Health Access Connect

Annual Report 2017

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Letter from the Executive Director

2017 was an eventful and challenging year for Health Access Connect. We received a $50,000 grant from ViiV Healthcare's Positive Action Challenges. That's a real validation of our model! We started expansion activities to reach new villages and health facilities in new districts, but it was slow going. That's a problem! Our vision is to spread mobile outreach clinic services all over Uganda and possibly beyond, but to do that we need to be able to reach new villages quickly. So what was the holdup?!

1. **We were too reliant on community groups.** Community groups were at the center of our model for coordination and oversight of the outreach clinics, but we were running into a variety of problems: groups fell apart, chairpersons were not around, members had disagreements and disbanded, groups were not meeting or discussing anything, and so on. After seeing these problems arise again and again, we decided to just work with community health workers (VHTs) to do the outreach clinic oversight, and this adjustment has made a huge difference!

2. **We were spending too long talking about outreach clinics before starting them.** We spent a lot of time going back and forth to villages to explain and re-explain how the outreach clinics work. Sometimes attendance would be poor. Other times people needed to be reminded. It was kind of like explaining a game over and over again: it is not clear how it works until you see it -- you need to just start and play! Now our Field Officers go into a village just three or four times before outreach clinics begin.

3. **We needed to hire more staff.** For our outreach clinics to expand, our organization must expand. Duh! We need more people going to the villages, going back and forth with health workers, and doing the day-to-day work of making outreach clinics work. We have hired an M&E Officer and an additional Field Officer, and we are planning on hiring at least three new staff in the first months of 2018. Onward!

4. **We need to use our connections to start working in new districts sooner.** One major holdup was getting approval from district government officials. We brought and discussed out MOU, but getting people to sign was not straightforward. Government officials would ask, "Who are you? Where have you worked?" We took for granted that this was an easy, rubber-stamp process, but we needed to explain ourselves better to government officials. After some meetings with our management team and calls with our partners in Kalangala District, officials signed the MOU enthusiastically!

By the end of 2017, we were serving nine villages. By the end of 2018, we hope to be serving 35 villages. We're looking forward to a big year!

Sincerely,
Kevin Gibbons
Executive Director

Organization Overview

Our mission is to link Ugandans living in remote areas with healthcare resources. Through the Medicycles program, HAC has established a model for mobile health clinics in remote villages that uses microfinance medicycles to transport health workers and medical supplies to ensure increased and sustainable access to robust healthcare services. HAC connects difficult to reach villages in Uganda with their healthcare system. Services offered include HIV testing, counseling, ART, maternal and child healthcare, family planning, perinatal treatment and essential health services like vaccinations, malaria testing and deworming to people who would otherwise struggle to reach living saving health services.

The main components broken down are:

1.) Transportation & microfinance
    Micro-financed motorcycle taxis/boats transport medical staff and supplies to remote villages
2.) One-day clinics
    Monthly one-day health outreach clinics in hard to reach underserved villages.
3.) Community oversight and cost sharing

HAC by the Numbers

Choose 4-5 most important stats of 2017

- Average number of patients at each clinic: 54.8
- Number of HAC supported outreach clinics in 2017: 46
- Number of villages served: 10
- Total number of patients served: 3,857 (August 2015-December 2017)

Monitoring and Evaluation Updates

M&E background and how we're growing.

- **Outreach Clinic Reporting Form**: We have a form that serves as the foundation of understanding the data coming from our outreach clinics. We have gotten better about collecting these data and using them to inform our activities.
- **Population Health Survey Conducted**: We built a baseline-midline-endline tool to collect information about the health-seeking behaviors of the communities we serve. It will serve as one of the core M&E activities of the organization.
- **Exit Interviews Conducted**: We have also conducted exit interviews with patients, and their feedback has informed what we focus on.

Partnerships

Partnerships and local counterparting are key parts to the Medicycles program. The overarching goal is to improve the ability of the Ugandan health system to serve its citizens. Thus, collaborating is at the center of all we do. Below we list some of the key roles that are filled by our partners.

Identifying Sites: Ugandan Ministry of Health Officials

Before we begin working in a district, we conduct meetings with the District Health Officer and other key administrators who tell us which communities we should target. These are villages that are over 5 km (3 miles) away from the nearest health facility, have high prevalence rates of HIV, and are difficult for health workers to reach.

Providing Services: Ugandan Ministry of Health

All health workers, medicine, and equipment are provided by the Ugandan government. These are services that are available for free at health facilities.

