LLFs?*

#### B1. Findings

As noted above, the SUSTAIN model assumes a ‘trickle-down’ theory of change: by strengthening management and enhancing efficiency and quality of health service delivery at RRHs, the wider health sector network would by proxy benefit from SUSTAIN activities; and RRHs serving as capacity building centers would stimulate adoption of improved management and services delivery practices by LLFs. In

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<sup>7</sup> SUSTAIN Annual Report September 2015-October 2016

responding to evaluation question #2, we explore this from various vantagepoints: directly, capacity-building, referral system, and hub network.

**Trickle-down effect.** Per Table 5, respondents generally perceived limited trickle-down effects of SUSTAIN support. While 60% of respondents perceived improved hub and related capacity generally, when asked about specific improvements, the percentage of respondents identifying concrete changes dropped to 31-56%. Less than half of respondents reported any improvements in HIV&AIDS testing, other testing, HIV&AIDS counseling and testing, lab turnaround times, lab services, and lab equipment. The most prized (56%) of the concrete benefits of the hub to the LLFs was the improvement in health worker laboratory skills and knowledge, as they benefited from SUSTAIN trainings and orientations. 75% of lab in-charges reported improvement of lab skills and knowledge at LLFs.

In parsing the data among stakeholders, 75% of both DHOs and RRH directors (8/12) interviewed believe there are improvements in hub capacity as result of SUSTAIN support. Other health workers at the RRH level share this perception (average of 75% between HIV and lab in-charges). However, only 25% of health workers at the LLFs perceived improvements via the hub, and this drops to 20% (2/10) among LLF clients in FGDs. However, 54% of clients cited improved lab skills and referrals.

Table 5. Trickle Down Effect to LLF: Perception of SUSTAIN as a Capacity Building Hub

| Areas of Improvement at LLFs                           | Number (n=84) | Percentage |
|--------------------------------------------------------|---------------|------------|
| Improved hub and related capacity                      | 50            | 60%        |
| Improved health worker laboratory skills and knowledge | 47            | 56%        |
| Improved referral system/increased referrals           | 43            | 51%        |
| Improved HIV&AIDS testing services                     | 40            | 48%        |
| Improved testing services                              | 39            | 46%        |
| Improved HIV&AIDS counseling and testing services      | 36            | 43%        |
| Improved turnaround time for laboratory services       | 26            | 31%        |
| Improved lab services                                  | 26            | 31%        |
| Improved lab equipment                                 | 18            | 21%        |

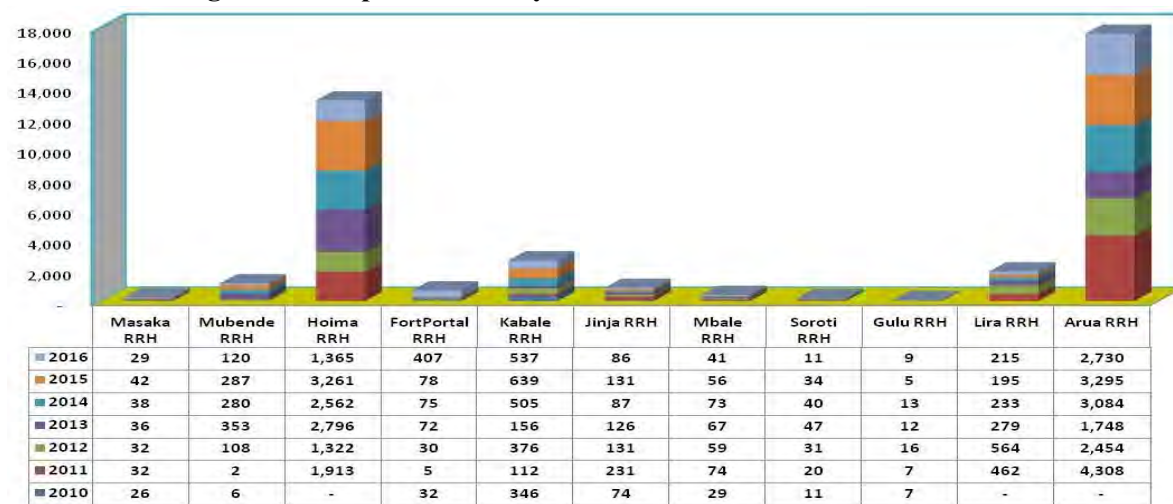
While there were reported improvements at LLFs, the general perception of informants is that the actual contribution to enhanced capacity at LLFs in the catchment areas was limited. We did not observe any deliberate effort to roll down capacity building to LLFs. This would require a special effort given RRHs are not mandated within the context of the Ugandan health system to oversee and build capacities of LLFs. LLFs report to the DHO, while the RRHs report directly to the MoH. Respondents noted that the DHOs have little involvement in planning and implementing SUSTAIN activities.

When LLFs did benefit, it was primarily during trainings, when some lower level staff were included in RRH staff trainings, and through support services, such as lab services and medical equipment maintenance, from the RRH. As noted by the Hospital Administrator of Fort Portal RRH, without the support of an engineer to maintain equipment in the district, an event such as the breakdown of an x-ray machine would seriously impact services provided to clients. SUSTAIN has also significantly improved turnaround time for repairs through support of a mobile maintenance van. The low level of real trickle-down is a shortcoming of SUSTAIN's approach since LLF patients should only be referred to the RRHs for specialized services. However, the lack of care improvement at LLFs means that patients go to RRHs which overburdens both users and referral hospitals.

**Referrals.** Patient referrals serve as a proxy for the degree of interaction and relationship between an RRH and LLFs. As an indication of a more highly functioning hub health care system following SUSTAIN interventions, 51% of all respondents reported improved referral rates to RRHs, including almost all (83%) of LLF in-charges and more than half (54%) of clients' FGDs. We also found that SUSTAIN enhanced the ability of RRHs to receive and manage referral cases from LLFs. To further

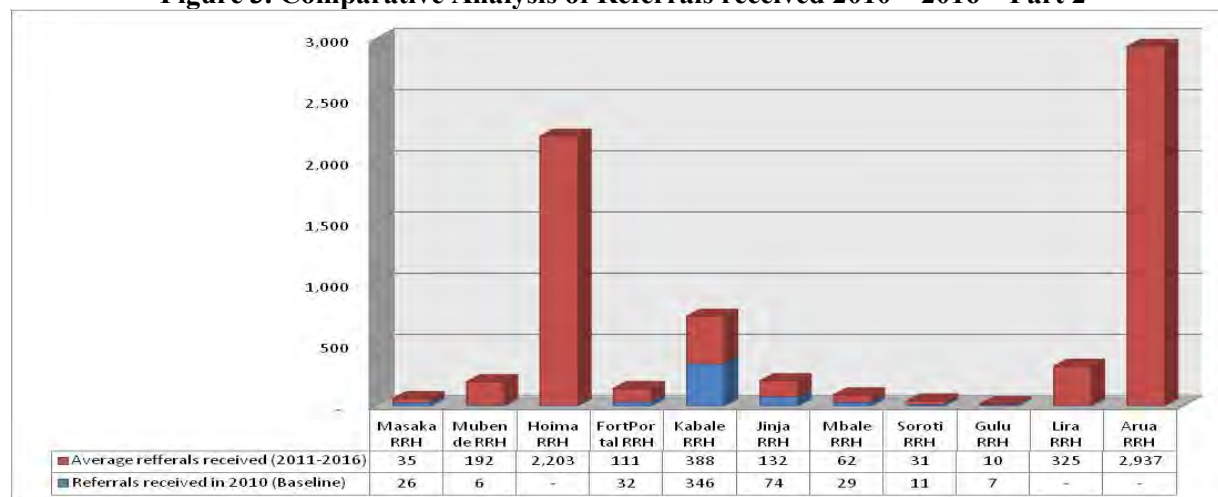
explore the degree to which a referral network has been advanced, we collected data on referrals between RRHs, LLFs, district hospitals, and HC IVs from 2010 to 2016, depicted in Figure 2. Overall, SUSTAIN-supported RRHs experienced an increase in the volume of patient referrals during this period. There was a sharp increase in referrals between 2010 and 2011 at the activity's inception, when comprehensive and integrated HIV&AIDS services were first introduced by SUSTAIN. Referrals declined in 2012 by 28.5% in 2012, but continued to slowly grow until 2015 when the SUSTAIN began to scale down activities.

**Figure 2. Comparative Analysis of Referrals Received 2010-2016 - Part 1**



With the exception of Arua, Lira, and Hoima, RRHs where baseline referral numbers in 2010 were not provided, the overall number of referrals doubled within six years in most of the remaining RRHs. As shown in Figure 3, Hoima, Arua and Kabale RRHs experienced the highest influx of patient referrals, indicating that LLFs in these districts lacked adequate HIV&AIDS service delivery capacity. Conversely several RRHs, namely Gulu, Soroti and Masaka, experienced very low numbers of referrals from the LLFs, possibly due to strengthened capacity of LLFs in those districts.

**Figure 3. Comparative Analysis of Referrals received 2010 – 2016 – Part 2**



**Lab Transport Network Hub.** The most frequently mentioned specific improvement related to overall capacity building of LLFs was improved efficiency of transporting samples within the hub to the regional labs at the RRHs and the National Public Health Laboratory. SUSTAIN supported 18 National Sample

Referral and Results Transport Network hubs at Jinja, Moroto, Hoima, Lira, Mbale, Soroti, Arua, Masaka, Mubende, Fort Portal, Kabale, Gulu, Tokora HC IV, Kotido HC IV, Kaabong, Abim, Matany and Kawolo. A total of 470 LLFs were served by the 18 hubs.<sup>8</sup> SUSTAIN's strategy included strengthening and improving the existing hub system. As indicated in the trend of referral figures above, it can be inferred that the hub system increased linkages and referrals, and HCWs were better equipped to follow up with clients. Activities that fell within conventional structural arrangements, such as the maintenance and repair services of Regional Medical Equipment traditionally undertaken at the regional level, benefited the most from situating RRHs as hubs.

SUSTAIN's provision of motorcycles, fuel, and maintenance made the largest impact. The hub rider forms a principal link between the RRHs and the LLFs, especially Health Centers III and IV. As noted by the Principal Hospital Administrator at Arua RRH, *"Now (lab) samples are quickly taken to every RRH. Before, there was inadequacy in community linkages, because RRHs could not support the lower units."* The hub transport system has become a lifeline to many smaller, outlying health clinics throughout the country and within the SUSTAIN network. By greatly reducing the cost of transporting samples and ensuring rapid return, HCWs were able to treat patients better and more quickly. SUSTAIN did face challenges with hub riders. Riders were tasked to collect referral forms to track clients and monitor the referral system. Often forms were lost or not used correctly, and information was sometimes disseminated in unstructured ways via the 17 hub riders supported by the activity.

In addition, empowering the hub system has facilitated the effective adoption of the recent HIV treatment guideline of viral load testing. Knowing CD4 counts and viral loads gives doctors a tremendous advantage in making more sophisticated diagnoses. Samples are collected from the LLFs and transported by the rider to the RRH or post office, and then to the National Public Health Laboratory (NPHL) in Kampala or the Uganda Virus Research Institute (UVRI) in Entebbe. The rider also transports results back to the LLFs. It was noted that turnaround time for tests from the NPHL is less than two weeks.

## **B2. Conclusions**

1. SUSTAIN's contribution to positioning RRHs as capacity-building and oversight hubs was most noted in improvements to the hub network, HCW laboratory skills and knowledge, and the referral network; all of which were cited by more than 50% of respondents. HIV&AIDS testing, other testing, and HIV&AIDS counseling and testing services were the next top ranked (43-48%). Approximately a third of respondents cited improvements in lab services including turnaround time.
2. Hoped for trickle-down effects from RRHs to the LLFs were minimally realized. Although LLFs benefited somewhat from SUSTAIN-sponsored trainings and other activities, their capacity was not sufficiently improved to take on a larger role and reduce pressure on the RRHs. Effective capacity building of the LLFs would have required a concerted effort, separately conceived, not a side effect of other interventions. This is especially the case given the Ugandan health care system in which the RRHs and LLFs report to different authorities.
3. Although the health referral system is not fully documented, SUSTAIN has improved its functionality with increased level of referrals between the LLFs and RRHs and an improved ability of the RRHs to handle the increase in referrals.
4. Through the hub riders, SUSTAIN strengthened the hub transport network for transferring testing samples between facilities, enabling HCWs to efficiently and effectively diagnose and treat clients. The sustainability of the hub rider approach after SUSTAIN closes remains a question.

## **B3. Recommendations**

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<sup>8</sup> SUSTAIN Annual Report October 2015- September 2016

1. Large scale activities, such as those supported by PEPFAR, should work on a scale that includes both district and regional needs.
2. Future programs should be circumspect about relying on trickle-down effects that do include specific strategies to either make the trickle-down effective or for directly undertaking work associated with an objective. Specifically, follow-on programming to SUSTAIN, if it plans to strengthen LLFs as part of a health system, should include specific activities directed at strengthening LLF capacities so that those facilities can provide the care intended for their level in the health system. This will incentivize clients to use lower-level health facilities instead of traveling to over-burdened regional hospitals.
3. The health referral system should be mapped and documented.
4. Maintenance and repair services should be provided regionally to further support RRHs as hubs.

### C. Question 3

*What issues emerged from SUSTAIN activities that facilitated or inhibited its activity performance? Issues could include political, economic, management, social, and cultural factors. How were these issues managed?*

#### C1. Findings

RRH directors, in-charges of HIV clinics and labs, DHOs, and SUSTAIN staff were the main respondents to this question.

**Summary of findings.** The top facilitating factor (60%) was SUSTAIN-provided, fully-deployed human resources working as part of the health system. Three additional factors cited by about one-third of respondents were financial support, good attitudes by RRH staff, and political leadership and ownership. On inhibiting factors, 24% of respondents mentioned the need for additional financial resources. Other challenges, discussed below, included: policy changes; lack of direct support to districts; and the limiting effect of poverty and stigma on access.

Table 6. Factors Facilitating or Inhibiting SUSTAIN Implementation

| Facilitating Factors                         | Number | Percent |
|----------------------------------------------|--------|---------|
| Fully-deployed personnel provided by SUSTAIN | 27     | 60%     |
| Financial resources provided by SUSTAIN      | 14     | 31%     |
| Good attitudes of RRH staff                  | 13     | 29%     |
| Political leadership/ownership               | 12     | 27%     |
| Inhibiting Factors                           |        |         |
| Lack of financing                            | 11     | 24%     |

**Challenging policy changes surmounted.** All SUSTAIN staff reported that the MoH supported SUSTAIN interventions throughout. Similarly, notwithstanding their minimal involvement, 50% (4/8) of DHOs noted that SUSTAIN receives political support from districts. Two-thirds of RRH directors said they did not encounter any district-level resistance to the activity. SUSTAIN staff reported that PEPFAR policy changes not previously anticipated have challenged the activity's interventions, necessitating adaptation of mid-stream activity changes. For example, 1) moving from prevention to elimination of mother to child transmission (PMTCT to EMTCT), 2) the inclusion of Voluntary Medical Male Circumcision (VMMC) and MDR TB that came later, and 3) the shift to 'Test and Treat' for HIV regardless of the CD4 count, necessitated modifications to the activity's approach. To adapt to these mid-contract policy changes, SUSTAIN swiftly mobilized additional technical staff to better enable the activity to cover the adjusted technical scope. SUSTAIN staff also reported that they received support from URC headquarters, the MoH, and from USAID in the form of prompt approvals.

**Strong commitment notwithstanding lack of direct support to districts.** 66% (8/12) of RRH directors and the SUSTAIN staff reported that the MoH and DHOs are committed to improving health service delivery at all facility levels, despite various constraints that limit MoH and DHO involvement. Even without direct support to the district level, we found that most DHOs have positive working relationships with the SUSTAIN activity and the RRHs they support. For example, the acting DHO in Kabale said that SUSTAIN staff has always been open to a free exchange of ideas. Most health service delivery staff interviewed at LLFs appear committed to improving health service delivery, notwithstanding the

challenges posed by inadequate facilities and lack of direct support. However, commitment among LLFs in remote and marginalized areas is tested by a variety of difficulties, particularly recruiting and retaining staff, which negatively affects client access to services. Some respondents believe SUSTAIN would have been more effective if it had also worked with the districts in addition to the regional referral system.

**Poverty limits access.** Respondents reported that many patients have limited access to health care facilities due to transportation constraints, i.e., the cost of transport or lack of transportation altogether in remote, high-poverty areas. For example, the RRH Director of Mubende said that “...people are poor so they do not come for the services...some don’t take medication as a priority to spend on.”

**Stigma still inhibits use of services.** Even though the HIV&AIDS epidemic is in its fourth decade, stigma around the disease is still prevalent in Uganda, and was reported by respondents as a barrier to accessing and using services. Reportedly, some patients preferred to visit distant facilities to keep their HIV status a secret. This increases use and congestion of RRHs.

**Refugee influx adds to RRH congestion.** Some RRHs are located in border districts near countries experiencing political and economic issues that spawn refugee populations. As a result, these RRHs have unanticipated clients among the refugee populations. The language barriers compromise the quality of services and the unanticipated additional client base puts pressure on the facilities. The Arua, Hoima, and Fort Portal districts reported a large number of immigrants from the DRC and Rwanda.

**Structural dissonance in district/regional reporting.** The structure of the Ugandan health system, which is divided into the regional and the district levels, affects the degree to which an activity like SUSTAIN can effect change. At the end of 2015, Uganda contained 111 districts outside of Kampala City. The Ugandan public health system is structured around RRHs, reporting to the MoH, and LLFs, which report to the DHO. RRHs therefore have no interaction with DHOs, yet reside within districts and in proximity to other healthcare facilities. The DHO of Hoima explained that the RRH is not answerable to him but reports to the MoH. He, like other DHOs, sits on the board of the RRH but he has no control over hospital management. The Hoima DHO also explained that his district government received no direct support (funds) from SUSTAIN because the activity worked at the regional level. There was ample evidence from the interviews that the dichotomy in the health system structure in some cases acted as an impediment to service delivery improvement.

