Policy for Public-Private Partnership for Health in Uganda.

Lessons from the Private Not-for-Profit Sub-sector.

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Ronald Kiberu Ssekabembe
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Dedication

This paper is dedicated to all vulnerable groups in Uganda that lack access to essential health services.

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List of Acronyms

AHSPR	Annual Health Sector Performance Report
ANC	Ante Natal Care
ARV	Antiretroviral
BEmOC	Basic Emergency Obstetric Care
BFP	Budget Framework Paper
CEmOC	Comprehensive Emergency Obstetric Care
CUAMM	Doctors with Africa
DDHS	District Director of Health Services
DPs	Development Partners
EPI	Expanded Programme for Immunisation
FY	Financial Year
GFATM	Global Fund for AIDS, TB and Malaria
GoU	Government of Uganda
HC	Health Centre
HDP	Health Development Partners
HMIS	Health Management Information System
HPAC	Health Policy Advisory Committee
HSSP	Health Sector Strategic Plan
HUMC	Health Unit Management Committee
JRM	Joint Review Mission
JMS	Joint Medical Stores
LLUs	Lower Level Units
MDGs	Millennium Development Goals
MOFPED	Ministry of Finance, Planning and Economic Development
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non Government Organisation
NHA	National Health Assembly
NHP	National Health Policy
NMS	National Medical Stores
NPM	New Public Management
OPD	Out-patient Department
PEAP	Poverty Eradication Action Plan
PEPFAR	President's (Bush) Emergency Plan for AIDS Relief
PHC	Primary Health Care
PHC-CG	Primary Health Care Conditional Grant
PHP	Private Health Practitioners
PMTCT	Prevention of Mother to Child Transmission
PNFP	Private not-for-profit
PPPH	Public-private partnership for Health

PPPH WG	Public-private partnership for Health Working Group
SWAP	Sector Wide Approach
TCMP	Traditional and Complementary Medicine Practitioners
UDHS	Uganda Demographic and Health Survey
UNMHCP	Uganda National Minimum Health Care Package
VCT	Voluntary Counselling and Testing
UCMB	Uganda Catholic Medical Bureau
UMMB	Uganda Muslim Medical Bureau
UPMB	Uganda Protestant Medical Bureau
WHO	World Health Organisation

Abstract

Starting in financial year 1996/1997, the Uganda government entered into a public-private partnership for health (PPPH) with the private not-for-profit sub-sector with an overall aim of curtailing the health crisis and improving its outlook. Specifically this partnership aimed at increasing accessibility, quality, efficiency, equity and sustainability of health services. The paper traces the history of this collaboration in Uganda including the current situation. It investigates the outcomes from this partnership with a thorough reflection on the triggers, conditions and challenges which could have influenced them.

Relevance to Development Studies

Poverty and its causal factors represent a central theme in development studies. In most developing countries ill health is one of the major causes and consequences of the worrying levels of poverty because it forces poor people to re-allocate their scarce resources on health care costs like transport, user-fees and medicines. The consequences could be adverse if the affected households are forced to liquidate their income-generating assets like livestock and land in order to meet these costs and at times entering into indebtedness.

In addition, poor health affects the household labour pool through the inflicted losses by sick individuals and the able-bodied ones who take care of them. With this vicious cycle, opportunities for improving health services have to be explored. In most developing countries, given the state's lack of resources for meeting these complex health needs, partnerships with the private sector could be a viable alternative. Given this background, the researcher explored the opportunities created by a public-private partnership for health in Uganda, especially with regard to its ability to improve accessibility, quality, efficiency, equity and sustainability of health services.

Keywords

Health, Public-Private Partnerships, Not-for-Profit Sub-sector, Primary Health Care, Uganda

CHAPTER ONE: INTRODUCTION

1.1 Background

Health constitutes a significant aspect in poverty reduction and several health indicators are part of the millennium development goals. The presence of good health improves people's well-being, income, production and economic growth. However, in most developing countries, deficiencies in public health systems sustain a vicious cycle of poverty and ill health, which mandates reforms aimed at "improving the functioning and performance of the sector and ultimately the health status of the people" (WHO 1997 cited in Bjorkman and Raman 2008: 3). Examples of such reforms include alternative financing, institutional management, public sector reforms and collaboration with the private sector (Abrantes 2003, Thomson 2002, WB 1993 all cited in Bjorkman and Raman 2008:3).

