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Sida Decentralised Evaluation

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Evaluation of Health Guarantee to Centenary Rural Development Bank in Uganda

Final Report

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September 2018**

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The views and interpretations expressed in this report are the authors' and do not necessarily reflect those of the Swedish International Development Cooperation Agency, Sida.

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Abbreviations and Acronyms

ABI	Agri-Business Initiative
ASSIST	Applying Science to Strengthen and Improve Systems
CMS	Credit Monitoring System
COBE	Census of Business Establishments
CRDB	Centenary Rural Development Bank
HMIS	Health Management Information System
MBChB	Medicine and Bachelor of Surgery
MOH	Ministry of Health
NDP	National Development Plan
PFP	Private-For-Profit
PHC	Primary Health Care
PNFP	Private Not-For-Profit
PPPH	Public Private Partnership for Health
SRHS	Sexual and Reproductive Health Services
TOC	Theory of Change
UMDPC	Uganda Medical and Dental Practitioners Council
UPHS	Uganda Private Health Support program
WHO	World Health organization

Preface

This assignment was contracted by the Swedish International Development Cooperation Agency (Sida) through the Framework Agreement for Evaluation Services, and conducted by the consortium led by FCG Sweden (formerly FCG SIPU International), with partners Itad and Sthlm Policy Group. FCG Sweden led this assignment.

The team that conducted the assignment consisted of the team leader, Ananda S. Millard, PhD, and team members Ulrika Enemark PhD (Health Economist) and Basil Kandyomunda (Ugandan consultant). The report was quality-assured internally and the project manager was Karin Nordlöf in the Evaluation Unit at FCG Sweden.

The findings of the report are entirely the responsibility of the team and cannot be taken as expression of official Sida policies or viewpoints.

The team would like to thank stakeholders at the Centenary Rural Development Bank (CRDB), Sida, and the Swedish Embassy in Uganda and USAID for constructive and useful cooperation throughout the evaluation process. In addition, the team would also like to thank loan recipients and patients who kindly agreed to share their experiences and perspectives with us.

Executive Summary

This evaluation examined the Health Guarantee to Centenary Rural Development Bank (CRDB) in Uganda co-funded by Sida and USAID (2012-2019) with a focus on the 2012 to present time-period. The principal objective of the evaluation has been to determine the degree to which the ***guarantees/services provided under the loans contributed to improved access to health for poor people, and if so how, or why not.***

In addition, the degree to which this project has been able to foster and nurture the private health sector and will enable the CRDB to develop products, in the future, that are able to continue to promote the development of the private sector have also been explored. In pursuit of this objective, this evaluation examined the achievements recorded thus far, following four of the five OECD/DAC standard criteria; relevance, efficiency, effectiveness and impact. Furthermore, based on the project experience and achievements, lessons learned have been identified as a platform from which actionable recommendations that can inform future activities by Sida have been drawn.

The assignment was conducted between March and June 2018, by a core team of three evaluators, and included 3+ person weeks of field data collection. During this time, staff at CRDB centrally as well as branches, loan beneficiaries (owners of facilities and staff), and users of health care services and representatives from national authorities were interviewed. Of the 127 loans disbursed, loan officers and borrowers associated with 51 loans were interviewed

It is important to underscore, that this assignment focused on exploring the degree to which the objectives met were aligned with Sida's strategic objectives for Uganda. Therefore, it can be expected that, at least some of the objectives as understood by USAID have been met, while at the same time not met when examined from the Swedish/Sida perspective.

The project experience has generated a number of positive and less positive results. These are noted in reference to the three main objectives that Sida pursued.

a) Have the guarantees increased the bank's ability and interest in lending to (relevant) business owners in health sector?

- i. There is almost no evidence that the loan served to expand the bank's client base. Indeed the majority (if not all) borrowers were CRDB clients prior to the issuing of the loan. However, according to the CRDB, the guarantee has allowed the bank to become better acquainted with the

health sector; and hence may feel more comfortable to lend to health sector business in future.

- ii. Health sector profit margins are simply incompatible with interest rates imposed by the bank. The profit margins secured by health care business as they are currently managed are not sufficiently high to be able to ensure loan repayment and simultaneously ensure a thriving business.
- iii. The evidence suggests that in the majority of cases the guarantee was not used to reduce collateral. 95 of 122 of borrowers were able to provide collateral equal or higher than 100% of the loan received.
- iv. The default rate for the loans (1-2%) was much lower than what the bank has experienced in other sectors. This has meant that the actual level of risk has been lower than initially expected.
- v. Despite the low default rates, and partly due to the high demand for loans from other sectors, there appears to be little interest by the bank to target health sector would be borrowers in the future (during the project there were no efforts to specifically target would be clients). Moreover, there is no evidence that the bank will develop a loan product that is better aligned with the demands of the health sector (i.e., lower interest rates that may allow for workable profit margins).
- vi. Technical assistance was provided to some loan officers and some borrowers, but the support was not consistently provided to all beneficiaries. Moreover, the support focused on the development and assessment of loan requests rather than on the development of business plans.
- vii. Although the loan guarantee did not focus on women business owners (in 2010 an estimated 44% of business were owned by women in Uganda), 10.2 % of loans were issued to female owned businesses.

b) Have borrowers been able to improve and increase their offer of affordable health services, in particular in rural areas?

- i. The majority of the loans were used to buy equipment or improve health care facilities (infrastructure). Still, the state of some of the facilities visited called into serious question the quality of care given.
- ii. While purchase of equipment has served to make previously unavailable (or less available) services available, in some cases equipment was purchased and is currently not used because the business model developed failed to consider operational costs, including the required permits and taxes.
- iii. Prices for services are strictly tied to what the market can bear. Indeed, there is no indication that the loans have affected, in any way, the costs of services provided.

- iv. 30% of loans were to be issued to “rural” borrowers. However, “rural” was understood to mean anything outside the central region, rather than non-urban areas around the country.
- v. Determining how many rural dwellers have been able to access improved care is difficult based on the available data. Still, it is important to note that while most facilities that received loans are located in urban centres, rural dwellers traditionally travel to urban centres to receive medical care. From this perspective it is likely that at least some rural dwelling patients benefited from the increased/improved facilities/care available as a result of the loan guarantee project.
- vi. The success of the project hinged, at least in part, on the successful development of capacity amongst loan officers and borrowers. While Technical Assistance (TA) support was provided to both, the support did not consistently target all beneficiaries of the loan. The support also appears to have not been based on an in-depth understanding of the capacity development requirements (the length of training appears to have fell short of what was needed to ensure the development of a solid knowledge base).
- vii. There is no evidence that the expansion of care opportunities in the private sector had a negative impact on the public health care sector. Indeed, the public sector representatives noted that they do not lack qualified staff and that an increase in private health care options can lead to a reduction in patient numbers at public facilities. This can in turn serve to improve the care provided to patients who cannot afford private care.

c) Has the target population (rural poor) increased their use of high quality health care facilities?

- i. Access to health care opportunities has generally increased because there are a greater number of facilities that have increased (or improved) care options.
- ii. For the most part health care facility owners feel that their patient numbers have increased, although data to support these claims is not available.
- iii. In one instance patient numbers have reduced because there is a faith based facility (high standard, cheaper) in the region. Pharmacies have also had difficulties to develop lucrative business plans. One of the two visited had been forced to close prior to completing the loan repayment (not defaulted), and the other was struggling.
- iv. Sector over-servicing was only seen in relation to the purchase of ambulances, where it was noted that, at least in one instance, the ambulance was seriously underused because the government had also provided ambulances to the local government hospitals.

- v. The conditions of some facilities, particularly ones away from major urban centres which had surgical facilities, failed to meet basic standards of hygiene. The type of weaknesses witnessed suggested a lack of knowledge base, and also serve to highlight government weaknesses in monitoring the quality of facilities.
- vi. Overall the project model is promising. The health care sector in Uganda remains limited, given demand, and is principal reliance on private facilities means that supporting these is an important step forward towards achieving quality health care access for all, including the poorest. However, the way in which the project was implemented in Uganda requires some revisions in order to ensure that it meets Sida's health and private sector strategic objectives.

Recommendations:

- An examination into the premises imbedded into the Theory of Change (ToC) demonstrates that the use of guarantees requires a more nuanced understanding of the interest of the bank, the private sector in the country where it is implemented, the sector where it is applied and the effort required to transform assumptions into realities. In Uganda, the support to private health care clinics can go a long way into supporting the provision of care of the poor. However, the poorest will most often rely on public service (unless referred to a private clinic) therefore this model is not likely to directly reach the poorest. Although it may reach the rural populations. The support for private sector does not necessarily mean that the private sector will thrive. It is therefore important to understand the sector more carefully and study the returns, business development opportunities etc.

Given this, Sida should not engage in bank guarantees without conducting thorough analysis of both the sector specific needs and the financial/business sector. Ensuring a solid understanding of both is essential to ensure that this type of product (guarantee) is compatible with all key elements required to succeed. In the case of Uganda this meant having loans with affordable terms; ensuring borrowers had viable business plans; ensuring that care was of high quality and recognizing that the direct beneficiaries would not be the poorest amongst the poor.

- This experience showed that in many instances the technical assistance support required by borrowers and loan officers was not made available to them, with a

consequence that investments were at times not well conceived, nor accompanied with sufficient technical knowledge. Since Sida was not engaged in the provision of technical assistance it had little influence on how it was delivered and to whom. The evaluation showed that solid technical assistance is both required and needs to be more robust than what was made available to borrowers under the Health Guarantee.¹

Consequently, ***Sida should not engage in guarantee projects when not engaged in the provision and, or design of the technical assistance package. Ensuring a clear role in both is essential to ensuring that Sida's strategic objectives are met. Providing technical assistance will increase costs, but will also ensure that Sida's overall objectives are better addressed.***²

- ***Technical support should specifically target loan beneficiaries.*** While general activities may also include other beneficiaries, it is highly important that borrowers receive targeted support.
- ***Technical support packages should be developed as a response to borrower and lender knowledge base.*** This means that in some cases the level of support will be extensive, while in others less so. For example, in Uganda business plan development is very weak. It is not reasonable, therefore, to assume, that the complexities of developing reliable business models can be achieved through a one-time short workshop.
- ***Technical support should also serve to ensure that data, both financial and patient care, is more rigorously recorded and used.***
- ***Technical support may also support loan officers to better assess the reliability of business plans,*** and not solely focus on repayment potential based on alternative sources of income.

¹ The evaluation team does not question the relevance, quality and extent of the private health sector technical support provided under the various USAID projects, since this was not the focus of this assignment. This evaluation does question, however, the seemingly tenuous link to the borrowers under the Health Guarantee.

² It is understood that this was one of the first guarantee that Sida engaged in. Since guarantees elsewhere have been less reliant on partners such as USAID.

- Ensuring the quality of care is an important element and a key objective for Sida. The experience gained through the health guarantee project shows that in Uganda donors cannot assume that the government is meeting its basic obligations in terms of ensuring quality care. The process to licence, regulate and monitor health care provision appears very weak. Therefore any effort to further support the sector must be accompanied by efforts to increase or assure quality of care. This could be done by supporting the government offices responsible for oversight and or by working with facilities directly. The information collected during the evaluation suggests that the challenge is twofold. On the one hand monitoring is weak; and on the other knowledge of basic demands (hygiene, for example) appears limited.

Therefore it may be necessary for *Sida to consider a two pronged approach to supporting quality: a) support for licencing, monitoring and oversight; b) support to borrowers to increase their own capacities to improve quality of care.*

- Ensuring that the partnering bank capitalizes on this experience, and moves forward to develop a product that is in keeping with the spirit of the intervention, also requires specific attention. It cannot be presumed that the bank will utilise key resources to develop new products, particularly for a market that is relatively limited in size. Therefore, Sida has two options:
 - *Sida can choose to not engage in loan schemes in cases where the bank does not show a clear interest in developing a product for a specific sector*, which would require a number of criteria be met, for example that the sector is large enough to warrant the bank's investment; and that the bank is able to use an interest rate and collateral demand that is aligned with the sectors specific growth expectations.
 - *Sida can engage directly or through engagement of a delegated cooperation partner with the bank to develop an adequate loan product.* This engagement should serve to ensure that the loans provided are well aligned with the business/subject area. The loans must allow the bank to make a profit, but must also serve to ensure that they are not solely serving the interest of the bank, but rather that they also allow the borrower to develop a thriving business. *Not doing this will stunt rather than develop the private sector.*

- **Future loan guarantee schemes must be grounded in an in-depth understanding of the sector to which the loan is being provided, and thus be developed to ensure profitability for the bank and ability to support private sector development.** On the one hand it is important that the bank profits in order to make it attractive to the bank to issue loans; on the other hand it is equally important that the conditions of the loans are carefully studied to make sure that these are aligned with the sector to which they are being issued. Investing in a better understanding of the sector, such as sector profit margins, repayment abilities, bank interest rate expectations and collateral will allow for the development of loan packages that are able to support the growth of the private sector and are interesting to the bank.

Doing this would serve to ensure that a revised loan package after the guarantee project ends is elaborated by the bank. Overall, this would mean that the development of a health sector loan product which takes into account sector specific characteristics could be developed. This would require an examination into how the bank would react to lower profits, given a more secure sector, and could also explore if more clients would be drawn to a more realistic (given the market) loan product.

- **There is no reason to indicate that providing health guarantees to the health sector is not a viable way to respond to the needs for improving patient care in Uganda or elsewhere. However, for the approach to achieve its objectives in Uganda, key changes would have to be made to the loan product.** The health care sector in Uganda does not allow for high profit margins. Therefore, the bank must be able to reduce interest rates against the lower risk and/or be in a position to allow longer repayment periods in order to make the loan a viable mechanism to promote development of the sector. It is possible that the bank has thus far underestimated the potential of the health sector in Uganda. Perhaps a better understanding of the magnitude of potential borrowers would serve as an incentive to develop alternative products. As it stands, and given the current loan conditions, the guarantee project does not appear to have been the best possible way to promote either health care or private sector development. Instead a micro credit option might be more aligned with local needs. This is particularly since larger private hospitals have existing relationships with the bank and are able to borrow even without a guarantee.

1 Introduction

The Swedish Embassy in Kampala commissioned this evaluation to examine the Health Guarantee to Centenary Rural Development Bank (CRDB) in Uganda (2012-2019), a project supported by Sida, in partnership with USAID. As is detailed further below, this assignment has both summative and formative objectives, and is multi-thematic. Specifically, this document aims to inform both the health, as well as the loans and guarantees officers at Sida and at the Embassy respectively. The assignment may also serve to inform other key stakeholders such as the Development Credit Authority (DCA) of USAID. While the focus is on the experience in Uganda the evaluation highlights issues which may be relevant to other contexts.

1.1 EVALUATION OBJECT AND SCOPE

The project under evaluation is anchored on the Swedish strategy for development cooperation with Uganda 2009-2013 and thus, the assignment broadly explores the degree to which the intervention has fit into promoted key strategic objectives. Specifically, focusing on the support for:

- Improved access by poor people to health services and a reduction in the spread of HIV/AIDS.
- Improved business and investment climate, a key objective part of an overarching effort to support private sector development. The strategy further highlights the importance of focusing on small and medium sized business and on female entrepreneurs.

Both health and private sector development are highlighted in Uganda's the National Development Plan (NDP) for 2009-2014 and 2015-2020 respectively, which makes Swedish priorities well aligned with national priorities and overarching objectives. More specifically, the objective of this assignment has been to determine to what extent the ***loans provided under the guarantees/services contributed to improved access to health for poor people, and if so how or why not.*** As well as the degree to which this project intervention model ***can/has supported the development of the private sector in Uganda.***

In pursuit of the above-mentioned overarching objectives, this assignment has first examined the achievements recorded thus far (i.e. results, in terms of activities, outputs and outcomes) following four of the five OECD/DAC standard criteria: relevance, efficiency, effectiveness and impact. Secondly, evidence-based lessons learned have been identified and translated into clear recommendations. The overall purpose of this assignment has been to provide for an improved understanding of the

causal-effect relationship between pursued results and investments made to enable an evidence-based discussion, amongst relevant stakeholders, on the best ways forward. This evaluation covers the time period between 2012, when the Health Sector Guarantee in cooperation with USAID project in Uganda started, and the present. The project life cycle is due to end in 2019.

1.2 KEY KONTEXTUAL FACTORS

The launching of the Health Guarantee project was preceded by the conduct of an appraisal which highlighted that the majority of health care service providers in Uganda are private enterprises. Specifically, the appraisal noted that out of four shillings spent on health care, three are used to pay for private services. Moreover, the World Health Organization (WHO), according to the health systems performance index, ranked Uganda 149 of 190 countries, placing the country squarely amongst countries with sub-standard medical care programmes.³

Furthermore, according to the WHO's African Health Observatory, the health status of Ugandans is poor, and exhibits both a low life expectancy and a high mortality rate. Both economic and social developments are undermined by these trends.⁴ In the field of finance, loans to the private sector in Uganda have been steadily increasing over the last 10 years, with current figures equating to six times the levels experienced 10 years ago (from 2000 billion to 12000 billion Ugandan Shillings).⁵ Current loan interest rates in Uganda range between 9-23% and inflation is calculated as under 6%.⁶ The clear need to improve the provision of care coupled with the high proportion of private health care facilities, and increase in private business borrowing (suggesting the general population has gained a greater degree of comfort with borrowing from the bank generally) suggested that at the outset this project was both relevant and well aligned to the local context.

³ See <http://thepatientfactor.com/canadian-health-care-information/world-health-organizations-ranking-of-the-worlds-health-systems/>

⁴ http://www.aho.afro.who.int/profiles_information/index.php/Uganda

⁵ <https://tradingeconomics.com/uganda/loans-to-private-sector>

⁶ <https://tradingeconomics.com/uganda/inflation-cpi>

1.3 EVALUATION QUESTIONS

This evaluation pursued 25 specific questions falling within four OECD DAC criteria: relevance, efficiency, effectiveness and Impact, 16 of which were identified in the Terms of Reference (ToR) (See Annex 1) and a further 9 which were included by the evaluation team at the time of the proposal. All questions are detailed in the Evaluation Matrix (See Annex 2).

The questions themselves focus on the following themes:

- Links between project activities and Swedish strategic goals for Uganda.
- Beneficiaries of health facilities, and specifically poor people living in remote areas, and the link between the loan facility and this sub set of beneficiaries. Specifically, disaggregation of demographic data by results.
- The relationship between projects costs and project outcomes.
- Relationship between the loan guarantee, the development of the health sector, and more broadly the promotion of the private health sector.

Overall the questions focused exclusively on their link to Sida's strategic goals and used Sida's definition/understanding of key concepts, such as urban vs. rural. This is an important clarification because the project was jointly funded by USAID, with USAID serving as the lead agency. In turn this means that in some instances findings which are relevant and accurate for Sida, may not be an accurate reflection for USAID.

Although the focus has been on Sida's vision for the project, activities by USAID have been examined, specifically the provision of Technical Assistance (TA), as this element is understood as integral to the project model. When examining the results of the TA, the evaluators examined the activities undertaken through Sida's strategic lenses rather than in relation to specific terms of reference and plans that may have been used by USAID.

While this report responds to all questions highlighted in the Evaluation matrix (Annex 2), some complexities that have affected the data collection and analysis, and thereby how the questions have been responded to, are worth highlighting here:

First, there are multiple types of beneficiaries:

- a) the Bank as the guarantee enables it, at the very least, limits their risk and hence allows the bank to be more prolific with its loans (i.e. the guarantee);
- b) the loan recipients who are able to develop their business, increase their access to the market and turn over, and hopefully improve their own incomes in the process;
- c) the health care services beneficiaries who can have access to improved health care as a result of the intervention;

- d) the general population which benefits from a more dynamic private sector resulting from the success of the local health care businesses.

The collection of beneficiaries mentioned, makes ascertaining the impact of the intervention difficult, not least because while some areas can be more easily assessed (i.e., level of risk for the bank); others, such as degree to which this business sector has contributed to a more dynamic private sector more generally are harder to establish. Still an effort has been made to explore the intervention from the view of the different beneficiary groups.

Second, the focus on Sida's goals and objectives: this evaluation examines a project that was partially funded by USAID, and where the TA was funded exclusively by USAID, not Sida. However, the evaluation itself focuses exclusively on how the intervention has met Swedish goals and objectives. The evaluation team is not in a position to assess or comment on the degree to which the intervention has met USAID goals.

2 Methodology

2.1 OVERALL APPROACH

The evaluation was anchored on three complementary approaches: **Utilization Focused Evaluation (UFE)**,⁷ **Equity Focused Evaluation (EFE)**⁸ and **Theory Based Evaluation (TBE)**.

UFE is concerned with ensuring quality of evaluations by incorporating the active participation of key stakeholders in the evaluation process. Including a full UFE would be too time-consuming and cumbersome for this type of evaluation. Therefore we identified specific steps during which active engagement was sought after:

- 1) **Inception phase:** the inception report was discussed with the Swedish Embassy and other stakeholders that the Embassy found appropriate, mainly USAID. This allowed us to ensure that the elements presented herein convey a common understanding of the assignment.
- 2) **During the data collection:** a participatory approach to data collection, and integrating preliminary analysis into the data collection process, was used and enabled participants to understand what the information they shared was to be used for, how it was understood, and how it was expected it would influence the end results. While the evaluation team may not agree with the conclusions and analysis results identified by respondents, the process was a valuable and empowering exercise that included a clear and real time feedback loop. Importantly how the objectives of the assignment were discussed with different beneficiary groups varied. An effort to not mention the terms of the guarantees and the way that part of the loan functions was successfully made. It was noted that most respondents were familiar with USAID engagement, but not with Sida's.
- 3) **Preliminary review of findings:** The data collection was conducted in an iterative manner which allowed for the whole team to share preliminary

⁷ Patton, Michael Quinn (2008), Utilization-Focused Evaluation (4th ed.). Sage.

⁸ http://mymande.org/human_rights_front?q=defining_equity_focused_evaluations

findings with the Embassy before finalising data collection with respondents in Kampala. This allowed for the use of the debrief as a way to identify and discuss any information gap with the Embassy and relevant stakeholders. The observations collected during the debrief enriched the assessment process and served to ensure that the evaluation benefited from all parties, not as passive respondents, but as active and knowledgeable counterparts to the evaluation process.

- 4) **Draft synthesis report:** Both Sida and the Embassy were invited to comment on the draft document, and thereby had a final opportunity to participate in the evaluation process prior to the final submission of the report. The Embassy and Sida, as our clients, were at liberty to decide who the draft report should be shared with. The draft was shared with USAID. Sida, the Embassy and USAID provided comments on the draft, which have been incorporated into this version of the document.

2.2 INSTRUMENTS FOR DATA COLLECTION AND LIMITATIONS

The team used three main data sources. **First, the systematic review of existing data.** This included **project documents** (See annex 2). In addition to gaining familiarity with the intervention itself through the review of project documents, **quantitative data** was used as a key element to support claims made. Specifically, data on loan provision, distribution between different types of enterprises including markers speaking to the purpose, location and target population as well as county population data from Uganda Bureau of Statistics, health infrastructure data and health management information system (HMIS) data from the Ministry of Health. Lastly, considerable original **qualitative data** was collected through case histories and semi structured interviews. Respondents included, Sida, USAID, and CRDB staff. At CRDB both headquarters and loan officers were interviewed. Borrowers and –when it was possible– patients were also interviewed. One focus group with patients was conducted.

The following main limitations to the data collection were encountered:

- In some instances, the bank failed to contact borrowers or loan officers and hence would-be respondents were either not informed or unavailable when the evaluation team arrived to meet with them. Efforts to remedy this problem were made by the evaluation team, by confirming appointments ahead of time. However, in some cases, contact information was wrong to begin with, hence efforts were futile. This meant that some of the targeted respondents were not reached. Still, given the response pattern and the number of interviewees,

there is no reason to believe that the missed respondents would have changed the outcome of the evaluation.