“The biggest barrier is answerability. We report to the central government and they report to local government...In the planning next time, we should be together. The most difficult one is the kind of relationship RRHs have with Health Centre IVs and District Hospitals....” - RRH Administrator of Soroti

## C2. Conclusions

1. The top facilitating factors are fully-deployed personnel provided by SUSTAIN, financial resources available by SUSTAIN, good attitudes of RRH staff, and political leadership/ownership.
2. Financing is the most reported inhibiting factor, ranging from lack of sufficient government financing for human resources to client resources for transportation to facilities.
3. Additional factors affecting SUSTAIN implementation include: challenging policy changes; strong lack of direct support to districts; poverty limiting client access; continuing stigma inhibits use of services; refugee influx adds to RRH congestion; and structural dissonance in district/regional reporting.

## C3. Recommendations

1. SUSTAIN would have been more effective if it had also worked with the districts in addition to the regional referral system. For district-level services, activity design needs to acknowledge and integrate the Ministry of Local Government. Efforts to generate commitment and political will within different levels and parts of government will thereby be more effective.

2. Different strategies need to be developed for regions and districts dealing with special circumstances, such as refugees.
3. HIV&AIDS service delivery programs need to straightforwardly address poverty and continuing stigma around HIV&AIDS to ensure access and use of services. This may mean, for example, collaborating more closely with PLHA networks and other CSOs.
4. Adaptation to policy changes throughout implementation should continue to be encouraged by USAID/Uganda as part of future activity designs, as there will always be unanticipated policy and context changes that can otherwise compromise activity success.

#### D. Question 4a

*Drawing from SUSTAIN's experience, what are the best practices that need to be consolidated to achieve sustainable delivery of HIV&AIDS services?*

#### D1. Findings

Mentorship, capacity building for human resources (62%) and laboratory improvements (59%) were the top two most noted best practices of SUSTAIN support to the RRHs cited by respondents (Table 7). HRH is a major challenge in service delivery countrywide in Uganda, because the country has a substantial proportion of unfilled positions and there is limited government support for in-service training. Therefore, SUSTAIN's support in this area made a visible difference. Respondents rated equipment support (54%), support to the hub (53%) as the next most important and roughly equivalent best practices. Almost 40% of respondents felt that support to HMIS and health infrastructure were also SUSTAIN best practices.

Table 7. Respondent Perception of SUSTAIN Best Practices

| Best Practice                                    | Number (n=74) | Percent |
|--------------------------------------------------|---------------|---------|
| Mentorship, capacity building, & HRH recruitment | 46            | 62%     |
| Laboratory improvements                          | 44            | 59%     |
| Equipment support                                | 40            | 54%     |
| Support to the hub                               | 39            | 53%     |
| Support to HMIS                                  | 29            | 39%     |
| Infrastructure support                           | 29            | 39%     |

It is clear SUSTAIN took a holistic approach to capacity strengthening, a best practice in itself since improved performance requires infrastructure, tools, equipment, and trainings for effective utilization of those inputs. Moreover, key MoH informants commended SUSTAIN implementers for their flexibility in adapting to specific needs of individual facilities. For example, some facilities required rehabilitation of existing labs, while others did not have adequate space to begin with. A holistic approach addressed variations in context and needs among health facilities.

**Mentorship and Coaching.** Table 8 parses respondent feedback specifically on SUSTAIN's mentorship and coaching activities, which was widely praised. Almost all (88%, 7/8) MoH respondents felt that SUSTAIN mentorship and coaching was very important in enhancing capacity and ownership. At the regional and district level, 75% of RRH Directors and DHOs rated mentoring and coaching highly as well, probably reflecting how SUSTAIN involved MoH and District officials in the mentorship activities. This perception dropped to 50% of all in-charges at the HIV clinic, lab, and LLF level.

Table 8. Respondent Feedback by Stakeholder Group on Mentorship and Coaching

| Respondent Category          | %        |
|------------------------------|----------|
| MoH (n=8)                    | 88% (7)  |
| Director RRHs (n=12)         | 75% (9)  |
| HIV clinic in-charges (n=12) | 50% (6)  |
| Lab in-charges (n=12)        | 50% (6)  |
| DHO (n=8)                    | 75% (6)  |
| LLF in-charges (n=6)         | 50% (3)  |
| Implementing Partners (n=5)  | 100% (5) |

The mentoring and coaching were important to skills acquisition and consolidation, as well as to building ownership. Most of this support is provided through the existing RRH system, for example, through RRH managers who participate in recruitment, supervision, and salary payments to SUSTAIN project-based staff. We found that this system supported the authority of RRH administration in personnel and budget management, and built accountability.

***Learning and sharing experience.*** SUSTAIN encourages HCWs and management of different facilities within the region<sup>9</sup> to interact and learn from each other. As HCWs look to other districts for problem-solving, new partnerships are formed. This mutual learning method is effective and has improved leadership skills for HIV services to the point that hospitals experienced a historically minimal need of external technical and managerial support.<sup>10</sup> SUSTAIN took a similar tack at the national level with the MoH by sharing information on policy activities; this facilitated evidence-based policy formulation.

Interestingly, when respondents were asked about practices that did not go well, few could cite any specific practices, and no themes emerged with any significant percentage.

## **D2. Conclusions**

1. SUSTAIN's approach to capacity building, which included a strong focus on mentoring, was perceived as very effective, as was the direct provision of health personnel. For this to be an enduring contribution, issues of sustainability need to be addressed, given current limitations on GoU financing.
2. Building and strengthening laboratories have a very positive and pervasive impact on the health system, especially important in any PEPFAR-related HIV&AIDS program with a focus on test-and-treat, and should continue to be a focus of future programming.
3. Other best practices identified by respondents are consistent with the need for a holistic approach to health systems strengthening in which equipment, tools, HMIS and other systems, and infrastructure are critical additional components for a well-functioning health system.

## **D3. Recommendations**

1. Address issues of sustainability related to direct provision of public health personnel.
2. Continue in future programming a strong focus on mentoring as part of any capacity-building initiative.
3. Continue to create focus around the need for including CLA-type best practice in future programming to reap the benefits of learning from other health workers engaged in similar work at the district, regional, and national level.

## **E. Question 4b**

*To what extent did the systems approach succeed in engendering quality and sustainability of HIV&AIDS services?*

### **E1. Findings**

***Quality.*** A theme throughout the respondent data presented in this report, corroborated by our review of documents and our observation, SUSTAIN has improved quality and introduced a system for continuous QI in a variety of ways in its health system strengthening efforts. This includes SUSTAIN's capacity

<sup>9</sup> Other health service delivery IPs: ASSIST, Star-E, Star-W, Nu-Hites, TRACKTB, IDI, Baylor College and Mildmay Uganda.

<sup>10</sup> Annual Report, October 2015-September 2016, p.27.

building and mentoring, laboratory strengthening, hub referral and transport system, HMIS development, and infrastructure and equipment improvements.

SUSTAIN used WHO's schema of Six Building Blocks of a robust health care delivery system: leadership and governance, health financing, health workforce, information, medical products and technologies, and service delivery. SUSTAIN's application of this approach made notable advances among the health care workforce and service delivery for HIV&AIDS and TB, leadership and governance, and technologies for laboratory services. The core strength of SUSTAIN's systems approach was its holistic nature, maximizing the synergistic interconnection among the six elements. The integration of HIV clinics into the hub system, along with a wider scope of testing for HIV into other sectors of health care (i.e., dentistry) is a powerful example of this holistic integration.

We focus the remaining comments on quality in the two areas highlighted by respondents as best practices: (1) mentoring, capacity-building, and HRH recruitment, and (2) laboratory improvements.

*Mentoring, capacity-building, and HRH recruitment.* Recognizing that quality depends on leadership, SUSTAIN appropriately focused on cultivating a QI culture at the leadership level and, over time, ownership of the quality assurance process. SUSTAIN used its management, leadership, and accountability trainings to help achieve this, as well as systematic, standardized mentoring and coaching to institutionalize QI among leadership at all levels, including hospital committees. By integrating the RRHs into the process of supporting SUSTAIN-sponsored staff (e.g., recruitment and staff payment), RRH ownership and accountability was enhanced. Other IPs independently account for resources, losing the benefit to host ownership. Respondents noted the benefit of SUSTAIN's approach; e.g., the Lira RRH HIV Clinic In-Charge felt SUSTAIN improved the clinic's accountability "1,000 times."

*Laboratory improvements.* Improvements to RRH laboratories, including new testing and diagnosis equipment, is one of the most visible improvements made by SUSTAIN. Technicians were provided with mentorship and training in lab quality management. At Mbale RRH, a Lab In-Charge credited SUSTAIN with advancing their lab towards national accreditation; six supported SLMTA labs have been selected by the MOH for fast tracking to achieve international accreditation, and many labs are enrolled in external quality assessment schemes.

**Sustainability** ultimately depends on continued financing of the health system. As noted above, Ugandan stewardship will increase in any elements directly financed by the GoU. The original SUSTAIN design envisioned transitioning the cost of the SUSTAIN-provided health workforce to GoU. However, the discussions and agreements to transition such personnel are pending, and it appears that the GoU is not in a position to absorb the 160 HCWs currently supported by SUSTAIN.<sup>11</sup> The skills and technical competence among these staff is sustainable, provided they are retained in Uganda's health system. The rehabilitated labs will remain functional as is for some time, before requiring further renovation; their continued functioning at current levels is dependent on availability of reagents and other supplies.

While just over 50% of respondents voiced hope that improved HIV&AIDS services will continue through MoH support, many doubt that the MoH would be able to sustain HIV&AIDS and TB service delivery in the RRHs following the end of SUSTAIN, if another activity/IP is not in place. The skepticism on sustainability probably reflects the dominant funding of HIV by donors, which has

Table 9. Respondent Perceptions on Sustainability Without Donor Financing

| Sustainability Questions            | Number (n=93) | Percent |
|-------------------------------------|---------------|---------|
| Continued HIV&AIDS service delivery | 50            | 54%     |
| Maintained SUSTAIN-provided HR      | 20            | 22%     |
| Maintained HMIS                     | 18            | 19%     |
| Sustained infrastructure            | 19            | 20%     |
| Maintained equipment                | 17            | 18%     |

<sup>11</sup> COP, Dr. A. Muhwezi interview, Kampala, 14 September 2016

decreased and is increasingly unpredictable.<sup>12</sup> When asked about services delivery after SUSTAIN, the MoH Pharmacy Division Head replied “*government does not have money, but as long as someone is doing it, then it will continue.*” Per Table 9, only about 20% of respondents believe the key elements of the health system will be sustained without donor funding, i.e., personnel, HMIS, infrastructure, and equipment maintenance.

## E2. Conclusions

The systems approach was very effective in engendering quality. Respondents particularly highlighted two areas: mentoring, capacity-building, and HRH recruitment, and laboratory improvements. However, sustainability depends on continued GoU financing which appears unlikely and therefore continuation of current services would be dependent upon continued external donor financing.

## E3. Recommendations

1. Accelerate discussions regarding GoU financing.
2. Replicate the SUSTAIN systems approach, including capacity-building, in other health programming.
3. Ensure continuation of the highly-regarded regional-level laboratory system, which is considered a special achievement and a linchpin in the HIV&AIDS and overall health services delivery system.

## F. Question 4c

*What key issues must be considered if USAID were to design a new program to deliver and sustain HIV&AIDS services within the public-sector context?*

Based on the above FCRs for each of the preceding questions, we recommend USAID consider the following in designing a new program to deliver and sustain HIV&AIDS services in the public sector:

**Model for capacity building.** SUSTAIN’s model for strengthening capacity across technical, management, and leadership translated into improved knowledge and skills among health staff, improved quality of care, and the competencies needed to fully benefit from other improvements such as upgrades to facility infrastructure and equipment. A feature widely viewed as key to SUSTAIN’s successful capacity building of more than 7,000 Ugandan health workers to deliver higher quality HIV&AIDS and TB services is their ongoing, standardized *mentoring and coaching approach*. In a follow-on design, we recommend USAID to emphasize the importance of on-the-job mentoring and coaching in the acquisition and consolidation of new information and skills.

**Systems approach.** Given the positive contribution of SUSTAIN’s adaption of the WHO Six Building Blocks approach to effective and efficient health systems strengthening, USAID should consider folding this into future designs. This holistic approach helps ensure that inter-related elements of the health system are addressed, thus maximizing the return on any investment.

**Trickle-down theory of change.** SUSTAIN included trickle-down in its theory of change, specifically that capacity improvements at the RRHs would trickle-down and be mirrored at LLFs. This was only minimally the case, and certainly did not result in such improved capacity that LLFs could more fully play their role in the health system and reduce pressure on RRHs. Effective capacity building of the LLFs require a planned effort, especially given that RRHs and LLFs in Uganda report to different authorities. We recommend future health programs be circumspect about relying on trickle-down effects that do not include specific strategies to make the trickle-down effective or for directly undertaking work associated

<sup>12</sup> UAC (2015). An AIDS Free Uganda, My Responsibility: Documents for the National HIV and AIDS Response, 2015/2016 – 2019/2020.

with an objective. If follow-on programming aspires to strengthen LLFs as part of a health system, we recommend it include specific objectives and activities directed at strengthening LLF capacities.

***Promoting ownership, stewardship, and sustainability.*** SUSTAIN enhanced MoH ownership and stewardship of HIV&AIDS delivery in partner hospitals and regions through a number of strategies, including development and use of a stewardship checklist, mentorship and coaching, and collaboration with MoH officials. Despite these efforts, MoH respondents expressed reservations about the degree to which they felt ownership or stewardship of SUSTAIN's activities. Little progress has been made to ensure sustainability in terms of additional GoU financing, particularly in terms of transitioning SUSTAIN-provided health workers to the GoU payroll. Generating a real sense of stewardship may be dependent on having additional GoU financing. We recommend future health programming put considerable emphasis on ways to advance these inter-related goals of ownership, stewardship, and sustainability; with continued financing dependent on meeting agreed upon metrics that show progress in achieving these goals.

***Integrating district and regional support.*** Supervision of LLFs by RRHs is not mandated currently. LLFs are under Local Governments, and RRHs under the MoH. This structure curtailed the degree to which LLFs benefited from SUSTAIN improvements. To address this, we recommend future health programs integrate both central and local government into the design.

***Alignment of HR policies.*** SUSTAIN and MoH HR policies were eventually aligned but this posed more of an implementation issue than ideal. In a future design, we recommend USAID require alignment with MoH HR policies from the start with any personnel that will transition eventually into the MoH. This is especially important for salary scales.

***Stigma around HIV&AIDS.*** Although the HIV&AIDS epidemic is in its fourth decade, stigma and discrimination continue to be determining factors in accessing and using services. It is important that ways to address stigma and discrimination are woven into all health programs so that every health activity is pulling in the same direction in changing these entrenched and unconstructive beliefs and attitudes.

***Health referral and transport network.*** The increased functionality of the health referral network achieved through SUSTAIN were widely appreciated and should continue into future health programming, with an emphasis on mapping and documenting so that functionality improvements can be better measured and the most beneficial interventions identified, e.g., hub riders.

***Refugee areas.*** Areas attracting refugees from nearby conflict areas require different strategies to help facilities deal with the influx of clients needing services.

***CLA.*** Adaptation to policy changes throughout implementation should continue to be encouraged by USAID/Uganda as part of future activity designs, as there will always be unanticipated policy and context changes that can otherwise compromise activity success. Similarly, future designs should continue to create focus around the benefits of learning from other health workers engaged in similar work at the district, regional, and national level.

***Laboratory strengthening.*** Future designs should ensure continuation of the highly-regarded regional-level laboratory system, which is considered a special achievement and a linchpin in the HIV&AIDS and overall health services delivery system.

***TB/HIV in isolation.*** Addressing TB separately from its MDR form or from its relationship to HIV and AIDS was viewed as problematic by in-charges of TB wards, who encouraged the activity to look at all forms of TB. The NTLF Program Manager also expressed a need for educating and engaging local communities about the interaction of TB with HIV.

## SECTION IV. LESSONS LEARNED

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This section responds to the SOW's request for any additional insights of use to people designing similar or related new or on-going programs in Uganda or elsewhere.

- SUSTAIN succeeded in part due to its extensive participatory and non-invasive style of management which is an important lesson for all activities.
- The holistic health systems strengthening approach is an excellent model to aspire to when planning health activities in countries such as Uganda.
- It is critically important to attempt as much as possible to 'work from within,' e.g., project planning and implementation succeed better if carried out in coordination and with the cooperation of the MoH and GoU. Planning should be based on country policy and practice and not 'imposed' from outside.
- SUSTAIN's approach to quality improvement was excellent and based on already existing policy. There is a powerful lesson in observing the manner in which this project brought together a group of implementers on a quarterly basis to share, to critique and to learn from each other.
- SUSTAIN used coaching and mentoring for activity purposes and simultaneously provided a model for future use by the health care delivery system, a good lesson in how to strengthen, not only the individuals who receive the attention, but the system itself. Mentoring was perceived by many respondents to be of great benefit and some admitted they had learned the true meaning of mentoring.
- Activity support integrated into hospital management structures enhances ownership and leadership.
- Reflecting on the much-respected leadership style of the SUSTAIN COP reminds us again that the importance of activity leadership cannot be under-estimated.
- There is a lesson to be learned from understanding the assumption on 'trickle-down.' The diffusion of some very good plans and practices was impeded by the existing structure of the health care system with its division into regional and district levels. Moreover, achieving trickle-down needed a more explicit strategy and set of tactics as well as a clear understanding of the existing health care structure.
- Flexibility of support enables responsiveness to the needs of the partner facilities. This is one of the most commendable aspects of the project that reportedly contributed to its success.
- For effective capacity building, HIV&AIDS support to the health system needs to be provided in an integrated manner.
- SUSTAIN's efforts in supporting the provision of integrated laboratory services for HIV&AIDS and other services was very fundamental in the delivery of services.
- SUSTAIN's QI approach was very effective, including sharing and critiquing best practices.