Amongst these strategies, partnerships seem popular given persisting fiscal problems, budget crises and shrinking social sector expenditure coupled with perceptions of inefficiencies and unresponsiveness associated with most governments. In addition, proponents of public-private partnerships argue that neither the public nor the private sector can independently operate in the best interest of health systems; rather both can gain from each other (ADBI 2000, Agha et al 2003, Bloom et al 2000 all cited in Bjorkman and Raman 2008).

Partnerships could incorporate features like performance contracts for service delivery, sharing of staff, institutional innovations, decentralization and involvement of the private sector in health policy-making (Brinkerhoff 2002a).The rationale for their adoption usually includes motivations for efficient utilization of scarce resources, mutual learning and sharing of ideas, and recognition of global interdependence (Fowler 1999 cited in Morse and McNamara 2006).

Though attractive, partnerships should be viewed with scepticism on their conceptual and practical underpinnings. For example the 'traditional public administration' perspective perceives them as vehicles for diluting political control over decision-making, while the New Public Management (NPM) school sees them as mechanisms that undermine competition between potential providers (ibid).

Partnerships with the private not-for-profit sector pose problems for government of exercising management supervision, ensuring a degree of accountability and encouraging coordination especially when decision-making is widely dispersed and vested in organizations with their own independent sources of authority and support (Salamon 1995: 103 cited in Bovaird 2004: 200). Salamon (1995) adds that public-private partnerships raise major governance issues for the non-profit sector because of the potential loss of independence, 'vendorism' or the distortion of the agency's mission in pursuit of available government funding and the resulting loss in flexibility and local control. Despite these contestations, partnerships remain dominant policy options that raise implementation questions like: whether they should be continued without further refinement, their effectiveness in meeting set goals and available lessons for their improvement (Lasker, Weiss and Miller 2001).

Narrowing to the Ugandan experience, the vicious cycle of poverty and poor health has been widely documented with poverty and illiteracy recognized as the underlying causes of the health situation (MOH 1999 cited in MOH 2008). With health accessibility limited to less than half of the population, there was concern

among policy makers for options that could address health sector development. As a result, government developed a policy on public-private partnership for health (PPPH) with an overall aim of increasing equity, accessibility, efficiency, quality and sustainability of essential health services.

This partnership policy is consistent with the Sector Wide Approach (SWAP), National Health Policy (NHP) and the Health Sector Strategic Plan (HSSP) and includes several actors like private not-for-profit (PNFP) providers, private health practitioners (PHPs), and traditional and complementary medicine practitioners (TCMP) in areas like policy formulation and development, co-ordination and planning, financial resource mobilization and allocation, human resource for health management, monitoring and evaluation of health care delivery outputs and service delivery/ health sub-district management. The undertaken partnership is envisioned to maximize the comparative advantage of both sectors and is governed by guiding principles like responsibility for policy and service provision, complementarity, identity, autonomy, equity, transparency and accountability.

To this end the study examines this partnership between the Uganda government and facility-based private not-for-profit providers (FB-PNFP) which include the non-profit oriented organisations that have a large infrastructure base of hospitals and health centres, which they use to provide health services and train health workers. This area of study was selected because there are mixed opinions and resentments by various stakeholders about the progress ascertained by this partnership and the implementation process (MOH 2008: 12). Also, since PNFPs own 42% of the 99 hospitals, 28% of the 1,617 lower level units and 30% of the human resources in the country, there was a justified need to study them with an aim of deriving lessons for partnership improvement.

Emphasis is laid on assessment of the outcomes of partnering using the yardstick of the pre-set objectives of increasing accessibility, equity, quality, efficiency and sustainability of health services. As expressed in chapter four, there are varied outcomes on these parameters based on the time context which is due to the various factors and challenges discussed in chapter five.

1.2 Research Questions

1.2.1 Main Research Question

Has public-private partnership for health with the facility-based private not-for-profit sub-sector in Uganda realised the intended outcomes?

