INSTITUTIONAL SUPPORT FOR THE PRIVATE-NON-FOR PROFIT (PNFP) HEALTH SUB-SECTOR TO PROMOTE UNIVERSAL HEALTH COVERAGE IN UGANDA

1. Background and justification

1.1. Background

1.1.1 Overview

Most developing countries face enormous structural problems such as financial shortages, inadequate human resources and poor infrastructures, which result in a poor quality of health services and insufficient coverage. Public funds for health services are becoming more and more scarce and insufficient to cover a constantly growing demand of health services. Both governments and donor agencies are becoming aware that to increase access to health services and assure equity, the public sector should work together with private sector health providers. The present global context calls for a mobilization of all available resources, public and private, towards the common objective of Universal Health Coverage (UHC).[1,2]

To utilize the full potential of the collaboration with the private sector, many African countries have already established Partnership Desks or Units within their respective MoH (Ghana 1997, Uganda 2000, Ethiopia 2007, Nigeria 2007, Zambia 2008, Kenya 2009). In addition, Ghana in 2003 and Uganda in 2012 have developed and approved a national policy for partnership with the private sector (National Policy on PPPH). These policies represent a unique opportunity to expand the capacity of the government to deliver health services with the full involvement of the private sector.[3]The Health Sector in Uganda has developed a realistic National Health Policy (2010/20) and Health Sector Strategic & Investment Plan (2010/15) which assigns a relevant role to the PNFP sub-sector in the achievement of the national health objectives. Thus, Uganda offers the opportunity to work with the PNFP sub-sector in an institutional way, in line with the indication of the Belgium Development Cooperation Policy Note which envisages the involvement and collaboration with key players from the civil society as a means to constructively reinforce democratization.[4]

1.1.2 The National Policy on PPPH

The complementary role between PNFP and government health services and the strategies to strengthen this complementarity is stated in a mutually agreed National Policy on PPPH.[5] The policy has the vision of *"universal access to affordable health care for all population of Uganda through an efficiently integrated public-private partnership in health"* The goal of the National Policy is to contribute to strengthening the national health system with the capabilities and full participation of the private sector. This will be achieved through establishing a clear institutional and legal framework to utilize the full potential of the public and private partnership in Uganda and supporting the functional integration of a pluralistic health care delivery system by optimizing the equitable use of available resources. The National Policy on PPPH also defines guiding principles, strategies, structures and tools of the partnership. However, most of the principles and strategies are still yet to be implemented, while some of the structures of representation and consultation are still to be established. The present level of public-private partnership in health service delivery leaves significant margins for improvement.

1.1.3 Public private partnership in the health sector in Uganda

The public and private sector are working in partnership with clearly defined roles and responsibilities. The public sector consists of the Central government, which is responsible for shaping the National Health System and leads in policy formulation and strategic plan. The Local government is responsible for implementing the health policies and managing service delivery at district level operating the government-owned health facilities. The private sector provides health services to the community where they operate by complementing the public sector and contributing to policy formulation, planning and evaluation. In Uganda, the private sector consists of three broad categories of service providers 1) the Private Not For Profit (PNFP), 2) the Private Health Providers (PHP) and 3) the Traditional and Complementary Medicine Providers (TCMP). The PNFPs are divided into two groups: the facility-based PNFPs (FB-PNFP) which offer comprehensive preventive and curative care; and the non-facility-based PNFPs (NFB-PNFP), which do not offer comprehensive services, but rather carry out advocacy, health education and community mobilization and may also provide health services at community level. NGOs and CSOs are also included under the NFB-PNFP[1].

In addition, PNFP are able to mobilize resources for health care at local and international level and during the past years, their contribution to the national health system has been significant in bridging the resource gap. Through the recently approved National Policy on PPPH the GoU acknowledges and formalizes the important role played by the private sector in health service delivery. Of all the private sector providers, the FB-PNFP have a long dated and strong partnership with the MoH since they are currently the most organized and aligned with the HSSIP priorities, with an emphasis on provision of services to rural populations, and they give a relevant contribution in delivering the Uganda National Minimum Health Care Package (UNMHCP) to the target population.