## ANNEX A. SCOPE OF WORK

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### 1. Introduction

The USAID/Uganda's Systems for Treating AIDS Nationally (SUSTAIN) activity is a six year \$58.2 million activity implemented by URC to strengthen the national systems for delivery of HIV&AIDS services in Uganda. The purpose of the activity is to provide quality and comprehensive HIV&AIDS care, related laboratory services at regional referral and district hospitals in Uganda as well as to build the capacity of the public health to sustain these services. URC services cover 12 RRHs i.e. Kabale, Fort Portal, Mubende, Hoima, Arua, Lira, Gulu, Moroto, Mbale, Soroti, Jinja, Masaka; two Private Not for Profit (PNFP) hospitals i.e. Amudat and Matany; three GHs i.e. Kaabong, Abim and Kawolo; and, two Health Center IV Kotido and Tokora.

The objectives pursued by SUSTAIN over the past five years include:

- 1) Ensuring the provision of HIV/AIDS care, treatment, and laboratory services within public regional referral and district hospitals.
- 2) Enhancing the quality of HIV/ AIDS care & treatment, and laboratory services at regional referral and district hospitals.
- 3) Increasing stewardship by the MoH to provide quality HIV/AIDS care, treatment, and laboratory services within the public health system.

SUSTAIN also supported Voluntary Medical Male Circumcision (VMMC), MDR TB, and regional medical equipment workshops.

This section outlines a Statement of Work for a program evaluation of the SUSTAIN activity as an intervention to build the capacity of the public sector to provide HIV/AIDS care and treatment in a sustainable manner.

Sustainability refers to ensuring the approach to programming PEPFAR dollars in host countries helps country stakeholders to lead, manage, coordinate, implement, and—over time and where appropriate—increasingly finance the national response while sustaining programmatic quality and coverage goals. Sustainability activities focus on how to shift the PEPFAR-funded HIV response in each country toward the four dimensions of country ownership: political ownership and stewardship, institutional and community ownership, capabilities, and mutual accountability.

### 2. Background

The purpose of the evaluation is to establish the extent to which SUSTAIN achieved its project objectives. The evaluation will further appraise SUSTAIN activity's collaborative work with the GOU, private sector and donors to expand sustainable access to services. This evaluation will therefore provide key lessons on the implementation process and effectiveness of the activity approach. Note that the focus is not so much on what targets have been achieved as this is already known from the ongoing performance monitoring processes, but more on understanding how this model and approach affected the activity outcomes.

### 3. Audience

The primary user of the evaluation findings is USAID/Uganda Mission staff, other United States Government agencies; USAID-funded IPs, MoH and other national and international stakeholders with interest in sustainable HIV/AIDS programming.

#### 4. Evaluation Questions

The specific questions to be addressed by this evaluation are:

1. How did SUSTAIN's specific strategy and technical approach contribute to:
  - a. Strengthening technical and leadership capacity at partner RRHs
  - b. Strengthening technical and leadership capacity at partner district hospitals
  - c. Enhancing MOH (and consequently GOU) stewardship and ownership of HIV/AIDS service delivery in partner hospitals and regions
  - d. Improving quality of services
2. What was the SUSTAIN activity's contribution to positioning the RRHs as hubs for capacity building and oversight to LLFs? While not a discrete performance objective, it was theorized that investments in improving quality and leadership at the RRHs would naturally results in improved capacity at LLFs within their referral zones.
3. What issues emerged from SUSTAIN activity's context that facilitated or inhibited its performance? Issues could include political, economic, management, social and cultural factors. How were these issues managed?
4. Drawing from SUSTAIN activity's experience:
  - a. What are the best practices that need to be consolidated to achieve sustainable delivery of HIV/AIDS services?
  - b. To what extent did the systems approach succeed in engendering quality and sustainability of HIV/AIDS services?
  - c. What key issues must be considered if USAID was to design a new program to deliver and sustain HIV/AIDS services within the public sector context?

#### 5. Methodology

The evaluation will apply cross-sectional design using a mixed method approach i.e. using both quantitative and qualitative methods. The evaluation team will build in before and after methods to understand changes that could be linked to the program. The evaluation team is expected to propose and use sound sampling techniques to determine districts, health facilities and their respective staff to be visited from which data will be collected.

Suggested data collection methods include:

- *Review of Program Documents and Related Literature:* The evaluation team will be expected to review several program related documents that have been produced by SUSTAIN activity. These documents may include solicitation documents, annual work plans, Activity Monitoring, Evaluation and Learning Plans (AMELPs), progress reports (e.g. quarterly, semi-annual and annual reports), district and health sector plans as well as strategy policy and performance documents.
- *Analysis of Secondary Data:* In addition to these documents, the evaluation team may access service delivery data through DHIS-2. The evaluation team will decide on the type of analysis

that can be conducted using these secondary data sources in order to answer the evaluation questions. Other relevant assessments that will be made available to the evaluation team include SUSTAIN quarterly quality assurance assessments, SUSTAIN client satisfaction surveys, MOH stewardship checklists, and MOH laboratory assessments. (Tools provided in Annex.)

- *Key Informant Interviews(KII)*: Using a structured questionnaire comprising primarily of open ended questions, the evaluation team will conduct in-depth interviews with respondents from USAID, MOH (including CPHL and UVRI), local government, non-government stakeholders, health facility managers and service providers in SUSTAIN activity's implementation area.
- *Focus Group Discussions*: FGDs will be another method that should be used to collect data from SUSTAIN's stakeholders. These may include staff from local governments, partner organizations, CSOs and clients who have utilized services offered through these activities, etc.
- *Survey of Key Stakeholders*: It is also suggested that the evaluation team consider conducting a survey of a stakeholders that were served by SUSTAIN activity. This survey could be used to assess the extent to which the SUSTAIN's approach was effective.
- *Follow up to Quality Improvement Activities*: Many individual QI activities occurred at RRHs with the support of the SUSTAIN activity, as outlined in quarterly and annual activity reports. Using HMIS data or sampling, the evaluation team could review QI projects that occurred in the earlier stages of the activity, in order to understand to what extent activities were sustained following the initial period of focus.
- *Network Analysis*: In order to understand the influence of the RRHs, the team should conduct a qualitative and quantitative network analysis that maps and measures the relationship between RRHs and district facilities. Using HMIS data or other sources, the team may track utilization and quality of services over time and identify potential relationships between RRH improvements and their corresponding district facilities. This analysis would provide insight into the extent to which investments and improvements at the regional level are transferred to the lower-level facilities.
- *Contribution Analysis*: During the course of implementation, many outside influences may have affected the activity's performance against its objective. By mapping the theory of change and identifying the relevant internal and external factors that have influence, the team can then assess the links in the theory of change according to what actually occurred during the activity period. This process of analysis allows the evaluation team to provide plausible conclusions about whether and how SUSTAIN activities contributed to higher level outcomes of interest.

The evaluation team will develop tools and detailed guidance for data collection and work closely with SUSTAIN, RRH and district staff as well as USAID/Uganda to identify appropriate respondents. All data collection instruments and guides will be approved by USAID/Uganda prior to the beginning of fieldwork.

The evaluation team will propose data analysis strategies and tools for both the qualitative and quantitative data. The team will be expected to conduct any other comparisons that could appraise the achievement of positive effects of the SUSTAIN activity. The team is expected to use thematic analysis or other techniques to interpret qualitative data, as well as implement strategies to reduce potential bias and increase inter-rater reliability. The evaluation team shall describe the type of software to be used for quantitative and qualitative data analysis. Data disaggregation and analysis by sex and age will be used to establish the differential effects of the activity on men, women and different age groups. The team will propose other analysis approaches. The evaluation team shall describe the type of software they use for

the quantitative and qualitative data analysis. Evaluation team is encouraged to use the tools listed in *J.4: Available assessment tools*.

## 6. Team Composition

The evaluation will be conducted by an external evaluator and a team that may include international and Ugandan team members. The evaluation team must include one team leader, two senior experts and may include research assistants/middle level evaluators as needed. Between them, the team must have:

- 1) Expertise in the following major HIV/AIDS program areas:
  - a. Elimination of Mother to Child Transmission of HIV (EMCT)
  - b. Voluntary Medical Male Circumcision (VMMC)
  - c. HIV Counselling and Testing (HTC)
  - d. HIV/AIDS Care and Treatment
  - e. Health Systems Strengthening (HSS) with demonstrated experience in Leadership and Governance, Health Financing, Supply Chain Management and Human Resources for Health (HRH)
- 2) Skills to interpret Logistics and Commodity Management reports
- 3) Excellent understanding of Medical Records (specifically clinic registers and HMIS) and population based surveys e.g. AIS, DHS
- 4) Experience in decentralized health service delivery
- 5) Excellent knowledge of Uganda's health care system

The key personnel of this activity will be a Team Leader, Senior HSS Technical Expert and a Quality Improvement Expert. Following award, no changes to key personnel shall be made without approval from USAID/Uganda.

The Team Leader will coordinate the activities, assign tasks to team members and supervise performance. S/he will be the main point of contact between the evaluation Activity Manager at USAID/Uganda and the evaluation team. The Team Leader will review all plans and outputs and be responsible for submitting quality products to USAID on a timely basis.

The team leader shall have:

- A minimum of a Master's degree in health management, public health, applied research or related fields. PhD is preferred.
- Significant expertise in conducting evaluations with a minimum of ten years' experience in health evaluation management
- Played significant role designing, managing or executing a minimum of ten evaluations, at least five for a public sector health activities and at least two in Africa.
- Been team leader in a minimum of five evaluations, with at least one evaluating activities of similar scale
- Skills in quantitative and qualitative evaluation design and methods.

Other team members will perform tasks in a professional manner and assist the Team Leader to develop and review deliverables.

Senior HSS Technical Expert shall have:

- A minimum of an advanced degree in health economics or public health with demonstrated expertise in HSS, health management and governance. PhD is preferred.
- A minimum of seven years' experience in designing and management of HSS intervention.

- Knowledge of local health systems in Uganda
- Demonstrated excellent knowledge of PEPFAR programming
- Participated in a minimum of five evaluations.

Quality Improvement Expert shall have:

- A minimum of an advanced degree in an area related to health science, health management, development studies, governance or business management
- Over five years' experience in health care quality improvement; thorough knowledge and understanding of quality assurance/quality improvement theories and approaches, including the use of QA/QI teams
- Knowledge of local health systems in Uganda
- Experience evaluating and analyzing health care quality improvement efforts in Uganda.

## **7. Management Roles and Responsibilities**

The Contractor shall work directly with the USAID/Uganda Task Order Contracting Officer Representative (TOCOR). The Contractor will be responsible for identifying and obtaining the majority of the reference materials needed for this evaluation with only minimal assistance on the part of USAID/Uganda.

The Evaluation Team will liaise closely with the Agreement Officer's Representative (AOR) for SUSTAIN activity, the USAID Senior Strategic Information Advisor (SSIA) for the Health, HIV

and Education Team, M&E Specialist for the Health, HIV and Education Team, as well as the Program Office M&E Specialist, on coordination and clarification of USAID requirements and standards for maintaining effective communication on what is to be learned.

SUSTAIN activity will participate in the design and planning of the evaluation, support with logistics for implementation (avail copies of relevant documents, arrange for meetings and interviews, etc.), participate in the oral presentation and review the draft and final reports.

GOU/MOH will participate in the oral presentation and review of the draft and final reports. Other USAID IPs may be invited to presentations.

The evaluation contractor will provide own laptop computer(s) and other equipment necessary for performance of this activity; transport hire (within Kampala and upcountry), office supplies, communication costs, field work expenses (including survey, focus groups and dissemination). The evaluation contractor should also anticipate meeting field costs for government staff who may participate in the evaluation upon approval by USAID.

## **8. Schedule and Logistics**

In its proposal, the Contractor shall provide an illustrative work schedule which will be refined as part of the first Task Order deliverable. All deliverables are expected to be completed within 180 days of the award of the Task Order.

The Contractor is responsible for all administrative and support arrangements. The Contractor's Team Leader will coordinate logistical arrangements with the TOCOR, and will work with the TOCOR to schedule meetings and site visits acceptable to the Mission.

## ANNEX B. SUSTAIN-SUPPORTED HUBS

### USAID-SUSTAIN Project Supported Hubs: Facilities & Daily Routing

|   |         | Monday               | Tuesday                   | Wednesday           | Thursday            | Friday               |
|---|---------|----------------------|---------------------------|---------------------|---------------------|----------------------|
| 1 | Masaka  | Masaka RRH           | Masaka RRH                | Masaka RRH          | Masaka RRH          | Masaka RRH           |
|   |         | Villa Maria Hospital | Bukeeri                   | Kiyumba             | TASO Masaka         | Uganda cares         |
|   |         | Kalungu H/C IV       | Buwonga                   | Ssunga              | Kitovu Hospital     | Masaka Municipality  |
|   |         | Kyamulibwa H/C IV    | Kimwanyi                  | Bukakata            | Lukaya              | Masaka Police clinic |
|   |         | Kyamulibwa H/C III   | Nkoni                     | Kako                | Mpugwe              | Kyanamukaka          |
|   |         |                      | Post office Masaka        | Nyendo              | Butende             | Bukoto               |
|   |         |                      |                           | Post office Masaka  | Bukolola            | Posta masaka         |
|   |         |                      |                           |                     | Post office Masaka  | Post office Masaka   |
|   |         | Monday               | Tuesday                   | Wednesday           | Thursday            | Friday               |
| 2 | Mubende | Mubende RRH          | Mubende RRH               | Mubende RRH         | Mubende RRH         | Mubende RRH          |
|   |         | Nyamarwa             | Bukuya                    | Nyanzi              | Kasambya            | St. Joseph Madudu    |
|   |         | Kakumuro             | St. Gabriel Mirembe marie | Kiganda             | Kabamba             | Kabbo                |
|   |         | Kyabasanja           | Kyamamugera               | Kalonga             | Butawata            | CMRC                 |
|   |         | Kiyuni               | St. Matia Mulumba         | Kitenga             | Nabugoola           | Post office Mubende  |
|   |         | Madudu               | Post office Mubende       | Musozi              | Kibalenga           |                      |
|   |         |                      |                           | Post office Mubende | Post office Mubende |                      |
|   |         | Monday               | Tuesday                   | Wednesday           | Thursday            | Friday               |
| 3 | Gulu    | Gulu RRH             | Gulu RRH                  | Gulu RRH            | Gulu RRH            | Gulu RRH             |
|   |         | Alokolum H/C II      | Lapainat H/C III          | Punena H/ C II      | Total Gulu          | Laroo H/C III        |
|   |         | Patuda H/C II        | Lakwatomer H/C III        | Coo Pee H/C II      | Unyama H/C II       | Bardege H/C III      |
|   |         | Ongako H/C III       | Lanenober H/CIII          | Pabwo H/C III       | Te Atoo H/C II      | Independent hosp     |
|   |         | Lela obaro H/C II    | Lujorongole H/C II        | Rwotobilo H/C III   | Omel H/C II         | Military Hosp        |
|   |         | Minakulu Bobi H/C II | Lacor opit                | Pugwinyi H/C II     | Cwero H/C III       | Prision H/C III      |
|   |         | Tekulu H/C II        | Awoo H/C III              | Patiko H/C III      | Kal Ali H/C II      | Layibi Techo H/C III |
|   |         | Minakulu Bobi H/C II | Bobbi hc iii              | Gwengdiya H/C II    | Pukony H/C II       | Aywee H/C III        |
|   |         | Tekulu H/C II        | Post office Gulu          | Lapeta H/C II       | Awach H/C IV        | Lacor Hosp           |

|          |               |                         |                             |                           |                              |                           |
|----------|---------------|-------------------------|-----------------------------|---------------------------|------------------------------|---------------------------|
|          |               | Palenga H/C II          |                             | <b>Post office Gulu</b>   | Paibona H/C II               | JCRC Gulu                 |
|          |               | Koro Abili H/C II       |                             |                           | <b>Post office Gulu</b>      | TASO Gulu                 |
|          |               |                         |                             |                           |                              | <b>Post office Gulu</b>   |
|          |               | <b>Monday</b>           | <b>Tuesday</b>              | <b>Wednesday</b>          | <b>Thursday</b>              | <b>Friday</b>             |
| <b>4</b> | <b>Kawolo</b> | Kawolo Hospital         | Kawolo Hospital             | Kawolo Hospital           | Kawolo Hospital              | Kawolo Hospital           |
|          |               | Tongolo H/C II          | Kiyuni H/C III              | HIA-Uganda H/C II         | Jinja Hub                    | Basabaga H/C III          |
|          |               | Nangunga H/C II         | Bukaya H/C II               | HIA-Association           | Buwagajjo H/C III            | Kasubi H/C III            |
|          |               | Buzinka H/C II          | Kisakye H/C                 | Buikwe H/C III            | Nyenga Hospital              | Ngogwe H/C III            |
|          |               | Ebeneza H/C II          | Kalagala H/C II             | Buikwe Hospital           | Lugazi H/C II                | Nkokonjeru Hospital       |
|          |               | Ngogwe                  | Mubeezi Health Centre       | Makindu H/C III           | Njeru H/C III                | Ssi H/C III               |
|          |               | Lugazi Muslim H/C II    | Living Water Medical Centre | Kisimba H/C II            | St. Francis Hospital H/C III | Kavule H/C II             |
|          |               | Lugazi Mission H/C II   | Metha Hospital              | Kingdom Life H/C III      | Wakisi H/C III               | Ssenyi H/C III            |
|          |               |                         | Kawolo Hospital             | Makonge H/C III           | Naminyia H/C II              | Bubiro H/C II             |
|          |               |                         | Jinja Hub                   | Kabizi H/C II             | Mbikko Medical entre         | Ddungu H/C III            |
|          |               |                         | <b>Post office Lugazi</b>   | <b>Post office Lugazi</b> | Najjembe H/C III             | Namulesa H/C II           |
|          |               |                         |                             |                           | <b>Post office Lugazi</b>    | <b>Post office Lugazi</b> |
|          |               | <b>Monday</b>           | <b>Tuesday</b>              | <b>Wednesday</b>          | <b>Thursday</b>              | <b>Friday</b>             |
| <b>5</b> | <b>Lira</b>   | Lira RRH                | Lira RRH                    | Lira RRH                  | Lira RRH                     | Lira RRH                  |
|          |               | PAG HC IV               | Bala HC III                 | Ogur HC IV                | Ayago HC III                 | <b>Post office Lira</b>   |
|          |               | Boro HC III             | Okole HC II                 | Barjobi HC III            | Ongica HC III                |                           |
|          |               | Amach HC IV             | Ayer HC II                  | Okwang HC III             | Kristina HC III              |                           |
|          |               | Aliali HC III           | Apala Barowo HC III         | Barocok HC II             | Anepmoroto HC II             |                           |
|          |               | Omoro HCIII             | Alito HC III                | Okwongo HC III            | Atangwata HC III             |                           |
|          |               | Alebtong HC IV          | Aromo HC III                | Aliwang HC III            | Ogwete HC III                |                           |
|          |               | Aloi HC III             | Abala HC III                | Alango HC II              | Olilim HC III                |                           |
|          |               | Akura H/C II            | Ngetta HC III               | Abia HC II                | Orum HC IV                   |                           |
|          |               | Barr HC III             | <b>Post office Lira</b>     | Apala HC IV               | <b>Post office Lira</b>      |                           |
|          |               | <b>Post office Lira</b> |                             | <b>Post office Lira</b>   |                              |                           |
|          |               | <b>Monday</b>           | <b>Tuesday</b>              | <b>Wednesday</b>          | <b>Thursday</b>              | <b>Friday</b>             |