1.2.2 Sub Questions

1. What have been the outcomes of this partnership in terms of increasing accessibility, equity, quality, efficiency and sustainability of health services in Uganda?
2. What factors and conditions influenced the outcomes of this partnership?

1.3 Research Methodology and Limitations

To operationalise the research, the study combined a desk review with twelve key informant interviews. Generally, the study adopted these methods given the resource limitations that controlled the researcher. A desk study was chosen because several

forms of grey literature were available while key informant interviews were preferred because of the accessibility of informants. Data collection was undertaken in the months of July and August 2008.

The study was limited to facility-based private not-for-profit (FB-PNFP) sub-sector. Non-facility-based private not-for-profit (NFB-PNFP) providers, private health practitioners and traditional and complementary medicine practitioners were excluded due to resource constraints.

Key informants were purposively selected for their previous involvement in PPPH implementation. These included ministry of health, public service and finance officials, facility-based private not-for-profit officials and development partners as highlighted in Annex A. Because of time and logistical limitations, the researcher was unable to target some key actors which in the process could have influenced the findings in chapter four and five. Among those missed were political leaders at the centre, district political leaders, health care users represented by the respective civil society organizations and district health officials (district health officers, PPPH desk officers and in charges of health sub-districts). The data collected were analyzed according to key issues and themes that emerged with specific reference to the Brinkerhoff (2002b) framework.

Practical Limitations

Given that the field research occurred at end of the financial year, most key informants were on leave. In addition, time and logistical limitations prevented the researcher from following up on some of the emerging issues with individual hospitals, dioceses and local governments.

1.4 Structure of the Paper

The paper comprises six chapters. The first chapter provides a background to the study including the problem statement, justification, methodology and limitations. The next chapter describes the progressive chronological processes this partnership has gone through since the colonial period. It also discusses the key actors and their contributions at the various levels. Chapter three shows the conceptual framework with a brief discussion of key analytical concepts and review of literature. Chapter four presents the outcomes of partnership while the next chapter shows the conditions, triggers and shortfalls that influenced the outcomes in chapter four. The last chapter gives conclusions and suggestions for future research.

CHAPTER TWO: PARTNERSHIP PROCESS

2.1 Introduction

This chapter elaborates the PPPH process in Uganda since the 1950s to the finalization of the draft policy document in 2003. It identifies the main actors in this partnership including their roles and responsibilities with a special focus on the different forms of support provided by government.

2.2 The history of Public-Private Partnership for Health in Uganda

The first instance of collaboration between the public and private sector in Uganda can be traced to 1954 when the Frazer Commission recommended the introduction of public subsidies for the voluntary health sector (UCMB et al 2007:29). However, due to the political and economic turmoil in the 1970s, this arrangement was stopped which worsened the health situation. Coupled with the 1986 political revolution, a Uganda health policy review was commissioned that recommended the revival of the collaboration between public and private providers which was re-emphasised in the 1993 cabinet white paper (Giusti 2002:2).

With the growing interest by government to form a partnership, both the Uganda Protestant Medical Bureau (UPMB) and the Uganda Catholic Medical Bureau (UCMB) submitted a memorandum to Ministry of Health (MOH) in February 1996 in which they denounced the impending crisis of the health sector (UCMB et al 2007). As a result, the then health minister established a task force in December 1996 to study options and propose recommendations to cabinet to justify subsidies to the private not-for-profit sub-sector. Subsequently in June 1997, 800 million Uganda Shillings (USD 1= UGX 1020) were earmarked in the national budget as subsidy to a group of hospitals in poor districts which was increased and extended to other hospitals in the following financial year with added objectives of improving access to care, staff remuneration and provision of public health services (UCMB et al 2007).

Further to the provision of the subsidy, in 1999, representatives of the private not-for-profit sub-sector participated in the launch of the Sector Wide Approach (SWAP) at World Health Organisation (WHO) in Geneva and by 2000 public-private partnership for health had been included in the national health policy (MOH 2000). At the same time, representatives of the bureaus were incorporated as members of the Health Policy Advisory Committee (HPAC) and participated in the formulation of the heath sector strategic plan (HSSP). Following the launch of the first health sector strategic plan in 2000, partnership was re-emphasised as one of the health sector priorities especially in increasing the scope of the services provided, staff remuneration and reduction of fees. With this sound momentum, a public-private partnership for health desk was established in Ministry of health in 2000 with support from the Italian Cooperation to coordinate partnership activities and formulate the PPPH policy (Kirunga et al 2007).

