2019

ANNUAL REPORT

Health Access Connect

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Linking remote communities to healthcare

Health Access Connect

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VISION

To set the standard for how to bring sustainable, equitable health services to remote, marginalized communities.

MISSION

To link remote communities to healthcare

CORE VALUES

Do a lot with a little
Sustainability from Day One
Share and collaborate
Give the real story
Root for each other

COMMITMENTS

To the communities we serve…
We commit to partnering with you to improve your health in the long term.
To the health workers we serve…
We commit to partnering with you to develop long-term solutions to serving your patients.
To our donors, investors, and friends…
We commit to being a steward of your investment toward making a better life for marginalized groups.
To our employees…
We commit to helping you to maximize your positive impact on the world.
To our world…
We commit to sharing openly, serving vulnerable communities, and working at the highest levels of integrity.

LETTER FROM THE BOARD CHAIRPERSON

In 2019, Health Access Connect (HAC) continued setting the standard for how to bring sustainable, equitable health services to remote, marginalized communities. For patients who are geographically isolated, poverty and distance to health facilities are more than barriers to accessing healthcare -- they contribute to death and sickness. When vulnerable populations cannot reach established medical facilities and much-needed healthcare, Health Access Connect brings it right to them…on a motorcycle.

I'm proud to share that this has been a year of positive growth for HAC. Among our most significant achievements:

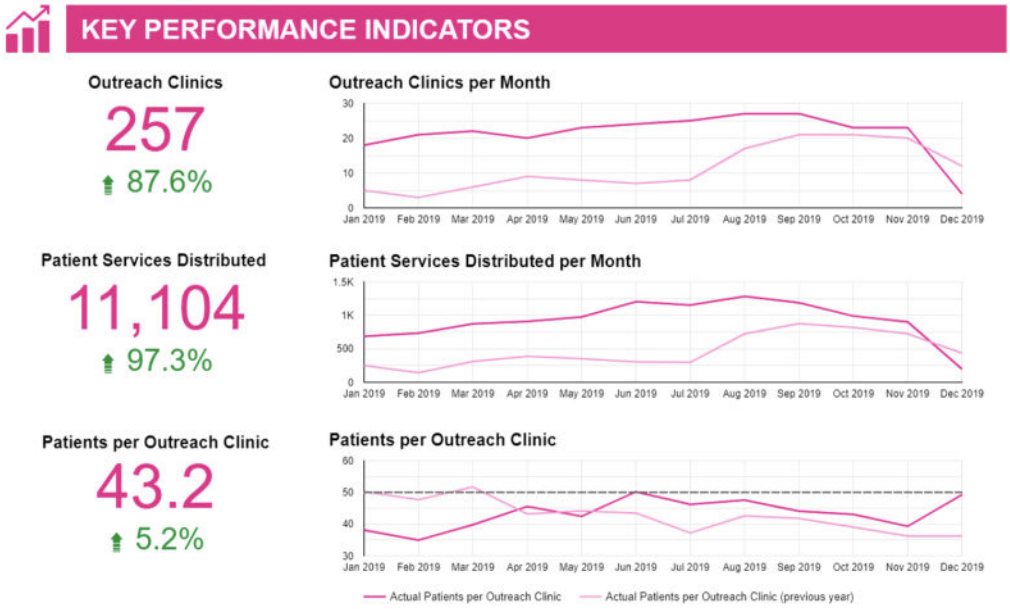
- We solidified our established distribution network, and expanded operations so we now reach more than 43 villages serving 11,000 patients in five districts.
- We have recruited a multinational Board of Directors based on two continents. Its distinguished members represent experience with global health programs, healthcare delivery systems and logistics, organization and partner development, international law, communications, and fundraising.
- Our Kampala-based team is competent to manage both outreach clinics and liaise with local officials, so leadership can focus on future programs and global relationships.
- We established a critical relationship with Africa Resource Centre that elevates HAC into a highly visible role of a respected Technical Advisor.
- We implemented a new financial tracking and management system, supporting our promise to be responsible stewards of the investments our donors make in our work.