- Reaching patients was problematic. It was originally expected that the evaluation team would be able to discuss with patients on a regular basis at a large number of facilities. The expectation was that the patient base at any one facility would allow for the conduct of focus group discussions with patient numbers ranging in the 10-15. However, only one focus group was possible because on visiting locations the following challenges were encountered:
 - 1) About half of the facilities had very few (1 or 2) patients present at the time of the visit. The other half had no patients (or clients) when the facility was visited. Only larger hospitals (2 visited) had multiple patients (a focus group was conducted in one). In some cases, patients were wary of the evaluation team and this too limited access.
 - 2) Patients who were hospitalized or severely sick could not be asked to engage in a focus group or interviews. Indeed, care was taken to ensure that the interview in no way interfered with the care patients were receiving or due to receive (time spent) and that patients were not interviewed when their levels of physical discomfort prevented them from doing so comfortably (i.e., patients that were in pain).
 - 3) In the case of pharmacies one of the pharmacies had been closed and the other had no clients during the visit despite the evaluation team spending some time at the premises. This could have very well been due to low stock and to it being located across the street from a much larger pharmacy.
 - 4) In view of this, an effort was made to fill the potential data gaps in the following two ways:
 - a) Individual interviews were conducted with patients who were waiting for or had just received care, were in condition to speak with the evaluation team, and willing to do so.
 - b) An extensive set of questions on patients (demographics, changes in care needs, patterns of care, access to other facilities, reasons they chose the facility or not) were included consistently in all interviews with owners and administrators of health facilities. The response patterns to these questions were very uniform. In some cases, bank officers also had knowledge of facilities in the area and hence they too were asked questions about access to health care (as clients). In addition, spot check type data was collected through short and unplanned interviews

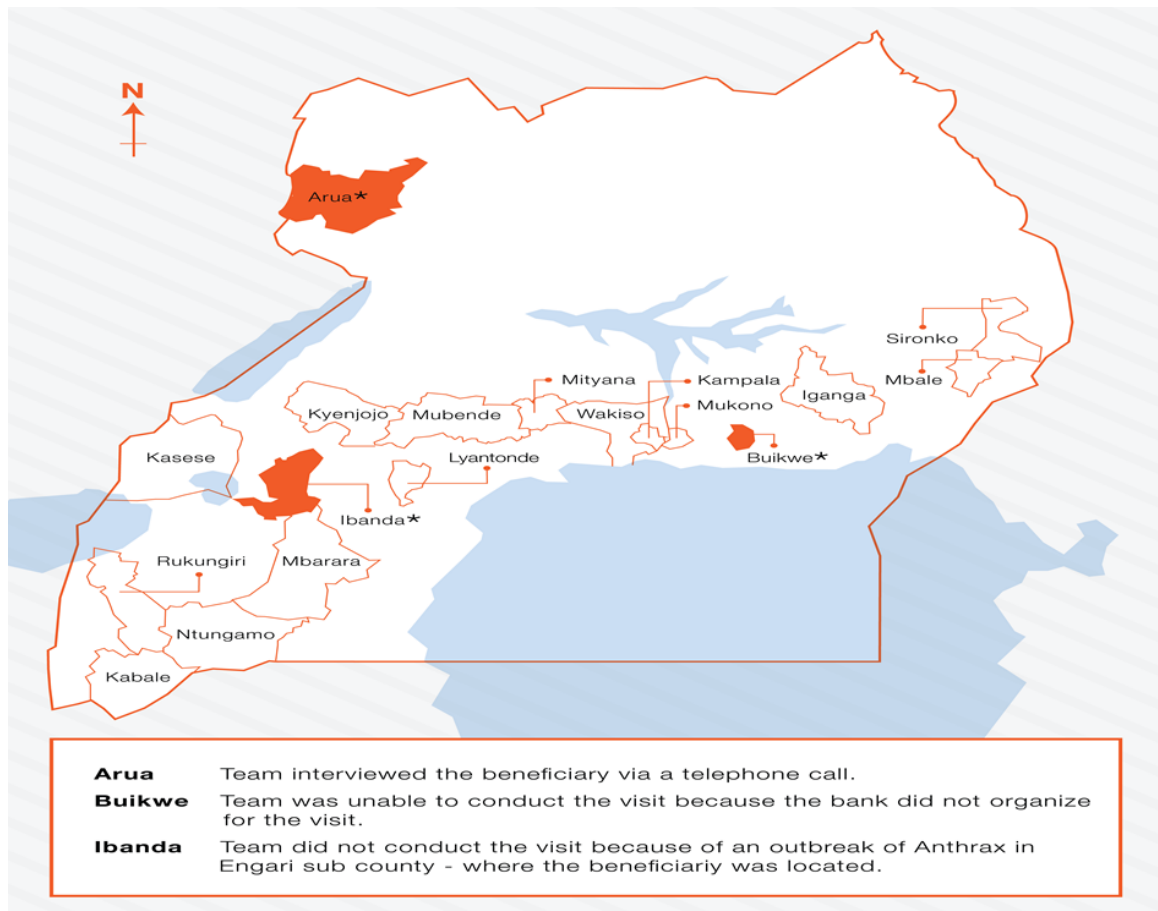
with other health care workers (such as nurses, doctors, assistants, pharmacy assistants, staff from partner organizations/facilities) as a way of complementing and supplementing patient information.

- c) Although it is clear that there is considerable deviation from the original interview plan, the evaluation team feels confident that given the uniformity of the response patterns across all respondent types, the information collected is very solid.
- Lastly, the available data did not allow for an examination of health care service provision to specific groups. However, in some cases it appears more evident that services were improved for a specific target group, specifically pregnant mothers. The purchase of ultrasound equipment (6 of 127 borrowers) has been primarily used to monitor pregnancies. The services provided by other facility owners were far more general and less targeted to a specific client base. Therefore, it is not possible to know if any specific group, or patient category, was specifically serviced/targeted. Private health care providers do not consistently report through the HMIS system even though they are mandated to do so by the law. Only a few providers reported into the HMIS system during the period under review. Especially for those who started reporting recently, the quality of the data varies. This meant that it was not possible to consistently compare HMIS data from before and after the project was launched. This challenge and the fact that the CRDB has collected limited amounts of data and has not disaggregated data by type of facility, detailed use of loan, etc. posed severe limitations on the evaluators' ability to analyse information and provide evidence based conclusions. In all cases where the data was not available, we have highlighted this in the report.

2.3 SAMPLING

Our sampling approach aimed to ensure that the findings were consistent across the area serviced by the project. In total 23 medical facilities were visited, two locations scheduled for a visit were cancelled; one because the team at the facility was not informed and a second due to an outbreak of anthrax in the location where the facility was located. The sample was purposive and aimed to target as many districts as possible. Given the concentration of the loans in the southern part of the country, and the available time to collect data, a decision was made to exclude Northern Uganda from the field visit sample as only two loans were disbursed to facilities in Northern Uganda. However, information was collected from one facility from the north through a phone interview. The Map overleaf (See Figure 1) shows all the districts visited during the data collection and illustrates that the centre, west and east of the country were targeted.

Figure 1 Map of areas visited during data collection



2.4 PROCESS OF ANALYSIS AND DEVELOPING CONCLUSIONS

All qualitative data was collected, collated and analysed in a manner that ensured triangulation. Importantly, the experience of loan officers and borrowers was extremely consistent. In cases where there are exceptions, this has been duly noted.

A quantitative data set was developed which combined information on borrowers and loans with geographical information on population and health services. For each borrower the location of the healthcare business at sub-county level was obtained from CRDB, and merged with data from health service statistics and health infrastructure inventories which were obtained with the assistance from the Ministry of Health. The location data was double checked and took into account changes in administrative units. A few health facilities where the location could not be confirmed were omitted from the analysis.

2.5 ETHICS AND PARTICIPATION

The team members followed the principles listed below:

- Harm to participants of the study was avoided. This extended to a variety of aspects including mention to loan recipients and end beneficiaries of the guarantee. It is recognised that highlighting the existence of the guarantee may lead loan recipients to default. Therefore, this information will not be disclosed.
- Participation (respondents) in this evaluation was voluntary and free from external pressure. Information that might affect respondents' willingness to participate was not withheld. All participants were given the right to refuse to participate and/or withdraw from the interview, or withdraw information provided, at any time. Signed consents were not issued because previous experience demonstrated that this level of formality makes respondents more apprehensive. However, the evaluators made clear efforts to ensure that respondents were very aware that at no time will their responses affect them/their role etc. and that there was a clear freedom to choose to stop participation at any time.
- The confidentiality of information, privacy and anonymity of study participants has been ensured. The only exceptions apply to organizations/government etc. positions which are public or to bank representatives when they spoke of official bank business.
- The team operated in accordance with international human rights conventions and covenants, local and national laws.
- The team was culture-sensitive: that is, considered the differences in culture, local behaviour and norms, religious beliefs and practices; perspectives on sexual orientation, gender roles, disability, age and ethnicity and other social differences such as class when conducting data collection.
- The team ensured and encouraged social inclusion and participation
- The team kept all material in confidence and ensured that material collected was destroyed after the completion of the assignment. Key interviews were only recorded when authorised, data collection and analysis workshops were not recorded.

3 Project Model and Implementation

3.1 PROJECT MODEL

Swedish engagement in the project under review was prompted by USAID. Since the start of this project in 2012, USAID and Sida have engaged in multiple joint guarantee projects and programmes using diverse project modalities and in multiple sectors. Despite some variation, guarantee projects broadly, and this one specifically, includes a number of elements and actors:

- a) a donor/guarantors,
- b) provision of TA,
- c) a partnering bank,
- d) a loan product,
- e) borrowers,
- f) direct beneficiaries of the services that are provided by borrowers,
- g) indirect beneficiaries or the effect on the private sector more generally.

The relationship between these actors and elements for the Health Guarantee is depicted in Figure 2 and described below.

- a) **The guarantors:** Sida and USAID were co-guarantors of this product. As guarantors they collected an origination and utilization fee respectively and are responsible for reimbursing the bank up to a pre-agreed amount in cases of default. In the case of this loan the guarantee is equal to 60% of the borrowed amount. This is explained further later.
- b) **The Technical Assistance (TA):** In the case of this guarantee, Sida did not provide, or fund, the provision of TA; rather USAID was solely responsible for this element of the project. USAID provided the TA through a wide series of projects and activities which overlapped with other USAID objectives and efforts mainly under its Private Health Sector (PHS) programme.

- c) **The Partnering Bank:** In Uganda the CRDB was selected as the partnering bank. The CRDB has an extensive nationwide coverage, which made it ideal to reach places beyond the capital.⁹
- d) **A Loan product:** In this case the loan was designed by the CRDB without the intervention of the donors. This means the CRDB established the parameters which would determine loan amounts, interest rates and payback plans. The guarantors only determined project length, and provided requirements for coverage (i.e., 30% of loans should target rural areas).
- e) **Borrowers:** The borrowers were business owners (individuals or groups) of health-related service delivery facilities. These included a wide range of types of facilities such as hospitals, clinics, pharmacies, training centres etc.
- f) **Beneficiaries:** The expected beneficiaries of this project can be divided into two distinct categories.
 - a. **Health care facility clients:** The principal beneficiary group of interest for Sida are the users of the health care facilities (i.e., patients). As noted earlier, a main objective of the loan guarantee project was the expansion of health care provision to the rural poor. Therefore, the principal target beneficiaries were the rural poor.
 - b. **Owners of the facility given the loan:** The borrowers are also expected to be beneficiaries in so far as the loan was expected to enable them to consolidate their businesses, ensure that they were able to secure their income, enable them to be more active members of the business community. The loan was intended to facilitate the strengthening of the business sector by strengthening a key business area (i.e. health).
 - c. **The Bank:** The bank is also expected to be a beneficiary. The loan guarantee was intended to enable the bank to better understand the health business sector and facilitate the development of banking products that can serve to better respond to health sector business needs.

⁹ During interviews with Sida the evaluation team was told that other guarantee projects had been unsuccessfully attempted with other banks.

The Theory of Change (ToC) of the project under review (See Figure 3) has three main elements: The guarantor, the bank and the beneficiaries. The Guarantors (Sida and USAID) agreed to guarantee up to 60% of the loan and provide technical support. Together these efforts are intended to reduce the bank's risk when giving loans, and build capacity both at the bank and amongst borrowers. The capacity development was intended to strengthen the bank's ability to assess risk in this sector (i.e., health) and support borrowers to develop solid business plans.

In turn the bank was expected to gain both experience and capacity to conduct risk assessments that were better fitted to the health sector and be able to develop products that could better meet the demands of the health care sector borrower. Lastly, the loans were to assist borrowers in providing end beneficiaries (health service users, and specifically the rural poor) with improved access to quality health care on the one hand; and also solidify their own roles/businesses as part of the private sector more generally. In this way the loans were to strengthen both the health care and the private business sectors (see Figure 3).

Figure 2 Project Model

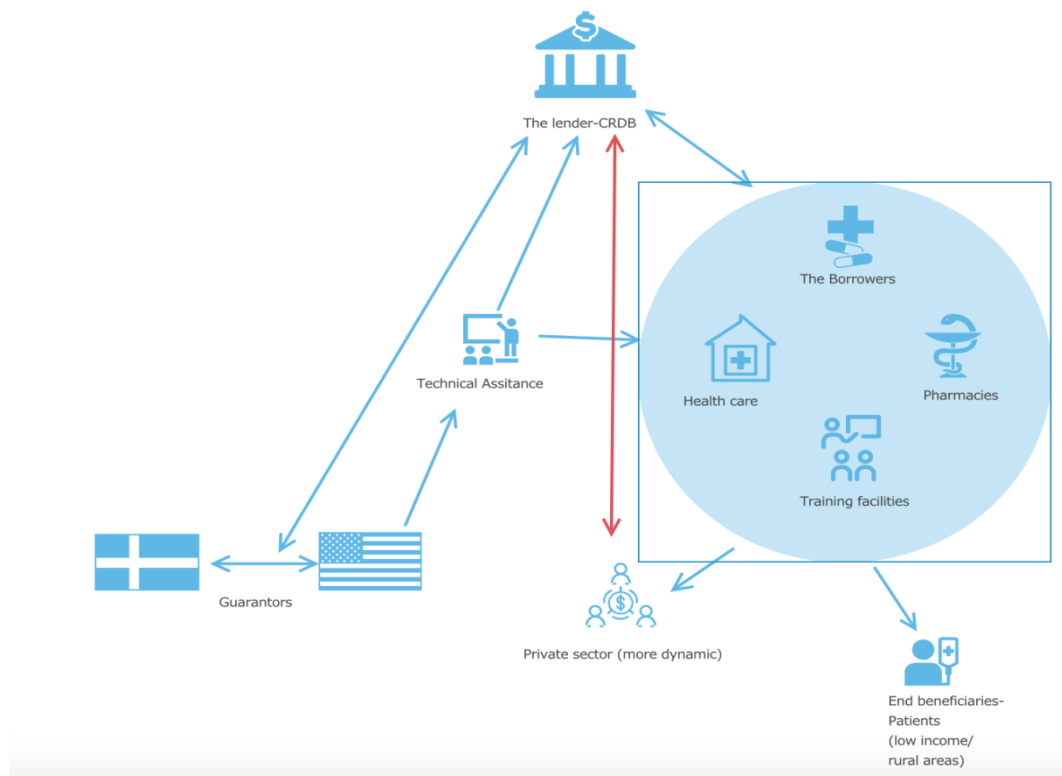
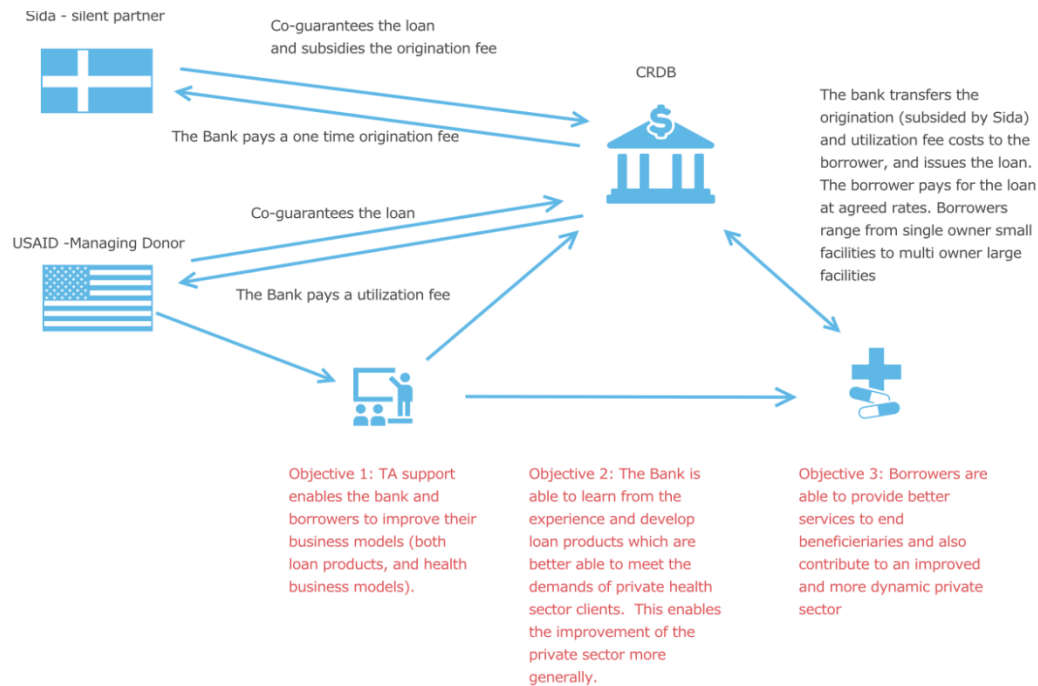


Figure 3 Theory of Change

The ToC is predicated on a number of assumptions which should be highlighted:

- That the bank does not provide loans to the health sector because the health industry lacks collateral that would enable the taking of loans.
- That loans were not provided because the bank was not familiar with the (health) sector.
- That if the bank became familiar with the sector it would be more prone to lend to the sector.
- In turn the above assumptions lead to a central assumption: that lending is an adequate way to support the health sector because the health sector is primarily private.
- That loans would enable the development of the health private sector and that this in turn would serve to expand the quality care provided to the rural poor.
- That facilities receiving loans were able to provide high quality care.
- That private facilities were able to care for the needs of the rural poor.
- That support needed (TA) should focus on business aspects (i.e., that health care providers could alone, or with the existing support provided by the state guarantee good quality).

However, there are some key questions that appear not to have been carefully considered by the ToC. Central among them:

- **The bank:** Did the bank see the health sector as a field that was worthy of specific investment (what would the expected comparative returns of developing specific products for this sector be)? Are there any incentives for the bank to create a loan product that was in keeping with the business demands of the sector?
- **The (health) business sector:** Did the sector expected profit margins allow for loans using the terms imposed by the bank?
- **The borrowers:** Did borrowers have sufficient business knowledge to be able to develop business plans that would generate a profit? Did borrowers have sufficient oversight to ensure good quality? Were borrowers in locations that supported access by the rural poor?
- **End users:** Can the rural poor afford private health care?
- **The government:** How is government health care impacted by the presence of private health care? And specifically, how much private health care is required in order to unburden the public health care service and improve the care provided to the poorest amongst the poor?

The above questions have been ones that have emerged throughout the evaluation as central to the success or failure of this effort. These questions are again examined in the conclusions of this report to explore the degree to which the project model has been premised on relevant issues, and the degree to which some of the factors mentioned here have affected the end results of the project.

3.2 PROJECT IMPLEMENTATION

The Health Guarantee is set up in such a way that by paying a one-time origination fee to Sida, CRDB is guaranteed 30% coverage of losses (up to a credit maximum) in the event that borrowers default and loans cannot be recovered. Similarly, payment of a utilization fee to USAID guarantees a further 30% coverage of potential losses. Sida's guarantee ceiling for this project is 900,000 USD and the funds originated through the one-time origination fee are 1% of Sida's ceiling is equal to 9,000 USD. CRDB passes this fee on to the clients by charging a higher administration fee. Since the bank has paid the fee up front, it has an incentive to place as many loans as possible under the Health Guarantee. The bank does not register the justification for why it includes any one loan under the guarantee, or in fact why other loans are excluded.

During data collection health business owners included facilities which had a long history of loans with CRDB with some loans included under the guarantee and others not, but no clear noted distinction or reason why this was so. Since many of the

borrowers were able to provide collateral for 100% or more of their respective loans, it is unclear why such borrowers were put under the guarantee since being placed under the guarantee increased the administration fee and thereby the costs of the loan for borrowers. From CRDB's point of view the Health Guarantee project functions like an insurance mechanism. The origination fee is subsidized by Sida in the sense that it does not cover the expected full cost that Sida may incur in relation to the expected claims regarding recovery of CRDB's losses when taking into account all risks. It is important to underscore that while Sida and USAID pay claims on defaults, both organizations also share in any eventual recoveries accessed by the bank through their own collection efforts. The ability to collect on recoveries also serves to reduce the ultimate costs of the guarantee.

This type of intervention includes a number of uncertainties for multiple parties, including both the donor(s) and the bank. Sida measures the risk it is subjected to based on a number of assumptions regarding potential defaults. The central uncertainty for Sida is that not all potential factors affecting defaults are known. For this project, the risk level was determined based on a risk assessment that included country risk, CRDB financial strength and loan portfolio performance as well as performance of Ugandan Banks in general, and taking into account that the group of borrowers are inherently risky (when they belong to an unknown market niche, considering their business management skills are limited, and they often count with unsophisticated levels of governance).

Uncertainty (and risk) is also based on the banks willingness to give loans to "weaker" clients, which has not been the case. The cumulative default rate expected at the start of the program was 14.5%. Aside from the in-house resources used for administering the intervention, the expected costs to be covered by Sida were estimated at 1 million SEK on top of the amount covered by the origination fee (the expected cumulative default rate which was used to determine the Swedish budget: $14.51\% \text{ of } 900.000 \text{ USD} = 130.590 \text{ USD}$, which at the time corresponded to a little more than 900.000 SEK). The initial risk assessment was undertaken by USAID. At the time a high risk for this type of borrowers was expected and therefore standard interest rates applied. It was expected that the CRDB reduce collateral requirements as part of the guarantee, but this was not a requirement. Indeed, it seems the guarantee did not generally contribute to reducing collateral requirements.

For this project, thus far the reported default rate, defined as failure to pay after 90 days, has been between 1-2%, much lower than the expected default rate. It is also noted that according to both annual and biannual reports only a few loans have been under review. Furthermore, as of the end of 2016 all arrears had reportedly been recovered, and no claims had been made under the guarantee. At the time of this evaluation there were 36 active loans, i.e. with a positive principal balance. Among these, 1 loan was written off because the client died, and three loans were written off due to failure to pay. The bank was in the process of preparing the paperwork to make claims on the guarantee for these four defaulted loans. It is noteworthy that 78% of

the guarantees have over 100% collateral, additional to the combined 60% guarantee provided by Sida and USAID. The data released to the evaluation team does not permit a clear assessment of how collateral and/or the guarantee will be used to cover loss. Although as noted earlier there is an expectation that both Sida and USAID will share in any recoveries made. Notably, documentation explaining how recovered assets would be distributed between the bank, USAID and Sida was not made available.

According to the USAID Health DCA QLS dated April 2018, the total principal balance registered in the Credit Monitoring System (CMS) on these four loans is equivalent to 86 million UGX. If this amount is claimed under the guarantee (30% of which is payable by Sida), then the Sida's payment will be well within the amount collected by Sida through the use of the origination fee initially paid by CRDB. However (potential) future write-offs that are registered prior to the completion of the project in 2019 will ultimately determine how much of Sida's budget of 1 million SEK will actually be used.