2.3 Partnership Policy

With the high momentum PPPH had ascertained in the first five years (1996 – 2000) and the high prioritisation it had caught on the health agenda, there were bound to be initiatives for its formalisation and regulation. As a result, by April 2001 during

the Joint Review Mission (JRM), there was a directive to the public-private partnership for health working group (PPPH-WG) to develop a draft policy which was presented to the October joint review mission. The draft policy was introduced to the district stakeholders in financial year 2002/ 2003, where specific points for non-facility-based private not-for-profit providers, private health practitioners and traditional and complimentary medicine practitioners were introduced. By the end of 2003, preliminary work was completed, though by the time of the study cabinet had never approved the policy.

The draft policy provides partners to work together in planning, implementation and management of health services. The draft policy guidelines stipulate that this partnership has a responsibility to ensure that health care users are aware of their rights, responsibilities, quality and scope of services they should expect and demand. This policy envisions healthy competition, increased consumer choices and improved quality. The partnership policy is expected to streamline referrals across public and private providers and specifically to ensure a positive attitude and supportive environment for patients (Kaitiritimba 2005: 119). With a partnership policy in place, it's expected that partners will sensitize healthcare users on all aspects of the referral chain with strong emphasis on primary health care (PHC) and promotion of public health. This will have a resultant effect on promotion of disease prevention behaviours and reduction on treatment costs especially for malaria, HIV/AIDS, nutrition and reproductive health (ibid: 120).

2.4 Key Stakeholders

Although several actors are involved in the PPPH policy--namely private health practitioners, traditional and complementary medicine practitioners--this study emphasises collaboration between government and the facility-based private not-for-profit providers.

2.4.1 The PNFP Sub-sector

This represents the larger networks of civil society service delivery points spread across the country that began at the end of the 19th century and cover a third of the country's total health services (UMCB 2007: 5). Their central aim isn't making profits but rather extending services to very poor communities.

The legal ownership and existence of most PNFP facilities is linked to the trustees of the respective denominations at local level (dioceses for Christian denominations; districts for their Muslim counterparts) and their governance is executed through boards. The boards are appointed by the legal owner who secures participation from stakeholders including public administrators and local communities (ibid 24). Their routine operation is undertaken through management committees composed of employees with a significant degree of participation of the population in lower levels (ibid 25).

Overall coordination of these facilities is undertaken by the respective medical bureaus namely the Uganda Catholic Medical Bureau, the Uganda Protestant Medical Bureau and the Uganda Muslim Medical Bureau which were established in 1956, 1955 and 1978 respectively. They provide services in exchange for compliance with set priorities among affiliated units. Such services include advocacy and representation at national level, information, capacity building, facilitation of procurement of medical supplies and drugs through Joint Medical Stores (JMS), studies, research and technical assistance. In exchange for services, affiliated units

solicit annual accreditation based on achievement of agreed criteria, harmonious with national policies and priorities. In summary, these bureaus are brokers or catalysts than real coordinating agencies (ibid 26).

2.4.1.1 The Uganda Catholic Medical Bureau (UCMB)

This umbrella organization coordinates Catholic affiliated hospitals and lower level units (LLUs). UCMB has a clear policy and mission which aligns with government policies and guidelines coupled with well established offices. Uganda Catholic Medical Bureau coordinates semi-autonomous hospitals directly and lower-level units through the diocesan health coordinators. UCMB derives its loose coordination mandate from the Episcopal conference which is the custodian of catholic health institutions. It operates an accreditation system for health units based on their faithfulness to the UCMB mission (MOH 2008:37). The health units in each diocese are overseen by the diocesan board of trustees.

2.4.1.2 The Uganda Protestant Medical Bureau (UPMB)

Although owned by Church of Uganda (C.O.U), the Uganda Protestant Medical Bureau also coordinates other Christian based non-catholic units. Its supreme body is the annual conference composed of key stakeholders mainly founding hospitals, lower level unit representatives, Ministry of health officials and representatives from Anglican churches offering health services. There is a board for governance and various agencies in the country with regularly held regional meetings.