|   |             |                            |                            |                            |                            |                            |
|---|-------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 6 | Kabale      | Kabale RRH                 | Kabale RRH                 | Kabale RRH                 | Kabale RRH                 | Kabale RRH                 |
|   |             | KAKOMO                     | KYANAMIRA                  | BUFUNDI                    | MPARO                      | RUSHOROZA                  |
|   |             | BUBARE                     | KANJOBE                    | BUTANDA                    | KITANGA<br>NGO             | KAMUKIRA                   |
|   |             | KAKORE                     | MAZIBA                     | RUBAYA                     | KITANGA<br>GOVT            | AIC                        |
|   |             | HAMURWA                    | KAHARO                     | KITOOMA                    | BUCUNDURA                  | RHU                        |
|   |             | RUBANDA                    | KAKATUNDA                  | KAMUGANG<br>UZI            | KASHAMBYA                  | KIHEFO                     |
|   |             | MUKO IV                    | BUKINDA                    | BUHARA<br>NGO              | Post office<br>Kabale      | RUGARAMA                   |
|   |             | MUKO NGO                   | KAMWEZI                    | BUHARA<br>Govt             |                            | Post office<br>Kabale      |
|   |             | Post office<br>Kabale      | KYOGO                      | Post office<br>Kabale      |                            |                            |
|   |             |                            | Post office<br>Kabale      |                            |                            |                            |
|   |             | Monday                     | Tuesday                    | Wednesday                  | Thursday                   | Friday                     |
| 7 | Fort Portal | Fort Portal<br>RRH         | Fort Portal<br>RRH         | Fort Portal<br>RRH         | Fort Portal<br>RRH         | Fort Portal<br>RRH         |
|   |             | Kabarole<br>Hospital       | KIDA Hosp                  | Kabende H/C<br>III         | Post office<br>Fort Portal | Kidubuli<br>H/CIII         |
|   |             | Virika Hospital            | Nkuruba H/CIII             | Tooro Kahuna<br>H/CIII     |                            | Post office<br>Fort Portal |
|   |             | Kataraka H/C<br>IV         | Rutete H/CIII              | Kijura H/CIII              |                            |                            |
|   |             | Post office<br>Fort Portal | Kiko H/CIII                | Kicwamba H/C<br>III        |                            |                            |
|   |             |                            | Kaswa H/CII                | Bukuku H/C III             |                            |                            |
|   |             |                            | Kasenda HC III             | Mitandi H/C III            |                            |                            |
|   |             |                            | Iruhura HC II              | Post office<br>Fort Portal |                            |                            |
|   |             |                            | Post office<br>Fort Portal |                            |                            |                            |
|   |             | Monday                     | Tuesday                    | Wednesday                  | Thursday                   | Friday                     |
| 8 | Hoima       | Hoima RRH                  | Hoima RRH                  | Hoima RRH                  | Hoima RRH                  | Hoima RRH                  |
|   |             | Mparangasi<br>HCIII        | Mukabara<br>HCIII          | Buhimba HCIII              | Buseruka HCIII             | Bugambe<br>HCIII           |
|   |             | Buhanika<br>HCIII          | Bujalya HCIII              | Rwenyawawa<br>HCIII        | Kabaale HCIII              | Bugambe TEA<br>HCIII       |
|   |             | Buraru HCIII               | Muwihiju HCIII             | Kyamgwali<br>HCIV          | Kaseeta HCIII              | Bijugu HCIII               |
|   |             | Butema HCIII               | Kabwoya<br>HCIII           | Nsozi HCIII                | Karongo HCIII              | Dwoli HCIII                |
|   |             | Bujjunbura<br>HCIII        | Kikuube HCIV               | Kisaaru HCII               | Kyehoro HCIII              | Kigorobya<br>HCIV          |
|   |             | Azur HCIV                  | Post office<br>Hoima       | Post office<br>Hoima       | Post office<br>Hoima       | Post office<br>Hoima       |
|   |             | Post office<br>Hoima       |                            |                            |                            |                            |
|   |             |                            |                            |                            |                            |                            |
|   |             | Monday                     | Tuesday                    | Wednesday                  | Thursday                   | Friday                     |

|    |            |                        |                    |                    |                     |                          |
|----|------------|------------------------|--------------------|--------------------|---------------------|--------------------------|
| 9  | Jinja      | Jinja RRH              | Jinja RRH          | Jinja RRH          | Jinja RRH           | Jinja RRH                |
|    |            | St. Benedict's H/C III | Budondo            | Wakitaka H/C III   | Taso                | Post office Jinja        |
|    |            | Kakira H/C III         | Lukolo             | Kakaire H/C III    | Family hope         |                          |
|    |            | Kakira Hospital        | Butagaya HC III    | magamaga H/C III   | SCSC-KIMAKA         |                          |
|    |            | Busedde H/C III        | Budiima HCIII      | Buwege Hospital    | Gaddaffi HCIII      |                          |
|    |            | Mpandwa H/C III        | Post office Jinja  | Buwege Hospital    | Jinja Islamic HCIII |                          |
|    |            | Buluba Hospital        |                    | Post office Jinja  | Muwumba HCIII       |                          |
|    |            | Post office Jinja      |                    |                    | Post office Jinja   |                          |
|    |            | Monday                 | Tuesday            | Wednesday          | Thursday            | Friday                   |
| 10 | Soroti RRH | Soroti RRH             | Soroti RRH         | Soroti RRH         | Soroti RRH          | Soroti RRH               |
|    |            | Lwala Hospital         | Asuret H/C III     | Kapir H/C III      | Amuria HC IV        | Western Division H/C III |
|    |            | Otuboi H/C III         | Serere H/C III     | Atokora HC IV      | Katakwi H/C III     | Lalle HC II              |
|    |            | Anyara H/C III         | Post office Soroti | Ngera Hospital     | Toroma HC III       | Kamuda HC II             |
|    |            | Tiriri H/C III         |                    | Ngora HC IV        | Gwesi HC III        | Soroti HC III            |
|    |            | Tubur H/C III          |                    | Kabwin HC III      | Post office Soroti  | Princess Diana H/C IV    |
|    |            | Dakabela H/C III       |                    | Agu HC III         |                     | Eastern Division H/C III |
|    |            | Post office Soroti     |                    | Post office Soroti |                     | Kichinjaji HC III        |
|    |            |                        |                    |                    |                     | TASO Soroti              |
|    |            |                        |                    |                    |                     | TSAIP                    |
|    |            |                        |                    |                    |                     | Medical Associates       |
|    |            |                        |                    |                    |                     | Post office Soroti       |
|    |            | Monday                 | Tuesday            | Wednesday          | Thursday            | Friday                   |
| 11 | Mbale      | Mbale RRH              | Mbale RRH          | Mbale RRH          | Mbale RRH           | Mbale RRH                |
|    |            | Namawanga III          | Nyondo III         | Buwangwa III       | Iki-iki III         | Bumadada III             |
|    |            | Makhonje III           | Kolonyi III        | Busano III         | Kaderuna III        | Bufumbo III              |
|    |            | Busiu III              | Nakaloke III       | Naiku III          | Lyama III           | Namanyonyi III           |
|    |            | Lwangoli III           | Namatala III       | Bunapongo III      | Naboa III           | Bungokho III             |
|    |            | Siira III              | Namakwekwe III     | Busamaga III       | Kamonkoli III       | Busamaga III             |
|    |            | Bushikori III          | Malukhu III        | Sitta and Save III | Katira III          | Wanale III               |
|    |            | Hope medical centre    | Police III         | Riverside          | Kameruka III        | Budwale III              |

|    |        |                    |                     |                        |                    |                           |
|----|--------|--------------------|---------------------|------------------------|--------------------|---------------------------|
|    |        | St. Augustine II   | Prison III          | Municipal II           | Sapiiri III        | Cure hospital             |
|    |        | Post office Mbale  | Post office Mbale   | TASO Mbale             | Kerekereni III     | Mt. Elgon hospital.       |
|    |        |                    |                     | Post office Mbale      | Post office Mbale  | Post office Mbale         |
|    |        | Monday             | Tuesday             | Wednesday              | Thursday           | Friday                    |
| 12 | Arua   | Arua RRH           | Arua RRH            | Arua RRH               | Arua RRH           | Arua RRH                  |
|    |        | Vurra H/C III      | AJIA HC III         | Aroi H/C III           | Orivu H/C III      | Oluvu H/C III             |
|    |        | Logiri H/C III     | Inde H/C III        | Kijomoro H/C III       | Riki H/C III       | Kamaka H/C III            |
|    |        | Anyavu H/C II      | Ogoko H/C III       | Nyadri H/C III         | Ocodri H/C III     | Eliofe H/C III            |
|    |        | Lazebu             | Rhino Camp H/C IV   | Ovujo H/C III          | Siripi H/C II      | Adumi Oje Mission H/C Iii |
|    |        | Bondo H/C III      | Ocodri H/C III      | Maracha Hospital       | Yinga H/C II       | Adumi H/C IV              |
|    |        | Kuluva Hospital    | Arua Police H/C III | Oleba H/C III          | O'dupi H/C III     | Pajulu H/C III            |
|    |        | Ediofe H/C III     | Post office Arua    | Dranya                 | Otuambori H/C III  | Post office Arua          |
|    |        | Oli H/C IV         |                     | Koboko H/C IV          | Omugo H/C IV       |                           |
|    |        | Post office Arua   |                     | Dricile H/C III        | Cilio H/C II       |                           |
|    |        |                    |                     | Koboko Mission H/C III | Aripea H/C III     |                           |
|    |        |                    |                     | Ayipe H/C III          | Post office Arua   |                           |
|    |        |                    |                     | Ludara H/C III         |                    |                           |
|    |        |                    |                     | Gborokulongo H/C III   |                    |                           |
|    |        |                    |                     | Lobule H/C III         |                    |                           |
|    |        |                    |                     | Tara H/C III           |                    |                           |
|    |        |                    |                     | Wadra H/C III          |                    |                           |
|    |        |                    |                     | Yivu Abea H/C III      |                    |                           |
|    |        |                    |                     | Wandi H/C III          |                    |                           |
|    |        |                    |                     | Orijini H/C III        |                    |                           |
|    |        |                    |                     | Post office Arua       |                    |                           |
|    |        | Monday             | Tuesday             | Wednesday              | Thursday           | Friday                    |
| 13 | Kotido | Kotido HC IV       | Kotido HC IV        | Kotido HC IV           | Kotido HC IV       | Kotido HC IV              |
|    |        | Lookorok           | Panyangara          | Rengen                 | Lokiding           | Kanawat                   |
|    |        | Nakapelimoru       | Post office Kotido  | Lopuyo                 | Post office Kotido | C.O. U                    |
|    |        | Post office Kotido |                     | Nakwakwa               |                    | Post office Kotido        |
|    |        |                    |                     | Maru                   |                    |                           |
|    |        |                    |                     | Post office Kotido     |                    |                           |

|    |         | Monday                  | Tuesday                | Wednesday             | Thursday                   | Friday                  |
|----|---------|-------------------------|------------------------|-----------------------|----------------------------|-------------------------|
| 14 | Moroto  | Moroto RRH              | Moroto RRH             | Moroto RRH            | Moroto RRH                 | Moroto RRH              |
|    |         | Lorengedwat H/C III     | Lopotuk H/C III        | Moroto Airfield       | Nandunget H/C III          | St. Pius Kidepo H/C III |
|    |         | Post office Moroto      | C III                  | Lotome H/C III        | Ngoleriet H/C II           | Moroto Army H/C IV      |
|    |         |                         | Post office Moroto     | Iriiri H/C III        | Kangole H/C III            | Moroto RRH              |
|    |         |                         |                        | Loren geghora H/C III | Matany Hospital            | Nakapelimen H/C II      |
|    |         |                         |                        | Post office Moroto    | Lopoko H/C III             | DMO'S Clinic H/C II     |
|    |         |                         |                        |                       | Lopeei H/C III             | Post office Moroto      |
|    |         |                         |                        |                       | Post office Moroto         |                         |
|    |         | Monday                  | Tuesday                | Wednesday             | Thursday                   | Friday                  |
| 15 | Kaabong | Kaabong Hospital        | Kaabong Hospital       | Kaabong Hospital      | Kaabong Hospital           | Kaabong Hospital        |
|    |         | Kaimese HC II           | Loyoro HCIII           | Kaabong Mission       | Post Office Kotido         | Lokoliala HCIII         |
|    |         | Karenga HC VI           | Kopoth HCIII,          | Lokerui HC II         |                            | Kalapata HCIII          |
|    |         | Lobalangit HCII         |                        |                       |                            | Lotim HCII,             |
|    |         |                         |                        |                       |                            | Kathile HCII            |
|    |         | Monday                  | Tuesday                | Wednesday             | Thursday                   | Friday                  |
| 16 | Abim    | Abim Hospital           | Abim Hospital          | Abim Hospital         | Abim Hospital              | Abim Hospital           |
|    |         | Amita H/C II            | Obolokome H/C II       | Kiru H/C II           | Opopongo H/C II            | Post Office Kotido      |
|    |         | Kanu H/C II             | Morulem H/C III        | Awach H/C II          | Nyakwae H/C III            | OR                      |
|    |         | Atunga H/C II           | Kathabok H/C II        | Gangming H/C II       | Oretha H/C II              | Post Office Soroti      |
|    |         |                         | Wilela H/C II          |                       | Pupukumia H/C II           |                         |
|    |         |                         | Koya H/C II            |                       | Adea H/C II                |                         |
|    |         |                         | Alerek H/C II          |                       | Orwamuge H/C III           |                         |
|    |         | Monday                  | Tuesday                | Wednesday             | Thursday                   | Friday                  |
| 17 | Tokora  | Tokora HC IV            | Tokora HC IV           | Tokora HC IV          | Tokora HC IV               | Tokora HC IV            |
|    |         | Nabilatuk Mission HC II | Lorengedwat HC III     | Lemusuii HC III       | St. Mathias Amaler H/C III | Post Office Moroto      |
|    |         | Nabilatuk HC IV         | 407 BDE Moruita HC III | Alakas H/C II         | Namalu Prisons H/C II      |                         |
|    |         | Nayonai angikalio HC II | Moruita HC II          | Amudat Hospital       | Namalu HC III              |                         |
|    |         | Lolachat HC III         | Karinga HC II          |                       | Nabulenger HC II           |                         |
|    |         | Natirae HC II           | Nakapiripirit HC III   |                       | Nakaale HC II              |                         |
|    |         | Monday                  | Tuesday                | Wednesday             | Thursday                   | Friday                  |

|    |        |                   |                    |                    |                    |                        |
|----|--------|-------------------|--------------------|--------------------|--------------------|------------------------|
| 18 | Matany | Manatany Hospital | Manatany Hospital  | Manatany Hospital  | Manatany Hospital  | Manatany Hospital      |
|    |        | Nawaikorot HC II  | Lorengedwat HC III | Apeitolim HC II    | Iriiri HC III      | Lorengchora HC III     |
|    |        | Morulinga HC II   | Lotome HC III      | Lokopo HC III      | Nabwal HC II       | Namendera HC II        |
|    |        | Kangole HC III    |                    | Lopeei HC III      | Amedek HC II       | Nakichumet HC II       |
|    |        |                   |                    | Post Office Moroto | Post Office Moroto | Matany barracks HC III |
|    |        |                   |                    |                    |                    | Post Office Moroto     |

## District: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Health Facility:\_\_\_\_\_ Facility Level:\_\_\_\_\_

| S | Name of participant | Sex | Tel Number |
|---|---------------------|-----|------------|
| 1 |                     |     |            |
| 2 |                     |     |            |
| 3 |                     |     |            |
| 4 |                     |     |            |
| 5 |                     |     |            |
| 6 |                     |     |            |
| 7 |                     |     |            |
| 8 |                     |     |            |
| 9 |                     |     |            |
| 1 |                     |     |            |
| 1 |                     |     |            |
| 1 |                     |     |            |

Interview done by: \_\_\_\_\_

|              |      |      |           |
|--------------|------|------|-----------|
| Facilitator: | Name | Date | Signature |
|--------------|------|------|-----------|

Interview done by: \_\_\_\_\_

Note taker:      Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

## 2. FGD Guide for Health Facility Clients

*This tool is to be used to interview Health Facility clients.*

### Introduction:

Hello. My name is , and I am working with PANAGORA on an evaluation of the activities supported by SUSTAIN at the Regional Referral and other Hospitals/facilities in Uganda. I wish to ask you a few question regarding the delivery of health care services in this area, in particular services for HIV and AIDS in Government Health Facilities. These questions are about your opinion and experience about how things have been or changed in the past 5 or so years. Your answers will help us to learn more about service delivery in area and to help in future planning activities for health quality improvement in this area and country in general.

The answers you give will be kept strictly confidential—and the findings will be analyzed as an aggregated piece of information and not by who said what. Taking part in this study is voluntary, that means that you do not have to participate if you don't want to, but I would greatly appreciate if you participate. It is possible that you may feel uncomfortable answering some of the questions. You don't have to answer questions you don't want to and if you don't understand something that I ask you, please tell me and I will ask the question again. This will only take about 40mins to 1 hour. Do you have any questions for me right now?