It is worth noting that at the time of this evaluation, none of the currently active 32 loans was overdue. Indeed, most loans (23) appeared, at the time of the evaluation, to be on track in the sense that the percentage of the principal remaining to be paid largely corresponds to the percentage of the tenor remaining. Three loans with due dates within 8 months could potentially be at risk of activating the health guarantee down the line due to relatively large outstanding balances compared to tenor remaining (75-80% of the original principal is outstanding with around 15% of the repayment period remaining). It is also worth noting that two loans were evidently wrongly registered in the data provided to the evaluation team because their maturity was dated prior to the start of the loan. This implies that there could be inaccuracies in the registration of other loans as well. While it is impossible to know, from the data available, if other loans are also incorrectly registered, according to USAID review reports efforts to ensure correct registrations are being made.

As per first quarter 2018, 6.7 bn UGX had been disbursed in loans under the Health Guarantee, and 5.7 bn UGX had already been paid back, leaving the principal balance outstanding at 1.0 bn UGX corresponding to 15% of the original principal. With only 1.5 years left of the 7 year project life cycle, it can be expected that more loans will be written off and further claims will be made against the guarantee in the coming years. It is important to underscore that the financing available for this project, from Sida's side, is equal to the 9000 USD received by Sida as the origination fee paid by the bank, as well as 1 million SEK additional budgeted funds. While it is likely that the funds generated through the origination fee area exhausted, the funds allocated through the 1 Million SEK budget are unlikely to be surpassed.

Sida's in-house administration costs are relatively low as the Health Guarantee is implemented through delegated cooperation with USAID (silent partnership) (See Figure 3). This means that all communication with CRDB, monitoring utilisation and

management of the claims process etc. is undertaken by USAID. In principle, this is a cost-efficient strategy, given the relatively low level of Swedish engagement necessary, but it does require that objectives and goals between Sida and USAID be closely aligned. As future sections of this report demonstrate, this has not always been the case. Other costs associated with the project include the provision of TA support. Although Sida did not provide TA support, understanding the type of costs incurred is important to gain a better picture of overall costs. However, since the TA provided for this project by USAID did not exclusively target the CRDB and borrowers under the guarantee, but also included unrelated beneficiaries, it is not possible to isolate the costs of TA assistance linked to this project.

Neither Sida nor USAID consider the guarantee element of this project as a stand-alone activity, rather it is understood as closely linked to, and in fact dependent on, the provision of technical assistance to support the capacity strengthening of both the lender and borrowers. The technical assistance envisaged proposed supporting borrowers with the development of simple business and expansion plans with financial projections (i.e. cash flow projections) that would serve to demonstrate the viability of taking a commercial loan. In addition, lending officers specifically, and the bank more generally, were to gain capacity on the assessment of sector specific risks. In short, both lending officers and borrowers were to be closely linked with relevant USAID TA programs.

In line with expected TA support, USAID has implemented several relevant TA projects with both the bank and borrowers. These include the Uganda Private Health Sector project (UPHS), the Uganda Health Marketing Group, STRIDES for Family Health and the Applying Science to Strengthen and Improve Systems (ASSIST) with Uganda Private Health Support program (UPHS).

The UPHS support has aimed to expand availability, increase affordability and improve quality of care in private health facilities. The planned technical assistance included support for borrowers (e.g. trainings to support access to finance, business strengthening assistance to CRDB borrowers and development of a referral system with a pool of loan applicants), as well as support for the bank (change of risk perception by improving understanding of the health sector, market research, loan officer training and product refining). In addition, technical support through, for example, the ASSIST program was meant to complement the UPHS business skills and financial management training, in recognition of the importance of improvements in the quality of care provided – also to help increase profitability and ability to repay loans. ASSIST was expected to roll out this support to all the project borrowers and to work with UPHS to agree on and streamline the content and depth of this support.

Progress reports mention the conduct of 13 workshops which targeted a total of 116 participants conducted in different locations around the country, during the first year of implementation of the intervention. These workshops consisted of a one-day event, targeting potential borrowers, focused on financial management skills and skills to

articulate financing needs through viable project proposals backed with financing plans and follow-up individual TA support to those interested in applying for a loan. It is noted that these workshops were conducted in collaboration with CRDB staff. Targeted technical support was provided to distressed borrowers in efforts to re-schedule their respective loans. Other activities included an unspecified number of training workshops for loan officers, market research and baseline and follow up survey.

Clearly much was achieved by the TA, however there appears to be a disconnect between the support provided by the TA and the targets of the loan guarantee. This materialized into two key challenges: the relevance or link between the loan guarantee programme and a) who was targeted for the workshops and b) the themes covered by the workshops. The majority of loan officers interviewed noted that they had not received specific training to support their ability to work with health care sector clients, a limited number had engaged in the aforementioned workshops, which they described as events that facilitated a link between the bank and would-be borrowers. Loan officers noted that they had received guidelines on how to use the standard formats for assessing loan applications. These guidelines did not include any form of market assessment. In fact, with one exception all lending officers interviewed noted that the principal threat to market development in their area was lack of collateral.

This shows, as does the documentation used to assess the viability of businesses that the bank has focused almost exclusively on ability to repay the loan, and not on other factors such as viability of the business model, increase in access to health care of vulnerable groups, etc. While a commercial bank would not usually consider policy goals such as increased access to health care in lending decisions, the placement of loans under the Health Guarantee could be expected to reflect key related policy goals. The question is, however, how clearly the policy goals and the intention behind the Health Guarantee have been vocalised by the partners in discussions with the bank, and have transcended into criteria for placing a loan under the guarantee etc. Similarly, the majority of borrowers interviewed had not received any type of support.

The exceptions included: two or three (the borrowers themselves were unsure) borrowers that attended workshops where the loans were introduced; and one borrower who attended an event where options for health sector cooperatives were introduced as an option for increasing business options. What all borrowers agreed upon was that the bank had demanded that they clean their books prior to the application. Some borrowers interviewed highlighted that this counsel had been mentioned in common meetings (i.e. the importance of keeping accurate financial records). Off the record some borrowers highlighted that they had hired accounting support to prepare their books to secure the loans and admitted that the documents provided to the bank were not always accurate. Likewise some loan officers admitted that they were aware that the finances of some businesses were not accurate.

However, since collateral was available, the loan officers turned a blind eye to expected or known inaccuracies in financial documents.

4 Findings

In this section the findings from the evaluation team's inquiry are presented. The questions have been responded to sequentially following the OECD DAC criteria as main headings.

4.1 RELEVANCE

Relevance, according to the OECD DAC criteria,¹⁰ focuses on the extent to which the activity is suited to the priorities and policies of the target group. More specifically the following two questions have been focused on:

1. To what extent is the guarantee still relevant given Sweden's current development assistance strategy in Uganda?
2. To what extent did the project conform to the needs and priorities of the beneficiaries (defined as poor people and/or those living in remote areas)?

First, the degree of relevance of this intervention to the Swedish strategy for Uganda was examined. This project is anchored on the 2009-2013 development strategy for Uganda, which highlighted improved access to health services, and a reduction in the spread of HIV/AIDS, for poor people as a key area of focus. Moreover, the pursuit of the aforementioned objective is very well aligned with the goals of Uganda's NDP, specifically the improvement of access to quality health care. As noted in the introduction, and relevant to this evaluation, the Swedish strategy (2009-2013) also focuses specific attention on private sector development. In the current Swedish strategy for Uganda (2014-2018), the principal focus is poverty, and therein support aiming to improve access to basic health through:

- a) Improved access to high quality child and maternal care, and
- b) Improved access to Sexual and Reproductive Health Services (SRHR) for women and men, girls and boys.

In addition to the Swedish strategy being aligned with the Ugandan NDP, the Ugandan government's Public Private Partnership for Health (PPPH) strategy aims to

¹⁰ See: oecd.org

improve access to quality health services. As part of this strategy the Ministry of Health (MOH) is interested in encouraging the establishment or expansion of the private health sector in rural and remote areas. The ministry underscored that Private Not-For-Profit (PNFP) providers are considered most appropriate for the most remote areas of the country, while it is hoped that Private-For-Profit (PFP) providers can be attracted to urban and peri-urban locations also in primarily rural districts. This suggests that developing the private sector through loans that aim to support rural areas facilities would be less fitting. However, the MOH does have examples of PFP providers (e.g. in Kiruhura district) that are set up to serve population from remote areas. In some few cases, the MOH allocates Primary Health Care (PHC) grants to such facilities to enable the provision of primary health care services. These grants, however, are small and do not cover all the costs related to the provision of primary health care (e.g. staff time is excluded).

Despite exceptions, there are several noted barriers that make rural and remote areas less attractive to PFP businesses. These include low revenue potential and lack of access to low cost financing. With low revenue potential good business planning and management are especially important to ensure the development of sustainable PFP businesses that can provide quality services. Due to challenges in profitability access to low cost financing is important. In recognition of this the MOH has recently decided to commit two MUSD to a credit fund for the private health sector under the Uganda Health Federation. The credit fund will combine technical assistance to support the development of business plans, quality of care and financial management with a credit facility at low cost along the lines of the agricultural credit program known as the Agri-Business Initiative (ABI).

Given that a new Swedish strategy is currently under development it is hard to say whether the Health Guarantee will still be relevant in relation to the new Swedish cooperation priorities. Notably, the concept of the Health Guarantee is still very much in line with the Ugandan PPPH strategy and priorities of the MOH.

The relevance of the design of this guarantee specifically, however, is questioned, specifically in relation to the provision of **quality** health care and as pertains to efforts to **strengthen** the private sector.

- a) The Swedish strategy focused specific attention to **quality** medical care. This suggests that Sweden is not only interested in the provision of medical care in some form, but also in ensuring that patients receive a minimum standard of care. While it is important to underscore that this evaluation did not include an assessment of medical practice, it is equally important to note that during the data collection 23 health care facilities were visited. Their general quality varied considerably, with a minority of facilities appearing to meet high quality in terms of cleanliness and order; a majority that raised questions regarding basic public health practices; and some facilities veering on negligence.

Examples of the latter included the establishment of surgical wards with holes in the ceiling and walls rendering efforts to keep a sterile environment pointless; open-hole latrines next to surgical wards; the equipment appeared dirty to the naked eye. Clearly, these facilities have been licenced by the Ugandan government, which calls into question the current capacity and or ability to adequately oversee existing facilities by the different agencies responsible for accreditation and oversight.¹¹ Still, the question needs to be asked: Does Sweden have a responsibility to also ensure that the facilities they support meet basic standards? Arguably, if Sweden highlights quality as a key element of its support, then it must also recognize that Uganda is currently not overseeing quality in a manner that ensures minimum standards.

- b) The strategy focused on the strengthening of the private sector. Interviews with loan recipients, with one noted exception, thought that the loan had led to their ability to expand their business, potentially attract more customers, increase their standing, etc. However, these positive steps had not led to an increase in the purchasing power of facility owners or the improved salaries of owners. The majority of business owners were themselves medical practitioners. They noted that it was virtually impossible to secure their own salary at the level they might get from a public facility. In some cases, their own income was not generated at all from the health care facility they owned. The reason given for this was the loan repayment. On average loans provided under the guarantee has an interest rate of 23%, with some loans having interest rates as low as 15% (1 loan) and some as high as 43% (3 loans) (See Figure 4). These interest rates, interviews revealed, are incompatible with the health care market profit margins. Essentially what this means is that borrowers are able to repay the loan (default rate is between 1-2%), but they are not able to generate a profit that would allow the business to grow or the owner to secure a decent livelihood for him/herself during the repayment period even though they perceive that business has improved.

This suggests that the growth generated as a result of the expansion/new equipment, which was enabled by the loan, does not compensate for the increased costs (repayment of loan – principal and interest) they experience as a result of the loan. Tied to this, interviews with beneficiaries also served to

¹¹ The Uganda Medical and Dental Practitioners Council (UMDPC) accredits health centres run by Doctors and Dentists; and the Nurses and Midwives Council accredits the health units and maternity units run by nurses and midwives.

highlight that in a majority of cases business owners did not have the necessary skill to develop a business plan that could ensure profitability. In the most extreme of cases, equipment was bought even though it could never allow for a profit, while in others, profit or breaking even, might be in the not so distant horizon. For example, the purchase of an ambulance was found, through a very quick calculation, not to be able to generate profit; while the purchase of scan machines is more likely to generate a profit. This is due, at least in part, to the relationship between usability (number of expected users) and price. Essentially, scan machines are used much more often and the price of use is much lower than that of ambulances, which are used less often to start with.

Another example of lack of business development skills is highlighted by the common reasoning given by business owners for the securing of loans. While in a limited number of cases, two larger hospitals¹² in urban areas for example, business owners understood business development; in most cases business owners knew (with varied degrees of accuracy) that the expansion of their business would not generate a considerable profit due to the loan costs. Still, they took the loan for one of two reasons: first, because they felt they had an altruistic obligation to their community; second, because they thought that the business expansion would solidify or increase their status within the community.

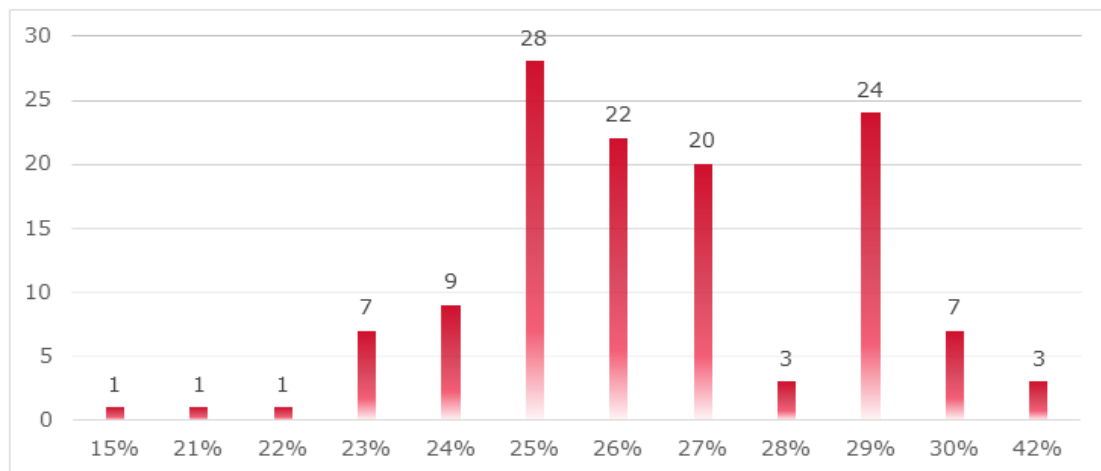
Importantly in some more extreme cases, business or parts of businesses have had to close because the losses they incurred were too great. Specifically, this was witnessed in relation to pharmacies where the loan was taken to support a pharmacy, but the costs of running a pharmacy were not well calculated and subsequently they were closed. In one case where this was witnessed, the borrower has not defaulted on the loan because the owner of the pharmacy also owned a health post which has remained open.

The Bank, however, has been able to benefit financially from the loan guarantee. The guarantee has reduced the risk, and the bank has gained through the charging of interest. Multiple Bank loan officers noted that they often recommended to borrowers to use some of the funds they had received through the loan to ensure they built collateral. For example, using loan funds to carry out all legal processes to secure deeds of purchase over the property they owned. Using the loan under the guarantee to develop a collateral platform allows for future loans to be disbursed to the same client.

¹² It is noted that well established hospitals were able to secure more favourable loan terms.

Thus, while the intervention model is aligned with Swedish strategy, it is clear that some elements prevented the full achievements of the Swedish vision. Mainly, ensuring that a mechanism was in place to support business owners in the development of business plans and strategies that are realistic and enable both the facility/business to develop and generate a profit. Overall it was consistently found that the bank had benefited financially, but the degree to which other beneficiaries (patients and borrowers) consistently received good quality care and businesses were allowed to thrive was less clear. Moreover, there is no evidence that the intervention has led the bank to develop new products that cater specifically to the health sector. Although bank representatives in Kampala note that they are more familiar with the health sector as a result of the intervention, in future health sector business owners will be subject to loan terms akin to any other business owner. There is no evidence that loans to the health sector will be promoted or that the low default rates, and low profit margins experienced by health care businesses will be taken into consideration in the development of any new loan product.

Figure 4 Number of loans by interest rate



Second, the project's ability to meet the needs of poor people living in remote areas, a key beneficiary group identified by Sida. It is noteworthy that the baseline data available says little about the level of wealth of population groups. The presumption is that by and large people living in areas further away from urban centres are lower income (poorer), but this is not always the case. Therefore, the focus here has been on rural vs. urban rather than on levels of wealth (poverty).

Still a few remarks on level of wealth of beneficiaries are important.¹³ Although available statistical data (either health or loan specific) is not able to speak to the economic status of end beneficiaries the qualitative data collected during this assignment consistently showed that level of wealth was a self-excluding, rather than a provider excluding mechanism. Both patients and owners of service providing facilities interviewed consistently agreed that no return patient had ever been turned away, or held against their will, due to their inability to pay. While this information is anecdotal, its consistency suggests a strong degree of representativeness. The data collected further showed that prices for certain services were the same across facilities, for example malaria tests. Which services have costs determined by the state depends extensively on a wide range of factors including which scheme any one facility is engaged in. Therefore, providing a full list of services is not possible. Still despite parity of prices some patients chose facilities of worse standard even when better facilities were available in the close vicinity (judging by very basic criteria, such as level of cleanliness of the establishment). Although we cannot statistically ascertain as to why this is the case, both patients and health care providers interviewed consistently noted that patients gravitate towards certain facilities due to one or a combination of the following factors:

- A) the patient knows the medical practitioner
- B) the facility was recommended to them by someone they know
- C) they were referred to the facility by someone they know (family or neighbour)
- D) the facility is closest to their residence
- E) the facility is the only one that has a particular service in the vicinity
- F) price of the service

Return patients, also noted that they continued to use the facility because they had been well cared for. With four exceptions, no practitioner, and without exception, no patient interviewed stressed quality of medical care as a key factor in choosing a facility or securing clients. The exceptions included three larger health care facilities

¹³ Corresponding question from the Proposal: Are all sub groups within the "poor people" category serviced equitably or are there some groups that are better serviced than others?

(Mt Elgon hospital in Mbale, Mbale Clinic Zam Zam¹⁴ and Doctors Clinic Seguko¹⁵) all of which stressed that providing quality care was important, identified this as a key goal. None of the aforementioned health care facility representatives were able to say if their focus on quality drew clients, but all were confident that it was important. A fourth facility noted that having an ambulance parked in front of the facility made passers-by gain further confidence on the services they provided and attracted clients by giving the impression of quality. At the time of the visit the latter facility had only one patient, and she noted that the facility had been recommended to her. She did not think that the ambulance had influenced her decision at all. Moreover, she was a patient that had to be transferred for a C-section to a larger hospital and she had not made use of the ambulance because her economic resources did not allow for it. Instead her husband had driven her to the closest hospital where a C-section could be performed.

The aforementioned is not intended to exclude the role played by price. Indeed, patients interviewed, as well as care providers, did mention price as a deciding factor in choosing a facility (see list above). Importantly, all available patients were return patients (see methodology). Although the interview team queried the degree to which price determined care choices, all interviewees stressed that price played no role in determining care, except in the purchase of medicine as these need to be provided by the client. This was so even though prices vary vastly in some cases, for example a natural birth is half the price of a C-section. When prodded patients interviewed said that if the price of care had exceeded their budget, since they were return patients, they would be able to make a long-term payment plan. Facility owners agreed that no emergency care was denied due to inability to pay. What is less clear is when procedures are carried out because facility owners know the patients can pay, for example, unnecessary C-sections. Health care facility owners denied that any unnecessary care is provided. Still with prices ranging's so vastly it is a subject of concern. As can be expected, the data collected also shows that the poorest of the poor are less likely to secure care in private facilities. This suggests that price does play a role in choosing facilities; indeed some patients interviewed noted that they had changed facilities once they were able to afford improved care. While price may play a role in selecting a facility, no evidence showing that price played a role in determining treatment choices once the facility has been chosen were found.

¹⁴ Importantly in this case the hospital was visited and staff interviewed, but the loan was used for a pharmacy owned by the hospital owner in the nearby town. Therefore this information while interesting is not directly applicable to the sample for this evaluation.

¹⁵ There is some confusion regarding if this facility was or was not part of the health guarantee.

The location of the healthcare businesses may provide some guidance on the extent to which remote or under-served areas where poverty is more prevalent have benefited. According to the data provided by the CRDB, the Health Guarantee project allowed for the provision of loans to private healthcare providers in 32 districts. The data further shows that the majority of the loans were provided to enterprises in the western and central region of Uganda (See Figure 5).

More specifically, most of the loans were provided for healthcare providers in Kampala (26 loans; 21%) or other areas within the Central Region (29 loans; 23%). The remaining loans were mostly provided in the Western Region (44 loans; 35%) with fewer (20 loans; 16%) in the Eastern region and least (7 loans; 6%) in the Northern Region (CRDB data). Generally speaking, the central and western regions tend to be wealthier than the northern and eastern regions of the country. Using 2014 census data, and excluding borrowers from Kampala and Wakiso District, which are largely urban (100% and 60% respectively), the majority of remaining borrowers came from districts where the population was between 59% and 93% rural, and where the percentage of households located more than 5km away from a health care facility ranged from 15% to 66% across districts.