1.2. Justification for the project

The PNFPs constitute a significant fraction of Uganda's health care system with most of them being rural and complementing government efforts to reach the less accessible. One additional advantage PNFPs have, which partly accounts for higher performance and makes the sub-sector particularly attractive for funding, is that the medical bureaus allow great degree of autonomy at facility level thus providing closer supervision and more responsive decision making. The PNFPs governance and management structures also recognize the need for complete accountability and have made deliberate efforts to improve this toward internationally acceptable standards.

The government grant given to PNFPs, which in the past (FY 2003/04) represented 6% of total Government of Uganda health sector budget, presently amount to just 2% of the national health budget. On the other hand, PNFPs provide 35 to 40% of the output of the HSSIP indicators (17% of Out-patients, 35% of deliveries and 35% of DPT3 doses). Furthermore, it is generally agreed

[1] An extract from National Policy on PPPH, pages 4-6

that PNFP is able to provide higher quality of care, as compared to the public facilities, at a lower cost. It has been reported that PNFP facilities treat approximately three times more outpatients per professional employee than government facilities.[6]From a business-like point of view, the GoU is getting higher return for money (value for money) given to PNFPs in terms of HSSIP output indicators, in terms of increasing access in rural areas and in terms of demonstrated efficiency and productivity. Some HDPs are also utilizing PNFP in complementary way together with MoH to deliver health services to the population. However, in most cases this modality is utilized for specific programmes (Malaria, HIV/AIDs etc) or cover specific facilities or institutions.

Although the PNFP sub-sector contributes significantly to the Public health service delivery in Uganda and represents an essential stakeholder to achieve UHC in Uganda, it is currently facing the following constraints:

- The coordination and complementary roles of PNFP and government services are not optimal, leading to inefficient use of scarce resources.
- The sub-sector has difficulties in structuring levels of care and coordinating the referral system with the public facilities
- The PNFP facilities encounter problems related to diminishing funding and an inefficient resource allocation mechanism of GoU subsidies, presently not linked to work load.

It is against this background that the new IDCP 2012-2016 for Uganda that was signed in April 2012 provided a budget of 8million Euro to support the PNFP sub-sector. The project will first support the stewardship role of the MoH, facilitating the establishment of the coordination structure to effectively implement the partnership for a better long-lasting collaboration between PNFP and the government. Then, it will concentrate its efforts in enhancing the governance of the partnership and improving the financial allocation mechanism which presently rule the disbursement of subsidies. This action is expected to reduce leakage and diversion of funds allocated to PNFP presently not reaching the intended structures, and estimated at 25% of the GoU contribution. When the system will give sufficient guarantees of transparency, the project can utilize part of the total allocation to finance concrete needs of the PNFP sub-sector and reverse the present trend in allocation of subsidy for the PNFP, which have been stagnating since FY 2003/04. To promote equity, an effort will be done in linking level of subsidies for each facility to agreed services outputs with the objective of increasing access to health services to the most vulnerable population, as stated by the National Policy on PPPH and HSSIP.

2. Proposed partner institution

The project will be directly implemented by the MoH. To facilitate the operationalization of the National Policy on PPPH, the MoH has approved the establishment of a PPP Unit within the Planning Division. This decision is now waiting for the necessary endorsement by the Social Services Committee to create the new positions for the staff who will work in the Unit. It is proposed that the project would be anchored within this PPP unit to facilitate the startup phase of this structure, which is expected to be institutionalized during the life of the project.

3. General and Specific Objectives of the Project:

The NHP II and HSSIP share the same goal: *"To attain a good standard of health for all people in Uganda in order to promote a healthy and productive life"*. The strategy to achieve this goal is **"***To ensure universal access to quality Uganda National Minimum Health Care Package (UNMHCP) consisting of promotive, preventive, curative and rehabilitative services for all prioritized diseases and conditions, to all people of Uganda, with emphasis on vulnerable population* .The main focus is on preventive care, specifically for young children and pregnant women. An increased capacity of public and private facilities, together with a reduction of user fees, are the necessary conditions to provide greater access to basic health services for the poor. To achieve this goal the project will have the following objectives.

3.1. General objective

- Contribute to strengthen service delivery capacity at district level to effectively implement PHC activities and deliver the UNMHCP to the target population.

3.2. Specific Objective

- Build the capacity of the MoH to strengthen and effectively implement the partnership with the PNFP sub-sector, supporting its stewardship role and enhancing governance of the sub-sector, in addition to improving the funding and disbursement mechanisms currently utilized by GoU to subsidize the PNFP and delivering additional financial resources to the sub-sector.