2.4.1.3 The Uganda Muslim Medical Bureau (UMMB)

This umbrella organization coordinates Islam-based health units and officially belongs to Uganda Muslim Supreme Council (UMSC). It was started in 1978 but the 1970s' political turmoil undermined its leadership and only resumed operations in 1999. The coordinated health units under UMMB belong to Uganda Muslim Supreme Council and Muslim individuals who applied and fulfilled the required criteria (ibid). The affiliated institutions are required to have a constitution and to become members; they have to fulfil a number of verifications including an authenticated memorandum of understanding. Under its operational mandate, Uganda Muslim Medical Bureau has a general assembly as the supreme decision making body where common issues are discussed and ironed out.

2.4.1.4 PNFP Share of the Health Facilities

The three bureaus own 44 (42.3%) of the 104 hospitals with a total bed capacity of 6,943 (42.9%), 558 (22%) of the 2,536 lower level health facilities and 19 (70.7%) of the nursing and midwifery training schools as highlighted in table 1. When hospitals and lower level units are combined the three bureaus constitute 75% of all PNFP facilities.

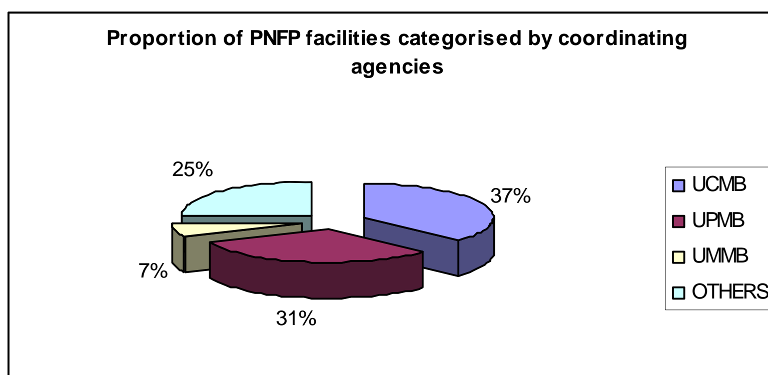
Table 1 Ownership of Health Facilities

LEVEL	OWNERSHIP			
	Government	**PNFP**	**PFP**	**Total**
Hospitals	56	44	4	104
Health Centre Grade Four	143	8	3	154
Health Centre Grade Three	650	147	12	809
Health Centre Grade Two	845	362	262	1469
Total	1694	558	282	2536
Health Training Schools	8	19		27
Number of beds	9132	6943	100	16175

Source: UCMB et al (2007)

However, the number of facilities varies per coordinating bureau as evident in the graph below. Uganda Catholic Medical Bureau owns the majority (37%) followed by Uganda Protestant Medical Bureau (31%), other non-religious based NGOs (25%) and lastly Uganda Muslim Medical Bureau (7%).

Figure 1: Proportion of PNFP facilities Categorised by coordinating agencies



Source: UCMB et al (2007). Computation based on list provided by PHC CG MOH 2006/07

The status of PNFP coordinated facilities appears to be fluctuating taking into account the 2004 and 2007 comparisons. For instance by 2004, 41% of PNFP facilities were coordinated by UMCB, 30% by UPMB, 7% by UMMB and the rest by others who were attached to non-bureau organizations or not attached to any (ibid: 26). The percentage levels reflected in the chart shows a reduction in facilities coordinated by Uganda Catholic Medical Bureau which could be due to the increasing number of non governmental facilities registered by Ministry of health on the PNFP list (ibid).

2.4.2 Local Governments/ Districts

These are charged with disbursing funds from central government to private not-for-profit providers. By design of the financial allocation system, subsidies are budgeted under Ministry of health but are transferred to local governments through their respective accounting officers (Chief Administrative Officers) in form of conditional grants. In essence, the Chief Administrative Officers are responsible for disbursing

funds to PNFP units within their areas of jurisdiction. Furthermore, local governments are required to play a role in supervising PNFPs, seconding staff, providing moral support, constructing houses for staff and recommending donors.