Both HAC and our outstanding Executive Director and Founder are increasingly being recognized by government agencies, health officials, and potential partners as a force and a resource. They are now on the radar of key international funding organizations and major foundations. Health Access Connect is more strongly positioned than ever to bring sustainable, equitable health services to remote, marginalized communities, and to make the provision of healthcare more equitable and patient-centered.

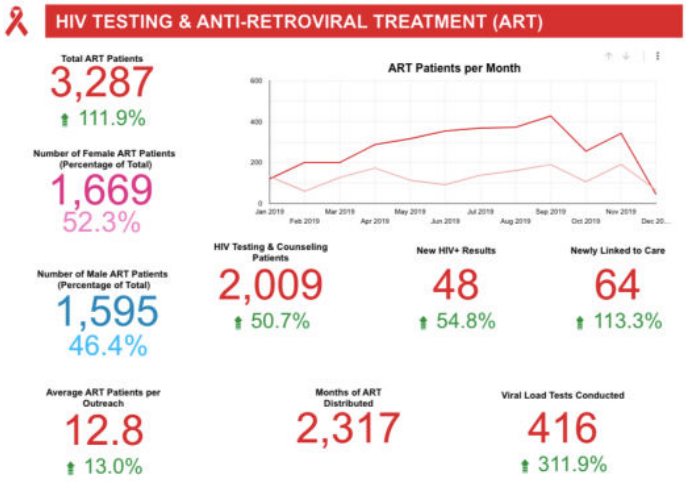
Sincerely,
Jan Baskin
Board Chairperson

Accomplishments

In the past year we strengthened our presence from 25 active sites and now reach 43 remote communities with monthly or bimonthly outreach clinics, helping health workers to provide more than 11,100 service interactions to patients. At each of our outreach clinics communities themselves contribute to pay the costs of the transportation expenses for the health workers.

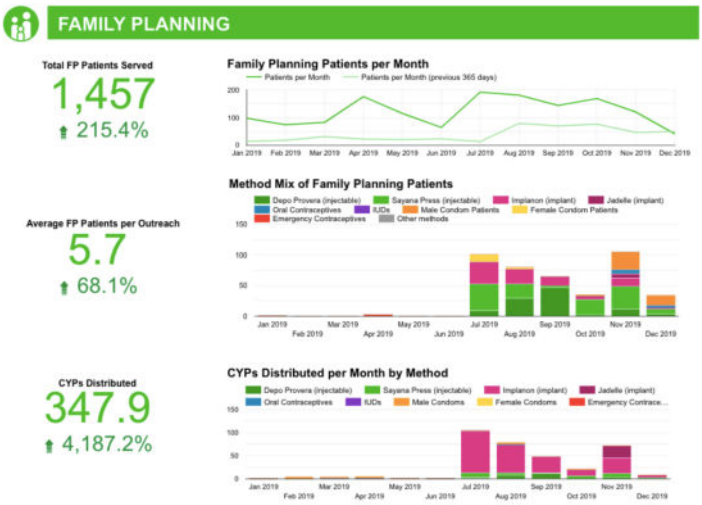


With community support, this model becomes sustainable and means many people have received and can continue to receive healthcare in difficult-to-reach areas. The following images are from our outreach clinic dashboards and they highlight just a few of our accomplishments in 2019. (Please note: service delivery numbers decline in December due to government holidays.)