4. Location, target groups and beneficiaries

4.1. Location and target groups

This is a national project that will target all levels of the health sector supporting both public and private institutions at central, district and facilities level.

Central level target group

The project will support the MoH in refining and creating conditions for an effective partnership with PNFP. First, it will support the MoH to make the PPP Unit fully operational and fulfill its role of coordination and improvement of the governance of the public private partnership.

Once the PPP Unit will be fully operational, support will be provided to the PNFP sub-sector, mainly to strengthen the managerial capacities of the four Medical Bureaux, but also to facilitate the establishment of national representative bodies and coordination structures for the NFB-PNFP, NGO and CSO, already operating in the health sector, but in most cases not aligned and coordinated with the MoH initiatives.

As a first step to supporting NFB-PNFP, NGOs and CSOs, the project will encourage the regulation of the sub-sector and the creation of their national representative bodies.

District level target group

While targeting the Health Districts and their planning process, the project will also facilitate the creation of coordination structures for the PNFP at district level to institutionalize the partnership as foreseen in the National Policy on PPPH (Page 19-23).

The MoH facilities will indirectly benefit from the intervention as a result of better coordination and complementarity expressed by the joint district planning. An integrated planning at this level will allow optimal resource allocation.

Community level target group

The project will directly target PNFP Hospitals and Health Centers. The FB-PNFP that currently have national representative bodies and coordination structures through the four medical Bureaux will be given priority in line with national policy on PPPH.

4.2. Beneficiaries of the project

In line with the goal and objectives of the NHP, HSSIP and National Policy on PPPH, the project's beneficiaries will be represented by all the population of Uganda, through the universal access to the UNMHCP. The PNFPs constitute a significant fraction of Uganda's health care system with most of them being rural and complementing government efforts to reach the less accessible. Specifically, the majority of the beneficiaries are the communities in rural and remote areas where the services of PNFP facilities are concentrated.

Due to the difficulties in identifying the poor and again the poorest of the poor, the Medical Bureaux recommend focusing on vulnerable groups when implementing exemption and flat fee policies, including without limitation: a) Pregnant women; b) Children under 5 years of age. Therefore within the rural and remote communities, the project will give priority in particular to pregnant women and children.

5. Alignment to the MDGs, country NDP and national health policies

5.1 Link with the MDGs.

The link with the MDGs is clear in the aim of the project to increase service delivery and access for the most in need population, both through a reduction or abolition of user fees as well as with an increase in services offered. The strategy to reduce user fees for pregnant mothers and children will impact mainly maternal and infant mortality rate in line with objective 5 and 4 of the MDGs.

5.2 Link with NDP.

The NDP strategy for the health sector aims at implementing the HSSIP through a single harmonized in-country implementation effort which will involve all stakeholders. This includes the full integration of PNFP sub-sector support and activities within a joint national plan. The project strategy is perfectly in line and consistent with the NDP aim and its strategies for the health sector listed below (Page 258):

"Strategy 1. Provide integrated promotive, preventive, curative and rehabilitative services that have been proved effective, cost effective and affordable in conjunction with the private sector."

"Strategy 2. Improve access to quality hospital services at all levels in both the public and private sector"

5.3 Link with the NHP II and HSSIP

Both, the NHP II and HSSIP share the common objective *"To effectively build and utilize the full potential of public and private partnership in Uganda National Health development by encouraging and supporting participation in all aspect of the National Health Policy, at all levels, and according to the National Policy on PPPH."*

To achieve this objective, the NHP II defines, among the four priority areas the following:

"Establish a functional integration within the public and between the public and private sectors in healthcare delivery, training and research."(Page 14)

Meanwhile the HSSIP, among others, specifically mentions the following interventions (page 128):

"Establish PPPH structures at central and lower level necessary to facilitate coordination and consultation among partners and promote active participation of the private sector in district health planning and service delivery"

"Support CSOs to streamline organization, coordination and regulatory mechanisms to strengthen their role in policy formulation, funding and service delivery"

"Develop and implement in consultation with PNFP a MoU which would link level of subsidies to agreed services outputs with the objective of increasing access to health services for most vulnerable population."

These strategies and interventions are consistent with the project specific objectives and the link between the project and the national policies is evident.