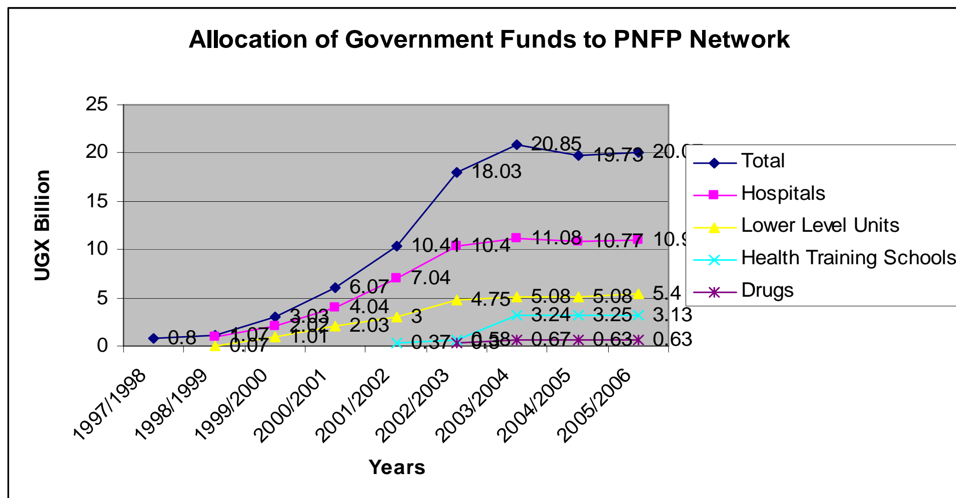
2.4.3 Central Government

Central government as a key stakeholder controls 1,694 health units in addition to provision of several forms of support to the PNFP sub-sector. Famous among these are government subsidies, drug credit lines, seconded staff, laboratory credit lines and invited spaces for PNFP participation in policy making.

2.4.3.1 Government Subsidies

Starting from financial year 1997/98 government resumed provision of subsidy to the facility-based PNFPs under the primary health care conditional grant (Kirunga et al 2007:3). This is a recurrent non-wage grant channelled through local governments (ibid). The first allocation totalled UGX 0.8 billion (1USD = UGX 1020) which peaked 20.85 billion (1 USD= USD 1963) in 2003/2004 if drugs are considered (UCMB et al 2007:8). Since then, there has been a decline in total allocations as shown in the figure below.

Figure 2 Allocation of Government Funds to PNFP Network

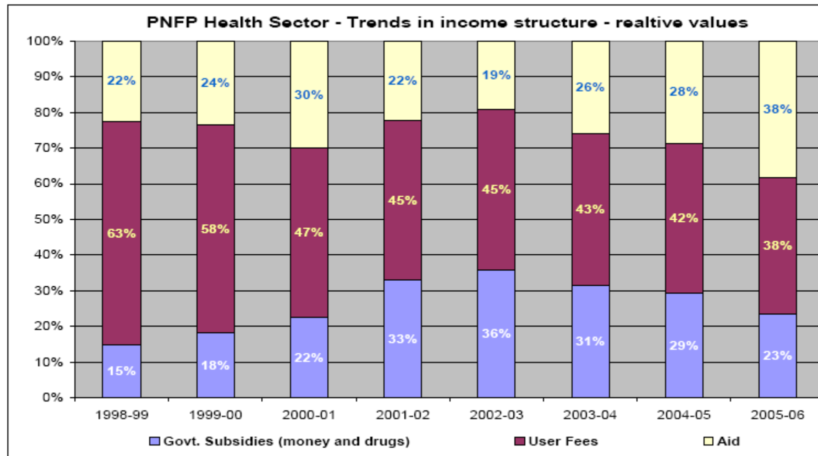


Source: UCMB et al (2007:8)

Government Subsidy as Percentage of PNFP Income

The government subsidy represented a significant proportion of PNFP income in years 2001/2002 - 2003/2004 as shown in figure three. The relatively significant subsidy provided in 2001/2002 to 2003/2004 was not only important in filling the gaps in donor support but also helped in reducing user-fees as shown in figures three and seven.