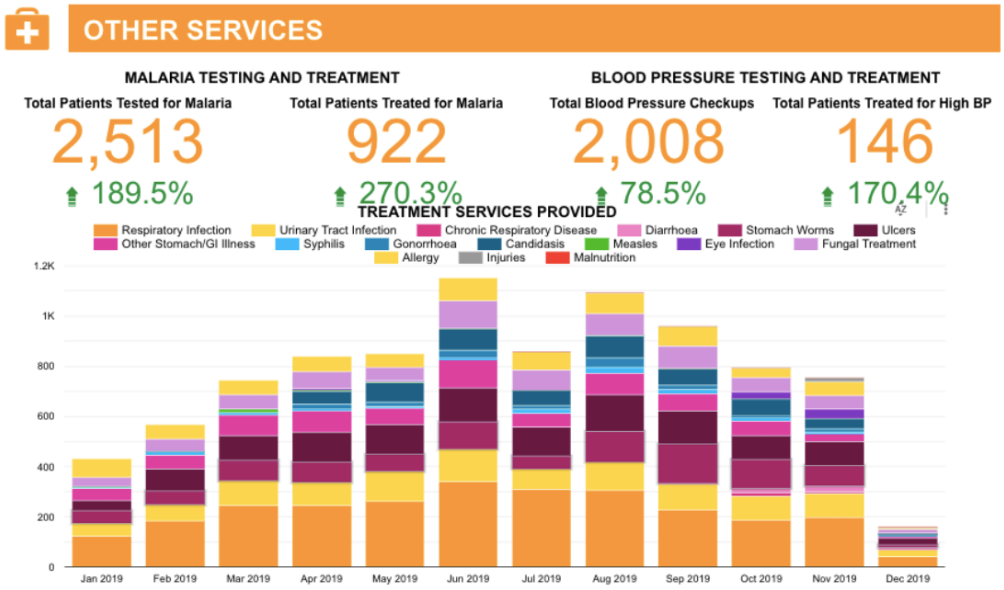


We work in areas with high HIV prevalence. Once diagnosed with HIV, maintaining a treatment regimen is critical. Without medications, patients die. One of the key services we provide is the delivery of antiretroviral treatment (ART) to patients in remote areas where getting to health centers for medication supplies is not their priority. Our ART delivery numbers increased overall and as a percentage of services provided. This is significant, proving that access to ART in remote communities continues to be an important gap that HAC is filling in healthcare delivery.

Based on feedback and requests from patients and an assessment of services deemed most essential in the areas we serve, this year we began a robust program to incorporate family planning services into our outreach clinics. We were awarded a grant from The Erik and Edith Bergstrom Foundation in October to specifically support our family planning services, and will continue to develop these programs and increase our capacity in this area going forward.



Our health worker partners continue to provide a variety of other healthcare interventions in each clinic dictated by the needs of the communities we serve, resulting in a more “integrated care” model that makes HAC unique and effective in meeting multiple demands.



Other accomplishments:

- We received $25,000 from the Conservation, Food and Health Foundation to conduct a program focused on promoting general good health, in addition to the $25,000 awarded by The Erik and Edith Bergstrom Foundation for our Treat & Teach family planning program. These grants are critically important in enabling us to enhance services offered at HAC outreach clinics.
- We have established a collaboration with the prestigious Access-to-Medicines Research Center at KU Leuven in Belgium, known for its international research and training programs in medicine. We anticipate developing research and publications as one product of this relationship.

Failures

Failure is a wonderful teacher, and in 2019 we persevered and learned from it. Here are highlights of some of our disappointments this year:

- **We did not reach our 2019 clinic expansion target of 60 villages.** -Due to staff turnover at the Field Coordinator position, there was a management gap of our Field Officers. We hired a very solid Coordinator in March, and things have steadily improved. -We depend on partnerships and the approval of district and local politicians in each area we target for outreach clinics. But if a District Health Officer is replaced or the political winds shift, it can -- and did -- put an end to outreach clinics that were ready to go. -Funding is foundational to our work. We were disappointed we did not raise sufficient funds to hire needed coordinators, or to purchase motorcycles to support additional clinics.
- **Quality of care/privacy at existing clinics is as important as more clinics.** We want to help as many patients as possible, which previously has meant expansion, expansion, expansion; however, we have realized our clinics must offer a measurable standard of high quality services, even though each is implemented by different health workers with whom we partner in each District.
- **No Ambulances for All program-- for now.** We had planned to add affordable emergency medical transportation to our portfolio of services for remote communities this year, but expected funding never came about. Most grantors and foundations do not want to pay for staff, and we cannot start this program without a project officer. Stay tuned.
- **There were no published reports (nor resulting visibility or credibility) from HAC research projects.** Although we collected data and initiated research projects in 2018 and 2019, we were unable to secure publication in academic journals. Our data collection and analysis depends primarily on staff, interns, and grad students.
- **We raised insufficient funding to support planned scale-up.** Our plans depended on securing an unrestricted annual budget of $100,000; however, our budget for 2019 totalled $55,794..