5.4 Link with the National Policy on PPPH

The National Policy on PPPH's vision, goal and general objectives are consistent with the Project's goal and objectives. In addition, the National Policy clearly states the priority areas and implementation strategies of the partnership with PNFP, the tools and mechanisms which will guide the project towards the defined objectives.

6. Project synergy with other bilateral and multilateral interventions

The institutional support to the PNFP should be strategically delivered to achieve a synergistic effect in relation to the programs supported by other bilateral and multilateral development partners in the health sector. So far most of the partners have funded the PNFP sub-sector at different times and to a different extent. Some HDPs try to balance their funding between the

public and private sector (DFID), others give priority to the PNFP as receptor of international aid (USAID), concentrating on the sub-sector a greater amount of resources than those disbursed to the GoU. The most common approach to support the PNFP sub-sector, across all HDPs, is to deliver directly the assistance to the facilities, without the involvement of the GoU, the MoH, and in same case even the Medical Bureaux (CDC). This approach creates problems of overlapping, increased transaction costs with an additional administrative burden for the PNFP facilities, and it is certainly not in line with the Paris Declaration and the all-encompassing principles of alignment and harmonization.

The new project will represent an opportunity for alignment and coordination of the various interventions in support to the PNFP sub-sector within the institutional framework and the strategic objectives of the HSSIP. In particular, a fully staffed and efficient PPP Unit in the MoH will be essential to rationalise the support for PNFP. However, the effective coordination of the various interventions in support to the sub-sector will depend on the capacity of the MoH to fulfil its stewardship role and the willingness of the HDP to align their interventions. The prospects for realisation of these potentials can be better assessed during the formulation phase.

Table 1summarises the potential for synergies between the proposed institutional support to the PNFP and interventions by all other development partners as seen through the lens of relevant development objectives and approaches.

Table 1: Summary potential for synergies

	HDP (health sector)	Development objective(s)	Working approaches	Potential for synergies
1	**EU**	Eradication of poverty in the context of sustainable development with particular focus on attainment on the MDGs	Strengthen civil society capacity to advocate for service delivery and monitor GOU performance	Off track MDGs for Uganda are the health MDGs (3 & 4). Improved availability of PNFP health services is likely to contribute to moving these MDG targets. Stronger civil society should result in increased demand for health services including PNFP services
2	**SIDA**	Improved access to health services by poor populations and reduced spread of HIV and AIDS	Human rights approach, respect for democratic principles Focus on developing joint donor mechanisms to channel funding to civil society and the private sector	Possible linkages between SIDA and BTC within an earmarked funding approach for the facility based PNFP
3	**DFID**	Support Uganda in its transition to a prosperous and stable democracy, positioned to exploit the benefits of oil for all Ugandans and able to protect the interests of the most vulnerable.	Use of program and project based instruments to improve accountability, foster private sector growth	A possible cross learning opportunity exists from the DFID funded results based financing project involving facility based PNFP in Northern Uganda.

			and use innovations to achieve results for the poor	Possibility to exclude PNFP facilities in the Acholi region for the funding
4	**Italian Cooperation**	Human development, with particular reference to district health management	Strengthen public private partnerships	Current focus on PPPH strengthening at district level provides opportunity to generate evidence for district monitoring of service delivery by PNFP in a context of increased inputs
5	**USAID**	Improved health and nutrition status in focus areas and population groups	Health systems strengthening to address underlying service delivery by both government and private sector providers	Provision of technical assistance for strengthening PNFP management, business and supply chain systems enhances PNFP capacity to utilize institutional support more efficiently and sustainably
6	**WB**	Strengthening Health System	Align with national priorities, ensure development partner coordination	Opportunities for sharing information and levering synergies for policy dialogue through the Local Development Partners Group (LDPG) chaired by WB
7	**IFC**	Support the operationalization of the National policy on PPPH	Provide technical assistance to MoH to disseminate and implement the National Policy on PPPH	Possible division of labour in the startup phase and operationalization of the PPP Unit, in the Dept. of Planning, MoH. Support to joint district planning.
8	**UN**	Vulnerable populations in Uganda, especially in the north, of Uganda increasingly benefit from sustainable and quality social services by 2014.	Building the capacity of individuals, families and communities to demand for and utilize health services with focus on vulnerable populations	Possible synergies at national and system levels to share good practices and influence policy dialogue for access to services by vulnerable populations in rural areas
9	**CDC**	Comprehensive provision of comprehensive HIV services and control of outbreaks and epidemics	Competitive tender and direct contract to PNFP facilities for cash and in kind support	Integration of this support in the district planning to improve coordination and synergy other public and private district health activities