Figure 5 Map of location of loan recipients

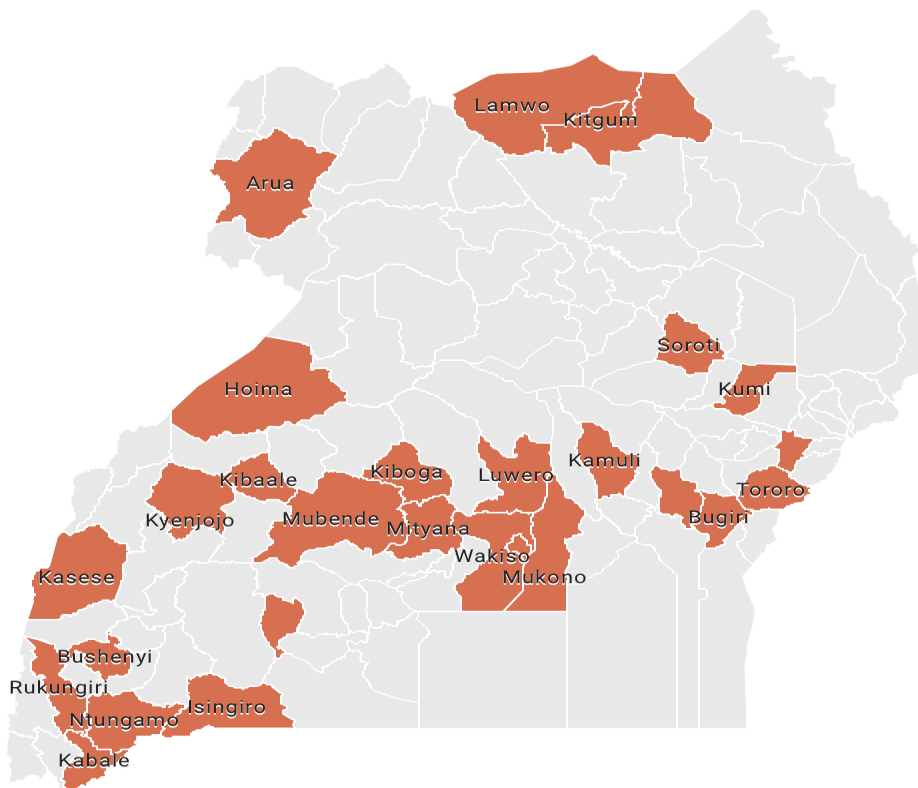
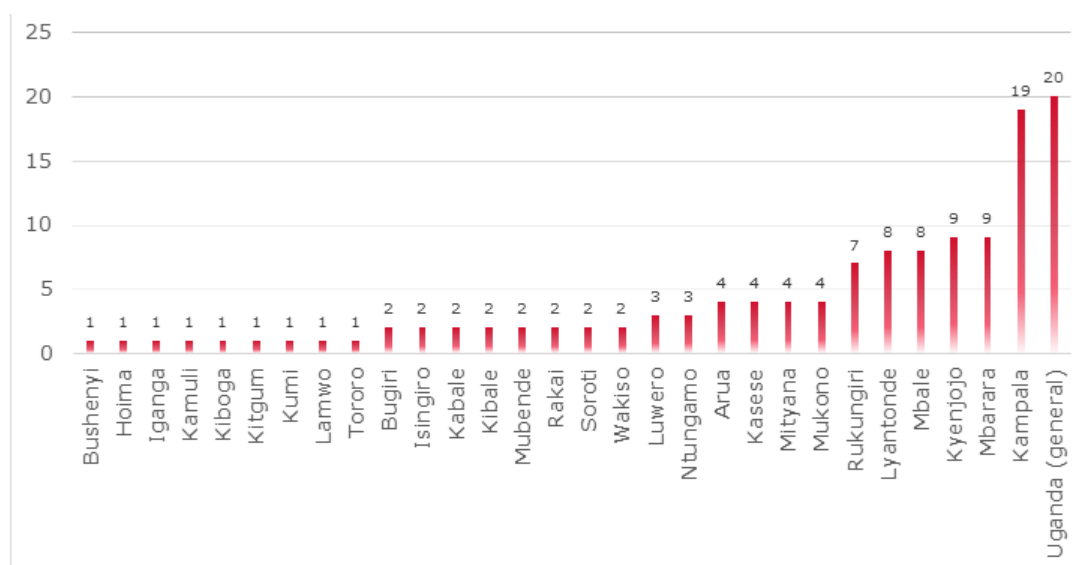


Figure 6 Loans by district



An examination into census data (2014) on whether the district was targeted for loans under the Health Guarantee project shows that there is on average very little difference between districts where the project was or was not implemented in relation to the percentage of population living in rural areas, percentage of households with more than 5km distance to nearest health facility and population per health facility (See Table 1). Importantly, the limited difference which is noted between districts with and districts without loans under the guarantee cannot be simply attributed to the project, but rather could be a result of a wide range of alternative factors.

Table 1 Location and coverage characteristics of districts with (intervention) and without (non-intervention) healthcare businesses with loans under the Health Guarantee

	Districts with no interventions	Districts with interventions
Mean percentage of rural households	82%	87%
Mean percentage of households with more than 5 km to nearest health facility	31%	37%
Mean population per health facility	11 433	12 410

In a further effort to explore the degree to which health care facilities responded to the needs of people living in remote areas, the sub-counties in which the healthcare businesses were located were identified. These sub-counties are not always the same as where the borrower resides or where the CRDB Branch providing the loan is located. This examination revealed that in most cases the healthcare business was located in a town, but would most likely also be serving nearby sub-counties and rural areas therein.

The population per health facility in the sub-counties in which healthcare business were located ranged from around 4000 up to 50000 and the proportion of households

with more than 5 km to nearest health facility ranged from 3% to almost 80%. At the national level, the population per health facility is on average around 6400 and the percentage of households located within 5 km of a health facility is 68%.¹⁶

Within the districts, the sub-counties in which the healthcare businesses were located were often not the worst off in terms of these two parameters, but also not the best off. For example, about a third of the sub-counties with healthcare business that borrowed funds through the guarantee were located within the third of sub-counties in that district with the highest population per health facility, and about a quarter of the sub-counties was within the third of the sub-counties with the highest percentage of households with less than 5km to nearest health facility. As highlighted earlier, price is one determining factor in accessing care. Therefore it is unsurprising that health care businesses are not specifically targeting the poorest of areas. Rather it would be expected that the poorest populations seek care from public facilities.

The above analysis suggests that based on the location of health facilities, some people living in areas with high population per health facility and long distance to health facilities may have benefited from improved services. Thus, while unsurprising that health care facilities gravitate towards areas with high concentration of population, the most striking is the large variation in access indicators across sub-counties, which may suggest that targeting to improve access to quality health care to remote areas, as expected by Sida, has not been successful.

It is also important to underscore that the understanding and expectation of Sida regarding how urban and rural areas are defined varies considerably from how USAID has understood and defined these terms. While Sida's understanding of a rural target means the targeting of individuals residing in rural areas, the project defined "rural" as everything outside the central region. In this sense the intervention was never conceptually aligned with Sida's expectation as its focus was on the decentralization of support, away from the capital, rather than the deliberate support to people living away from urban centres. Keeping with the definition of urban-rural used for the project, the criteria applied demanded that 30% of the loans be issued to borrowers outside the central region. The evidence suggests that this criteria was met even though the bank did very little to target would be borrowers. Indeed, their aim was primarily on borrowers who were already bank clients. The only clear effort to

¹⁶ Based on Uganda Bureau of Statistics: Housing and Population Census 2014 and Ministry of Health: Health Sector Development Plan 2015/16 to 2019/20. For comparison it may also be noted that the intended catchment population per health centre level I is 1000, for level 2 5000, for level 3 20000 and for level IV 100,000 population. Information at sub-county level is available from constituency specific reports, but would have to be extracted manually from each district report, which was beyond the scope of this assignment.

specifically target borrowers from outside Kampala was led by USAID-funded technical advisor (TA) who attempted to develop a pool of potential borrowers outside Kampala. The degree to which this effort targeted more vulnerable areas is unknown. But the data does show that a proportion of the potential borrowers identified in the pool did apply for loans. These borrowers only constitute a portion¹⁷ of the total borrowers, as the bank itself offered loans to other would-be borrowers directly.¹⁸

Understandably loans were granted or not based on the expected ability to repay. However, according to loan officers interviewed, ability to repay was not tied to the solidity of the business model/plan or to expected business growth. Rather loan officers focused on repayment opportunities based on available collateral and access to other forms of income. There was no clear evidence that would-be borrower assessments paid close attention to how the loan would potentially generate increased revenue. In essence the bank focused on examining current assets as the main source for repayment. This is confirmed by borrowers who found that the business they developed with the borrowed funds did not serve to increase their income, in fact in some cases the loans were used for activities that had no success potential.

In these cases, still, borrowers have been able to repay because they have been able to rely on existing businesses to cover repayment obligations. For example, the two pharmacies visited were tied to other health care facilities. In both cases the loan had been used to establish or expand the pharmacy respectively. In one case the borrower noted that the pharmacy was struggling and might be forced to close, and in the other the pharmacy had already closed. In both instances the loan was being repaid through income generated by the existing business. In both instances borrowers noted that they vastly underestimated the costs of establishing and running a pharmacy; and had also overlooked the fact that the area where their pharmacy was to be established, or due to grow, was already serviced by an existing and larger pharmacy. Similarly, a health care clinic that had used the loan to purchase X-ray equipment had failed to assess the costs of using the equipment (i.e, permits and licences required under Ugandan law), therefore although able to repay the loan, the equipment purchased

¹⁷ According to the Year 2 report (Our Programme Documentation ref #12, p. 16): “Out of the 64 borrowers under the Centenary DCA loan portfolio guarantee, 25 of them are a direct result of our efforts”. The Carnegie report (ref #6, p.82) likewise refer to 40% of loans under the HG being trained clinics according to the TA. However, they are not in a position to confirm this from their fieldwork as the region they visited was not well represented in the TA portfolio. Later reports do not provide specific figures.

¹⁸ Corresponding question from the Proposal: What efforts have been made to ensure that provision of services is targeting poor people/has there been a determination to ensure that particularly vulnerable areas are targeted?

with the loan is not being used, did not generate an income for the business owner, nor is it generating a service for the expected beneficiary group.

4.2 EFFICIENCY

Efficiency, according to the OECD DAC criteria,¹⁹ focuses on measuring the qualitative and quantitative outputs in relation to inputs. To this end the evaluation has explored if the costs of the project can be justified by its results?²⁰

Given the available information it was not possible to assess total project costs. Examining Sida's costs specifically, and given that this project intervention delegated the general administration and provision of TA support to USAID, the direct costs for Sida have been relatively low and are unlikely to reach 1 million SEK, in addition to the in-house resource costs associated with the general administration of the intervention. However, in examining efficiency it is important to take the question a step further and inquire into the degree to which Sida funds have been used wisely and have provided value for money.

It is important to start by underscoring that, Sida has, for a relatively low cost, been part of an effort that can be credited with mobilizing considerable funding for private health care businesses in Uganda. The utilisation rate of the Health Guarantee is high, and the default rate thus far has been low, which indicates a measure of success. Although it is notable that most (63%) of those loans could have been obtained anyway given the relatively high collateral demands made of borrowers under the guarantee (and the application of the general bank standards regarding interest and tenor (See Figure 7). Indeed, 18% (22) of borrowers provided less than 100% collateral, and less than 5% (6) of borrowers provided guarantees for 30% or less of their loan. According to CRDB documents one borrower provided no guarantee,²¹ one borrower provided collateral worth 10% of their loan, and three borrowers provided collateral worth 15%, 18% and 22% of their loan respectively.

The evaluation of guarantees as a tool for market development and poverty reduction led by Carnegie²² also highlighted the challenges in quantifying the effect of this type of intervention due to the lack of baseline data. Said reports have ultimately

19 See: oecd.org

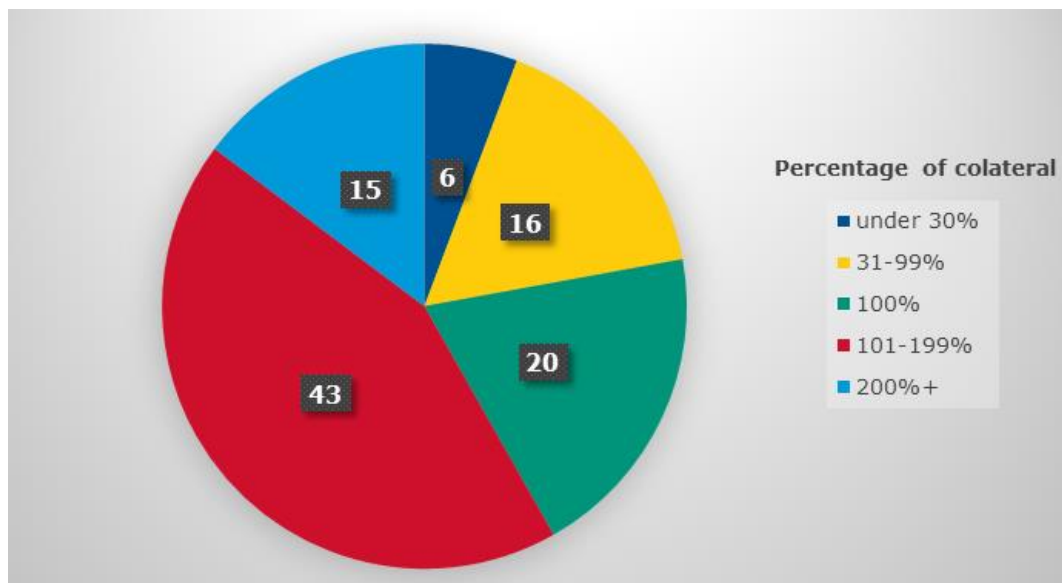
20 Corresponding question from the ToR: Can the costs of the project be justified by its results?

21 It is quite possible this information is incorrect, but the statement is based on the data provided by the CRDB.

22 Carnegie Consult, 2016. Evaluation of Sida's use of guarantees for market development and poverty reduction. Sida, Stockholm

concluded that some borrowers have obtained loans of a size which they would not otherwise have had access to, and some have obtained longer repayment and lower interest rates than would have otherwise been possible. These concessions have allowed borrowers to move to commercial loans rather than rely on microcredit, which would have been their alternative. For borrowers who would have been able to obtain a loan under similar conditions anyway, the placement under the Health Guarantee may have actually increased costs unnecessarily as CRDB shifted the cost of the origination and utilisation fees on to the clients in the form of an increased administration fee.

Figure 7 Number of borrowers distributed by percentage of collateral they were able to provide to the CRDB as a guarantee (n=122)



Source: CRDB data covering a total of 122 borrowers (5 loans, of a total of 127, were excluded due to a clear error in the statistics provided)

The majority of borrowers interviewed consistently remarked and provided detailed examples of how that the loan interest rates were often crippling given the returns that can be expected from the health care market. The impact of the high interest rates was felt not only by business owners who, in some cases, could not afford to pay themselves even basic salaries, but was also noted in the reduced ability of business to develop and grow without resorting to repeat loans. Indeed 34% of borrowers were repeat borrowers.

Basically, on the one hand the high interest rates and costs associated with the loans eliminated any plausible profit (See Figure 4 for details on interest rate distribution); and on the other hand, most business owners wanting to continue to develop or grow their business have no option than to continue to borrow again and again because they are unable to save capital.

According to the CRDB, the interest rates they adhere to are aligned with the current market (i.e. other banks and other loan products). CRDB was an ideal bank for this project because it has the widest nationwide coverage which means that their own transaction costs associated with local representation and follow up for local clients has not been increased by this project (loans to the health sector). The effect of the high interest rates on the health sector, however, calls into question the value of this product if not modified to better meet sector demands.

For Sida, the focus of the intervention, and hence the focus of an examination into how well costs justify results must look beyond the achievements in the bank sector and healthcare businesses into how the target beneficiaries, the population accessing health care, has benefited. As mentioned earlier, quantitative evidence on the increased access to care for poor people and people in remote areas that can be attributed to the Health Guarantee is limited. However, some of these facilities are in districts and sub-counties that are predominantly rural, with relatively low access to healthcare.

Although cost-effectiveness cannot be fully quantified, still it appears likely that the intervention is relatively cost-effective from Sida's perspective. The baseline report requested by Sida found that the majority (78%) of the borrowers at the time (end of 2013) had observed an (unquantified) increase in clients served. According to the mid-line survey, 80% of healthcare business surveyed noted an increase in their facility's average monthly revenue at midline as compared to the average monthly revenue the facility recorded prior to receiving the DCA loan. However, some questions need to be raised as the mid line also highlights that borrowers stress the challenges they face with non-paying customers and with high interest rates. Since the reported increase in revenue noted from the baseline to the mid-line is of 177% this seems to be at odds with the challenges faced and with the data collected during this evaluation.

Regardless of how low direct cost for Sida may have been, it is also important to inquire if more could have been achieved. Responding to this, is not solely a question of the number of additional services, but also of the quality of services provided to end-beneficiaries. Although there was a clear understanding by both USAID and Sida that the overall success of the project hinged on the provision of technical assistance, the evaluation team found no clear guidelines of how different TA programs were expected to be linked with the Health Guarantee project. How efforts to strengthen business development in the health care sector, including processes that supported an improvement in the quality of care, were delivered, who received them and what their outcomes were, was particularly difficult to establish given the available data.

It is known that only some of the healthcare providers trained chose to apply and ultimately obtained a loan, and not all borrowers received any training. For example, in the second year of the project only 25 of the 64 borrowers participated in any training provided by the TA. Unsurprisingly, borrowers interviewed had by and large

not participated in any capacity development. Those who had, mentioned that the activity focused on financial aspects of running their business (how to keep the books) and on how the loan programme could be accessed. Business owners interviewed who had participated in capacity development noted that efforts had not focused on developing business plans to ensure that their business might flourish or on ensuring basic standards of care (quality of the facility).

The available data further showed that there appeared to be no mechanism or system to ensure that borrowers who were part of the project were referred by the CRDB in an effort to ensure they could benefit from the technical support provided under the PHS or ASSIST programs. There is no documentation that can map out the framework that was established to facilitate the channelling of borrowers under the Health Guarantee projects into the ASSIST program. In fact, the available documentation does not detail how any of the borrowers under the Health Guarantee benefited from the ASSIST program. None of the persons interviewed knew of any referral system by which borrowers under the Health Guarantee were offered support through either PHS or ASSIST to improve how they developed their business including improving processes of care. This suggests that there were missed opportunities which could have contributed to a better outcome and higher cost-effectiveness.

There was no evidence to suggest that the TA provided focused any specific attention on ensuring high quality care. Quality of care, as detailed in the section on relevance, is an issue of concern highlighted in the Swedish strategy. It would not be possible to say that costs effectiveness is adequate if the service provided to end beneficiaries is of sub-standard quality to begin with. Facilities which appeared to meet quality standards did so irrespective of the Health Guarantees project, and facilities which did not appear to meet basic standard of care were in no way discriminated in relation to their loan taking.

On a separate but linked issue, it was found that the TA provided to the CRDB focused on supporting loan officers to enable them to build pipelines for potential borrowers and market research at the onset of the intervention. Far less support was given to improving the capacity of loan officers in the development of a lending strategy for the private healthcare sector, or in the development of a health sector product, or in providing support that might lead to the building of a unit within CRDB with core competences in the health sector business and which may be responsible for the continued promotion of loans in this sector. This is noted because it was a Sida intention, that this project would enable the CRDB to build both their experience and capacity in the health sector and facilitate the development of health care specific products that can in the future, after this project is over, continue to facilitate borrowing by health sector business owners.

The available data on operational costs of the project and of other interventions tied to it does not allow for the provision of an evidence-based determination on the degree

to which the continuation or upscaling of this intervention can be justified.²³ It is worth noting that the number of loans was limited, a total of 127, and that providing support to borrowers to ensure that they can financially administer their businesses, develop business plans that are realistic, and ensure the quality of care meets basic standards should not demand considerable TA person power.

4.3 EFFECTIVENESS

Effectiveness, according to the OECD DAC criteria,²⁴ focuses on measuring the degree to which objectives have been met. Here the focus was turned to the following six questions:

1. To which extent did the project contribute to intended outcomes? If so, why? If not, why not?
2. To what extent have the guarantees/loans been implemented in rural areas?
3. How has gender sensitive implementation been taken into consideration? Are there any gender-specific results?
4. Has the intervention led to increased number of patients at health facilities under the intervention? Has the intervention led to diversification/adding of services, and if so, what kind of services?
5. In case of increased utilization of health services, has this affected other health providers in the same catchment area?
6. Is there any evidence that restrictions due to the Helms Amendment have had/have an effect on the type of services that the loan beneficiaries are providing?

First, the degree to which intended outcomes were met. The degree to which high quality health care has been made available to vulnerable populations, particularly in rural areas is debatable. It is clear that much of Uganda is under-serviced. As has been noted earlier, some health care facilities attend to populations of 50,000 and in many areas large portions of the population need to travel more than 5 km to reach the closest health care facility. From this perspective, the expansion of health care facilities can be assumed to be positive. However, there are some important nuances that need to be examined before the intervention can be hailed as effective.

The project intention was multi-fold:

²³ Corresponding question from the Proposal: Can the operational cost justify continuation/upscaling?

²⁴ See: oecd.org

- a) it aimed to support the expansion of good quality health care to vulnerable rural populations;
- b) it aimed to support the development of viable health care business; and
- c) it aimed to enable the CRDB to become better acquainted with health care and hence be willing to develop loan products that were specifically targeted at the health sector.

Quality of care is treated generally and includes anecdotal remarks based on the field data collection experience. This evaluation does not focus on technical medical aspects of quality of care, for which technical medical knowledge would be required, and a methodology that allowed for an in-depth examination into the procedures used, and current understood minimum recognized standards.

Quality health care and vulnerable populations: Based on the field visits to health care facilities quality health care raised concern. Some facilities visited (a minority) did appear to meet very high standards. However, as was mentioned in section 4.1, a number of the facilities visited fell far short from being able to meet even the most basic quality standards. This was particularly worrisome in cases of facilities with surgical wards (Facilities ranked at Level III). In Uganda medical school is equal to a five-year bachelor's degree upon the completion of which the candidate must engage in a one-year supervised internship (Bachelor of Medicine and Bachelor of Surgery-MBChB). After this, the Uganda Medical and Dental Practitioners Council (UMDPC) will grant the candidate an unrestricted license to practice medicine and surgery. The unrestricted nature of the license means that facilities may not, for example, count with the support staff required to ensure that surgical wards are properly cared for (clean), or have the knowledge to ensure that architectural minimum requirements are met (i.e., surgical wards with sealed walls, surgical wards away from open latrines etc).

The aim of supporting vulnerable populations through this type of project is discussed in the section on relevance. However, it is worth stressing that while it is difficult to define “vulnerable”, and the facilities, by virtue of being private, may exclude some would be users, the evidence suggests that in a majority of cases care which was previously unavailable has been made available or made more widely available. For example: the purchase of CT- Scan Machine in Mbale means that patients from the region, and even from Northern Uganda, are able to access care which was previously only available in Kampala.

Aside from the broad focus on quality of care, Swedish strategic goals specifically focus on support to the reduction of HIV-AIDS. While some of the facilities visited did provide support to HIV-AIDS patients, none of the facilities visited used their loan to further develop their HIV-AIDS care options. Moreover, the general information available on loan use does not provide the level of detail required to know if facilities not visited used the loan to develop products or services specifically

geared at HIV-AIDS patients. However, it is also noted that the midline report does highlight that according to the data collected for it, eight facilities had started to provide HIV-AIDS treatment which was not previously.

Development of health care business: The data collected consistently shows that business plans were often weak, and that business owners often lacked the skills to develop profitable business models. Indeed, as noted in section 4.1 some businesses failed due to a poor understanding of the market and requirements linked to establishing the business. Interviews with loan officers revealed that none of them had invested time or attention to ensure that business plans presented were viable. It is noteworthy that loan officers have limited incentive to better understand the sector and support improved business plans because the health sector yields few potential borrowers compared to other sectors, such as the agricultural sector, which has a much larger potential client base.

This evaluation did not conduct a market assessment of the public sector, the financial state of most facilities, compared to the success of a few, suggests that it is possible to develop a solid business in the health care field in Uganda. However, doing this requires a strong business understanding and adequate planning. Seemingly successful facilities that appeared to deliver a high standard of care were larger entities which had considerable collateral and therefore were able to secure lower interest rates. While smaller businesses with more limited opportunities for profit paid higher interest rates. Owners of smaller businesses can borrow little at high interest and loans are used to make small upgrades to their facilities which in the best of circumstances yield some profit which allow for the repayment of the loan.

On the other hand, cheap loans could lead to business plans that are even less thought through. The evidence collected during this assignment shows that smaller businesses lacked business planning skills to such a degree that even their understanding of the loan dynamic and the costs they would incur was limited. This means that the actual cost of the loan was not closely considered in relation to how it may influence profit margins. Indeed, many business owners were unable to make clear separations between their personal and business assets, or between their health facility business and other businesses they may engage in.

CRDB's ability to better cater to the needs of the private sector: One of the objectives of the health guarantee was that it would allow the CRDB to become better acquainted with the health sector while not incurring too much risk. In turn it was expected that the guarantee would allow the bank to experience and learn about the sector and as a result be able to provide products to health care sector borrowers that are better aligned with the needs and opportunities of the sector. This starts from the premise that the bank is interested in expanding into a relatively new sector. The CRDB, at the central office, notes that the project has enabled them to learn more about the sector. Yet, there are no measurable indications that this experience will lead to the development of new products that are better fitted to the health sector

needs. According to the bank, even though these loans have had a default rate of between 1-2%, and loans in the agricultural sector have a default rate of 6%, there are no indications that loans to the health sector will benefit from lower interest rates, which would in turn allow the business to develop (see previous point).