[Interviewer give some time to answer questions if the respondent has one]

### Would it be ok for me to ask you a few questions?

No

STOP. Interviewer: *Can I ask why you would not like to participate in this survey?*

Write reason for refusal: \_\_\_\_\_

Interviewer: *Thank you for taking time to listen.*

Yes



\_\_\_\_\_

### Discussion themes

#### Effectiveness of Service Delivery

1. Who are the key HIV/AIDS service providers in your area?

**Probe for:** Other providers including private and not for profit service providers.

2. Looking at the past five years, what particular aspects of these HIV&AIDS services have changed (compare the last 5 years and now) e.g. PMTCT, HCT, ART/Care, Laboratory services, Health worker numbers and attitudes, Time spent to receive a service, Infrastructure (space and medicines) and stigma

3. What HIV&AIDS services do you get from this facility?

**Probe for:** Whether these services are integrated (accessing HIV RELATED-PMCT, EID, ART, TB at the HIV clinic)

4. What other HIV&AIDS services do you access from other health facilities and why

**Probe for:** Easy access, affordability, friendliness of providers, etc.?

5. What top three HIV&AIDS services do you think have experienced the biggest positive change/improvement?

**Probe for:** Services around PMTCT, HCT, ART/Care, Laboratory services and medicines

6. What top three HIV&AIDS services would you want this facility to improve and how?  
**Probe for:** Consider cross-checking why the clients prefer to receive services from this particular facility.
7. What HIV/AIDS services have you received from the community and who provides them?

### **Referral & Its Effectiveness**

8. In your view, how have the community referral and follow up system changed over time- In the last 5 years?  
**Probe for:** What services are most referred for and whether referred clients access services at this facility?
9. For Participants at District Hospitals, HCIVs & HC IIIs: Comment on the referral approach/mechanism by this facility to the regional referral?  
**Probe for:** Specific services referred for and whether those referred do receive the services sent for.

### **Sustainability of interventions**

10. How have you been involved in the process of delivering HIV&AIDS services? Family Support Groups, Expert clients, VHTs, peer HIV Counselors, etc.?
11. In your opinion what factors will enable quality of HIV/AIDS services to continue being provided at this facility?  
**Probe for:** Why do you think so?

Do you have any other comments/ questions on the issues we have been discussing above?

**Thank you very much for the information and your time.**

### 3. KII Discussion Guide: Other Partners

*This tool is for other HIV/AIDS implementing partners e.g., STAR-EC, Mildmay, TASO, etc.*

#### Introduction:

Hello. My name is , and I am working with PANAGORA on an evaluation of the activities supported by SUSTAIN at the Regional Referral and other Hospitals/facilities in Uganda. I wish to ask you a few question regarding the delivery of health care services in this area, in particular services for HIV and AIDS in Government Health Facilities. These questions are about your opinion and experience about how things have been or changed in the past 5 or so years. Your answers will help us to learn more about service delivery in area and to help in future planning activities for health quality improvement in this area and country in general.

The answers you give will be kept strictly confidential—and the findings will be analyzed as an aggregated piece of information and not by who said what. Taking part in this study is voluntary, that means that you do not have to participate if you don't want to, but I would greatly appreciate if you participate. It is possible that you may feel uncomfortable answering some of the questions. You don't have to answer questions you don't want to and if you don't understand something that I ask you, please tell me and I will ask the question again. This will only take about 40mins to 1 hour. Do you have any questions for me right now?

[Interviewer give some time to answer questions if the respondent has one]

#### Would it be ok for me to ask you a few questions?

No

STOP. Interviewer: *Can I ask why you would not like to participate in this survey?*

Write reason for refusal: \_\_\_\_\_

Interviewer: *Thank you for taking time to listen.*

Yes



\_\_\_\_\_

#### Discussion themes

#### SUSTAIN's contribution to HIV/AIDS service delivery

1. What do you know about SUSTAIN project?
2. How have you worked with SUSTAIN and on what areas?
3. What unique things does SUSTAIN do differently from other HIV&AIDS implementing partners including you?
4. What significant changes have you observed in service delivery in the past five years as a results of SUSTAIN's support to facilities.

**Probe for:** Improvements in quality assurance, planning, allocation of resources –human and financial, involvement of PHAS, leadership and management of health facilities).

#### Trickle Down & partnership effect

1. In your view, other than at the Regional Referral, are there any observable changes related to HIV/AIDS services in the lower level facilities due to SUSTAIN's support?

**Probe for:** Changes in Human Resource, Referral & linkages, HMIS, Leadership & governance, essential medicines and supplies {stock outs}

2. In what ways has SUSTAIN activities impacted on your own programs?

### **Best Practices**

3. What can you or other Implementing Partners learn from SUSTAIN's approach of supporting HIV&AIDS interventions in the country?

**Probe for:** Human Resource, Referral & linkages, HMIS, Leadership & governance, essential medicines and supplies and infrastructure

4. What would SUSTAIN have done differently to create more impact on the HIV&AIDS services delivery in Uganda?

### **Sustainability of interventions**

5. In your view, how will government/district or you other implementing partners be able to take forward the activities SUSTAIN is currently supporting?

**Probe for:** What specific SUSTAIN activities are likely to be taken over by the government/districts and other implementing partners; and what activities are unlikely to be taken over by Government/districts and other implementing partners and why?

6. What sustainability mechanisms would you recommend to ensure continued SUSTAIN'S contributions to the HIV&AIDS sector?

**Probe for:** Recommendations at MOH, RRHs, District and Community levels

Do you have any additional comments/questions on the issues we have been discussing?

**Thank you very much for the information and your time.**

#### 4. Key Informants' Topic Guide for National Level

*This tool is to be used to interview key informants such as MoH Headquarters (DG for Health services, AIDS Control Program, Head TB programme, Pharmacy Division, Etc.)*

##### Introduction:

Hello. My name is , and I am working with PANAGORA on an evaluation of the activities supported by SUSTAIN at the Regional Referral and other Hospitals/facilities in Uganda. I wish to ask you a few question regarding the delivery of health care services in this area, in particular services for HIV and AIDS in Government Health Facilities. These questions are about your opinion and experience about how things have been or changed in the past 5 or so years. Your answers will help us to learn more about service delivery in area and to help in future planning activities for health quality improvement in this area and country in general.

The answers you give will be kept strictly confidential—and the findings will be analyzed as an aggregated piece of information and not by who said what. Taking part in this study is voluntary, that means that you do not have to participate if you don't want to, but I would greatly appreciate if you participate. It is possible that you may feel uncomfortable answering some of the questions. You don't have to answer questions you don't want to and if you don't understand something that I ask you, please tell me and I will ask the question again. This will only take about 40minis to 1 hour. Do you have any questions for me right now?

[Interviewer give some time to answer questions if the respondent has one]

##### Would it be ok for me to ask you a few questions?

No

STOP. Interviewer: *Can I ask why you would not like to participate in this survey?*

Write reason for refusal: \_

Interviewer: *Thank you for taking time to listen.*

Yes

→ \_\_\_\_\_

#### Topics for Discussion

##### **Contribution of SUSTAIN Specific Strategy and Technical Approach:**

How has the SUSTAIN project benefited the delivery of HIV and AIDS services in Uganda?

**Probe for:** district level contribution, Quality improvement; Human Resource, Essential supplies, medicines & Infrastructure, service delivery, HMIS & leadership/governance.

##### **Partnerships**

What is your comment on the partnership between the MOH and SUSTAIN Activity?

**Probe for:** Participation/support and role of SUSTAIN in relation to MOH; MOH's engagement in SUSTAIN activities; support for the HIV&AIDS technical working groups partnership arrangements (MOU), mutual support etc.

##### **Relevance of SUSTAIN activity**

How has SUSTAIN contributed to meeting the national HIV&AIDS priorities?

**Probe for:** contribution towards realization of National policies, addressing key HIV&AIDS gaps in service delivery, human resources, guidelines, etc.

##### **Best Practices**

In what ways has the SUSTAIN activity differed from other HIV&AIDS projects in its implementation in the country (compare past & present)?

**Probe for:** Differences in targeted facility levels (RRHs), approaches/strategies & strengthening capacity (human resources)

What in your view worked well and why?

What in your view may not have worked well and why?

**Sustainability**

In your view, how will government be able to take forward the activities SUSTAIN is currently supporting?

**Probe for:** What specific SUSTAIN activities are likely to be taken over by the government; What activities are unlikely to be taken over by Government and why,

Do you have any additional comments/ questions on the issues we have been discussing?

**Thank you very much for the information and your time.**

## 5. Key Informants' Topic Guide for Health Facility In-charges/Regional Directors

*This tool is to be used to interview key informants for Health Facility Staff at RRHs, District Hospitals and HCIVs & HCIIIs (HC In-charges, Hospital Directors)*

### Introduction:

Hello. My name is \_\_\_\_\_, and I am working with PANAGORA on an evaluation of the activities supported by SUSTAIN at the Regional Referral and other Hospitals/facilities in Uganda. I wish to ask you a few questions regarding the delivery of health care services in this area, in particular services for HIV and AIDS in Government Health Facilities. These questions are about your opinion and experience about how things have been or changed in the past 5 or so years. Your answers will help us to learn more about service delivery in area and to help in future planning activities for health quality improvement in this area and country in general.

The answers you give will be kept strictly confidential—and the findings will be analyzed as an aggregated piece of information and not by who said what. Taking part in this study is voluntary, that means that you do not have to participate if you don't want to, but I would greatly appreciate if you participate. It is possible that you may feel uncomfortable answering some of the questions. You don't have to answer questions you don't want to and if you don't understand something that I ask you, please tell me and I will ask the question again. This will only take about 40 minutes to 1 hour. Do you have any questions for me right now?

[Interviewer give some time to answer questions if the respondent has one]

**Would it be ok for me to ask you a few questions?**

No

STOP. Interviewer: *Can I ask why you would not like to participate in this survey?*

Write reason for refusal: \_\_\_\_\_

Yes →

Interviewer: *Thank you for taking time to listen.*

### Topics for Discussion

#### **Contribution of SUSTAIN Specific Strategy and Technical Approach:**

Q1a: How have you been working with SUSTAIN?

**Probe for:** The activities/support engaged in and relationship between the facility & SUSTAIN

Q1b: What has been the benefit of the above Activities/support to your health facility?

- i. How these activities contributed towards improving the quality of HIV and AIDS services?
- ii. How these activities contributed to Strengthening Supervision of service delivery
- iii. How these activities contributed towards improving facility infrastructure (Lab, clinics, equipment, etc.).
- iv. How these activities contributed towards improving the Health Management Information System; What activities has SUSTAIN done with you to strengthen your Human Resources for Health (HRH)?
- v. How the HRH support was provided such as through trainings, mentorship, recruitment, and coaching?
- vi. What is your comment on the way trainings, mentorship, recruitment and coaching of the different staff/cadres were delivered?
- vii. In your opinion, how did the trainings, mentorships, recruitment and coaching impact on your work?

**Probe for:** positive and negative impact

Q1c. What has been the benefit of SUSTAIN's activities towards strengthening your governance and leadership systems?

**Probe for:** Board activities, relationship between Board & management, financial management – Budgeting & Accountability, etc.

Q1d. What services did SUSTAIN do differently from other partners?

Q1e. What are the merits and demerits of the approach of the SUSTAIN project?

### **Trickle-down effect**

Q2: How have the SUSTAIN supported activities (mainly targeting RRHs) benefited the lower level facilities such as HCIVs and HCIIIs- within the referral zone?

Q3: Which facility level have benefited the most from this linkage?

**Probe for:** In what way and or how?

Q4: What facilitated the linkage between your facility and the lower level HCs?

Q5: What barriers did you encounter in linking to the lower level health facilities?

**Probe for:** Whether these barriers were managed or still exist?

Q6: How could these barriers encountered be better handled by future programs?

Q7: What is your overall opinion on the linkages with lower level facilities?

**Probe for:** Whether the way it was planned worked or didn't work and whether the expectations from it were met or not?

### **Factors for success / Failure**

Q8: What factors at the local level have facilitated the implementation of the SUSTAIN project in this region?

**Probe for:** *Political issues; Economic situation in the area, social relations and other aspects, cultural issues etc., and ask how these issues enhanced implementation process?*

Q9: What factors at the local level have limited the implementation of the project?

**Probe for:** *Political issues; Economic situation in the area, social relations and other aspects, cultural issues etc., and ask how these issues affected and were managed?*

Q10: What factors at national level do you think have facilitated the implementation of the SUSTAIN project?

**Probe for:** *Political issues; Economic situation in the area, social relations and other aspects, cultural issues etc., and ask how these issues affected and were managed?*

Q11: What factors at national level do you think have limited the implementation of the SUSTAIN project?

**Probe for:** *Political issues; Economic situation in the area, social relations and other aspects, cultural issues etc., and ask how these issues affected implementation and how they were managed?*

**Best Practices & Significant change**

Q12: Considering the different activities of the SUSTAIN project,

- a. What in your view worked well and why?
- b. What didn't work well and why?

Q13: How has SUSTAIN's support changed the way things are done at this facility? Ask respondent/participant to compare;

- a. Situation before and now along Human Resources for Health
- b. Situation before and now along infrastructure development and essential medicines & supplies including equipment, procurement/supply chain management
- c. Situation before and now along Leadership and Governance
- d. Situation before and now along services delivery for HIV/AIDS and others
- e. Situation before and now along Health Management Information System (HMIS)

**Sustainability**

Q14: What things are likely to continue the way they are after the project has ended? And why do you think so?

**Probe for:** What will happen on service delivery, HRH, HMIS, infrastructure and equipment and leadership and financing?

Q15: Do you have any questions or comments on the issues we have been discussing?

**Thank you very much for the information and your time.**

## 6. Key Informants' Topic Guide for Implementer

*This tool is to be used to interview key informants at SUSTAIN such as*

- 1. Chief of Party (KII)*
- 2. Deputy Chief of Party, Senior Advisors for M&E, F&A, HSS, (Small group discussion)*

### Introduction:

Hello. My name is \_\_\_\_\_, and I am working with PANAGORA on an evaluation of the activities supported by SUSTAIN at the Regional Referral and other Hospitals/facilities in Uganda. I wish to ask you a few questions regarding the delivery of health care services in this area, in particular services for HIV and AIDS in Government Health Facilities. These questions are about your opinion and experience about how things have been or changed in the past 5 or so years. Your answers will help us to learn more about service delivery in area and to help in future planning activities for health quality improvement in this area and country in general.

The answers you give will be kept strictly confidential—and the findings will be analyzed as an aggregated piece of information and not by who said what. Taking part in this study is voluntary, that means that you do not have to participate if you don't want to, but I would greatly appreciate if you participate. It is possible that you may feel uncomfortable answering some of the questions. You don't have to answer questions you don't want to and if you don't understand something that I ask you, please tell me and I will ask the question again. This will only take about 40 minutes to 1 hour. Do you have any questions for me right now?

[Interviewer give some time to answer questions if the respondent has one]

**Would it be ok for me to ask you a few questions?**

No

STOP. Interviewer: *Can I ask why you would not like to participate in this survey?*

Write reason for refusal: \_\_\_\_\_

Yes

Interviewer: *Thank you for taking time to listen.*

## Topics for Discussion

### Achievements and Benefits

What in your view are the main successes of the SUSTAIN Activity in delivery of HIV&AIDS mandate?

**Probe for:** Overall performance; specifics by objective; and what facilitated the success?

In what technical area of your systems approach did you achieve the most? And why do you think so?

### Contribution of SUSTAIN Specific Strategy and Technical Approach:

How has SUSTAIN contributed to realizing national HIV&AIDS priorities?

**Probe for:**

- a. Strengthening technical and leadership capacity at partner RRHs;  
**Probe:** Supervision; building capacity of leaders, management of facilities etc.
- b. Strengthening technical and leadership capacity at partner district hospitals;
- c. Enhancing MOH (and consequently GOU) stewardship and ownership of HIV/AIDS service delivery in partner hospitals and regions;

- d. To what extent did the systems approach succeed in improving the quality of HIV/AIDS services?

### **Trickle-down effect**

Other than the RRHs that were the main target of the SUSTAIN Activity, what other health facilities/institutions/organizations have gained from the interventions? How? Probe: for benefit to HCIVs, HC IIIs & National Coordination Umbrella (PNFPs)

### **Factors for success / Limitations**

What external factors have:

- a. Enabled the SUSTAIN activity implementation?
- b. Created limitations/hindered SUSTAIN activity implementation?  
**Probe for:** Economic, Social, Cultural, political, technological, etc.
- c. How were these SUSTAIN activity limitations managed?

### **Best Practices**

Drawing from the experience of SUSTAIN interventions, activities:

What are the best practices that could be replicated for effective delivery of HIV/AIDS services?

**Probe for:** What worked and why? What didn't work and why?

### **Sustainability**

Considering the different SUSTAIN interventions:

- a. What sustainability mechanisms/plans/strategies did you put in place?
- b. What aspects are likely to be carried on by Government after the SUSTAIN's support; and why do you think so?
- c. What Aspects are unlikely to be carried on by Government after the SUSTAIN's support and why do you think so?

Do you have any additional questions or comments on the issues we have discussed?