7. Cross cutting issues

7.1 Social Economy

In 2008/09 Uganda has an estimated population of 30.7 million persons and with a population growth rate of 3.2% the population is estimated to rise to 37.9 million by the end of the HSSIP (2015), with 88 % of the population living in rural areas. The percentage of the population living below the poverty line was 31 % in 2005. Poverty continues to be a rural phenomenon with 96% of the poor living in rural areas in 2004/05. Most of the rural population is served by PNFP. A

direct relationship exists between poverty and prevalence of diseases such as malaria, malnutrition, diarrhea and NTDs as they are more prevalent among the poor compared to the rich households.[7]

The vision of the NHP is "A healthy and productive population that contributes to socioeconomic growth and national development" and the goal "to attain a good standard of health for all people in Uganda in order to promote a healthy and productive life". The project is expected to contribute to this goal by increasing access to health services for the most poor and in need population, through a reduction in user fees, and concentrating on strengthening peripheral health services.

7.2 Gender

Gender roles and relations directly and indirectly influence the level and quality of the utilization of health services. This has been recognized in the NHP II and gender mainstreaming is premised on one of the guiding principles reading that "a gender-sensitive and responsive national health system shall be achieved and strengthened through mainstreaming gender in planning and implementation of all health programmes." Similarly, the HSSIP calls for a gender-sensitive and responsive health care, policy formulation & programming, gender norms, roles and relations. It includes among its recommendations "Achieving equity in health should be prioritized by the sector", this is refereed to allocation to all sector investments since "disparities in health services are often a reflection of disparities seen in investments".

There are several opportunities in the project to assist in the conceptualization of the gender and human rights concepts both at national and LGs levels. Among these are: to focus on identifying gender issues and how to plan to address them during the joint public-private district planning; to develop knowledge and understanding by key stakeholders on gender issues. The project objective to improve service delivery at district level will have a direct impact on reduction of maternal mortality and all pathologies and disabilities related to delivery. To monitor the implementation of the project objective, priority will be given to specific maternal health indicators (TT immunizations, ANC and PNC visits, number of assisted normal deliveries, cesarean sections, etc.)

7.3 Children rights

The GoU has ratified the convention on the Rights of the Child in 1990. In 2003 a report was submitted to the Committee on the Rights of the Child in 2003. Some of the recommendations from the Committee in 2005 are health related, including:

- to take all necessary measures to strengthen programmes for improving health care supporting those programmes with adequate resources and paying particular and urgent attention to mortality rates, vaccination uptakes, nutrition status, and management of communicable diseases and malaria;
- to provide children with disabilities with access to adequate social and health services;
- to ensure that professionals working with and for children with disabilities, including medical and paramedical personnel, are adequately trained;
- to prevent discrimination against children infected with and affected by HIV/AIDS
- to undertake comprehensive study to assess nature and extent of adolescent health problems and, with participation of adolescents, use it as basis to formulate adolescent

health policies and programmes with particular focus on prevention of early pregnancies and sexually transmitted infections, especially through reproductive health education

The project will contribute to the fight against child mortality and childhood disease, by concentrating efforts on the peripheral health facilities and rural areas where the bulk of sick children consult to fight child mortality. In addition, the project will facilitate access to health services for children promoting the abolition of user fees for all children less than 5 years, regardless of the diagnosis.

7.4 HIV/AIDS

Uganda has been badly hit by the HIV/AIDS epidemic Thanks to relatively early action in the field of information and prevention, the HIV/AIDS prevalence has come down but the national prevalence rate of 6.5% is still high and slightly on the rise again. Each year 124.300 people are newly infected and 64.000 people die from AIDS related diseases. Less than 50% of people in the need of treatment (CD4<350) have access. Ongoing procurement and logistic problems, high costs of drugs and commodities, limited physical and human resource capacity at district and facility level of the delivery of comprehensive care as well as the creation of parallel systems as a result of the vertical programmes are just some of the challenges in the fights against the epidemic. Strengthening the PNFP hospitals and lower level facilities capacity should have an impact on increasing the coverage of all national health programs, including the national HIV/AIDS programme. It should contribute to the effective decentralization of VCT and ARV services and increasing access to these services for the most vulnerable populations.