Lessons Learned

We will continue to learn -- from our partners and colleagues, as well as from our patients. These are some conclusions and new procedures we developed moving forward:

- We will continue to work to extend healthcare delivery services into additional remote areas, but in the short term we will focus **on improving quality of care**.
- We will maintain our streamlined operations and improve where needed, including the addition of a system to **collect > compile > analyze > decide** using digital tools.
- It is imperative that we develop **relationships with researchers and academics to partner with us to conduct research and publish findings**.
- We must **submit more and better targeted grant proposals** to increase our chances of winning awards. Our **fundraising efforts must become a priority** for everyone in the organization, and we must **build our networks of potential donors, and be more systematic about fundraising**.

I love all of our accomplishments, failures, and lessons learned from 2019. I look forward to continuing to accomplish, fail, and learn in the years to come!

Sincerely,
Kevin Gibbons
Executive Director

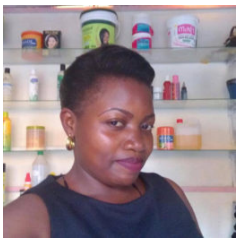
STAFF

Kevin Gibbons

Executive Director, Uganda

Carolyne Ariokot

Program Director, Uganda



Bridget Nanyonjo

Monitoring & Evaluation Officer, Uganda

Winfred Nakaweesi

Family Planning Coordinator & Trainer, Uganda

Costaritah Nalukwago

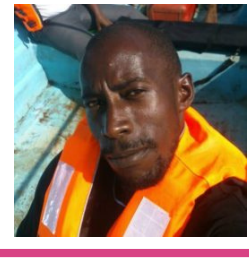
Field Coordinator, Uganda

Anthony Tisasirana

Finance & Administration Officer, Uganda

Ivan Walukhu

Health Promotion Coordinator, Uganda

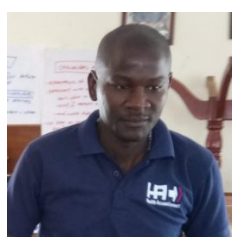


Mark Kayongo

Field Officer, Kalanagala, Uganda

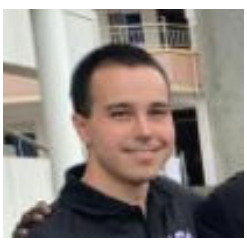
Ann Kugonza

Field Officer, Masaka, Uganda



Pascal Ssekalala

Field Officer, Rakai, Uganda

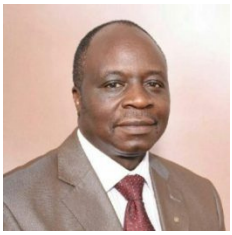


Chris Vakkur

Peace Corps Volunteer, Uganda

BOARD MEMBERS

Jan Baskin
Board Chairperson
Business Enhancement Strategies, LLC, USA



Dr. Benson Chirwa
Board Member
Right to Care, Zambia

Denise Birungi Evans
Board Member
Hillsborough County Anti-Drug Alliance, USA

Dr. Rebecca Kinney
Board Member
Primary Care Physician, USA

Nazeem Mohamed
Board Member
Aga Khan Foundation, Uganda

Allie Kibwika Muyinda
Board Member
Retired Ugandan Ministry of Health, Uganda

Amelia Nicholson
Board Member
Retired nurse, USA

Ronald Tibiita
Board Member
Global Health CITY, Uganda

Bruce Willis, JD
Board Member
Musgrove Law Firm, P.C., USA

OUR DONORS & PARTNERS

Health Access Connect extends its deepest gratitude to our donors. You help us provide basic healthcare services that also help restore dignity and hope to people whose lives are profoundly changed by your generosity. Your donations and the financial support of other individuals, foundations, and governments is what fuels every mile we travel. HAC mobile clinics make it possible for poor and underserved men, women and children to receive basic and preventive healthcare in the remote villages where they live and work -- some for the first time ever.

Your tax-deductible gifts provide services including: antiretroviral therapy, family planning, immunizations, and health screening now in more than 43 remote communities. It is thanks to our donors that we are able to reach more people every few months -- many of whom have lived caught in crisis their entire lives without the benefit of regular, accessible healthcare.

We also are thankful for the support of our grantors and partner organizations. They have supported our human-focused healthcare outreach, and our numbers-focused measurement and evaluation studies, which are essential to securing additional grant support. This year we received outstanding technical support from: Kalangala Comprehensive Public Health Services Project, Brick by Brick, and Kalangala Forum for People Living with HIV/AIDS Network.