Paying Transportation Costs of Clinics: Communities

By collecting $0.55 (2,000 Ugandan shillings) from each patient, our partner community groups pay for the overhead to conduct the clinics from month to month ($22-28 per clinic).

Offering Additional Services: Civil Society Partners

Partner NGOs (including Kalangala Forum for People Living with HIV/AIDS Network, Kalangala Comprehensive Public Health Services Project, and Brick by Brick) have helped us to add on additional services, such as teaching groups savings and loan management, counseling patients, and providing emergency medical services.

Assuring Continuity of Care: Health Access Connect

Our major value added is to guarantee monthly service in targeted communities by establishing the clinics and making sure that partners are ready and available every month. When challenges arise, such as low turnout, medicine stockouts, staff shortages, etc., HAC helps to overcome these obstacles and assure continuity of care.

Funding

Grants

- Two grants acquired: In 2017 we won a $50,000 Incubation Prize from Positive Action Challenges and a $2,000 award from the New Life OpenIDEO challenge.

Crowdfunding

- Annual crowdfunding: We have raised around $15,000 to 20,000 per year in 2016 and 2017,
    - Giving Tuesday
        - mostly through our annual fundraiser that starts on Giving Tuesday at the end of November and running through December 31.
    - Grants?

Future Goals

Maternal & Child Health

Research shows that women who are the poorest, the least educated, those living in rural or remote areas, and adolescents encounter the greatest barriers to accessing skilled birth attendance (Wirth et al. 2006, Gwatkin et al. 2007, Ortayli 2010). In Uganda, less than half of mothers deliver at health facilities, and “only 32.4% of pregnant women attend all four recommended antenatal visits” (Musinguzi et al. 2017). 30% of patients seen at HAC clinics are children and 59% are women and girls. Broadly-trained health workers can play a valuable role in these local communities. In 2018 it is one of HAC’s primary goals to incorporate maternal and child health care into the HAC clinic package.

Ambulances For All Program

Goal

To make affordable, accessible, and responsive emergency medical transportation available in the remote communities of Uganda

- We will start with a one-year pilot in Kalangala District
- Scale up to Masaka, Rakai, and other districts that HAC serves as a core component of their service package

The major aim is to get patients to the health facility and help transfer patients between health facilities where necessary.

Health Outcomes

1. To reduce infant and maternal morbidity and mortality rates
2. To reduce morbidity and mortality due to health emergencies.

Program Objectives

1. To set up motorcycle ambulance trailers at health facilities
2. To establish a single phone number that people can call to access emergency health services

3. To establish an emergency protocol for residents of remote areas to access emergency medical transportation, no matter the day or time
4. To train motorcycle taxi drivers on ambulance trailer driving
5. To pilot an emergency medical transportation system that can be integrated into HAC services

Expansion of Medicycles

HAC would like to raise approximately $200,000 per year for the next two years. That would allow HAC to increase its Year 1 impact by 15 motorcycles, and Year 2 impact by 25 additional motorcycles and 4 boats. By the end of Year 2, the total impact would include:

- 40 motorcycles
- 4 boats
- 125 villages served
- 77,000 patients served
- 3,200 people living with HIV/AIDS served with monthly anti-retroviral treatment
- 44 people given small business loans

Projected Impact

These numbers are the projected impact of adding on 40 motorcycles and 5 boats as part of our two-year plan.

- Serve 75 villages with monthly clinics
- 73,500 patients served per year (some of that includes return patients)
- 3,024 people living with HIV/AIDS given regular monthly ART
- 12,096 people tested for HIV per year
- 9,240 people given malaria treatment per year
- 3,000 women given family planning services

Who we are

Staff

- **Carolyne Ariokot**, Programme Director
- **Debra Bellanti**, Development Officer
- **Kevin Gibbons**, Executive Director
- **Bridget Nanyonjo**, Monitoring & Evaluation Officer

Board Members

- **Jan Baskin**, Board Member; Business Enhancement Strategies, LLC
- **Dr Benson Chirwa**, Board Member; Kheth'Impilo
- **Denise Birungi Evans**, Board Member; Hillsborough County Anti-Drug Alliance
- **Chelsea Takamine**, Board of Directors Chairperson; IDEO
- **Ronald Tibiita**, Board Member; Global Health Uganda
- **Bruce Willis**, Board Member; Musgrove Law Firm, P.C.

Pictures

Thank you!

Health Access Connect is thankful to its many supporters and followers! We thank all who believe in our mission of enhancing the capacity of the Ugandan healthcare system to cater to underserved population in rural Uganda. We couldn't do it without your support!

We hope to continue to be worthy of your support and also work to foster new relationships this coming year.