8. Budget and duration of the Project

The Project of institutional support to the PNFP sub-sector will have a total budget of 8 M Euro with an indicative duration of four years. The financial resources available will be utilised to achieve the project objectives implementing a pilot project approach. Given the set conditions, part of the allocation will be utilised during the duration of the Project to increase the current level of subsidy for the PNFP.

This will allow to explore the feasibility and possible risks of the financial mechanism jointly developed with the other stakeholders and, at the same time, assess the actual impact of the increased resources on the level of user fees and consequently on accessibility and service delivery.

A period of four years will not be enough to ensure the sustainability of the Belgian intervention. A commitment over a period of three consecutive IDCPs is therefore envisaged, as support over a longer period will more easily induce a change as well as consolidate it.

9. Sustainability

By improving the capacity of the health sector through supporting the newly established PPP Unit within the MoH and the implementation of the National Policy on PPPH, the sustainability will be guaranteed. The project will support MoH to implement its national health strategy and enable it gather the full benefits of the public private partnership in health. To achieve this, the MoH will have to develop a better level of partnership with the PNFP sub-sector in line with the HSSIP strategies to deliver heaths services to the population.

Secondly, the possibility that the institutional support to the PNFP will lead to a national system to subsidize the sub-sector, where government and HDP resources can converge, will depend on the capacity of the project to develop a sound and robust mechanism for channeling resources to the intended beneficiaries and link the same resources to the expected outputs. The development of such a mechanism is a strategy of the National Policy on PPPH and the HSSIP. The project will only support its establishment with the expectation that an efficient and transparent system will be accepted by other donors and will attract more resources from both HDP and Government. Hence, the success of the project and its capacity to achieve the set objectives will be the best guarantee of the sustainability of the system and its capacity to continue working in the years to come, even after the conclusion of the BE support.

There are additional considerations to be done while taking into account the sustainability of the intervention:

- **Development of the Health Financing Strategy (HFS)**. The MoH is presently engaged in the preparation of the national HFS. This is one of the HSSIP activities to be completed before the end of the HSSIP cycle in 2015. The HFS, together with the definition of a National Health Insurance Scheme (NHIS), should include the joint HDP/Government system to support the PNFP sub-sector. The integration of the subsidy system for PNFP in the HFS, and the possibility to channel funds to the sub-sector, additional to the present GoU allocation, will contribute to the sustainability of the initiative. Although the formulation of the HFS is a responsibility of the MoH, the HDP have called for wider consultation and a more active role in the definition of the strategy. BE in coordination with all HDP should make sure that the issue of funding the PNFP sub-sector will be addressed.

- **Reestablishment of an efficient district planning cycle**. The Planning Dept. of MoH is currently working to resume the district planning process, which has collapsed during the past years due to the increased number of districts and the insufficient work force in the Planning Department. The ICB Project is supporting the Planning Department in this activity utilizing the experiences gained during the past years in the two regions of Ruwenzori and West Nile. The new district planning will be conducted through regional workshops and with the active involvement of the PNFP representatives. The shift from a District/MoH planning to a joint public private district health planning will represent the best way to operationalize the National Policy on PPPH. This process will increase district stewardship and guarantee the inclusion of the PNFP facilities in the district plans, reflecting their role, expectation in terms of results, and financial needs. The inclusion of the resources for PNFP in the district plan will be a necessary condition to make sure that the funds allocated at central level will effectively reach the service delivery level.

- **Improved funding mechanism**. The Project aims to improve the funding and disbursement mechanism, currently utilised by the GoU to subsidize the PNFP, making it more efficient and transparent. The capacity of the project to develop a sound and convincing financial mechanism may directly affect the possibility to receive support from other HDP, which in the future can first integrate and then replace the current BE allocation.
  The SIDA Final Report evaluation on the Health Sector Programme Support in Uganda (2000-2010)[8] recommend an on-budgeted and more directly earmarked support for the PNFP, to overcame the stagnation of the current GoU funding and accelerate positive performance, as an additional potential modality and a possible new approach to deliver aid to the country. The recommendation is based on the same rationale of the institutional support to the PNFP. In this case, the future sustainability of the intervention for institutional support of the PNFP sub-sector will depend on the capacity of the project to produce the expected results.

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