We work with local District leaders to identify locations and establish community-supported programs that bring public sector health workers to remote communities (those over 5km from the nearest health facility) for one-day outreach clinics. The clinics provide integrated primary healthcare services like: antiretroviral treatment, antenatal care, immunizations, and family planning. We believe by leveraging existing government healthcare resources and operating in collaboration with local leaders our model is versatile and sustainable. We can adapt to individual community needs, global health priorities, campaigns, technologies, and evolving treatment regimens.

Our model of service implementation is at once simple and unconventional: health workers deliver healthcare directly to communities. HAC currently establishes a regular schedule for monthly, one-day, comprehensive health outreach clinics in 43 remote villages. Three-to-four government health workers and medical equipment (supplies, health information, and medications) are transported on a schedule to these locations. Patients contribute the equivalent of $0.55 (2,000 Ugandan shillings) to defray fuel costs-- significantly less than what they would pay to travel to the nearest health facility. All services offered are free to patients as they are provided by the Ugandan government. After an outreach site is established, health workers return on at least a bi-monthly basis to ensure continuity of care. We are steadily building our reputation in the communities we serve as an organization capable of linking existing healthcare services to even the most remote and vulnerable patients on a sustainable basis.

HAC develops partnerships with groups in these communities to help oversee the clinics -- fee collections, distribution of information, and communicating clinic availability -- so that operations can eventually be fully run by the community itself. Over time, HAC has helped many local communities take ownership of their health and has fully transitioned outreach clinic scheduling and programming to the villages, requiring less direct involvement by HAC.

In Uganda as in other countries around the world, people fail to access health services because of the expense and difficulty of traveling from their homes to the nearest health facility. Eighty-six percent of Ugandans live in rural areas, where only 15-20 percent of the country's doctors work, and round-trip transportation to a health facility can cost $2-12. These costs are above the means of the many rural residents who live on less than $2 a day. The model of waiting for patients to reach the health facility is anachronistic. We take healthcare to the patients. We help our partners use existing resources (public sector health workers, medicine, motorcycle taxis) to meet a pressing need: the lack of access to healthcare in remote areas.

PROGRAMS

HAC's primary programs include:

- **Medicycles**: Uses community contributions and micro-financed motorcycle taxis to deliver health workers and supplies for monthly or bimonthly integrated outreach clinics in remote areas.
- **Treat & Teach**: Improves access to family planning services by:
  - Providing low density, high frequency training certificates to healthcare workers;
  - Integrating family planning services into outreach clinics; and,
  - Providing family planning commodities to health facilities to reduce stockouts.
- **Health Promotion**: Improves access to reliable health information by training community health workers (VHTs) about family planning and the prevention of sexually transmitted infections.