**Thank you very much for your time and information.**

## 7. Referral Checklist for Regional Referral & Other District Hospitals

District: \_\_\_\_\_ Level of Facility: \_\_\_\_\_

Name of facility: \_\_\_\_\_

RRH linked to (for lower level facility):\_\_\_\_\_

| Year         | Number of Referrals received (RRH levels only) | Number of patients referred (lower level facility only) |
|--------------|------------------------------------------------|---------------------------------------------------------|
| 2010         |                                                |                                                         |
| 2011         |                                                |                                                         |
| 2012         |                                                |                                                         |
| 2013         |                                                |                                                         |
| 2014         |                                                |                                                         |
| 2015         |                                                |                                                         |
| 2016         |                                                |                                                         |
| <b>Total</b> |                                                |                                                         |

Completed by: \_\_\_\_\_  
(Research Assistant)      Name                      Signature                      Date

## 8. Hospital Observation Checklist

1. Look out for information Charts (e.g. on integration of PMTCT services, Flow charts etc. - displayed at visible corners at the facility)
2. Check for integration of services e.g. is the work plan-including M&E for the HIV clinic integrated into the broader hospital work plan.
3. Check for integration of District Work plans with those of the Project
4. Computers for data management
5. Organization Structure of the facility
6. Records e.g. support supervision reports by DHT?
7. Laboratory Equipment

| Template for description on infrastructure and equipment |             |          |
|----------------------------------------------------------|-------------|----------|
| Physical<br>Infrastructural<br>Support Provided          | Description | Comments |
|                                                          |             |          |
|                                                          |             |          |
|                                                          |             |          |
|                                                          |             |          |

## ANNEX D. SUSTAIN SUPPORT HISTORY

|                                             | Name of Health Facility       | District  | Scope                                              | Current Support Status                                        |
|---------------------------------------------|-------------------------------|-----------|----------------------------------------------------|---------------------------------------------------------------|
| <b>FACILITIES IN ORIGINAL SCOPE OF WORK</b> |                               |           |                                                    |                                                               |
| 1                                           | ARUA REGIONAL HOSPITAL        | ARUA      | Comprehensive, MDR, RMEW                           | Supported by SUSTAIN                                          |
| 2                                           | GULU REGIONAL HOSPITAL        | GULU      | Comprehensive, RMEW, MDR                           | Supported by SUSTAIN                                          |
| 3                                           | LIRA REGIONAL HOSPITAL        | LIRA      | Comprehensive, RMEW, MDR                           | Supported by SUSTAIN                                          |
| 4                                           | HOIMA REGIONAL HOSPITAL       | HOIMA     | Comprehensive, RMEW                                | Supported by SUSTAIN                                          |
| 5                                           | KAKIRA HOSPITAL               | JINJA     | Comprehensive                                      | Transitioned to JCRC in Year 1                                |
| 6                                           | JINJA REGIONAL HOSPITAL       | JINJA     | Comprehensive                                      | Supported by SUSTAIN                                          |
| 7                                           | KAABONG HOSPITAL              | KAABONG   | Comprehensive                                      | Supported by SUSTAIN                                          |
| 8                                           | KABALE REGIONAL HOSPITAL      | KABALE    | Comprehensive, RMEW, MDR                           | Supported by SUSTAIN                                          |
| 9                                           | FORT PORTAL REGIONAL HOSPITAL | KABAROLE  | Comprehensive                                      | Supported by SUSTAIN                                          |
| 10                                          | NSAMBYA HOSPITAL              | KAMPALA   | Comprehensive                                      | Transitioned to UCMB                                          |
| 12                                          | KIBOGA HOSPITAL               | KIBOGA    | Comprehensive                                      | Transitioned to IDI                                           |
| 13                                          | NGORA HOSPITAL                | KUMI      | Comprehensive                                      | Transitioned to Baylor Uganda                                 |
| 14                                          | MASINDI HOSPITAL              | MASINDI   | Comprehensive                                      | Transitioned to IDI                                           |
| 15                                          | MBALE REGIONAL HOSPITAL       | MBALE     | Comprehensive, RMEW, MDR                           | Supported by SUSTAIN                                          |
| 16                                          | MBARARA REGIONAL HOSPITAL     | MBARARA   | No support provided, only transition meetings held | Transitioned to MJAP early in Year 1                          |
| 17                                          | MOYO HOSPITAL                 | MOYO      | Comprehensive                                      | Transitioned to Baylor Uganda in Q1 Year 4                    |
| 18                                          | MASAKA REGIONAL HOSPITAL      | MASAKA    | Lab, TB, VMMC, HR                                  | Supported by SUSTAIN                                          |
| 19                                          | GOMBE HOSPITAL                | GOMBA     | Comprehensive                                      | Transitioned to Mildmay Uganda in Q1 Year 4                   |
| 20                                          | MUBENDE HOSPITAL              | MUBENDE   | Comprehensive, MDR                                 | Supported by SUSTAIN                                          |
| 21                                          | KAWOLO HOSPITAL               | BUIKWE    | Comprehensive                                      | Supported by SUSTAIN                                          |
| 22                                          | NEBBI HOSPITAL                | NEBBI     | Comprehensive                                      | Transitioned to Baylor Uganda in Q1 Year 4                    |
| 23                                          | SOROTI REGIONAL HOSPITAL      | SOROTI    | Comprehensive                                      | Supported by SUSTAIN                                          |
| 24                                          | KAGANDO HOSPITAL              | KASESE    | Comprehensive                                      | Transitioned to Baylor Uganda in Year 1                       |
| 25                                          | KALANGALA HC IV               | KALANGALA | Comprehensive                                      | Transitioned to Kalangala District HIV/AIDS program in Year 1 |

|                                                                                           |                                    |                |                   |                                                           |
|-------------------------------------------------------------------------------------------|------------------------------------|----------------|-------------------|-----------------------------------------------------------|
| 26                                                                                        | KAWEMPE HOME CARE INITIATIVE       | KAMPALA        | Comprehensive     | Transitioned to IDI in Year 1                             |
| 27                                                                                        | MUJHU                              | KAMPALA        | Comprehensive     | Transitioned to MUJHU in Year 1                           |
| 28                                                                                        | HOPE CLINIC LUKULI-MAKINDYE HC III | KAMPALA        | Comprehensive     | Transitioned to IDI in Year 1                             |
| 29                                                                                        | MUKUJU HC IV                       | TORORO         | Comprehensive     | Transitioned to Baylor in year 1                          |
| 30                                                                                        | MEDICAL RESEARCH COUNCIL           | WAKISO         | Comprehensive     | Transitioned to MRC in Q1 Year 4                          |
| 31                                                                                        | NAMUGONGO CHILDREN'S CLINIC        | WAKISO         | Comprehensive     | Transitioned to Baylor Uganda in Year 1                   |
| 32                                                                                        | ST PAUL HC IV                      | KASESE         | Comprehensive     | Transitioned to Baylor Uganda in Year 1                   |
| 33                                                                                        | KATAKWI HC IV                      | KATAKWI        | Comprehensive     | Transitioned to Baylor Uganda in Year 1                   |
| 34                                                                                        | LUWERO HC IV                       | LUWEERO        | Comprehensive     | Transitioned to Mildmay Uganda in Year 1                  |
| 35                                                                                        | MPIGI HC IV                        | MPIGI          | Comprehensive     | Transitioned to Mildmay Uganda in Year 1                  |
| <b>HEALTH FACILITIES NOT IN ORIGINAL SCOPE OF WORK BUT ADDED TO SUSTAIN PROGRAM LATER</b> |                                    |                |                   |                                                           |
| 36                                                                                        | Entebbe General Hospital           | Entebbe        | Comprehensive     | Transitioned to Mildmay Uganda in Q1 Year 4               |
| 37                                                                                        | Lwala Hospital                     | Lwala          | Brief lab support | Transitioned to Baylor Uganda in Q3 Year 3                |
| 38                                                                                        | Moroto Regional Referral Hospital  | Moroto         | Comprehensive     | Supported by SUSTAIN                                      |
| 39                                                                                        | Abim General Hospital              | Abim           | Comprehensive     | Supported by SUSTAIN                                      |
| 40                                                                                        | Matany Hospital                    | Napak          | Comprehensive     | Supported by SUSTAIN                                      |
| 41                                                                                        | Amudat Hospital                    | Amudat         | Comprehensive     | Transitioned to Amudat District/ Moroto Diocese in Year 5 |
| 42                                                                                        | Kotido HCIV                        | Kotido         | Comprehensive     | Supported by SUSTAIN                                      |
| 43                                                                                        | Tokora HCIV                        | Nakapiripiriti | Comprehensive     | Supported by SUSTAIN                                      |

## ANNEX E. DOCUMENT LIST

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### A. Documents Consulted during Evaluation of SUSTAIN – Print Copies

- Ministry of Health (MOH) *Addendum to the National Antiretroviral Treatment Guidelines*;
- MOH (September 2015) *Health Sector Development Plan 2015/16 – 2019/20*;
- MOH (January 2014) Health Infrastructure Division, (December 2013). *Operation Manual for Regional Medical Equipment Maintenance Workshops and Medical Equipment Maintenance Guidelines*;
- MOH (August 2015) *Five-year National Quality Improvement Framework and Strategic Plan 2015/16–2019/20*;
- MOH (October 2011) *The Integrated National Guidelines on Antiretroviral Therapy, Prevention of Mother to Child Transmission of HIV and Infant & Young Child Feeding*, 1st Edition.;
- MOH (July 2015) *National Medicines Policy; Report of the Assessment of Temporal Trends in Antiretroviral Therapy Outcomes in 277 Health Facilities in Uganda.*;
- MOH, *The HIV and AIDS Uganda Country Progress Report 2014*, June 1, 2015;
- MOH STD/AIDS Control Programme (June 2010) *The Status of the HIV/AIDS Epidemic in Uganda: The HIV/AIDS Epidemiological Surveillance Report 2010*;
- MOH STD/AIDS Control Programme (November 2010) *The Status of Antiretroviral Therapy Service Delivery in Uganda. Quarterly Report for July – September 2010*;
- MOH STD/AIDS Control Program (March 2011) *Status of Antiretroviral Therapy Services in Uganda: Quarterly ART Report for October – December 2011*;
- Uganda AIDS Commission (UAC) (April 2015) *The National HIV and AIDS Indicator Handbook 2015/2016 – 2019/2020*;
- UAC (April 2015) *The National HIV and AIDS Monitoring and Evaluation Plan 2015/2016 – 2019/2020*;
- UAC (2015) *The National HIV and AIDS Priority Action Plan 2015/2016 – 2017/2018*;
- UAC (April 2015) *National HIV and AIDS Strategic Plan 2015/1016 – 2019/2020: an AIDS Free Uganda, My Responsibility*; Our document review is a major part of the triangulation process and together with data gathered from USAID, URC, and other sources will build a verifiable representation of the project.

### B. Documents on SUSTAIN Website

- SUSTAIN REVISED TECHNICAL NARRATIVE (URC, APRIL 2010) FROM USAID SOLOME SEVUMA, 14.09.16
- SUSTAIN Quarterly and Annual Reports
- SUSTAIN Work Plans, Years 1, 2, 3, 4, 5, 6
- SUSTAIN Revised RFA – (n.d.) Strengthening Uganda’s Systems for Treating AIDS Nationally
- SUSTAIN (7 February 2014) Performance Management Plan (PMP) Core Indicators
- Results Chain (16 January 2014) Revised Draft Technical Briefers (6)
- Success Stories (11)
- Abstracts (22)

### C. Documents on Google Drive

- U.S. Department of State (September 1, 2015) FY 2015 Uganda Country Operational Plan (COP). Strategic Direction Summary.
- NS Health Scotland (n.d.) Social Science Methods Series. Guide 6 – Contribution Analysis. URC (November 2015) Arua Regional Referral Hospital Profile.
- John Mayne (June 1999) Addressing attribution through contribution analysis: using performance measures sensibly.
- Amy Hagopian, et.al. (January 2011) Satisfaction, motivation and intent to stay among Ugandan physicians: a survey from 18 national hospitals. In International Journal of Health Planning and Management.

## **ANNEX F. KEY INFORMANTS**

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### **National Level/GOU (8)**

- Assistant Commission of Clinical Services
- MOH Planning Unit (Human Resources)
- Program Manager, NTL
- HEAD: National Health Laboratories, Mr. Ayisu
- Senior Resource office. MOH, Louis Tugume
- Head, Pharmacy MOH Headquarters, Morris Seru
- MOH/Director Planning, Policy and Development, H.G. Mwebasa
- Ag. Principal Electrical Engineer, Central Mechanical Workshop Eng. Edward Kataha
- USAID, Dan Wamanya
- URC, COP, Deputy COP and Vice President

### **Other HIV & AIDS partners (At least three Partners)**

- TASO/IDI (adults and capacity building)
- MILD MAY/BAYLOR (pediatrics)
- STAR-EC/E/SW (comprehensive HIV services)
- PNFP – National Coordination Umbrella

### **URC - SUSTAIN (2 categories – small group interviews)**

- Chief of Party
- Deputy COP and Vice President

## ANNEX G. BREAKDOWN OF EVALUATION INTERVIEWS

| SN           | Interview Category                                     | Planned Interviews   | Actual Interviews | Informants and interview comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|--------------|--------------------------------------------------------|----------------------|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1.           | RRHs Staff KIIs                                        | 48                   | 46                | <ul style="list-style-type: none"> <li>RRH Director</li> <li>F&amp;A</li> <li>HIV clinic In-charge</li> <li>Lab In-charge</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 2.           | DHOs/HIV Focal Persons of RRHs                         | 12                   | 10                | <i>*Some DHOs turned down the interviews saying that they were not aware of SUSTAIN work in their districts</i>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 3.           | DHO/HIV Focal Persons of Trickle down districts        | 6                    | 4                 | <ul style="list-style-type: none"> <li>Two near districts</li> <li>Two far districts</li> </ul> <p><i>*Some trickle-down districts doubled as RRH districts.</i><br/> <i>**Some DHOs turned down the interviews saying that they were not aware of SUSTAIN work in their districts.</i></p>                                                                                                                                                                                                                                                                                                                         |
| 4.           | Trickle Down/ lower level Health Facilities Interviews | 12                   | 9                 | <ul style="list-style-type: none"> <li>HIV Clinic In-Charge</li> <li>Lab In-Charge</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| 5.           | Focus Group Discussions                                | 24                   | 23                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 6.           | Implementing Partners                                  | 15<br>(3 per region) | 8                 | <ul style="list-style-type: none"> <li>Baylor Uganda</li> <li>TASO in 3 regions</li> <li>Star-E</li> <li>Nature Uganda</li> <li>Uganda Cares</li> </ul> <p><i>*A number of IPs required special permission or writing to them directly from their head office.</i><br/> <i>**TASO was interviewed in different regions</i></p>                                                                                                                                                                                                                                                                                      |
| 7.           | National Level Interviews                              | 8                    | 7                 | <p>Planned interviews:</p> <ul style="list-style-type: none"> <li>Assist. Commissioner</li> <li>Clinical Services/MOH</li> <li>Quality Improvement Department</li> <li>AIDS Control Program</li> <li>MOH HRH</li> <li>NTLP</li> <li>Pharmacy Division</li> <li>UAC</li> <li>MoFPED</li> </ul> <p>Actual Interviews:</p> <ul style="list-style-type: none"> <li>MOH HRH</li> <li>MoH Planning unit</li> <li>CPHL</li> <li>USAID</li> <li>NTLP</li> <li>UAC</li> </ul> <p><i>*Difficulty in finding some key National level stakeholders due to several engagements, that have led to un-honored appointments</i></p> |
| 8.           | SUSTAIN Implementer (URC)                              | 2                    | 2                 | URC & SUSTAIN top leadership                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| <b>Total</b> |                                                        | 127                  | 109               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

## ANNEX H. INDICATOR PERFORMANCE SUMMARY: OCTOBER 2015 – SEPTEMBER 2016

**Indicator Performance Table: October 2015–September 2016**

| Performance Indicators                                                                                                                   | Target             | Q1                  | Q2                 | Q3                 | Q4                | % of Annual Target Achieved | Comments                                                                                                                                                                                                                                                                                                                                                                                                                  |
|------------------------------------------------------------------------------------------------------------------------------------------|--------------------|---------------------|--------------------|--------------------|-------------------|-----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                          | Oct 2015–Sept 2016 | Oct–Dec 2015        | Jan–Mar 2016       | Apr-Jun 2016       | Jul-Sep 2016      |                             |                                                                                                                                                                                                                                                                                                                                                                                                                           |
| HIV TESTING AND COUNSELING                                                                                                               |                    |                     |                    |                    |                   |                             |                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Number of individuals who received Testing and Counselling (T&C) services for HIV outside PMTCT-settings and received their test results | 225,935            | 88,284<br>(156.3 %) | 85,067<br>(150.6%) | 90,768<br>(160.7%) | 90,014<br>(159.4) | 354,133<br>(156.7%)         | During the year, the project targeted to provide HTC services to 225,935 individuals. Overall, 354,133 individuals were tested achieving 156.7% of the set target. Individuals counselled, tested and received HIV results included: 333,260 (94.1%) from OPD, IPD and VMMC, 3,576 (1.0%) 1st PCR tests for EID, 5,592 (1.6%) 1st time testers in PNC, and 11,705 (3.3%) males tested for the 1st time in PMTCT settings. |
| Number of individuals tested HIV +                                                                                                       | 8,880              | 2,614<br>(117.8%)   | 2,707<br>(121.9%)  | 2,811<br>(126.6%)  | 2,800<br>(126.1%) | 10,932<br>(123.1%)          | 10,932 clients were identified as HIV positive against an annual target of 8,880, a 123.1% achievement. This over achievement was made possible through targeted PITC in high yield entry points especially at in-patient units and intensified targeting partners and children of index clients in HIV clinics.                                                                                                          |
| Number of Individuals newly tested HIV+                                                                                                  | 7,992              | 2,412<br>(92.3%)    | 2,515<br>(92.9 %)  | 2,662<br>(94.7%)   | 2,591<br>(92.5%)  | 10,180<br>(93.1%)           | There was an improvement in screening for HTC eligibility to minimize known HIV positive individuals retesting. Overall 93.1% of the individuals who tested HIV positive were being identified for the first time.                                                                                                                                                                                                        |

| Performance Indicators                                                                                                                       | Target             | Q1           | Q2           | Q3           | Q4           | % of Annual Target Achieved | Comments                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------------------------------|--------------------|--------------|--------------|--------------|--------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                              | Oct 2015–Sept 2016 | Oct–Dec 2015 | Jan–Mar 2016 | Apr–Jun 2016 | Jul–Sep 2016 |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Percent of newly identified HIV+ clients linked to HIV care services                                                                         | 90%                | 85.7%        | 86.3%        | 86.5%        | 93.9%        | 88.2%                       | The overall annual linkage into care for newly identified HIV positive individuals was 88.2%. It increased by 8.2 percentage points from 85.7% in Q1 to 93.9% in Q4. This improvement was achieved through: use of hub riders to track successful referral to other lower level health facilities and return triplicate referral slips from these facilities to the regional referral and physically escorting patients to the HIV clinic. |
| Percent of newly identified HIV+ clients linked to HIV care services                                                                         | 90%                | 85.7%        | 86.3%        | 86.5%        | 93.9%        | 88.2%                       | The overall annual linkage into care for newly identified HIV positive individuals was 88.2%. It increased by 8.2 percentage points from 85.7% in Q1 to 93.9% in Q4. This improvement was achieved through: use of hub riders to track successful referral to other lower level health facilities and return triplicate referral slips from these facilities to the regional referral and physically escorting patients to the HIV clinic. |
| <b>VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC)</b>                                                                                            |                    |              |              |              |              |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period | 12,881             | 389          | 1,152        | 5,063        | 6,307        | 12,932 (100.4%)             | The annual target was slightly surpassed.                                                                                                                                                                                                                                                                                                                                                                                                  |