On the contrary, the bank sees their ability to lend to the health sector as a mechanism to secure profits at lower risks of default and with a total disregard for the influence they have in stunting the development of the sector. In order for facilities to improve further and develop, they need to have margins of profit that enable reinvestment and growth. The interest rates applied thus far have in some cases prevented, as has been noted, the payment of salaries for the owners of the businesses. The limited financial capacity and knowledge of how the loan functions and how to develop a viable business plan has meant that borrowers often have a limited understanding of how the loan, and interest rates, affect their business. Importantly, in the health sector, many business owners saw their health care facility as an opportunity to give back to the community and secure status (local standing and recognition) and not as an ability to secure a solid income.

Many interview respondents relied primarily on other forms of income to secure their own livelihoods, in some cases even subsidising their health care facility through other means. Examples of alternative income generation included: employment at local government hospitals; having non-profit organizations which had donor funding alongside their health care for profit facilities; engagement in subsistence farming; had other health care related facilities; had unrelated alternative and reliable forms of income (salary at other businesses); and/or had other businesses locally (in other fields such as local shops). The two borrowers who had secured loans for their pharmacies, for example, had a clinic and hospital respectively, in parallel. How much of their reliance is on other forms of income is difficult to establish, but multiple interviewees highlighted that they were unable to secure even a minimum salary for themselves from the health care facility they owned.

When challenged on the high interest rates, the CRDB notes that their interest rates are aligned with those provided by their competitors. This however, does not mean that the interest rates are ones that the sector can bear while simultaneously developing. It simply means that multiple banks are also party to stunting development by imposing interest rates that are not aligned with sector profit margins. It is worth noting that the inflation rate in Uganda is currently calculated at below 6% and that at the CRDB savings and investments interest rates do not exceed 9%. Altogether, this means that there is very little incentive to use savings products and that loan products in Uganda, at the current rates, given health care sector profit margins, are not conducive to sector development. As noted, while there is no evidence on a shift in trends from the bank, the CRDB does note that they will gladly welcome health care sector business owners to borrow in future, using the standard borrowing products available. They further note that having been engaged in this project has made them better aware of the health business sector, which previously

they knew little about. USAID's position is that, while they hope the bank will continue to provide loans to the health care sector, this is not an outcome they follow up.

Second, the degree to which loans have been provided to facilities in rural areas was also examined.²⁵ As was noted in previous sections, the project did not target rural areas in a way that was aligned with Sida's understanding of urban versus rural. This, compounded by the fact that traditionally populations travel to urban areas to seek medical care, means that it is hard to say how many rural versus urban populations have benefited. Nevertheless, it is clear that some rural population, which previously had less or no access to health care has now been serviced. The northern part of the country was very under-targeted by this loan product (See Figure 5-Map), however. The CRDB argues that businesses are fewer in the north and that risk is higher, but do not provide evidence to demonstrate this. It appears that since the bank did not proactively try to target their lending, but rather waited for would-be borrowers to approach them, the loan distribution has been driven by health care facility owners, who have limited knowledge of business development, rather than driven by demand (over/under serviced).

Third, the degree to which gender was taken into consideration in the implementation of this product was also examined. Although for Sida gender is a priority and female led entrepreneurship was specifically highlighted in the Swedish Strategy for Uganda, the loan guarantee did not have a gender focus. Initial results suggested that specifically targeting female led or owned business would be too complicated and thus the issue had been tabled early-on in the project development process. However, during the field data collection it was found that the CRDB actually does have loan products that target women specifically. According to the year 4, 3rd quarter report 10.2% of borrowers were female owned business. This means that, although women entrepreneurs were not targeted specifically, some did benefit.

Fourth, the degree to which the project has led to an increase in patients and or a diversification of services (and types) was explored. Upon Sida's request, a baseline survey was conducted in 2014, the follow up for which has been a valuable resource for this assessment. A review of the baseline and midline highlights that both exercises primarily focused on interview data without a verification of data

²⁵ Corresponding question from the ToR: To what extent have the guarantees/loans been implemented in rural areas?

through other sources. During interviews with managers and owners of health care facilities for this assignment, it was found that while they generally thought their client base had increased, they did not have a clear understanding of percentages of increase. While all noted that they have started to record their patients and patient care into the Health Management Information System (HMIS) a spot check onto HMIS records revealed that data quality was poor (incorrect data).

In interviews with business owners, a few acknowledged that in some cases it may be in their “hypothetical” interest to underreport since reporting could lead to an increased level of attention of the tax authority which could suspect their profits to be higher than what they actually are.²⁶ All of this suggests that generally patient numbers have grown, albeit gone unreported. The midline suggests that clients, and by extension profits, have drastically increased (profit increase 177%). It is noted that the reported increase recorded in the mid-line is at odds with the concern that taxes may skyrocket. Moreover, this evaluation found that assertions about potential growth did not appear fully reliable and therefore making an assertion of the level of growth would be ill-founded.

Despite the aforementioned shortcomings, an effort to provide some indication of patient number fluctuations has been made. For some of the healthcare businesses information on OPD attendance and admissions could be extracted from the HMIS. It was not possible to extract information on diagnostic services such as X-ray and ultrasound, which may more directly relate to the loans as many targeted the purchase of this type of equipment.

²⁶ This does not mean that those who made these statements are in fact under reporting. All respondents were aware that it is their legal requirement to accurately report. Given the sensitivity of the issue, the evaluation team agreed with respondents that these assertions would not be credited to them specifically. Moreover in an effort to protect their identity, the exact number cannot be disclosed. For methodological reasons is important, however, to assure the reader that this understanding of the realities faced by business owners was noted by more than 3 respondents.

Table 2 Loan purpose and service statistics for health care providers 2014-1st quarter 2018²⁷

District	Purpose of loan	Service statistics	2014	2015	2016	2017	2018 Q1
Arua District	Working capital + in 2016 ambulance	OPD	3217	7034	5489	4760	1630
		Referrals from	18	19	43	30	
		Admissions	556	1366	1278	1379	
Isingiro District	Equipment 2015	OPD				1726	177
Kitgum District	Complete construction of medical centre -2013	OPD			264	2263	1015
		Referrals from			2	20	
Lamwo District	Clinic expansion 2015	OPD			161	1636	661
		Referrals from			4	21	
		Admissions				38	
Soroti District	Complete construction of medical centre 2013	OPD	4826	4968	2558	4949	1088
		Referrals from	29	13	9	24	
		Admissions				399	
		CS				44	
Kumi District	Dental equipment 2013	OPD	1057	1644	1261	564	752
		Referrals from		11	1	1	
		Admissions	92				
		CS					
Mbale District	Ultrasound equipment 2015	OPD			2103	5627	2190
		Referrals from	49	102			
Mbale District	Theater and X-Ray 2015	OPD	6156	13220	25736	26618	8026
		Referrals from	15	4	77	166	
		Admissions	387	1181	1196	1115	
		CS	17	60	73	93	
Mbarara District	Working capital 2013	OPD	1736	2010	4781	3015	175
		Referrals from	19		72	57	
		Admissions		111	344	318	
Kyenjojo District	Expansion 2013, Equipment 2015	OPD	175	1502	409	695	8
Kyenjojo District	Working capital & equipment 2015-2016	OPD				948	521
Ntungamo District	Clinic expansion 2013 & 2016	OPD		228	4822	3118	474
Ntungamo District	Beds and medicine 2013	OPD	718	573			
Kabarole District	Working capital 2013	OPD			394	373	289
Wakiso District	Land to expand theatre 2013	OPD	15029	11590	20574	23693	6789
		Referrals from	315	132	129	211	
		Admissions	597	641	612	831	
		CS	26	38	42	60	
Mityana District	Purchase of land	OPD	4045	3669	2832	2689	844
		Referrals from	24	7	1	1	

²⁷ Loan data is confidential. Therefore it has been anonymized here.

District	Purpose of loan	Service statistics	2014	2015	2016	2017	2018 Q1
Kyotera District	Working capital	Admissions	1255	1322	908	738	
		CS					
		OPD	12851	9125	7445	9133	1951
		Referrals from					
Kampala District	Equipment and working capital 2012 & 2015	Admissions	1498	1714	1610	1625	
		CS	47	49	68	71	
Kampala District	Equipment 2013	OPD	7106	3216	1774	2297	217
		Referrals from	10	7	126	6	
Kampala District	Medical equipment 2015 & 2017	OPD	5298	2669	2897	2684	404
		Referrals from	36	73	21		
Kampala District		OPD	1525	5253	4549	3787	595
		Referrals from	24	61	24	18	

Based on the data shown in table 2, it appears that most health care facilities have experienced an increase in activity levels in the form of OPD attendance and in some cases referrals, admissions and C-sections. Increase in OPD care could be linked to improved services including availability of equipment, medicines and supplies, along with renovation or expansion of facilities. However, many other factors (for example increasing health literacy over the same period, general increase in household income, decrease in out-of-pocket expenditures as in the WB Voucher project in Mbarara) could also affect utilisation of health services. Indeed, the available data is inconclusive to allow for any attributable conclusions to be made based on the noted increase.

The closest links that could be made is that the purchase of an ambulance may lead to increased referrals and that the development of an operating theatre may also lead to more admissions and C-sections. For example, one healthcare provider in Arua District who invested in an ambulance, increased the number of referrals starting in 2016, which coincided with the time period when the loan was secured to purchase the ambulance, yet the increase in numbers was very low (from 1.5 per month to 2.5-3.5 per month). Also, two healthcare providers, in Mbale and Wasiko respectively, reported an increase in C-sections and admissions. The hospital in Mbale noted that their purchase of a CT-Scan machine now allows them to be the referral hospital for the east and the northern part of the country. They noted that the closest facility with such services is in Kampala around 5-hours' drive away.

Similarly the owner of a radiology clinic in Iganga noted that the equipment at the local government hospital located across the street, where he also worked, was not as good as the equipment he had in his clinic therefore many patients from the hospital

were referred to his clinic.²⁸ All of these examples suggest that increased equipment may lead to an increase in patient numbers, but this is not necessarily the case (for example, the ambulance was purchased just before the government supplied the region with ambulances).

Fifth, the degree to which increased utilization of services has affected other health care providers was also explored. In order to assess this, data on the development of activities at a limited number of health care facilities was examined and compared to the development of activities to other health care facilities in the same sub-county (See Table 3). This analysis appears to demonstrate that increased activity in one facility has not affected activity in other health facilities, except perhaps admissions in the Mbarara District, this could also be coincidental or due to other ongoing projects in this district. For example, the World Bank maternal health voucher program in Mbarara includes PFP facilities and could have contributed to a shift from public to private facilities.

²⁸ It is noted that in this particular case the referrals were often made from the hospital to the private business by the owner of the business as he worked as chief radiologist at the local hospital.

Table 3 Development of service provision statistics- comparative analysis between facilities within the same sub-county 2014-2018(first quarter)

District	Sub County	Health facility	Service statistics	2014	2015	2016	2017	2018 Q1
Soroti District	Soroti Western Division	Intervention facility	OPD	4826	4968	2558	4949	1088
			Admissions				399	
			CS				44	
	Soroti Western Division	Other facilities	OPD	32334	4196	4866	5167	17007
			Admissions	1122	1432	2583	2726	
			CS	0	3	49	209	
Mbarara District	Rubindi Sub county	Intervention facility	OPD	1736	2010	4781	3015	175
			Admissions		111	344	318	
	Rubindi Sub county	Other facilities	OPD	28966	2930	3541	3086	6624
			Admissions	514	549	711	408	
Kyotera District	Kyotera Town Council	Intervention facility	OPD	12851	9125	7445	9133	1951
			Admissions	1498	1714	1610	1625	
			CS	47	49	68	71	
	Kyotera Town Council	Other facilities	OPD	20467	2004	2359	2529	8961
			Admissions	2171	2669	2436	2980	
			CS	0	0	0	0	

Source: MOH-HMIS, extracted May 22 & May 24 2018.

There is limited evidence in the form of health statistics that utilisation of health services has increased at the level of the individual health facility. The development of OPD attendance at the lowest administrative level that could be identified for borrowing businesses was also examined, i.e. sub-county level. For all loan-taking health clinics, with exception of a few for which the location was unclear, OPD attendance at sub-county level was examined. The sub-counties varied in population size from about 7,500 to 100,000. The relative effect of additional service provision of a healthcare business under the Health Guarantee is obviously potentially much lower in the highly populated sub-counties. Furthermore, the small scale of the loans and the spread of the loans across the country also ‘thins’ out the effect.

Outpatient attendance in sub-counties with loan-taking healthcare businesses on increased on average by 8% over the period 2014-17.²⁹ This growth rate was on average 2% higher than the average growth rate for OPD attendance in the respective districts, i.e. the growth in the ‘intervention’ sub-counties was higher than the general trend in the district. While many factors (e.g. economic growth, other projects as mentioned earlier) may affect the observed growth in OPD attendance, these findings suggest that service use in other facilities has not suffered.

The qualitative data also supports the finding that increased number of facilities does not affect numbers of patients elsewhere. Most borrowers interviewed noted that their referral rate had increased and that they had good relationships with other facilities, and no fear that either them or their “competition” were lacking clients. The government health facility visited (Mukono Health Centre IV) was extremely busy and the medical superintendent was not concerned about undue competition from the private healthcare sector. Indeed, the respondent noted that fewer patients would allow improved care to remaining patients. He also highlighted that he faced no challenges attracting personnel.

Lastly, in relation to patient access and care, whether the loan facilities had experienced any restriction due to the Helms Amendment was examined. The Helms Amendment, first enacted by the USA in 1973, states that, “No foreign assistance funds may be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions”³⁰. Abortion in Uganda is legal for certain cases, such as in cases of incest, rape and defilement. Pregnancies where the mother’s health is at risk or where the foetus is severely ill can also qualify for abortion. In Uganda, legal abortions are technically allowed under the definition of the Helms Amendment, but the agreement is widely misinterpreted.³¹

The information on legal abortions is not widely disseminated, there is a lack of policy guidance from the MoH and abortion remains taboo.³² In this context, speaking about abortion openly is not common place and no facility visited openly shared their perspective on the practice. This may have been affected by the fact that USA’s position on the issue is widely known and their involvement in the loan was

²⁹ The evaluation team cannot exclude that other factors have influenced development, without undertaking a randomised controlled trial or more advanced statistical analysis which would require a larger data set to allow for control for other factors. This is clearly beyond the scope of this assignment.

³⁰ http://www.genderhealth.org/the_issues/us_foreign_policy/helms/

³¹ Ipas and Ibis Reproductive Health. 2015. U.S. funding for abortion: How the Helms and Hyde Amendments harm women and providers. Chapel Hill: Ipas.

³² <https://www.reproductiverights.org/sites/crr.civicactions.net/files/documents/Uganda-Abortion-Law-Experiences.pdf>

also known, even if some did not clearly understand the relationships and links. The limited available data suggests that in Uganda there are many barriers to providing legal and safe abortions. These are not only limited to USA funding policies, but unfortunately have much deeper local roots. In sum, it is not possible to know if facilities which have received loans do engage in abortions or not and, if not, why not.

4.4 IMPACT

Impact, according to the OECD DAC criteria,³³ refers to the positive and negative changes that are produced by an intervention. These may be intended, unintended, direct or indirect. In this section, the following seven questions were focused upon:

1. To what extent have the guarantees contributed to increased access of health services for different populations, including children, men, women, adolescents, and most at risk populations?
2. To what extent have the guarantees contributed to improved quality of health services? Are there any specific examples?
3. Are there any specific results within areas such as family planning, safe abortion, SRHR and services for youth/adolescent health?
4. What proportion of loans has gone to facilities, pharmacies, nursing schools etc., respectively? How have the various recipients contributed to improved health of the target population?
5. Considering the focus on private sector, are there any unwanted implications for the public sector (human resources constraints etc.)?
6. Have the loans provided under the intervention had any impact on user fees in private facilities?
7. What is the overall impact of the project in terms of direct or indirect, negative and positive results?³⁴

First, with few exceptions, the loans do not appear to have specifically targeted the provision of specific care to any specific group or at risk population.³⁵ In some cases it appears more evident that services were improved for a specific target group. Specifically, the purchases of ultrasounds (6 of 127 borrowers) are expected to lead to improved maternal health. This is because all respondents, those that bought ultrasound machines with loan funds and others who already had ultrasound

³³ See: oecd.org

³⁴ In order to reduce repetition, this question is addressed in the conclusions.

³⁵ Corresponding question from the ToR: To what extent have the guarantees contributed to increased access of health services for different populations, including children, men, women, adolescents, and most at risk populations?

machines, noted that one of the principal uses of ultrasound was to control pregnancies for abnormalities/risk factors. Additionally, HIV-AIDS focused care has, according to the midline, been introduced in eight facilities, as an additional type of care not available before the loan. Although it is unclear if this care was a direct result of the loan or resulted from other triggers. Aside from these specific services, it is not possible to know if any specific group, or patient category, was specifically serviced/targeted. A key challenge in determining which population category benefited most is tied to the lack of specificity in the purpose of the loans as registered in CRDB data. 35% of loans disbursed specified their intended use as “working capital”; a further 35% were secured to purchase equipment (mostly unspecified); 26% were registered as being for construction (mostly unspecified) including the procurement of land for expansion and 3% were for the purchase of ambulances. Of the above, only a proportion of those borrowing to expand their premises or purchase equipment were for health clinics, others were for pharmacies and training schools.

Second, the loans do not appear to have increased quality of care, although they may have expanded the types of care available.³⁶ As it was noted earlier in this document, the quality of health care provided by many of the facilities which borrowed under the guarantee is questionable. The District Health Office is responsible for overseeing quality of health services for all service providers in their respective district. Health inspectors oversee the private clinics, and pharmacies and drug shops are overseen by dedicated staff. However, this oversight function is challenged by lack of resources. There appeared to be no record of improvements or decreases in quality of care based on these assessments. Therefore, it is not possible to know if quality of care has, or has not, improved.

These challenges aside, some of the facilities which borrowed under the guarantee do provide quality health care and have been able to expand their treatment options as a result of the loan. Specifically, equipment that was not previously available has been purchased. The midline document notes that quality has improved, but the information appears to be based solely on the respondents’ assertion. The evaluation team saw no evidence that quality was understood as improving care, as opposed to expanding care options. For example, having a surgical ward where none existed before, is not an increase in quality if the surgical ward is sub-standard.

³⁶ Corresponding question from the ToR: To what extent have the guarantees contributed to improved quality of health services? Are there any specific examples?

Third, the evaluation could not determine if family planning, safe abortion, SRHR and services for youth/adolescent health has changed in anyway as a result of the loan.³⁷ Multiple facilities visited during data collection had partnered with Mary Stopes Uganda and provided family planning support under the auspices of Mary Stopes. It is not possible to link the Mary Stopes relationship with the loan guarantee, except in cases where the loan had enabled the provision of women's health care. Still, multiple borrowers interviewed stated that being able to expand their facilities made them more visible to other potential partners such as Mary Stopes. During a focus group with women visiting a hospital in a rural area, respondents stressed that the SRHR services they received at the hospital were the only ones they had close access to. The focus group was with a group of women who was being trained in contraceptive options under the Mary Stopes plan.

Fourth, the detailed use of the funds secured through the loan guarantee was not always clear.³⁸ As figure 9 demonstrates, the purpose of loans varied considerably, with the largest number of loans used to support “working capital”, a term that is nebulous at best. Even without this criterion, the data provided by the CRDB prevents establishing a clear distinction between health care facilities, pharmacies, training facilities and other health care support facilities. It is important to note the level of information held by loan officers regarding the end use of the loan varied. It appeared that loan officers who had a more detailed understanding of what the loan ultimately would be used for resulted from a personal interest rather than by an attempt to query the financial/business soundness of the investment. It was also noted that the level of detail provided by borrowers interviewed varied. Some could point to specific equipment such as scans, X-ray machines, ambulances, hospital beds, as the purpose of the loan; while others spoke of building improvements that ranged from funding parts of a new building to new paint jobs.

Additionally, it was found that pharmacies, at least those visited, had a very hard time keeping afloat. There are government-determined fees that need to be paid to a monitoring pharmacist. The fees, all respondents who owned pharmacies agreed, were crippling. Indeed, one pharmacy visited had been forced to close down even before the loan was repaid. It was also noted that in all locations where pharmacies

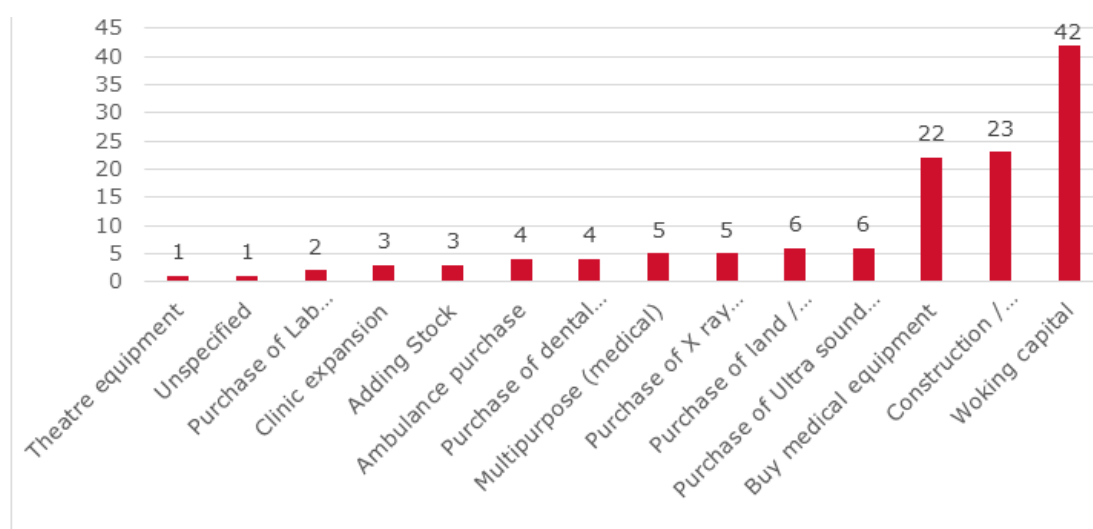
³⁷ Corresponding question from the ToR: Are there any specific results within areas such as family planning, safe abortion, SRHR and services for youth/adolescent health?

³⁸ Corresponding question from the ToR: What proportion of loans has gone to facilities, pharmacies, nursing schools etc., respectively? How have the various recipients contributed to improved health of the target population?

had been funded there were other pharmacies in the close vicinity implying stiff competition.

Regarding other types of service provision, including scans, X-Rays and general care, the limited number of patients interviewed consistently underscored that the single most important factor determining their use of the facility was how they were treated at a personal/human level. This was highlighted irrespective of the type of care required (i.e., pregnant mothers, HIV patients, general public). Patients interviewed went on to say that they did their utmost to avoid public facilities because care was slow and often not as personalized as private care.

Figure 8 Purpose of the loan



Fifth, it was found that the focus on the private sector has not had a negative impact on the public sector. Indeed, the DHO and the government facility representative interviewed in Mukono stressed that they faced no challenges securing personnel.³⁹ The qualitative data collected during interviews with facility owners revealed that in the majority of cases they could not afford to pay themselves the salaries that they would have been able to secure for themselves had they worked at state facilities. This was a result in part of lack of adequate business planning

³⁹ Corresponding question from the ToR: Considering the focus on private sector, are there any unwanted implications for the public sector (human resources constraints etc.)?

generally, and, more specifically, a consequence of the high interest rates they had to pay to the bank. Other staff (not the owner) had to be remunerated competitively and even more so in areas far from the capital. It was also found that, at least in some cases, business owners work at a local state health care facility as well. The MoH did recognize that the private health care sector around Kampala may appear more attractive to potential staff than working at a public facility in a remote area. However, securing staff in areas further afield was a concern that affected all facilities, not only the public sector

Sixth, there was no evidence that loans have affected fees charged to patients.⁴⁰

The data collected consistently showed that fees are established by one of two factors: a) a price established by the government, this applies to subsidized services which are paid by the government. In most cases these involve the provision of medication, for example, which is delivered to the health care facility free of cost; or b) a fee established by what the market might bear. Facility owners were well aware that they could not price themselves out of the market. Indeed, the evaluation team was told that, with the expansion of their facilities, or increase of equipment and treatment options, the possibilities for would-be patients to seek care despite being unable to pay has increased. Multiple health care facility owners emphasised that they were not able to turn patients away and therefore often found themselves incurring losses even though patient numbers may have increased. Patients interviewed noted that aside from being treated well, they were loyal to the same facilities because they were met with an understanding ear if and when they were unable to pay for the services they had received.