Privacy and Quality

At each of our outreach sites, we form strong relationships with community health workers who facilitate delivery of care at outreach clinics. As a result, we quickly address any issues with privacy and quality, and this year we incorporated the results and reports from our new M&E framework. Patients' rights to privacy and quality care are rights that we uphold as an organization. Our service model is based on providing indoor space with privacy curtains for patient interactions in the majority of our clinics, and continuing to be responsive to patient needs and concerns.

Expansion

Despite unforeseen setbacks, Health Access Connect did become active in the provision of care to isolated patients in a new district, Lwengo District. HAC added 20 villages to its list of outreach clinic sites throughout Kalangala, Masaka, Rakai and Lwengo Districts this year, bringing to 43 the total number of villages now provided with health services by HAC.

Stakeholders' Meetings

We planned and managed three stakeholder meetings for the districts of Masaka, Rakai and Kalangala, which were attended by partner health workers, district officials, community health workers, community leaders and HAC staff. This is a major initiative for building relationships, as well as getting feedback. We also get buy-in from stakeholders by involving them in our future planning. Their suggestions and ideas are always useful and appreciated.

Regional Global Health Practitioners Conference 2019

We were invited to attend and present the HAC healthcare delivery model at a Regional Global Health Practitioners conference in Nairobi, Kenya. In addition to other key health officials, Professor Miriam Khamadi Were, known as the African Mother of Public Health, was a special guest. She told HAC staff she “greatly appreciated the HAC model”. In addition to other regional presentations, we participated in a forum offering solutions to community health challenges. HAC was named one of the Finalists for its concept of “sustainability.”

Monitoring and Evaluation

This year saw our organization take major strides to strengthen its Monitoring and Evaluation (M&E) processes. This will enable more accurate and complete tracking of service provision, campaign coverage, and unmet needs which can be addressed in the years to come.Through our partnership with researchers at KU Leuven, next year we plan to generate essential data around our Key Performance Indicators with specific health outcomes in our communities (including numbers of new HIV+ patients identified, ART clients served, patients tested and treated for schistosomiasis, or children vaccinated) and other relevant data (such as commodity stock-outs or patient feedback scores). We currently show percent contribution of outreach clinics to HIV testing (currently 11% of new HIV+ patients identified in some areas) and ART distribution numbers (currently 19% of clients reached in some areas) based on CDC and Ministry of Health data sets combined with our service data. In 2020, we will focus on building out those data-sets and running additional comparison analyses of percent contributions, cost effectiveness, and service coverage.

More than most other global health nonprofit organizations, the core healthcare delivery and clinic outreach we do is funded primarily by our individual donors. We thank all our donors for their support of our mission to link remote communities to healthcare. We appreciate that all of our donors trust Health Access Connect to be a responsible steward of their investments in our ongoing work.

Year	Outreach Clinics	Villages	Patient Services Provided	Expenses	Cost per Patient Service
2015	9	3	458	$1,839	$4.02
2016	20	6	1,073	$2,952	$2.75
2017	59	9	2,765	$19,533	$7.06
2018	137	25	5,629	$34,720	$6.17
2019	235	43	11,104	$55,794	$5.02

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NEW COMMUNITIES

Health Access Connect extended healthcare to 43 communities in 2019

97%

INCREASE IN PATIENT SERVICES PROVIDED

Health Access Connect provided 11,104 patient services in 2019

In 2019, our donors, foundations, and partners enabled Health Access Connect to extend healthcare to 43 communities (18 new), providing more than 11,100 patient interactions and services to mothers and fathers, children, aunties, grandmothers and others who continue to contribute to their communities' unique histories. With ongoing support for Health Access Connect, people in additional villages, whose fragile lives and livelihoods are one health crisis away from disaster, will be able to stay on their life-saving medications, get preventative care, and receive the treatments they need to live healthier lives.