| Performance Indicators                                                                                                                                    | Target                     | Q1                           | Q2                           | Q3                             | Q4                            | % of Annual Target Achieved  | Comments                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------|------------------------------|--------------------------------|-------------------------------|------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                           | Oct 2015– Sept 2016        | Oct–Dec 2015                 | Jan–Mar 2016                 | Apr–Jun 2016                   | Jul–Sep 2016                  |                              |                                                                                                                                                                                                                                   |
| Number of males circumcised surgically or by medical device that experienced at least one moderate or severe adverse event(s) (AEs)                       | 43                         | 0                            | 4                            | 15                             | 31                            | 0.39%                        | Adverse events level maintained below 1% across the quarters as required mainly due to good infection control, adequate training for the circumcision teams and good VMMC client counselling to enable post circumcision hygiene. |
| <b>PMTCT</b>                                                                                                                                              |                            |                              |                              |                                |                               |                              |                                                                                                                                                                                                                                   |
| Percentage of pregnant women with known HIV status (includes women who were tested for HIV and received their results)                                    | 95%<br>(47,085/<br>49,563) | 97.5%<br>(12,579/<br>12,900) | 97.4%<br>(12,495/<br>12,835) | 100.7 %<br>(13,171/<br>13,083) | 100.4%<br>(12,086/<br>12,039) | 101.5%<br>(50286/<br>49,563) | The quarterly target was met as a result of availability of HIV test kits and competence which continued to motivate health workers to provide HTC services in Maternal and child health (MCH) settings                           |
| Percentage of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery | 100%<br>(3,904/<br>3,904)  | 89.0%<br>(921/<br>1,035)     | 91.9%<br>(884/<br>962)       | 90.91%<br>(1,050/<br>1,155)    | 96.3%<br>(983/<br>1,021)      | 98%<br>(3826/<br>3,904)      | The target was short by 2%. These women either were not psychologically ready and still undergoing counselling by end of the reporting quarter or were referred to other healthcare facilities for ART initiation upon request.   |
| Percent of HIV-positive pregnant women newly enrolled in HIV care services                                                                                | 100%                       | 79.2%<br>(323/408)           | 84.4%<br>(302/<br>358)       | 113%<br>(403/<br>356)          | 98.2%<br>(327/<br>333)        | 247%<br>(1352/<br>547)       | There was an over achievement due to the low set target of newly identified positives.                                                                                                                                            |
| <b>EARLY INFANT DIAGNOSIS</b>                                                                                                                             |                            |                              |                              |                                |                               |                              |                                                                                                                                                                                                                                   |

| Performance Indicators                                                                                                                   | Target                 | Q1                      | Q2                   | Q3                     | Q4                       | % of Annual Target Achieved | Comments                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------------------------------------------------------------------------|------------------------|-------------------------|----------------------|------------------------|--------------------------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                          | Oct 2015– Sept 2016    | Oct–Dec 2015            | Jan–Mar 2016         | Apr–Jun 2016           | Jul–Sep 2016             |                             |                                                                                                                                                                                                                                                                                                                              |
| Percentage of infants born to HIV-positive women who had a virologic HIV test done within 12 months of birth                             | 80%<br>(3,123 / 3,904) | 87.9%<br>(910 /1,035)   | 93.2%<br>(897 /962)  | 74.29%<br>(858 /1,155) | 89.23%<br>(911/1,021)    | 91.6%<br>(3576/ 3904)       | The indicator is measured against all HIV infected pregnant women identified during the reporting period despite the fact that some do not to return to the mother baby care points for EID services post-delivery. This indicator refers to 1st DNA PCR test only. An additional 2698 2nd DNA PCR tests were done this year |
| Infants who received a virologic test within 2 months of birth                                                                           | 2,811                  | 664                     | 622                  | 620                    | 688                      | 92.3%<br>(2594/ 2811)       | This performance is slightly below the set target because some mothers prefer to get EID services at lower health facilities near their homes while others delay to bring their exposed infants to the facilities for post- care delivery.                                                                                   |
| Percentage of infants born to HIV-positive pregnant women who were started on Cotrimoxazole (CTX) prophylaxis within two months of birth | 70%                    | 72.8%<br>(753/ 1,035)   | 71.83%<br>(691/ 962) | 60.17%<br>(695/ 1,155) | 70.13%<br>(716/ 1,021)   | 72.9%<br>(2845/ 3904)       | The indicator is measured against all HIV infected pregnant women identified during the reporting period despite the fact that some do not return to the EID care points for CTX refills after delivery                                                                                                                      |
| D.3. Percent of HIV-exposed infants given ARV prophylaxis (at birth)                                                                     | 97%                    | 97.5%<br>(1,108/ 1,136) | 94.9%<br>(889/ 937)  | 97.88%<br>(971/ 992)   | 88.24%<br>(1,013/1, 148) | 102%<br>(3981/ 3904)        | Quarterly target was achieved for the 1st 3quarters because of availability of NVP syrup at the supported health facilities and the vigilance of the health workers however, during quarter 4, NVP stock outs were experienced at 2 heavy volume health units (Lira and Hoima RRH) affecting the prophylaxis.                |

| Performance Indicators                                                                 | Target                     | Q1                       | Q2                     | Q3                      | Q4                      | % of Annual Target Achieved | Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|----------------------------------------------------------------------------------------|----------------------------|--------------------------|------------------------|-------------------------|-------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                        | Oct 2015– Sept 2016        | Oct–Dec 2015             | Jan–Mar 2016           | Apr–Jun 2016            | Jul–Sep 2016            |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| D.4. Percent of infants born to HIV-positive mothers and are found to be HIV- infected | 5.0%                       | 2.8%<br>(43/<br>1,550)   | 1.7%<br>(29/<br>1,662) | 2.09% (35/<br>1,672)    | 2.57%<br>(47/<br>1,519) | 3.7%<br>(146/<br>3,904)     | Transmission rates for individual hospitals ranged from 0.0% to 6.5% with Jinja RRH registering the highest positivity rate (6.5%) above the target. The denominator for this indicator is based on PCR results returned from the reference laboratory during the quarter, which includes some overflows from the previous quarters.                                                                                                                                                          |
| Final outcomes among HIV exposed infants registered in the birth cohort                | 100%<br>(3,123 /<br>3,123) | 79.1%<br>(888/<br>1,122) | 98.6%<br>(916/<br>929) | 98.36%<br>(899/<br>914) | 98.4%<br>(957/<br>973)  | 121.4%<br>(3,792/<br>3,123) | More exposed infants (3792) were registered in the cohorts compared to the set target (3123). However, cumulatively, 3.7% exposed infants had no documented outcome as a result of incomplete documentation. Registering exposed infants according to their birth cohorts has made it easy to monitor outcome and ensure complete documentation. The figures represent a percentage of exposed infants registered 24 months ago who had any of the following documented outcomes by 18 months |
| <b>HIV CARE</b>                                                                        |                            |                          |                        |                         |                         |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

| Performance Indicators                                                                                                                                                                                                       | Target              | Q1                       | Q2                       | Q3                       | Q4                      | % of Annual Target Achieved | Comments                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------|--------------------------|--------------------------|-------------------------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                              | Oct 2015– Sept 2016 | Oct–Dec 2015             | Jan–Mar 2016             | Apr–Jun 2016             | Jul–Sep 2016            |                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| Number of HIV-positive adults and children newly enrolled in clinical care during the reporting period who received at least one of the following at enrolment: clinical assessment (WHO staging) OR CD4 count OR viral load | 9,421               | 1,998                    | 2,106                    | 2,245                    | 2,060                   | 89.3%<br>(8,409/9,421)      | The annual target for enrolment of clients in care was not met as a result of 1,696 (16.7% of the newly identified as HIV positive clients preferring to enroll at other facilities and others undecided on enrolment in care despite being counselled.                                                                                                                                                                                                          |
| Number of HIV positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load                                              | 73,078              | 57,013                   | 56,713                   | 58,816                   | 59,006                  | 80.7%<br>(59,006/73,078)    | Target not met as a result of clients lost to care despite attempts to follow them.<br><br>The project did not achieve the annual target with this 80.7% target achievement. Despite the fact that the testing approach has changed to target high priority areas for some supported health facilities, the yield for the positives was not high enough to enable target achievement. For the clients in care, clinical assessments are done promptly as needed. |
| Percent of HIV-positive persons receiving Cotrimoxazole / Dapsone preventive therapy (CPT)                                                                                                                                   | 98%                 | 98.1%<br>(55,945/57,013) | 99.9%<br>(56,633/56,713) | 99.8%<br>(58,695/58,816) | 100%<br>(59,002/59,006) | 100%<br>(59,002/59,006)     | Target was achieved mainly due to the constant availability of Cotrimoxazole                                                                                                                                                                                                                                                                                                                                                                                     |

| Performance Indicators                                                                                 | Target                    | Q1                         | Q2                        | Q3                        | Q4                         | % of Annual Target Achieved | Comments                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------------------------------------------|---------------------------|----------------------------|---------------------------|---------------------------|----------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                        | Oct 2015– Sept 2016       | Oct–Dec 2015               | Jan–Mar 2016              | Apr–Jun 2016              | Jul–Sep 2016               |                             |                                                                                                                                                                                                                                                                                                        |
| Percentage of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit  | 100%<br>(73,078 / 73,078) | 97.5%<br>(55,566 / 57,013) | 96.7%<br>(54,844/ 56,713) | 93.6%<br>(55,061/5 8,816) | 94.0%<br>(55,487/5 9,0 06) | 94.0%<br>(55,487/5 9, 006)  | Target not met as a result of drug refills by treatment supporters affecting screening for TB.                                                                                                                                                                                                         |
| Percent of TB patients identified among HIV-positive patients who were started on TB treatment         | 3%                        | 0.2%<br>(125 / 57,013)     | 0.2%<br>(135/56,7 1 3)    | 0.3%<br>(169/58,8 16)     | 0.3%<br>(166/59,0 06)      | 1.0%<br>(595/ 59,006)       | Fewer than expected patients were found to be TB/HIV co-infected and started on TB treatment compared to the originally anticipated 3% (the national target) despite improved screening mechanisms. This may be attributed to better levels of immunological recovery at individual and cohort levels. |
| Percentage of PLHIV newly enrolled in HIV clinical care who start isoniazid preventative therapy (IPT) | 68%<br>(6,397 / 9,421)    | 0.3%<br>(6/1,998)          | 0.6%<br>(13/ 2,106)       | 0.8%<br>(19/2,245)        | 1.3% (27/ 2,060)           | 0.7%<br>(65/9,421)          | Target not met due to Stock out of isoniazid at the National Medical stores.                                                                                                                                                                                                                           |
| <b>TB/HIV</b>                                                                                          |                           |                            |                           |                           |                            |                             |                                                                                                                                                                                                                                                                                                        |
| Total number of registered new and relapsed TB cases, during the reporting period.                     | 2,775                     | 1,369                      | 1,516                     | 1,535                     | 1,565                      | 215.7%<br>(5,985/ 2,775)    | Performance doubled the annual target due improved use of Intensified Case Finding (ICF) guide and improved laboratory functionality across the hospitals along with improved sputum turnaround time as a result of QI implemented by the hospitals                                                    |
| Percentage of registered new and relapsed TB cases with documented HIV status                          | 100%                      | 92.8%<br>(1,270/ 1,369)    | 96.5%<br>(1,463/ 1,516)   | 96.02%<br>(1,474/ 1,535)  | 92.5%<br>(1,448/ 1,565)    | 94.5%<br>(5,655/ 5,98 5)    | Target nearly achieved due to institutionalized HIV testing at TB care points. Slight under achievement is due to gaps in documenting of HIV test result in unit TB register                                                                                                                           |

| Performance Indicators                                                                     | Target              | Q1               | Q2              | Q3              | Q4              | % of Annual Target Achieved | Comments                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------|---------------------|------------------|-----------------|-----------------|-----------------|-----------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                            | Oct 2015– Sept 2016 | Oct–Dec 2015     | Jan–Mar 2016    | Apr–Jun 2016    | Jul–Sep 2016    |                             |                                                                                                                                                                                                                                                      |
| Percent of TB/HIV co-infected clients receiving CPT                                        | 98%                 | 89.2% (547/613)  | 94.9% (647/682) | 97.4% (664/682) | 97.2% (620/638) | 94.8% (2,478/2,615)         | Performance is close to target due to improved systems for CPT access at TB care points. CPT is being dispensed at TB care points.                                                                                                                   |
| Percentage of HIV-positive new and relapsed registered TB cases on ART during TB treatment | 80% (954/1,193)     | 77.8% (477/613)  | 82.3% (561/682) | 83% (566/682)   | 86.5% (552/638) | 82.4% (2,156/2,615)         | Performance surpassed the target due to improved collaboration and networking between TB and HIV care points as well as establishment of TB/HIV one-stop shop services for 6 (Mbale, Kabale, Hoima, Arua, Fort Portal and Lira) hospitals.           |
| TB Treatment Success Rate (for new sputum smear-positive TB cases)                         | 85%                 | 72.74% (347/477) | 69.7% (395/567) | 70.1% (345/492) | 72% (375/521)   | 71.1% (1,462/2,057)         | Target not achieved due to limited systems for tracking self-transfers from regional referral hospitals to lower health facilities hence high lost to follow and high death rate from sicker patients referred for management at referral hospitals. |
| <b>DRUG-RESISTANT TB</b>                                                                   |                     |                  |                 |                 |                 |                             |                                                                                                                                                                                                                                                      |
| Number of patients detected with DR-TB                                                     | 60                  | 35               | 42              | 46              | 52              | 175/60 (292%)               | Over achievement is attributed to Rifampicin Resistant cases detected from samples of presumptive MDR cases referred from peripheral health facilities to the RRH for Gene Xpert testing                                                             |
| Proportion of DR-TB patients started on category IV TB treatment                           | 100%                | 88% (16/18)      | 77.7% (14/18)   | 91.2% (31/34)   | 97.3% (36/37)   | 91% (97/107)                | Target was not met due to facilities that experienced stock outs of MDR TB drugs during the various QTR's while other patients were still being prepared for initiation by reporting time                                                            |

| Performance Indicators                                                                                | Target                     | Q1                           | Q2                         | Q3                           | Q4                           | % of Annual Target Achieved  | Comments                                                                                                                                                                                                                                                                                                                                                                                                                 |
|-------------------------------------------------------------------------------------------------------|----------------------------|------------------------------|----------------------------|------------------------------|------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                       | Oct 2015–Sept 2016         | Oct–Dec 2015                 | Jan–Mar 2016               | Apr–Jun 2016                 | Jul–Sep 2016                 |                              |                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Proportion of MDR-TB patients with negative smear results at 5 or 6 months of DR-TB treatment         | 60%                        | 50%<br>(10/20)               | 80%<br>(12/15)             | 65%<br>(11/17)               | 76.5%<br>(13/17)             | 67.6%<br>(46/68)             | 46 (67.6%) patients culture converted, 7.4% (5/68) had unknown cultures (results were not ready by the reporting time), 13 (19.1%) patients died and 3 (4.4%) were lost to follow-up and 1 (1.5%) had not culture converted by reporting period                                                                                                                                                                          |
| Percent of DR-TB patients who had an HIV test recorded in the TB register during the reporting period | 100%                       | 94.4%<br>(17/18)             | 83.3%<br>(15/18)           | 91.2%<br>(31/34)             | 92%<br>(34/37)               | 90.7%<br>(97/107)            | Shortfall in HIV testing due to documentation gaps in Masaka, Arua and Gulu DR-TB treatment sites                                                                                                                                                                                                                                                                                                                        |
| Percent of DR-TB HIV co-infected clients receiving ART                                                | 100%                       | 91.7%<br>(11/12)             | 100%<br>(9/9)              | 94.7%<br>(16/17)             | 71.4%<br>(15/21)             | 86.4%<br>(51/59)             | Suboptimal performance in ART linkage due to co-infected patients still being prepared for ART initiation by the end of the respective reporting periods                                                                                                                                                                                                                                                                 |
| <b>NUTRITION</b>                                                                                      |                            |                              |                            |                              |                              |                              |                                                                                                                                                                                                                                                                                                                                                                                                                          |
| Percentage of People Living with HIV (PLHIV) in care and treatment who were nutritionally assessed    | 80%<br>(58,463/<br>73,078) | 94.5%<br>(53,861/<br>57,013) | 96%<br>(54,465/<br>56,713) | 92.7%<br>(54,523/<br>58,816) | 91.3%<br>(53,868/<br>59,006) | 91.3%<br>(53,868/<br>59,006) | The overall absolute numbers to be assessed target was not achieved but this mainly because the health facilities were not able to achieve the target of 73,078 HIV infected clients in care. However, through the quarterly performance, that target of assessing 80% of clients seen was achieved and this is as a result of nutrition integration at triage, coupled with training of health workers in revised NACS. |