⁴⁰ Corresponding question from the ToR: Have the loans provided under the intervention had any impact on user fees in private facilities?

5 Conclusions

The principal aim of this assignment has been to assess the extent to which the guarantees project has contributed to improved access to health care for poor people, and to the development of the health care private sector in accordance with Swedish strategic objectives in Uganda.

Before exploring the central questions for Sweden, the TOC itself requires query. It is important to ask if lending is an adequate way to support the health sector in Uganda:

- The evaluation found that most borrowers have a collateral equal or exceeding 100% of the loan. It appears to be little evidence that the project was able to reduce collateral and enable borrowers who would otherwise not qualify for loans, to access loans.
- The evaluation also found that in most (perhaps all, but exact data is not available) cases, borrowers were clients of the bank before the loans under the guarantee were issued. In fact, 34% of loans were given to borrowers that already had secured other loans under the guarantee. This means that the total number of loans disbursed is higher than the total number of borrowers. Importantly, repeat borrowing is not necessarily bad as it could be supporting the even further expansion of care. It does however, provide one indication of the limited interest (by the bank) to develop a new and expanded client base.
- The evaluation also found that while the bank was not familiar with the health sector per se as a potential borrower, it was familiar with many of the borrowers (see above) who had borrowed for their health care business. Moreover, there is no indication that familiarity with the sector is a foundation to provide for the development of more adept loan products. Rather it increases the bank's confidence to provide loan products that are aligned with the rules and parameters of loans used in other sectors.
- The evaluation also found that borrowers noted that they were well able to manage high quality care facilities and that their shortcomings were mainly on the business side, specifically on borrowing was short-sighted. In fact, borrowers needed support with business development as well as with ensuring high quality care.
- As pertains to care of the rural poor, the evaluation found that while an effort could have been made to specifically target facilities in rural areas, this was not a

key priority. Moreover, as can be expected, the poorest are not able to pay for care. These factors combined mean that the majority of care may not have targeted the poorest living in rural areas. However, improved care to a segment of the population could serve to reduce the demands of public facilities and, in so doing, improve the care provided to the poorest. This hypothesis would suggest that by providing support to the private health care, public health care is improving.

The aforementioned suggests that supporting the health sector in Uganda through bank guarantees could be a viable way to ensure better care, mainly because the health sector is primarily private. The level of knowledge required to ensure that the bank is able to develop products aligned with sectorial needs, that borrowers are able to develop thriving businesses, and that end users will be able to access and afford care requires more attention. **Specifically, in relation to the demands of this assignment the following questions are also important to respond to:**

- a) **Have the guarantees led to the increased ability and interest of the bank to lend to (relevant) business owners in health sector?**

Sida hoped this project would enable the CRDB to expand its loan scope into the private health sector. To some extent this has been achieved. Although, some of the borrowers had previous loans with CRDB before the guarantee (39 clients appear to be new) and according to all interviewed loan officers responsible for the loan application assessment (a limited number of loan officers had been transferred in later on and were unsure of the history) all borrowers were existing CRDB clients prior to borrowing under the guarantee.⁴¹ The CRDB management in Kampala also stressed that, prior to the project, they were wary of the health sector and as a consequence of the project they now feel more comfortable with lending to the health sector.

The data collected in the field consistently confirmed that the health sector profit margins are simply incompatible with interest rates currently imposed by the bank. When challenged on the terms of the loans, and specifically on how these inhibit business development, the CRDB poses that their interest rates are well aligned with the standard loan package of the bank, as are other requirements made of borrowers. It is worth noting that the government of Uganda has worked with the CRDB on the development and distribution of loan products that had much lower interest rates. Hence, there is precedence for reducing interest rates. In the case of the project under

⁴¹ It is possible that this was not the case in all instances as the data collected did not cover all borrowers or lending officers.

evaluation here, USAID noted that they do not interfere in the decisions of the bank regarding their own business model (i.e. interest rates). This evaluation found that the interest rate is a key determinant in success or failure of the scheme. Notably, not all business sectors have the same growth potential. Therefore, providing business growth promoting loans to one sector versus another cannot be based on identical criteria.

The profit margins in the Ugandan health sector, compared to other sectors in Uganda, such as the agricultural sector, to which most loans are provided, was not assessed. However, this project has demonstrated that the health sector has a much lower default rate (1-2%) than other sectors, such as the agricultural sector where the default rate documented by the CRDB is 6%. This means that through the guarantee the CRDB has been able to secure larger profit margins than what they can secure from other sectors without having to engage in default claims.

Moreover, the guarantee did not consistently serve to reduce collateral. Although the bank loan officers regularly noted that collateral was a principal challenge for borrowers. The statistics provided by the bank showed that the majority (95 of 122) of borrowers were able to provide collateral equal or higher than 100% of the loan received. This suggests that more limited lending to the health sector prior to the guarantee was primarily tied to a lack of familiarity with the sector rather than the inability of borrowers to meet bank borrowing criteria. Furthermore, loan officers and borrowers interviewed alike stressed that application amounts were often higher than the amount approved. How, if at all, the guarantee could have been used to increase borrowing amounts and how, if at all, higher borrowing amounts may have allowed better business growth is not possible to know given available information. Not least because business plans were generally weak.

What appears clear is that collateral was less of a challenge than interest rates. Hence, while the purpose of the guarantee is to allow for lower collateral, the experience and low default rates could have led the bank to develop a product that was better aligned to the health sector needs. Overall, the evidence collected strongly suggests that the loans, given the conditions imposed by the bank, and especially the high interest rates, are more of a short-term crutch than a long-term springboard.

During the project, the bank has been able to benefit financially from the loan guarantee. The guarantee has reduced the risk, and the bank has gained through the charging of interest. The evaluation team was not able to access full accounting details from the bank regarding how defaults are treated internally, however, the fact that many loans have full collateral and a guarantee calls into question how the bank is handling claims. Information provided by Sida revealed that this is a closely monitored process and that there are no opportunities for the bank to make claims to Sida which would enable the bank to benefit from both the Sida guarantee and the borrowers collateral simultaneously.

At the time of the evaluation there was no indication that the bank was intending to create a product that will be more aligned to the health sector needs (i.e., interest rates, payment plans, loan amounts etc.). Consequently, the likelihood that future loans will be able to fully support the health sector and ensure that health care facilities (and support facilities such as pharmacies, training centres etc.) are able to thrive as well as improve the provision of care and outreach, while also being healthy business is limited at best.

This suggests that although profit margins are good for the bank, and the risk limited, the overall profit is not sufficiently sizable to warrant further investment by the bank to identify potential borrowers and develop a product catered to them. Overall, the evidence suggests that in this particular case the project was primarily donor driven. This does not mean that nothing has been achieved or that it should not be emulated elsewhere. To the contrary, the experience in Uganda points to clear aspects that require attention, but also highlights the potential this type of intervention can have (see recommendations).

Aligned with the aforementioned, it was stressed by multiple loan officers that they did not have the resources or interest in actively pursuing loans in the health sector because, put simply, they had enough clients. Loan officers themselves seemed unconcerned that the risk for the bank is greater with loans that have no guarantee than with this loan; or sectors with higher default rates. Although multiple loan agents outside Kampala noted that the health sector was underserved in their areas, they admitted to having no incentive to actively pursue would-be borrowers.

Furthermore, the guarantee required that 30% of the loans to be issued outside the central region, but no specific effort was made to ensure that rural areas would be better serviced. It is important to highlight that there are several noted barriers which make rural and remote areas less attractive to PFP businesses. These include low revenue potential and lack of access to low cost financing. With low revenue potential, good business planning and management are especially important to ensure the development of sustainable PFP businesses that can provide quality services.

The lack of solid business models was a consistent trend amongst the majority of borrowers. Interviews revealed, however, that the TA provided did not necessarily target borrowers as the services were provided to a much broader audience category. However, in cases where borrowers received support, the focus was on developing the loan applications rather than on strengthening business development capacity.

This has meant that little attention has been paid to improving the profitability and viability, and therein sustainability, of the healthcare business.

Specifically, on gender, an issue important to Swedish strategy, the field data collected suggests that fears that targeting female owned business specifically would reduce the bank's ability to distribute loans may have been ill-founded. It seems that female led business in Uganda are proportionally high (estimated 44% in 2010)⁴². Loans were issued to 10.2% female business owners even-though the bank made almost no effort to advertise this loan product to anyone, not least female business owners.

b) Have borrowers been able to improve and increase their offer of affordable health services, in particular in rural areas?

The review of the loans issued, and interviews with borrowing parties reveals that, by and large, the loans have been used to either buy equipment or improve the facilities where care is provided. The state of some of the facilities visited called into serious question the quality of care given. That said, it is noteworthy that some of the loans have supported the expansion of services, such as made available treatment options which were otherwise not (or were less) available in the area (for example CT-Scan, ultrasounds, etc.). However, it is also true that in some cases equipment was purchased and is currently not used because the business model developed failed to consider operational costs, including the required permits and taxes. In the later type of cases, equipment has been purchased but its impact on patient care has been zero. In other cases, such as the establishment of pharmacies, both of those visited, served as examples of non-lucrative businesses that were established without a clear understanding of the running costs.

Prices for services are strictly tied to what the market can bare, therefore although some facilities have improved their ability to deliver specialised services, no business has been able to transfer the costs of the loan to clients/patients. In short there is no indication that the loans have affected, in any way, the costs of services provided. The data collected by the CRDB does not provide a great level of detail on the purposes of the loans. However, it is known that some were specifically used to buy equipment which was intended to improve patient care. The data available (national statistics and the CRDB) does not facilitate the identification of end users (patients).

⁴² https://www.ilo.org/wcmsp5/groups/public/---ed_emp/---emp_ent/---ifp_seed/documents/publication/wcms_360427.pdf

Additionally, the criteria for loan disbursements used for this project categorised everything outside the central region as rural, a view which is not akin to Sida's understanding of urban and rural areas. Adding to the complexity, the analysis of available data and interviewees with both patients and business owners revealed that rural dwellers often travel to urban centres to secure health care services. Moreover, there is no evidence that the bank engaged in any specific targeting to support the improvement of access to medical care to rural areas, it is noted that the bank was under no requirement to target specific areas beyond ensuring that 30% of the loans disbursed were to facilities outside the central region. Examined in conjunction the findings suggest that some of the end beneficiaries have been rural dwellers, however, it is not possible to know which proportion of end beneficiaries fit these criteria.

The success of the project depended in part on the provision of capacity to both borrowers and loan officers. However, the project did not systematically target borrowers and loan officers, nor did it examine if, when training was provided it was sufficient. As a result of this, not all borrowers and lending officers improved their skills. Many borrowers received no technical support and many lending officers only received briefings on how to issue the loans and fill applications. The findings consistently showed that borrowers had limited, if any, capacity in developing business plans and in running profitable businesses. Rather the support provided focused on developing the loan applications rather than on strengthening business development capacity.

Loan officers had a very narrow understanding of the market and consistently stressed (all respondents) that the principal constraint was the lack of collateral. This serves to underscore that loan officers focused almost exclusively on borrower's ability to repay the loan and not at all on their ability to repay the loan while simultaneously running a lucrative business. Borrowers that receive training noted that they had mostly learned how to apply for loans and how to keep basic financial records. This was a step forward, but insufficient to ensure that the business is successful. Of course, there were some limited exceptions, basically larger facilities that had professional management staff on-board.

The data collected showed no evidence that the expansion of private sector facilities had negatively impacted existing public facilities. To the contrary, it seems that available private facilities may serve to reduce overcrowding of public facilities, which attend to the poorest population (those unable to pay at all). Therefore, the loan guarantee might indirectly serve to improve the care given to the poorest amongst the poor. Additionally, the increase of services has also facilitated referrals. Public facilities are at liberty to refer patients to private facilities and therefore individuals who are unable to pay for care may also benefit from private facilities that were supported through the guarantee.

c) Has the target population (rural poor) increased their use of high quality health care facilities?

Access generally increased because there were facilities with increased capabilities. Overall, there is some, albeit weak, “hard” evidence that suggests that number of patients and services have increased in the health facilities under the Health Guarantee. This is supported by the qualitative data where most health care facility owners interviewed stated (although they could not provide supporting data) that their patient numbers have increased. The official data is not fully accurate because there is known under-reporting to the national database. Some health care facility owners interviewed did say that they had lost clients. Reduction in patients was primarily the case where faith-based organizations also provide medical services in the same area. Faith based facilities are often preferred by patients because they are regarded as high quality and are able to charge less than for-profit facilities because they are not for profit and are subsidised through external donations. However, of all the facilities visited only one suggested its patient numbers had decreased.

Despite lack of more solid statistics, there is no doubt that at least in some locations patients are better off, because health care is now provided or has been expanded, new diagnostic equipment is available or a new operation rooms now exists which allows for, for example, C-sections. Most of the loans were provided for healthcare providers in Kampala (26 loans; 21%) or other areas within the Central Region (29 loans; 23%). The remaining loans were mostly provided in Western Region (44 loans; 35%) with fewer (20 loans; 16%) in Eastern region and least (7 loans; 6%) in Northern Region (CRDB data). Indeed, most of the loans were provided for healthcare providers in Kampala (21%) or other areas within the Central Region (23%).

The majority of the remaining loans were provided in Western Region (35%), with only 16% in Eastern region and 6% in Northern Region (CRDB data). The loan distribution criteria defined all loans disbursed outside of the central region as “rural”. Indeed, the number of loans disbursed to facilities located in areas that can genuinely be understood as rural locations is very limited. The importance of this is questionable, but it is worth underscoring that patients and facility owners noted that the single most important constraint to accessing health care facilities is securing transport. This applied to both people living in far way removed areas (rural) and to people living in urban areas far from the facility they wanted to use (loyalty). Unlike payment plans to cover costs of care, transport requires cash in hand. Therefore, there may be cases where patients would normally access a particular facility because they believe it offers a good service (amicable patient treatment), but cannot because they lack transport.

In relation to this it was highlighted, by both patients and facility owners, with the exclusion of pharmacies, that patient-facility loyalty was an important factor.

Therefore, return patients, at least, were not turned away despite their inability to pay. This means that a wider range of services has been able to potentially benefit patients that may not be able to afford them without a long term payment plan.

The loan distribution by geographical area shows that the project model, as implemented, did not include any mechanism to ensure that the most vulnerable rural poor were specifically targeted; however, it is plausible that care improved in public health care facilities as patients able to afford care in private facilities go to these instead. There are examples of private facilities referring patients for diagnostic tests in government health facilities and vice versa. One example is how the construction of an operation theatre in one private health facility feeds into an overall district service delivery plan.

Given the above, and the relatively small scale of the project, there are no indications that the project has led to over-servicing as a result of lack of planning and consideration of private sector expansion by District Health Offices. This was so even though there is little evidence to suggest that active coordination by the District Health Office responsible for coordination with the private sector, including the certification, planning and monitoring of service delivery to ensure complementary care (reducing over servicing). Moreover, it is important to underscore that there is no evidence that the support for the private sector limits the availability of quality personnel for public facilities. One exception to the question of over-servicing was linked to the purchase of ambulances. A small percentage of borrowers used the funds for the purchase of ambulances (3%).

Ensuring quality care was not a goal of the guarantee, but good quality care is a Swedish strategic goal. Therefore, although ensuring quality of care is the responsibility of the state (Ugandan government) pointing out these shortcomings is important as they directly affect the overall strategic goals of the Swedish government. The observations in the field showed that the conditions of some facilities, particularly ones away from major urban centres which had surgical facilities, failed to meet basic standards of hygiene. This suggest that health care practitioners, particularly those running facilities equal to level III, which include surgical wards, require technical support that can serve to ensure that their facilities meet basic standards of good care. What this evaluation has found is that quality of care cannot be presumed as a foregone conclusion when working with private health care facilities in Uganda. Therefore, it is an issue that requires attention.

Broadly speaking, data collected, both qualitative and quantitative, during the course of this evaluation suggest that despite some shortcomings, which require keen attention, the project model itself is highly promising. The health care sector in Uganda is largely reliant on private facilities and therefore support to the private health sector is an important step forward towards achieving quality health care access for all, including the poorest. Clearly it is important to recognize that the

poorest amongst the poor may be a secondary beneficiary, rather than a direct beneficiary of the use of this model.

The project experience provides some clear lessons learned regarding how Sida's objectives might be overlooked when working with a partner that has a different vision and approach, as appears to be the case with USAID. Moving forward it would be imperative that Sida re-examine the intervention model to ensure that efforts are taken to facilitate the achievement of Sida's strategic goals in Uganda. Specifically, to expand the provision of quality health care to rural populations in Uganda, and facilitate the development of the private sector. This evaluation shows that achieving these specific goals goes beyond facilitating the provision of loans to health care facility owners. In sum, although the results fall short of what was expected in Uganda, it does not mean the approach is ill founded, but rather that there was a need for further steps in planning and detailing of expectations and commitment, which appear to have been overlooked.

6 Recommendations

In this section we list some key recommendations and, where relevant, how these tie to lessons learned which the evaluation team regards as central to the successful implementation of this type of project in the future either in Uganda or elsewhere; as well as responding to health care and business sector development in Uganda. Indeed, some of their elements noted below may very well be transferable to other context.

- An examination into the premises imbedded into the Theory of Change (ToC) demonstrates that the use of guarantees requires a more nuanced understanding of the interest of the bank, the private sector in the country where it is implemented, the sector where it is applied and the effort required to transform assumptions into realities. In Uganda, the support to private health care clinics can go a long way into supporting the provision of care of the poor. However, the poorest will most often rely on public service (unless referred to a private clinic) therefore this model is not likely to directly reach the poorest. Although it may reach the rural populations. The support for private sector does not necessarily mean that the private sector will thrive. It is therefore important to understand the sector more carefully and study the returns, business development opportunities etc.

Given this, Sida should not engage in bank guarantees without conducting thorough analysis of both the sector specific needs and the financial/business sector. Ensuring a solid understanding of both is essential to ensure that this type of product (guarantee) is compatible with all key elements required to succeed. In the case of Uganda this meant having loans with affordable terms; ensuring borrowers had viable business plans; ensuring that care was of high quality and recognizing that the direct beneficiaries would not be the poorest amongst the poor.

- This experience showed that in many instances the technical assistance support required by borrowers and loan officers was not made available to them, with a consequence that investments were at times not well conceived, nor accompanied with sufficient technical knowledge. Since Sida was not engaged in the provision of technical assistance it had little influence on how it was delivered and to whom. The evaluation showed that solid technical assistance is both required and

needs to be more robust than what was made available to borrowers under the Health Guarantee.⁴³

Consequently, ***Sida should not engage in guarantee projects when not engaged in the provision and, or design of the technical assistance package. Ensuring a clear role in both is essential to ensuring that Sida's strategic objectives are met. Providing technical assistance will increase costs, but will also ensure that Sida's overall objectives are better addressed.***⁴⁴

- ***Technical support should specifically target loan beneficiaries.*** While general activities may also include other beneficiaries, it is highly important that borrowers receive targeted support.
- ***Technical support packages should be developed as a response to borrower and lender knowledge base.*** This means that in some cases the level of support will be extensive, while in others less so. For example, in Uganda business plan development is very weak. It is not reasonable, therefore, to assume, that the complexities of developing reliable business models can be achieved through a one-time short workshop.
- ***Technical support should also serve to ensure that data, both financial and patient care, is more rigorously recorded and used.***
- ***Technical support may also support loan officers to better assess the reliability of business plans,*** and not solely focus on repayment potential based on alternative sources of income.

⁴³ The evaluation team does not question the relevance, quality and extent of the private health sector technical support provided under the various USAID projects, since this was not the focus of this assignment. This evaluation does question, however, the seemingly tenuous link to the borrowers under the Health Guarantee.

⁴⁴ It is understood that this was one of the first guarantee that Sida engaged in. Since guarantees elsewhere have been less reliant on partners such as USAID.

- Ensuring the quality of care is an important element and a key objective for Sida. The experience gained through the health guarantee project shows that in Uganda donors cannot assume that the government is meeting its basic obligations in terms of ensuring quality care. The process to licence, regulate and monitor health care provision appears very weak. Therefore any effort to further support the sector must be accompanied by efforts to increase or assure quality of care. This could be done by supporting the government offices responsible for oversight and or by working with facilities directly. The information collected during the evaluation suggests that the challenge is twofold. On the one hand monitoring is weak; and on the other knowledge of basic demands (hygiene, for example) appears limited.

Therefore it may be necessary for *Sida to consider a two pronged approach to supporting quality: a) support for licencing, monitoring and oversight; b) support to borrowers to increase their own capacities to improve quality of care.*

- Ensuring that the partnering bank capitalizes on this experience, and moves forward to develop a product that is in keeping with the spirit of the intervention, also requires specific attention. It cannot be presumed that the bank will utilise key resources to develop new products, particularly for a market that is relatively limited in size. Therefore, Sida has two options:
 - *Sida can choose to not engage in loan schemes in cases where the bank does not show a clear interest in developing a product for a specific sector*, which would require a number of criteria be met, for example that the sector is large enough to warrant the bank's investment; and that the bank is able to use an interest rate and collateral demand that is aligned with the sectors specific growth expectations.
 - *Sida can engage directly or through engagement of a delegated cooperation partner with the bank to develop an adequate loan product.* This engagement should serve to ensure that the loans provided are well aligned with the business/subject area. The loans must allow the bank to make a profit, but must also serve to ensure that they are not solely serving the interest of the bank, but rather that they also allow the borrower to develop a thriving business. *Not doing this will stunt rather than develop the private sector.*

- **Future loan guarantee schemes must be grounded in an in-depth understanding of the sector to which the loan is being provided, and thus be developed to ensure profitability for the bank and ability to support private sector development.** On the one hand it is important that the bank profits in order to make it attractive to the bank to issue loans; on the other hand it is equally important that the conditions of the loans are carefully studied to make sure that these are aligned with the sector to which they are being issued. Investing in a better understanding of the sector, such as sector profit margins, repayment abilities, bank interest rate expectations and collateral will allow for the development of loan packages that are able to support the growth of the private sector and are interesting to the bank.

Doing this would serve to ensure that a revised loan package after the guarantee project ends is elaborated by the bank. Overall, this would mean that the development of a health sector loan product which takes into account sector specific characteristics could be developed. This would require an examination into how the bank would react to lower profits, given a more secure sector, and could also explore if more clients would be drawn to a more realistic (given the market) loan product.

- **There is no reason to indicate that providing health guarantees to the health sector is not a viable way to respond to the needs for improving patient care in Uganda or elsewhere. However, for the approach to achieve its objectives in Uganda, key changes would have to be made to the loan product.** The health care sector in Uganda does not allow for high profit margins. Therefore, the bank must be able to reduce interest rates against the lower risk and/or be in a position to allow longer repayment periods in order to make the loan a viable mechanism to promote development of the sector. It is possible that the bank has thus far underestimated the potential of the health sector in Uganda. Perhaps a better understanding of the magnitude of potential borrowers would serve as an incentive to develop alternative products. As it stands, and given the current loan conditions, the guarantee project does not appear to have been the best possible way to promote either health care or private sector development. Instead a micro credit option might be more aligned with local needs. This is particularly since larger private hospitals have existing relationships with the bank and are able to borrow even without a guarantee.