| Performance Indicators                                                                       | Target                     | Q1                         | Q2                       | Q3                       | Q4                       | % of Annual Target Achieved | Comments                                                                                                                                                                                                                                                                                                                                                                                                                    |
|----------------------------------------------------------------------------------------------|----------------------------|----------------------------|--------------------------|--------------------------|--------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                              | Oct 2015– Sept 2016        | Oct–Dec 2015               | Jan–Mar 2016             | Apr–Jun 2016             | Jul–Sep 2016             |                             |                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Percent of HIV-positive clients identified to be acutely malnourished                        | 38%<br>(21,924/<br>58,463) | 2.0%<br>(1,104/<br>53,861) | 2%<br>(1,096/<br>54,465) | 1.5%<br>(797/<br>54,523) | 1.6%<br>(851/<br>53,868) | 6.6%<br>(3,848/<br>58,463)  | The prevalence of malnutrition during FY16 was 6.6% among the HIV clients. This is lower than the target of 38%. The supported health facilities have continued to provide clients with preventive messages on healthy eating during health education and counselling sessions.                                                                                                                                             |
| Proportion of clinically undernourished PLHIV who received therapeutic or supplementary food | 8%<br>(1,754/<br>21,924)   | 67.5%<br>(746/<br>1,104)   | 69.7%<br>(764/<br>1,096) | 87.6%<br>(698/797)       | 78.7%<br>(670/851)       | 13.1%<br>(2,878/<br>21,924) | The target of 8% for identified clients enrolled on RUTF was achieved. The project has built the capacity of health facilities to monitor RUTF consumption and provide timely orders, hence stabilization of stocks. The health facilities have also established systems like nutrition corners and dispensing RUTF in HIV clinic pharmacies. This has enabled majority of HIV malnourished clients to be enrolled on RUTF. |
| <b>ANTI-RETROVIRAL THERAPY (ART)</b>                                                         |                            |                            |                          |                          |                          |                             |                                                                                                                                                                                                                                                                                                                                                                                                                             |
| Number of adults and children newly enrolled on antiretroviral therapy (ART)                 | 15,234                     | 1,652                      | 1,441                    | 1,651                    | 1,819                    | 43.1%<br>(6,563/<br>15,234) | The target was not met mainly due to unrealistically high target, low HIV positive yield despite targeted testing and transfer of clients to lower level facilities.                                                                                                                                                                                                                                                        |

| Performance Indicators                                                                                                    | Target                     | Q1                           | Q2                           | Q3                           | Q4                           | % of Annual Target Achieved  | Comments                                                                                                                                                                                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------------|------------------------------|------------------------------|------------------------------|------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                           | Oct 2015–<br>Sept 2016     | Oct–Dec<br>2015              | Jan–<br>Mar<br>2016          | Apr–Jun<br>2016              | Jul–Sep<br>2016              |                              |                                                                                                                                                                                                                                                                                                                                              |
| Number of adults and children with HIV infection receiving antiretroviral therapy (ART)                                   | 68,190                     | 52,760                       | 52,742                       | 54,798                       | 55,289                       | 81.1%<br>(55,268/<br>68,190) | Target clients on ART was not met because of clients that were lost despite deliberate follow- up, (over 3905/8965 (43.5%) of the clients on ART that were lost to care in this year could not be traced upon follow-up) and lower than previously anticipated identification of HIV positives through HTC by the scale/priority facilities. |
| Percentage of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy | 85%<br>(10,001/<br>11,766) | 86.0%<br>(2,555/<br>2,970)   | 83.4%<br>(2,066/<br>2,477)   | 85.2%<br>(1,847/2,<br>168)   | 86.0%<br>(1,779/<br>2,069)   | 85.3%<br>(8,268/<br>9,691)   | Target met with 8 out of 12 facilities meeting the target of 85% and 2 above 84%. Hoima RRH retained 74% on ART. Hoima RRH was affected by clients lost to care with 74.6% (94/126) of these having no phone contacts for follow up.                                                                                                         |
| Percentage of ART patients with a viral load result documented in the medical record within the past 12 months            | 80%<br>(54,552/<br>68,190) | 42.8%<br>(16,005/<br>37,378) | 45.5%<br>(22,619/<br>49,720) | 44.8%<br>(21,803/<br>48,651) | 67.1%<br>(31,891/<br>47,548) |                              | Target not met due to reagent shortages in Q2 and Q3. Significant gains were made in Q4 with 19,686 tests done as a result of client education to demand for the test, established mechanisms to track clients due for a viral load and ensuring access to the test                                                                          |
| Percent of children aged 0 to 14 years active in HIV care who are on ART                                                  | 95%                        | 99.6%<br>(4,580/<br>4,599)   | 99.6%<br>(4,203/<br>4,220)   | 99.2%<br>(4,397/<br>4,433)   | 99.6%<br>(4,298/4,<br>316)   | 99.6%<br>(4,298/<br>4,316)   | The target for children aged 0 to 14 years was met due to the continued implementation of the new MoH HIV care and treatment guidelines in Q3 of FY 14 and data review mechanisms to ensure prompt ART initiation.                                                                                                                           |
| <b>LABORATORY SERVICES</b>                                                                                                |                            |                              |                              |                              |                              |                              |                                                                                                                                                                                                                                                                                                                                              |

| Performance Indicators                                                                                               | Target             | Q1            | Q2           | Q3            | Q4                      | % of Annual Target Achieved | Comments                                                                                                                                                                                                                                                                                                                                   |
|----------------------------------------------------------------------------------------------------------------------|--------------------|---------------|--------------|---------------|-------------------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                      | Oct 2015–Sept 2016 | Oct–Dec 2015  | Jan–Mar 2016 | Apr–Jun 2016  | Jul–Sep 2016            |                             |                                                                                                                                                                                                                                                                                                                                            |
| Proportion of hospital laboratories that have attained at least “Star 3” under the MOH SLMTA programme               | 18                 | 6% (1/18)     | 33% (6/18)   | 38.9% (7/18)  | 38.9% (7/18)            | 38.9% (7/18)                | These include Mbale (5 Stars), Kabale, (4 stars), Fort portal, Masaka, Kawolo, Lira and Kaabong (3 stars). The deficiencies at the other facilities have been identified and the team is actively engaging the management teams to realize improvement.                                                                                    |
| EQA: Proportion of laboratories enrolled on UKNEQAS CD4 EQA Scheme that submitted acceptable test results            | 100% (17/17)       | 47.1% (8/17)  | 59% (10/17)  | 76.5% (13/17) | 70.6% (12/17)-Panel 297 | 70.6% (12/17)               | Twelve of the 13 laboratories that received CD4 EQA (panel-299) submitted acceptable results. Four enrolled laboratories of Kaabong, Kotido, Mubende and Tokora did not receive panels in time due to panel distribution challenges that we continue to work on.                                                                           |
| <b>SUPPLY CHAIN MANAGEMENT SYSTEMS</b>                                                                               |                    |               |              |               |                         |                             |                                                                                                                                                                                                                                                                                                                                            |
| Percent of hospital credit-line orders submitted to NMS on time as per the NMS delivery schedule                     | 100%               | 95.8% (91/95) | 98% (98/100) | 97.9% (93/95) | 97% (97/100)            | 97% (97/100)                | Jinja RRH faced staffing challenges in quarter 3 thus TB orders were not submitted. Kabale and Mubende RRHs did not submit timely test kits and TB reports respectively in quarter 4 because they were sufficiently stocked. The facilities are continuously being encouraged to submit reports regardless of the prevailing stock status. |
| <b>TRAINING AND MENTORSHIP OF SERVICE PROVIDERS</b>                                                                  |                    |               |              |               |                         |                             |                                                                                                                                                                                                                                                                                                                                            |
| Number of healthcare workers who successfully completed an in-service training programme during the reporting period |                    |               |              |               |                         |                             |                                                                                                                                                                                                                                                                                                                                            |
| Quality Improvement                                                                                                  | 82                 | 0             | 0            | 107           | 0                       |                             | There quite a number of new staffs in some facilities and this led to training more staffs than initially targeted.                                                                                                                                                                                                                        |

| Performance Indicators         | Target              | Q1           | Q2           | Q3           | Q4           | % of Annual Target Achieved | Comments                                                                                                                                                                                                                                                      |
|--------------------------------|---------------------|--------------|--------------|--------------|--------------|-----------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                | Oct 2015– Sept 2016 | Oct–Dec 2015 | Jan–Mar 2016 | Apr–Jun 2016 | Jul–Sep 2016 |                             |                                                                                                                                                                                                                                                               |
| HIV Treatment (ART)-core teams | 240                 | 0            | 69           | 125          |              |                             |                                                                                                                                                                                                                                                               |
| PMTCT-EID (cohort monitoring)  | 180                 | 140          | 0            | 0            | 0            | 77.8% (140/180)             | Some facilities were trained under the pilot training program by MoH                                                                                                                                                                                          |
| Family planning                | 240                 | 0            | 91           | 199          | 0            | 120.8% (290/240)            | Over 25 staffs were at each of the supported hospitals for the training despite the originally planned 20 per facility                                                                                                                                        |
| NACS                           | 240                 | 0            | 0            | 245          | 0            | 102.1% (245/240)            | All sites were trained and target was met                                                                                                                                                                                                                     |
| Adolescent friendly services   | 300                 | 313          | 0            | 0            | 0            | 104.3% (313/300)            | The target was met with some few facilities fielding more staffs than planned.                                                                                                                                                                                |
| VMMC                           | 11                  | 0            | 0            | 0            | 47           | 427.3%                      | 34 staff received training in implementation of pre-SMC tetanus toxoid (TT) vaccination whereas 13 were trained in VMMC service provision in the month of July and August 2016. The TT training had not been previously planned for, but was demanded by MOH. |
| TB-IPT                         | 130                 | 0            | 101          | 65           | 0            | 166                         | Some facilities fielded more staff than previously planned for hence the over achievement of the target.                                                                                                                                                      |
| M&E- revised Open MRS          | 24                  | 0            | 0            | 0            | 33           | 137.5%                      | More staffs were trained in effort to ensure that skills were cascaded even to the records officers instead of just the data officers.                                                                                                                        |

| Performance Indicators                                                                             | Target              | Q1           | Q2           | Q3           | Q4           | % of Annual Target Achieved | Comments                                                                                                                                         |
|----------------------------------------------------------------------------------------------------|---------------------|--------------|--------------|--------------|--------------|-----------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                    | Oct 2015– Sept 2016 | Oct–Dec 2015 | Jan–Mar 2016 | Apr-Jun 2016 | Jul-Sep 2016 |                             |                                                                                                                                                  |
| SMLTA Receptor mentors training                                                                    | 18                  | 18           | 0            | 0            | 0            | 100%                        | A one off training conducted for the year during quarter 1                                                                                       |
| Biosafety/Biosecurity training                                                                     | 36                  | 36           | 0            | 0            | 0            | 100%                        | One off training conducted for the year in quarter 1                                                                                             |
| Laboratory Information Management system(LIS)                                                      | 36                  | 0            | 0            | 0            | 0            | 0%                          | Roll out centrally coordinated by the MoH, currently working on installation and software development and trainings will follow.                 |
| Laboratory SPARS                                                                                   | 36                  | 0            | 0            | 0            | 0            | 0%                          | Centrally coordinated activity by MoH, Training schedules not yet provided to implementing partners                                              |
| SLMTA                                                                                              | 36                  | 36           | 0            | 0            | 38           | 205.6% (74/36)              | Supported the 3rd SLMTA workshop for Cohort 3 enrolled laboratories,16 labs sent 2 representatives each while Mbale and Jinja had 3 participants |
| Internal Laboratory Audit Training                                                                 | 18                  | 0            | 18           | 0            | 0            | 100%                        | One off activity conducted in quarter 2                                                                                                          |
| Refrigeration and Air Conditioning Maintenance Training                                            | 14                  | 0            | 23           | 0            | 0            | 164.2% (23/14)              | One off activity conducted for the year in quarter 2                                                                                             |
| Pediatric TB Management Training                                                                   | All Health Workers  | 0            | 0            | 604          | 0            | 604                         | All targeted health workers were trained.                                                                                                        |
| <b>MOH STEWARDSHIP</b>                                                                             |                     |              |              |              |              |                             |                                                                                                                                                  |
| Number of hospitals with HIV clinics overseen and managed by respective hospital senior management | 12                  | 9            | 9            | 9            | 8            |                             | Kawolo, Moroto, Kabale and Mubende have not been able to fill these position due to the lack of specialists.                                     |

## ANNEX I. UGANDA, MOH, HEALTH SECTOR DEVELOPMENT PLAN, 2015/16-2019/20), P. 41.

### Human Resources

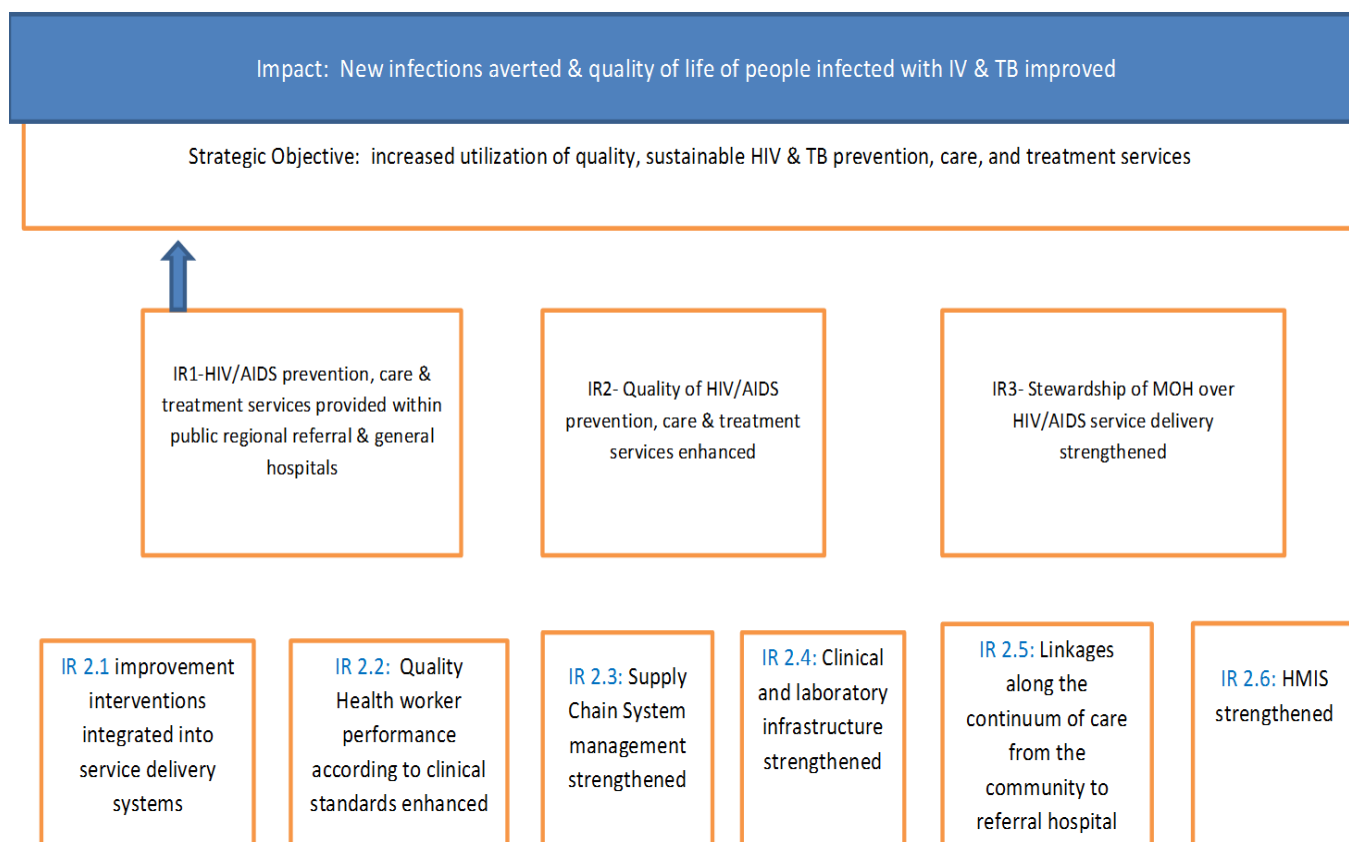
The health workforce is still a key bottleneck for the appropriate provision of health services, with challenges in adequacy of numbers and skills, plus retention, motivation, and performance challenges. Efforts by the GoU and Partners have facilitated recruitment of much-needed staff increasing the proportion of approved posts from 56% in 2010 to 69% in 2013/2014. There is improvement in recruitment of health workers, largely driven by efforts in 2012 to improve staffs at HC III and IVs. There are however variations by district, facility type and by cadres. Only 45% of positions at HC II are filled, as compared to 70% / 71% at HC II and IV respectively...Overall, staffing is skewed in favor of specialized health institutions and larger health facilities (RRH 81%; GH 69%, HC IV 85%, HC III 75% and HC II 49%).

*Table 1 Health Sector Development Plan - Staffing 2015/16*

| Name                           | No. of units | Total approved (Norm) | Positions filled | Vacant        | Filled     | Vacant     |
|--------------------------------|--------------|-----------------------|------------------|---------------|------------|------------|
| Mulago NRH                     | 1            | 2,801                 | 1,880            | 581           | 67%        | 34%        |
| Butabika NRH                   | 1            | 424                   | 359              | 63            | 85%        | 15%        |
| UBTS                           | 1            | 242                   | 215              | 27            | 89%        | 11%        |
| UCI                            | 1            | 213                   | 122              | 91            | 57%        | 43%        |
| UHI                            | 1            | 190                   | 134              | 56            | 71%        | 29%        |
| RRH                            | 14           | 4,744                 | 3,820            | 924           | 81%        | 19%        |
| <b>Sub-Total Central Level</b> | <b>19</b>    | <b>8,272</b>          | <b>6,530</b>     | <b>1,742</b>  | <b>79%</b> | <b>21%</b> |
| Total district staffing        | 111          | 46,851                | 31,357           | 15,494        | 67%        | 43%        |
| Health facilities in KCCA      | 17           | 3,933                 | 2,792            | 1,141         | 71%        | 29%        |
| Municipal Councils             | 22           | 176                   | 111              | 65            | 63%        | 35%        |
| <b>Sub-total LG</b>            | <b>150</b>   | <b>50,960</b>         | <b>34,260</b>    | <b>16,700</b> | <b>67%</b> | <b>33%</b> |
| <b>Total National</b>          | <b>169</b>   | <b>59,232</b>         | <b>40,790</b>    | <b>18,422</b> | <b>69%</b> | <b>31%</b> |

*Source: MoH HRH Biannual Report, April 2015*

## ANNEX J. SUSTAIN'S RESULTS FRAMEWORK



## ANNEX K. WORLD HEALTH ORGANIZATION (WHO) HEALTH SYSTEM BLOCKS