Annex 1 – Terms of Reference

Terms of Reference for the Evaluation of Health Guarantee to Centenary Rural Development Bank in Uganda

Date: 2018-01-22

1. Background

In 2012 Sida, together with USAID, entered into a guarantee agreement with Centenary Rural Development Bank (CRDB) Uganda. The guarantee was set-up as a loan portfolio guarantee covering term-loans to privately-owned and operated micro, small, and medium enterprises as well as healthcare workers in the health value chain. The total cover is 60% of the principal amount of which Sida and USAID each guarantees 30%. The maximum authorised portfolio was set at the UGX equivalent of USD 3 million and the guarantee was to have a total duration of seven years, from September 2012 to September 2019. The guarantee was set up with the following restrictions; 30% of the guaranteed portfolio is restricted to lending outside of the Central region; the maximum cumulative principal amount made to one borrower is the UGX equivalent of USD 300,000; the loan cannot be used for refinancing purposes, repayment or repurchase of an existing loan without specific request to and permission from USAID. The guarantee was complemented with a Technical Assistance component focusing both on the bank and the borrowers.

Sida's guarantee support to CRDB was initiated under Sweden's Cooperation strategy for development cooperation with Uganda 2009-2013. The specific objective for health under the Swedish strategy was "Improved access by poor people to health services and a reduction in the spread of HIV/AIDS". The strategy also states that "Greater emphasis and increased resources will be focused on supporting civil society agents and processes of change actively engaged in ensuring that health services and HIV/AIDS prevention initiatives are accessible, acceptable and of good quality". Under the current Results strategy for Sweden's international development cooperation with Uganda 2014 – 2018, results area 3 - "Improved basic health" focuses on "Improved access to high quality child and maternal care" and "Improved access to sexual and reproductive health and rights for women and men, girls and boys".

The main objective of the guarantee for Sida is to promote access to private health care in Uganda, with special attention to rural areas, by catalysing private capital for investments in the health sector. USAID initiated the project and carried out a detailed assessment for selecting the implementing financial institution. By September 2016, the CRBD health guarantee had performed well, with a utilization rate of 63%. 108 loans had been disbursed with an average loan size of US\$17,917 and no claims had been paid to date. Targeted

borrowers for the health guarantee fall along the broad private healthcare value-chain, including pharmaceutical wholesalers, retail dispensaries, service delivery franchisers and private clinics and hospitals, as well as service providers in their official capacity.

According to Sida's decision taken in 2012, use of the Embassy's development assistance was justified by the assumption that the intervention would "increase access to health care for poor people, including an active focus of financial resources on rural areas". An evaluation of the guarantee to CRDB was conducted in 2016 by Carnegie - "Evaluation of Sida's Guarantees for market development and poverty reduction". However, the outcomes assessed were focused on the banking sector and not the end user of the system, which according to the Swedish strategy should be poor people. The Embassy of Sweden in Uganda wishes therefore to conduct an evaluation that will focus on the effects on the health sector as well as on health outcomes, specifically whether or not the intervention has increased access to health care for poor people in Uganda and improved health for the population.

2. Evaluation purpose: Intended use and intended users

The purpose of the evaluation is to assess health-related outcomes of the Sida/USAID supported Health Guarantee to Centenary Rural Development Bank in Uganda. This will help the Embassy of Sweden, Sida and its partners to learn from what works well and less well, and inform decisions on future guarantees focusing on the health sector.

The primary intended users of the evaluation are the Swedish Embassy in Uganda, Sida's unit for Loans and Guarantees and USAID.

The evaluation is to be designed, conducted and reported to meet the needs of the intended users and tenderers shall elaborate on how this will be ensured during the evaluation process.

3. Evaluation object and scope

The evaluation object is the project "Health sector guarantee in cooperation with USAID in Uganda 2012-2019". The evaluation should have as its starting point Sweden's Strategy for development cooperation with Uganda (2009-2013) and the market and risk assessments that were conducted during the appraisal. These documents, together with Sida's appraisal document, provide a background of the situation in the health sector at the time. The agreement between the Embassy of Sweden, USAID and Centenary Bank provides the terms of the portfolio guarantee, which should also be taken into account. Sida's appraisal does not include a theory of change specifically for the intended effects on the health sector, rather it focusses on changes expected in Centenary bank's lending practices.⁴⁵

⁴⁵ See Evaluation of Sida's use of guarantees for market development and poverty reduction. Sida;2016:1, p.99.

The scope of the evaluation is the rural and poor populations in Uganda in geographical areas covered by the guarantee instrument. The time period assessed shall be from the start of the intervention until today. However, taking into account that more recent loans under the guarantee support will probably not have generated any results, the consultants will define the realistic cut-off or period for assessing the specific loans. Existing evaluations of the intervention and technical assistance provided by USAID and Sida should be included where relevant to the aim of this evaluation.

For further information, relevant project documentation is attached as annexes. The scope of the evaluation shall be further elaborated by the evaluator in the inception report.

4. Evaluation objective and questions

The purpose of the evaluation is to assess the relevance, efficiency, effectiveness and impact of the guarantee instrument on the health of the target population and particularly, *to what extent poor people and/or those living in remote areas benefited from implementation of the guarantee intervention?*

The overall evaluation question is:

- Have the guarantees/services provided under the loans contributed to improved access to health for poor people, and in this case how? Are there specific examples?

The specific evaluation questions are:

Relevance

- To what extent did the project conform to the needs and priorities of the beneficiaries (defined as poor people and/or those living in remote areas)?
- To what extent is the guarantee still relevant given Sweden's current development assistance strategy in Uganda?

Efficiency

- Can the costs of the project be justified by its results?

Effectiveness

- To which extent did the project contribute to intended outcomes? If so, why? If not, why not?
- To what extent have the guarantees/loans been implemented in rural areas?
- How has gender sensitive implementation been taken into consideration? Are there any gender-specific results?
- Has the intervention led to increased number of patients at health facilities under the intervention? Has the intervention led to diversification/adding of services, and if so, what kind of services?

- In case of increased utilization of health services, has this affected other health providers in the same catchment area?
- Is there any evidence that restrictions due to the Helms Amendment have had/have an effect on the type of services that the loan beneficiaries are providing?

Impact

- To what extent have the guarantees contributed to increased access of health services for different populations, including children, men, women, adolescents, and most at risk populations?
- To what extent have the guarantees contributed to improved quality of health services? Are there any specific examples?
- Are there any specific results within areas such as family planning, safe abortion, SRHR and services for youth/adolescent health?
- What proportion of loans has gone to facilities, pharmacies, nursing schools etc., respectively? How have the various recipients contributed to improved health of the target population?
- Considering the focus on private sector, are there any unwanted implications for the public sector (human resources constraints etc.)?
- Have the loans provided under the intervention had any impact on user fees in private facilities?
- What is the overall impact of the project in terms of direct or indirect, negative and positive results?

Questions are expected to be developed in the tender by the tenderer and further developed during the inception phase of the evaluation.

5. Methodology and methods for data collection and analysis

It is expected that the evaluator describes and justifies an appropriate methodology and methods for data collection in the tender. The evaluation design, methodology and methods for data collection and analysis are expected to be fully presented in the inception report.

Sida's approach to evaluation is utilization-focused which means the evaluator should facilitate the entire evaluation process with careful consideration of how everything that is done will affect the use of the evaluation. It is therefore expected that the evaluators, in their tender, present i) how intended users are to participate in and contribute to the evaluation process and ii) methodology and methods for data collection that create space for reflection, discussion and learning between the intended users of the evaluation.

Evaluators should take into consideration appropriate measures for collecting data in cases where sensitive or confidential issues are addressed, and avoid presenting information that may be harmful to some stakeholder groups.

6. Organisation of evaluation management

This evaluation is commissioned by the Embassy of Sweden in Kampala. The evaluation will serve as an input to inform the Embassy on whether it should continue working with health guarantees under future strategies, and thus the main intended user is the commissioner. Other intended users are Sida's Loans and Guarantee Unit and USAID. USAID has contributed to the ToR and will be provided with an opportunity to comment on the inception report as well as the final report, but will not be involved in the management of the evaluation. Hence the commissioner will evaluate tenders, approve the inception report and the final report of the evaluation. The start-up meeting and the debriefing workshop will be held with the commissioner only. All intended users are invited to the evaluation brief/dissemination meeting.

7. Evaluation quality

All Sida's evaluations shall conform to OECD/DAC's Quality Standards for Development Evaluation⁴⁶. The evaluators shall use the Sida OECD/DAC Glossary of Key Terms in Evaluation⁴⁷. The evaluators shall specify how quality assurance will be handled by them during the evaluation process.

8. Time schedule and deliverables

It is expected that a time and work plan is presented in the tender and further detailed in the inception report. The evaluation shall be carried out from February to June 2018. The timing of any field visits, surveys and interviews need to be settled by the evaluator in dialogue with the main stakeholders during the inception phase.

⁴⁶ DAC Quality Standards for development Evaluation, OECD, 2010.

⁴⁷ Glossary of Key Terms in Evaluation and Results Based Management, Sida in cooperation with OECD/DAC, 2014.

The table below lists key deliverables for the evaluation process.

Deliverables	Participants	Deadlines
1. Start-up meeting (over video conference)	Embassy of Sweden	20 February 2018
2. Draft inception report		13 March 2018
3. Inception meeting (over video conference)	Embassy of Sweden Sida's Loans and Guarantees Unit USAID (optional)	20 March 2018
4. Comments from intended users to evaluators		27 March 2018
5. Final inception report		10 April 2018
6. Debriefing workshop	Embassy of Sweden	8 May 2018
7. Draft evaluation report		15 May 2018
8. Comments from intended users to evaluators		29 May 2018
9. Final evaluation report		12 June 2018
10. Evaluation brief/ dissemination seminar (over video conference)	Embassy of Sweden Sida's Loans and Guarantees Unit USAID (optional)	19 June 2018

The inception report will form the basis for the continued evaluation process and shall be approved by Sida before the evaluation proceeds to implementation. The inception report should be written in English and cover evaluability issues and interpretations of evaluation questions, present the methodology, methods for data collection and analysis as well as the full evaluation design. A specific time and work plan for the remainder of the evaluation should be presented which also cater for the need to create space for reflection and learning between the intended users of the evaluation.

The final report shall be written in English and be professionally proof read. The final report should have clear structure and follow the report format in the Sida Decentralised Evaluation Report Template for decentralised evaluations (see Annex C). The methodology used shall be described and explained, and all limitations shall be made explicit and the consequences of these limitations discussed. Findings shall flow logically from the data, showing a clear line of evidence to support the conclusions. Conclusions should be substantiated by findings and analysis. Recommendations and lessons learned should flow logically from conclusions. Recommendations should be specific, directed to relevant stakeholders and categorised as a short-term, medium-term and long-term. The report should be no more than 35 pages

excluding annexes. The evaluator shall adhere to the Sida OECD/DAC Glossary of Key Terms in Evaluation⁴⁸.

The evaluator shall, upon approval of the final report, insert the report into the Sida Decentralised Evaluation Report for decentralised evaluations and submit it to Citrus (in pdf-format) for publication and release in the Sida publication data base. The order is placed by sending the approved report to sida@citrus.com, always with a copy to the Sida Programme Officer as well as Sida's evaluation unit (evaluation@sida.se). Write "Sida decentralised evaluations" in the email subject field and include the name of the consulting company as well as the full evaluation title in the email. For invoicing purposes, the evaluator needs to include the invoice reference "ZZ610601S," type of allocation "sakanslag" and type of order "digital publicering/publikationsdatabas.

9. Evaluation Team Qualification

In addition to the qualifications already stated in the framework agreement for evaluation services, the evaluation team shall include the following competencies: experience from and understanding of 1) private sector market development in health, 2) banking and loan systems, and 3) health systems and policy. These competencies must be relevant for the Ugandan context.

It is desirable that the evaluation team includes the following competencies: 1) health economics, and 2) equity in health.

For team members that are not core team members, or a quality assurance team member, a CV shall be included in the call-off response and contain full description of the evaluators' qualifications and professional work experience.

It is important that the competencies of the individual team members are complimentary. It is highly recommended that local consultants are included in the team.

The evaluators must be independent from the evaluation object and evaluated activities, and have no stake in the outcome of the evaluation.

10. Resources

The maximum budget amount available for the evaluation is 850 000 SEK.

The contact person at the Swedish Embassy is Anna Thomson, programme officer for health. The contact person should be consulted if any problems arise during the evaluation process.

Relevant Sida documentation will be provided by Anna Thomson, programme officer for health.

⁴⁸ Glossary of Key Terms in Evaluation and Results Based Management, Sida in cooperation with OECD/DAC, 2014

Contact details to intended users (cooperation partners, Swedish Embassies, other donors etc.) will be provided by Anna Thomson, programme officer for health.

The evaluator will be required to arrange all the logistics for example booking of interviews, preparing meetings and field visits etc. USAID's team could provide guidance to the evaluation team in outlining key informants for interviews and best logistical arrangements given time outline.

11. Annexes

Annex A: List of key documentation

1. Beslut om insats USAID CRDB Uganda
2. Appraisal of intervention, Health sector guarantee in cooperation with USAID
3. DCA Risk assessment CRDB Health Guarantee
4. Assessment Uganda Guarantees
5. Guarantee Agreement Sida - Uganda Signed
6. Guarantee Evaluation 2016 Full Version
7. Uganda CMS Rapport CRBD 201711
8. Annual Health Review Report 2013 - Final 26Nov
9. Annual Health Review Report 2015 – FINAL
10. Baseline_Report_DCA_final_october 22 2014
11. Uganda August 2016 Country Report Final
12. Program Annual reports-DCA extracts
13. USAID-Uganda Private Health Support Program_Yr4 - A2F BDS quarterly reports
14. Sweden's Cooperation strategy for development cooperation with Uganda 2009-2013
15. Results strategy for Sweden's international development cooperation with Uganda 2014-2018

Annex B: Data sheet on the evaluation object

Information on the evaluation object (i.e. intervention, strategy, policy etc.)	
Title of the evaluation object	Uganda Health Guarantee - USAID
ID no. in PLANIt	51180047
Dox no./Archive case no.	2012-000753
Activity period (if applicable)	2012-2019
Agreed budget (if applicable)	
Main sector	Health
Name and type of implementing organisation	Centenary Rural Development Bank, Public-private partnerships
Aid type	Guarantee
Swedish strategy	Uganda (2009-2013) and (2014-2018)

Information on the evaluation assignment	
Commissioning unit/Swedish Embassy	Embassy in Kampala
Contact person at unit/Swedish Embassy	Anna Thomson
Timing of evaluation (mid-term review, end-of-programme, ex-post or other)	Other
ID no. in PLANIt (if other than above)	12010

Annex 2 – Evaluation Matrix

Below the evaluation matrix which was used during this assignment is detailed.

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
Relevance	To what extent did the project conform to the needs and priorities of the end beneficiaries (defined as poor people and/or those living in remote areas)?	• Health infrastructure statistics • Perception of improved services	• Document (statistics) review • Interviews • Data collection and analysis workshops	• Health statistics • Loan recipients • End beneficiaries	Tabulation of statistical data Tabulation of qualitative data Identification of MSC stories
	To what extent is the guarantee model still relevant given Sweden's current development assistance strategy in Uganda? Is the project relevant? (but perhaps not the model)? Note: that the model failed with another bank in Uganda). What are the critical elements that affect relevance. ⁴⁹	• Strategic objectives • NDP	• Document review • Interviews	• Health authorities • Sida and Embassy representatives	Tabulation of statistical data Tabulation of qualitative data

⁴⁹ It's important to underscore that this evaluation is not an evaluation of the model per se, but will ask questions regarding the degree to which this model is in keeping with Swedish approaches.

ANNEX 2 – EVALUATION MATRIX

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
	Are all sub groups within the “poor people” category serviced equitably or are there some groups that are better serviced than others?	- Health infrastructure statistics - Perception of improved services	- Document (statistics) review - Interviews - Data collection and analysis workshops	- Health statistics - The CRDB - Loan recipients - End beneficiaries	- Tabulation of statistical data - Tabulation of qualitative data - Identification of MSC stories
	What efforts have been made to ensure that provision of services is targeting poor people/has there been a determination to ensure that particularly vulnerable areas are targeted?	- Health infrastructure statistics - Perception of improved services	- Document (statistics) review - Interviews - Data collection and analysis workshops	- Health statistics - The CRDB - Loan recipients - End beneficiaries	- Tabulation of statistical data - Tabulation of qualitative data - Identification of MSC stories
	Were loans provided in areas where coverage was low?	- Health infrastructure statistics - Perception of improved services	- Document (statistics) review - Interviews - Data collection and analysis workshops	- Health statistics - The CRDB - Loan recipients - End beneficiaries	- Tabulation of statistical data - Tabulation of qualitative data - Identification of MSC stories
	Are (following the loan) some areas over-served; because district health infrastructure planning has not taken into account the expanded private sector service?	Health infrastructure statistics	- Document (statistics) review - Interviews	- Health statistics - The CRDB - Heath authorities	- Tabulation of statistical data - Tabulation of qualitative data - Identification of MSC stories
Efficiency	Can the costs of the project be justified by its results?	- Expenses versus coverage ratios - Service saturation	- Document review - Interviews	- Heath authorities - Sida and Embassy representatives - The CRDB	- Tabulation of statistical data - Tabulation of qualitative data
	Can the system capacity building costs be justified by the likely long term results? (this is	Capacity development markers (indicators that	- Document review - Interviews	- Sida and Embassy representatives - USIAD - The CRDB	- Tabulation of statistical data - Tabulation of qualitative data

ANNEX 2 – EVALUATION MATRIX

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
	understood as the capacity building provided to loan recipients to support them in their ability to effectively repay)	- speak to growth in capacity will be identified) - Costs of capacity development		Loan recipients	
	Can the operational cost justify continuation/up scaling?	Expected operational expenditures versus coverage rates	- Document review - Interviews	- Health authorities - Sida and Embassy representatives - The CRDB	- Tabulation of statistical data - Tabulation of qualitative data
Effectiveness	To which extent did the project contribute to intended outcomes? If so, why? If not, why not?	- Health infrastructure statistics - Perception of improved services - Perception of economic/business growth by loan recipient - Statistics supporting growth by loan recipient	- Document (statistics) review - Interviews - Data collection and analysis workshops	- Health statistics - The CRDB - Loan recipients - End beneficiaries	- Tabulation of statistical data - Tabulation of qualitative data - Identification of MSC stories
	To what extent have the loans under the guarantee been implemented in rural areas? More specifically what is the geographical loan distribution of CRBA loans and what are the reasons behind the current distribution?	Geographical coverage (focus will be placed on where populations are under services vs. where loans have been given. Findings will be contextualised to include servicing of populations).	- Document (statistics) review - Interviews	- Health statistics - The CRDB	- Tabulation of data - Visual representation of loan distribution (map)
	How has gender sensitive	Identification of	Document (statistics)	The CRDB	Tabulation of statistical

ANNEX 2 – EVALUATION MATRIX

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
	implementation been taken into consideration? Are there any gender-specific results?	gender markers (loan recipients, end users)	review - Interviews - Data collection and analysis workshops	- Loan recipients - End beneficiaries	data Tabulation of qualitative data Identification of MSC stories
	Has the intervention led to increased number of patients at health facilities under the intervention? Has the intervention led to diversification/adding of services, and if so, what kind of services?	Type of service markers (before/after intervention)	- Document (statistics) review - Interviews - Data collection and analysis workshops	- Health statistics - Loan recipients - End beneficiaries	Tabulation of type of services
	In case of increased utilization of health services, has this affected other health providers in the same catchment area (including both private and public health service providers who deliver similar services)?	Type of service markers (before/after intervention)	- Document (statistics) review - Interviews - Data collection and analysis workshops	- Health statistics/Health authorities - Loan recipients - End beneficiaries	Tabulation of type of services provided by area Tabulation of statistical data
	Is there any evidence that restrictions due to the Helms Amendment have had/have an effect on the type of services that the loan beneficiaries are providing? In line with this we will also explore the MCP/PLGHA and specifically in relation to Sida/Swedish Sexual and Reproductive health policy. https://www.sida.se/English/how-we-work/our-fields-of-work/health/Sexual-and-reproductive-rights/	Type of service markers (before/after Helms amendment)	- Document (statistics) review - Interviews - Data collection and analysis workshops	- Health statistics/Health authorities - The CRDB - Loan recipients - End beneficiaries	Tabulation of type of services provided by area Tabulation of statistical data

ANNEX 2 – EVALUATION MATRIX

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
	To what extent have the loans under the guarantee been implemented in peri-urban or urban areas with poor underserved population?	Geographical coverage (focus will be placed on where populations are under services vs. where loans have been given. Findings will be contextualised to include servicing of populations).	- Document review (statistics) - Interviews	- Health statistics - The CRDB	- Tabulation of data - Visual representation of loan distribution (map)
	In case of increased utilization of health services, has this crowded out or stimulated (through complements) services by other health providers in the same catchment area?	Type of service markers (before/after intervention)	- Document review (statistics) - Interviews - Data collection and analysis workshops	- Health statistics/Health authorities - Loan recipients End beneficiaries	Tabulation of type of services provided by area Tabulation of statistical data
Impact	To what extent have the loans under the guarantee contributed to increased access of health services for different populations, including children, men, women, adolescents, and most at risk populations	Type of service markers (before/after intervention) by group type	- Document review (statistics) - Interviews - Data collection and analysis workshops	- Health statistics - Loan recipients - End beneficiaries	Cross tabulation of type of service and beneficiary group
	To what extent have the loans under the guarantee contributed to improved quality of health services? Are there any specific examples?	Markers for improvement based on MSC derived responses	- Interviews - Data collection and analysis workshops	- Loan recipients - End beneficiaries	MSC stories, most change responses.
	Are there any specific results within areas such as family planning, safe abortion, SRHR and services for youth/adolescent health?	Type of service markers (before/after intervention) by service type	- Document review (statistics) - Interviews - Data collection and analysis workshops	- Health statistics - Loan recipients - End beneficiaries	Cross tabulation of type of service and service type

ANNEX 2 – EVALUATION MATRIX

Evaluation criteria	Evaluation questions	Indicators	Data collection instruments	Sources of information	Data analysis
			analysis workshops		
	What proportion of loans has gone to facilities, pharmacies, nursing schools etc., respectively? How have the various recipients contributed to improved health of the target population?	- Type of recipient - Service markers	- Document (statistics) review - Interviews	- Health statistics - Loan statistics	Cross tabulation of type of facility receiving loan and types of services required
	Considering the focus on private sector, are there any unwanted implications for the public sector (human resources constraints etc.)?	Positive and negative impact indicator (as identified by respondents)	- Document (statistics) review - Interviews - Data collection and analysis workshops	- The CRDB - Loan recipients - End beneficiaries	Tabulation of positive and negative results on the private sector.
	Have the loans provided under the intervention had any impact on user fees in private facilities?	Changes in prices of services	- Document (statistics) review - Interviews - Data collection and analysis workshops	- Health statistics - Loan recipients - End beneficiaries	Prices of services over time. Experience in changes in price and service delivery
	What is the overall impact of the project in terms of direct or indirect, negative and positive results? This will be explored at 3 levels: the bank, the loan recipients and the end beneficiaries.	Positive and negative impact indicator (as identified by respondents)	- Document (statistics) review - Interviews - Data collection and analysis workshops	- The CRDB - Loan recipients End beneficiaries	Tabulation of positive and negative results.
	Are there any cultural or customary practice issues that facilitate or prevent access to traditional health care? If yes, have these been addressed/how are they addressed?	indicator (as identified by respondents)	- Document (statistics) review - Interviews - Data collection and analysis workshops	- The CRDB - Loan recipients End beneficiaries	Tabulation cultural and customary factors and how they link to traditional health care and health care generally.

Annex 3 – Data collection instruments

Interview guides general questions:

Here the focus is on case history interviews. Therefore, the same line of questions will be used with multiple respondent categories (Sida, Embassy, USAID, Bank personnel, loan recipients)

1. Please describe your engagement with (the project *) and your experience with it?
2. What are the principal lessons that you have learned from the experience thus far?

Note: importantly we will cater the reference to the project on a case by case basis (see ethics)

Draft interview guides for health system focus:

The following questions may be supplemented with questions that arise out of the first part of the field work and the debriefing workshop at the Embassy in Kampala.

Interview guide – CRDB team (central)

(The focus here is on issues related to costs, in order not to duplicate; I assume that they or USAID TA would have helped with the geographic details of loan recipients before the field work)

1. What kind of technical support do loans under the guarantee recipients under the USAID-Sida programme receive? Is that different from other loan recipients?
2. On which basis are loan recipients selected? How do you make the risk assessment for health care businesses?
3. How are the conditions of the loan (collateral, interest rate, period) determined? Is that different from other loan recipients?
4. Do you spend less or extra time and other resources on loan recipients under the Sida guarantee compared to other loan recipients? If yes, can you roughly estimate how much less/more?
5. Would any of the loan recipients under the Sida guarantee have been rejected, if there was no guarantee?

6. For clients who have taken multiple loans, have the first loans matured already and been successfully repaid? (please describe the process)
7. Has the loan project changed the way the bank does business?
8. Has the project led to any shifts within the bank that you feel will outlast the project?
9. Are there any other positive or negative impacts (results) that you attribute to the project?
10. What mechanism do you have in place to assure transparency?
11. What opportunities are there to support female led businesses?

Interview guide – CRDB team district level

1. What do you think are the main hindrances to business development in your area?
2. How proficient in business development are loan applicants?
3. What kind of technical support do loan recipients under the USAID-Sida guarantee receive? Is that different from other loan recipients? Is the support provided sufficient?
4. On which basis are loan recipients selected? How do you make the risk assessment for health care businesses?
5. How are the conditions of the loan (collateral, interest rate, period) determined? Is that different from other loan recipients?
6. Do you spend less or extra time and other resources on loan recipients under the USAID-Sida guarantee compared to other loan recipients? If yes, can you roughly estimate how much less/more?
7. Would any of the loan recipients under the Sida guarantee have been rejected, if there was no guarantee?
8. Has the loan project changed the way the bank does business?
9. Has the project led to any shifts within the bank that you feel will outlast the project?
10. Are there any other positive or negative impacts (results) that you attribute to the project?
11. What mechanism do you have in place to assure transparency?

12. What opportunities are there to support female led businesses?

Interview guide – loan recipient

1. What was the purpose of taking the loan?
2. How easy was it to obtain the loan? – If you have taken a loan before, has it become easier over time or is it the same as before?
3. If you have more than one loan, did you first repay the first and then apply for a new one (please describe the process)
4. Did you get any technical support from the bank or others (USAID) to help you improve the operation of your business? If yes, then what kind of support?
5. How has the loan affected your business? Has the level of activity changed in terms of number or range of services? If yes, how.
6. Has the loan allowed you to upgrade the status of your facility (for example to level III)?
7. Do you submit reports through the HMIS system? Could you kindly share information on the trend in your activity level before and after you took the loan (preferably 2 years before and up to now)?
8. In your view, how has the development of your clinic/drug shop/ affected the community? (Probe: better access, better quality, more affordable).
9. In your view, how have other health care providers been affected?
10. What has been the impact of the loan on your personal economy (household economy)? Has your overall revenue increased/decreased? What has been the broader impact of this?
11. What do you think have been other positive or negative impact from your loan experience?
12. What would you say is the single most important result of the loan for a) you, b) for your business, c) for the service you provide and d) for the community?

Interview guide – Service delivery actors

1. What changes to the service you provide is a result of the loan?
2. Has your client base changed at all as a result of the new services/goods/product you can now provide?
3. Has your target population changed at all as a result of the changes made?
4. Will you be able to continue to provide the service in future?
5. Do you believe your client base will stay the same/change in the future?

Interview guide – Sida/Swedish Embassy

1. How does this program tie to other efforts in the health and private sector development field?
2. Have you been able to influence the role of the TA in any way?
3. What has been the cost of the program?
4. What is included in this amount? Does it include staff time?
5. What has the partnership experience been like (pluses/minuses)?
6. What are the key lessons that can be learned from the project experience thus far?

Interview guide – MOH, Planning Department (& HMIS)

1. How can the private health sector contribute to increased health coverage?
2. Is there a role for the private health sector in reaching vulnerable populations? For example in rural areas?
3. Which barriers to expansion to rural areas or to improve quality does the private health sector face?
4. Sida has provided loans under the guarantee for some private health sector providers with a view to improving access, affordability and quality. We would like to compare the development in activities for these private health sector providers and nearby health facilities over time (and the number of nearby facilities). The purpose is to assess firstly whether *for* example expansion of a private clinic (or purchase of new equipment) leads to an increase in utilisation of the specific health facility and secondly, whether it is an overall increase or whether users are just

shifting from other health facilities. To undertake this comparison we would need HMIS data. Can you kindly assist us with that?

Interview guide – District health authorities

1. How can the private health sector contribute to increased health coverage? For example in rural areas? Do you have any examples?
2. Which barriers to expansion to rural areas or to improve quality does the private health sector face?
3. Has the private health sector expanded a lot in your district – in terms of number and range of services? How does that affect your planning?
4. In your experience, what are the consequences of increased service delivery in the private sector? Does it contribute to overall higher service delivery or is it merely shifting service delivery between service providers? Does it increase human resources for health in the community or just shift them from one provider to another?

Interview guide – TA, USAID

1. How valuable/relevant do you think this type of intervention is to developing the health sector and developing the private sector in Uganda? Why?
2. On which basis are loan recipients selected? How are the conditions of the loan (collateral, interest rate, period) determined? Is that different from other loan recipients?
3. Is it your impression that any of the loan recipients under the USAID-Sida guarantee would have been rejected, if there was no guarantee? Would loan conditions have been different?
4. In your view, how has the loans to the private health sector affected communities and other health providers? (Access, affordability, quality; crowding out)
5. What are the main issues arising from the Follow-up study to the Baseline survey? (Elaborate question when we get the report)?
6. What has been the cost of the program related to the Sida Health Guarantee, i.e. workshops and capacity building etc.?

7. Is it your impression that CRDB spend less or extra time and other resources on loan recipients under the USAID-Sida guarantee compared to other loan recipients?
8. What do you think are the main outcomes of the project experience?
9. What do you think are the main lessons that can be learned from the project experience?

Annex 4 - Documentation

Author	Title	Location	Date
Carnegie Consult	<i>Evaluation of Sida's use of guarantees for market development and poverty reduction</i>	Sida, Stockholm	2016
MFA, Sweden	<i>Strategy for development cooperation with Uganda, March 2009 – December 2013</i>	MFA, Sweden	
MFA, Sweden	<i>Results strategy for Sweden's international development cooperation with Uganda, 2014 – 2018</i>	MFA, Sweden	
Sida	<i>Appraisal of Intervention, Health Sector Guarantee in Cooperation with USAID in Uganda</i>	Kampala, Uganda	
Sida	<i>Guarantee Agreement</i>	Kampala, Uganda	September, 2012
USAID	<i>Health Sector Guarantee in Cooperation with USAID in Uganda</i>	Kampala, Uganda	September, 2012
USAID	<i>Memorandum re: DCA Guarantee Opportunity for USAID/Uganda</i>	Kofi Owusu-Boakye	November, 2011
USAID	<i>Annual Review of the USAID/Uganda Health DCS Program</i>		October, 2013
USAID	<i>Annual Review of the USAID/Uganda Health DCS Program 2015</i>	Kampala, Uganda	October, 2015
USAID	<i>Baseline Survey Report of DCA Borrowers</i>	Cardno Emerging Markets USA, Ltd Uganda	October, 2014
USAID	<i>Uganda DCA Portfolio Report</i>	USAID	September, 2016

Annex 5 – List of interviewees

Name	Position	Organisation	Date of interview
Aaron Bamwite	CLO	CRDB	Iganga Branch
Anna Thompson	Health	Swedish Embassy	Kampala
Asiimwe Catherine	Proprietor	Fukang Health Centre	Kyenjonjo
Bemera Emmanuel	Proprietor	Rhona Medical Centre	Kabalagala
Christopher Onajin	Loans and Guarantees	Sida	Skype
Crescent Nimusiima	CLO	CRDB	Mukono Branch
Ddamba Andrew	Loans dept	CRDB	Skype
Ddamba Andrew		CRDB, HQ	Kampala
Deo Mugisha	CLO	CRDB	Kabale Branch
Dr. Elijah Wekemukhe	Radiologist	Mt. Elgon Hospital Ltd	Mbale
Dr. Geoffrey Kasirye	Medical Officer Incharge	Mukono Health Centre IV	Mukono
Dr. Nsubuga	Proprietor	Doctor's Clinic Ltd Sseguku	Seguku, Wakiso
Dr. Sebulime Stephen	Proprietor	Sebbi Medical Centre Ltd	Nansana, Wakiso
Dr. Tumushabe Elly	DHO	Mukono District Local Government	Mukono
Dr. Twesiime Innocent	Proprietor	Polly Care Medical Centre	Rubaare, Ntungamo
Dr. Twinomuhanji John William	Proprietor	Mbale General Clinic. zam-Zam	Mbale
Dr. Wabwona George William	Proprietor	St. Martin Medical Centre	Mubende
Dr. Wasukira Richard	Proprietor	Devine Health Centre	Budadiri East, Mbale
Edimond Mugarura	Branch Manager	CRDB	Kabale Branch
Edwin Akankwasa	Loans dept	CRDB	Skype
Edwin Akankwasa	Commercial Section	CRDB, HQ	Kampala
Elena Sahlin	Loans and Guarantees	Sida	Skype
Emmanuel Rukundo		CRDB	Kyenjonjo Branch
Francis Zukusooka	Consultant	Cardno	Kampala
Fred Wejuli	CLO	CRDB	Kabalagala Branch

ANNEX 5 – LIST OF INTERVIEWEES

Ganatusanga Matovu	Clinician	DOM Medical Centre	Bunamwaya, Wakiso
Golias Arinaitwe	CA	CRDB	Rukungiri Branch
Grace Hoerner	Relationship Manager	DCA-USAID	Skype
Grace Ssali	Executive Director	Uganda Healthcare Federation	Kampala
Jessica Atayi	CEO	Mt. Elgon Hospital Ltd	Mbale
John Arinaitwe	CLO	CRDB	Mbarara Branch
John Bosco Katakoba	CLO	CRDB	Mubende Branch
Jude Arinaitwe	CLO	CRDB	Ntungamo Branch
Jude Semakula	CLO	CRDB	Lyantonde Branch
Juma Ali Mubiru	Branch Manager	CRDB	Mityana Branch
Kaate Stephen	Proprietor	Sir. Albert Gen. Clinic and Nursing Home	- 0772952526
Kizito Tusubira		CRDB	Kabale Branch
Leyla Ashstrom	Relationship Manager	DCA-USAID	Skype
Lillian Khabugho	CLO	CRDB	Najjanankumbi
Martin Semaganda	CLO	CRDB	Mityana Branch
Mbabaali Joseph	CLO	CRDB	Wakiso Branch
Migadde Joseph	Administrator	DOM Medical Centre	Bunamwaya, Wakiso
Mr. Martin	Senior Health Inspector	Mukono District Local Government	Mukono
Mrs. Anguyo	Programme Manager	Kigonzi Nursing Home	Kabale
Mrs. Baluku	Nurse / Partner	Holistic Medicare Clinic	Sanga, Kiriura
Muhabuzi Benon	Branch Manager	CRDB	Kasese Branch
Muhumuza Herbert	CLO	CRDB	Kyenjonjo Branch
Mwinganiza Carol	Nurse / Partner	Kyenjonjo Pharmacy	Kyenjonjo
Namara Annet	Sonographer / Proprietor	Kadoth Medical Centre	Rukungiri
Nangero Ruth	Nurse / Proprietor	Kanana Pharmacy (Closed)	Lyantonde
Nelson Nimusiima	Administrator	Medik Hospital	Bwaise, Kampala
Ninsiima Gordian	Accountant	Polly Care Medical Centre	Rubaare, Ntungamo
Oshabe B. Carolyn	Manager, Credit	CRDB	Mbarara Branch
Paul Lubega	Loans dept-Head	CRDB	Skype
Paul Rhone Lubega	Commercial Section	CRDB, HQ	Kampala
Ronald Batte	CA	CRDB	Mukono Branch

ANNEX 5 – LIST OF INTERVIEWEES

Sandra	Intern	Swedish Embassy	Kampala
Sandra Kebirungi	Senior Planner	PPPH Node	Ministry of Health
Stadem Mirembe	CLO	CRDB	Mbale Branch
Stephen Akena Abwoye	Biostatistician	HMIS	Ministry of Health
Sunday Julius	Ag.CLO	CRDB	Rukungiri Branch
Tumusiime Habert	Proprietor	St.Luke Medical Centre Bukuya	Bukuya, Mityana
Wakabi J.	CLO	CRDB	Rukungiri Branch
Wambuzi Milton	Proprietor	Iganga Medical Centre	Iganga
William Aloma	CLO	CRDB	Bwaise Branch

Annex 6 - Sample

The following facilities were targeted for visits during the field data collection. Of these only two were not visited; one, due to an anthrax outbreak, and the second because CRDB failed to inform the loan recipient of the visit.

Facility ID	Transaction Report ID	Beneficiary Name	Facility	Disbursement Date	City/Town	Region	Purpose of Loan	Criteria for section
33	420391	Kunonya Edward	Medik Medical Centre	2013/02/06	Bwaise	Central	Purchase of medical equipment	- Central (Kampala) Kawempe Division - City suburb (probably targeting urban poor) - Multiple loans (*5) between 2013 and 2015 hence able to assess impact - General medical services
12	506700	Bemera Emmanuel	Rhona Medical Centre	2015/01/22	Kabalagala	Central	Purchase of medical equipment.	- Central (Kampala) Makindye Division - City suburb (probably targeting urban middle class) - Multiple loans (*2) between 2012 and 2015 hence able to assess impact General medical services
12	420376			2012/11/27	Kabalagala	Central	Working capital clinic	
44	420395	Medicare Health Professionals College Ltd.	Medicare Health Professionals College Ltd.	2013/04/02	Kampala	Central	Complete construction of classroom blk.	- Central (Kampala City) - Urban - Loan in 2013 for construction of classroom hence able to assess impact - Medical training (talk to trainees)

ANNEX 5 – LIST OF INTERVIEWEES

Facility ID	Transaction Report ID	Beneficiary Name	Facility	Disbursement Date	City/Town	Region	Purpose of Loan	Criteria for section
52	524947	Nambiro Annet	Dom Medical Centre	2015/11/09	Najjanankumi	Central	Purchase of medical equipment	- Central (Kampala City) Rubaga Division - Urban 2 Loans in 2015 and 2017 - General medical services
46	501628	Mt Elgon hospital ltd	Mt. Elgon Hospital Ltd	2015/01/22	Mbale	Eastern	Purchase of drugs, theatre supplies and X-ray	- Represents Eastern Uganda. As a hospital with theatre should be having a large clientele base. - Has received three loans since 2015, therefore assumed to be a good client
75	501637	Twinomuhangi John William	Mbale General Clinic, zam-Zam	2015/01/22	Mbale	Eastern	Purchase of digital ultra sound equipment	- Eastern Uganda - Loan for specialized service which should boost clientele base - Urban - Two loans for the same purpose
75	524945			2015/10/01	Mbale	Eastern	Purchase of Digital Ultra Sound Scan	
78	479639	Wasukira Richard	Devine Health Centre	2014/08/01	Mbale	Eastern	Construct new premises for the health unit	- Eastern Uganda - Old client since 2014 - Provides general medical services
78	501619			2015/01/22	Mbale	Eastern	construction	
78	524949			2015/12/03	Mbale	Eastern	Purchase of medical equipment	
77	541433	Wambuzi Milton	Atlas Artho lab & Physical Rehab centre	2016/11/10	Iganga	Eastern	Purchase of medical equipment	Represents eastern region. Provides a unique medical service that is rare in many areas outside the major towns / city

ANNEX 5 – LIST OF INTERVIEWEES

Facility ID	Transaction Report ID	Beneficiary Name	Facility	Disbursement Date	City/Town	Region	Purpose of Loan	Criteria for section
69	501620	Tumusiime Habert	St.Luke Medical Centre Bukuya	2015/01/22	Mityana	Central	purchase of land	- Central - Rural (out of town) - Multiple loans (*2) in 2015 - General medical services - Involved purchase of land and property
69	519437			2015/07/23	Mityana	Central	Purchase property where clinic is located	
76	434530	Wabwona George William	St. Martin Medical Centre	2013/06/20	Mubende	Central	Complete construction of medical centre	- Central - Rural - Multiple loans (*2) since 2013 hence able to assess impact - General medical services
76	501613			2015/01/22	Mubende	Central	construction of medical centre	
6	420378	Asiimwe Catherine	Information not available	2013/01/24	Kyenjojo	Western	Purchase X-ray unit	- South Western - Rural - Multiple loans (*3) since 2013 hence able to assess impact General medical
6	524937			2015/10/01	Kyenjojo	Western	Working capital	
6	529885			2016/04/22	Kyenjojo	Western	Additional working capital for inventory	
34	524956	Mwinganiza David Benjamin	Kyenjojo Pharmacy	2016/02/26	Kyenjojo	Western	Additional working capital	- South Western - Rural - Multiple loans (*4) since 2013 hence able to assess impact on the medical facility as a business - Pharmacy
34	420377			2013/01/11	Kyenjojo	Western	Working capital stock pharmacy	
34	501608			2015/01/22	Kyenjojo	Western	Adding Stock	
34	519427			2015/07/10	Kyenjojo	Western	working capital for inventory	
71	479637	Tumwebaze Godfrey	Community Medical Centre	2014/07/18	Kasese	Western	Additional working capital.	- Western - Rural - Multiple loans (*4) since 2014
71	501618			2015/01/22	Kasese	Western	Adding Stock	

ANNEX 5 – LIST OF INTERVIEWEES

Facility ID	Transaction Report ID	Beneficiary Name	Facility	Disbursement Date	City/Town	Region	Purpose of Loan	Criteria for section
71	524951			2016/01/07	Kasese	Western	Clinic expansion	hence able to assess impact on the medical facility as a business General medical
71	542059			2017/05/26	Kasese	Western	Working capital for inventory	
64	436257	Rutahigwa Elisa	Rujumbura Medical Services Limited	2013/07/22	Rukungiri	South Western	Additional working capital	- South Western - Rural - Multiple loans (*4) since 2013 hence able to assess impact on the medical facility as a business - General medical services
64	519435			2015/07/23	Rukungiri	South Western	Additional working capital.	
64	519361			2015/11/11	Rukungiri	South Western	Working capital	
64	501617			2015/01/22	Rukungiri	South Western	Additional working capital	
74	531348	Twine David	Quality Clinic	2016/04/01	Rukungiri	South Western	Purchase of equipment for the clinic	- South Western - Rural - Multiple loans (*3) since 2015 - General medical
74	524943			2015/10/01	Rukungiri	South Western	Purchase of medical equipment	
74	524953			2016/01/25	Rukungiri	South Western	Purchase of medical equipment	
73	436260	Twesiime Innocent	Polly Care Medical Centre Rubaare	2013/08/28	Ntungamo	South Western	Construction more clinic rooms	- South Western - Rural - Old client since 2013 - General medical services
73	524957			2016/03/31	Ntungamo	South Western	Clinic expansion	
4	519424	Anguyo	Kigonzi	2015/07/10	Kabale	South	Purchase of medical	South Western

ANNEX 5 – LIST OF INTERVIEWEES

Facility ID	Transaction Report ID	Beneficiary Name	Facility	Disbursement Date	City/Town	Region	Purpose of Loan	Criteria for section
		Geoffrey	Nursing Home			Western	equipment	Urban
24	519423	Kamara Thadeus Nicholas	Reni-Homely Clinic	2015/09/01	Kabale	South Western	Purchase of medical equipment	- South Western - Urban
11	519436	Baluku Sunday Dan	Holistic Medicare Clinic	2015/07/24	Mbarara	South Western	Renovation of clinic premises	- South Western - Urban - Multiple loans since 2014 - General medical services
11	519362			2015/11/11	Mbarara	South Western	Purchase of laboratory equipment	
11	499092			2014/10/07	Mbarara	South Western	Renovation of clinic premises	
27	424028	Kigaane Muhumuza Solomon	Engari Community Health Centre	2013/04/16	Ibanda	South Western	Construction of theatre,	South western - Rural - Construction of theatre - Old loan (2013) hence easy to assess impact on the community
53	434607	Nangero Ruth	Kanana Pharmacy	2013/06/25	Lyantonde	Central	Add working Capital to the clinic	- Central - Rural - Multiple loans (*5) since 2013 hence easy to assess impact - Pharmacy
53	501614			2015/01/22	Lyantonde	Central	Additional working capital	
53	519434			2015/07/23	Lyantonde	Central	Increase working capital	
53	519360			2015/11/11	Lyantonde	Central	Working capital	
53	531245			2016/08/03	Lyantonde	Central	Working capital for inventory	

ANNEX 5 – LIST OF INTERVIEWEES

Facility ID	Transaction Report ID	Beneficiary Name	Facility	Disbursement Date	City/Town	Region	Purpose of Loan	Criteria for section
67	434606	Semakula Emmy	Devine Orthopedic Clinic	2013/07/20	Lyantonde	Central	Increase working capital	- Central - Rural - Multiple loans (*5) since 2013 hence easy to assess impact - Specialised medical service
67	501615			2015/01/22	Lyantonde	Central	Additional working capital	
13	436188	Doctor's clinic Seguku Limited	Doctor Seguku Clinic	2013/07/04	Wakiso	Central	Purchase of land to expand theatre	- Central (Kampala Suburb) - Urban - Loan in 2013 expansion of theatre - General medical services
55	519426	Nanvuma Gladys Lugoloobi	Nkokonjeru Pharmacy	2015/07/20	Buikwe	Central	Additional working capital.	- Central - Rural - Loan in 2015 for additional working Capital - Pharmacy



Evaluation of Health Guarantee to Centenary Rural Development Bank in Uganda

This evaluation was commissioned by the Embassy of Sweden in Kampala with the purpose to assess health-related outcomes of the Sida/USAID supported Health Guarantee to Centenary Rural Development Bank (CRDB) in Uganda.

Sida and USAID entered into a guarantee agreement with CRDB Uganda in 2012. The guarantee is set-up as a loan portfolio guarantee covering term-loans to privately-owned and operated micro, small, and medium enterprises as well as healthcare workers in the health value chain. The main objective of the guarantee for Sida was to increase access to private health care in Uganda, with special attention to rural areas, by catalysing private capital for investments in the health sector.

The evaluation focused on two key areas; what extent the loans provided under the guarantees contributed to improved access to health for poor people and, to which degree this project intervention model has supported the development of the private sector in Uganda. The evaluation applied the following four of the five OECD/DAC standard criteria; relevance, efficiency, effectiveness and impact.

The evaluation provides key recommendations to Sida, and presents lessons learned central to the successful implementation of similar projects in the future, either in Uganda or elsewhere.

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