Figure 3 Trends in PNFP income

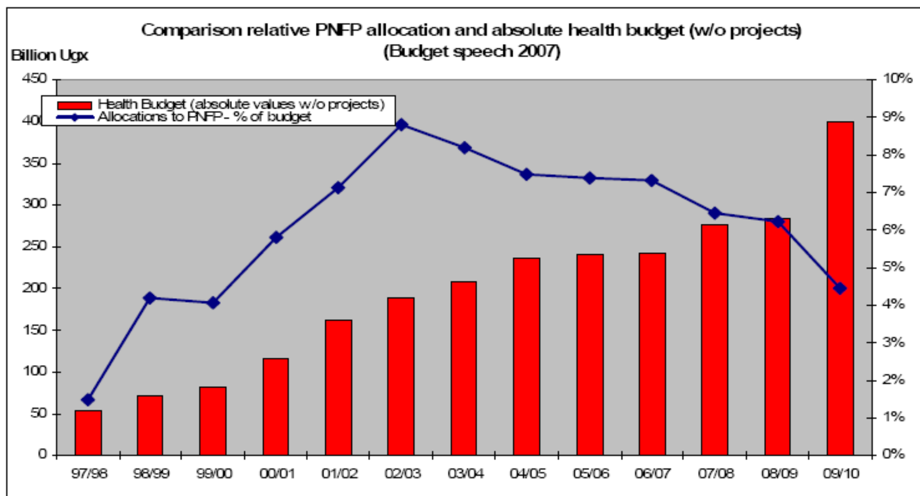


Source: UCMB et al (2007)

Government Subsidy as Proportion of the Health Budget

From figure four, it's evident that the allocation to PNFPs grew relatively with the growth in the health sector budget between 1997/1998 to 2002/2003. However, there was a fall in 2003/2004 and 2004/2005 despite the absolute increase in the health sector budget, which emphasises the absence of senior management support as a hindrance to partnership success. The stagnation of the subsidy in 2004/2005 to 2006/2007 corresponds with the stagnating allocation by government to the health sector due to the increase in off-budget donor support.

Figure 4 Comparison relative PNFP allocation and absolute health budget

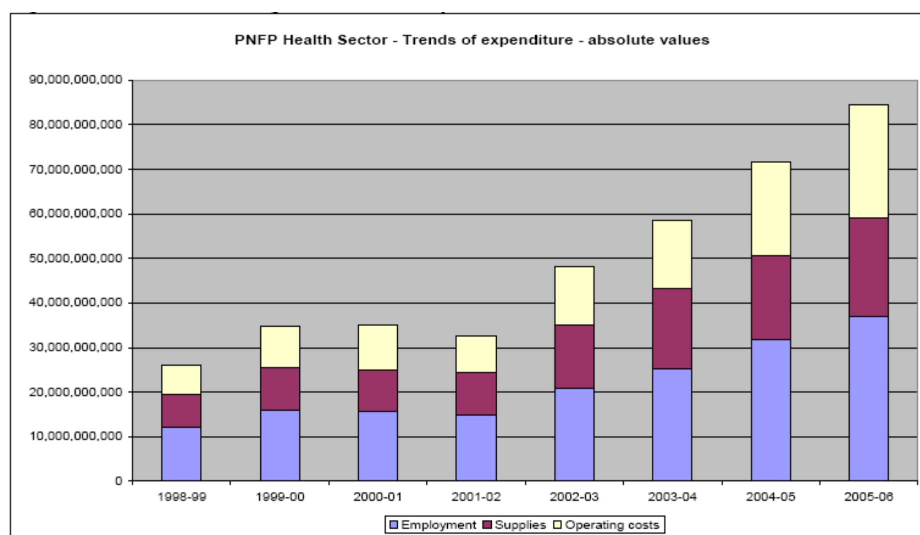


Source: UCMB et al (2007)

Government Subsidy as Proportion of PNFP Expenditure

In general, the government support is inadequate given the rising expenditure of PNFPs as shown in figure five driven by labour costs.

Figure 5 Trends in PNFP expenditure



Source: UCMB et al (2007)

2.4.3.2 Credit Lines for Essential Drugs

In addition to the primary health care grants (subsidy), government--through the National Shared Services Programme together with development partners through the second Health Sector Support Programme Project--support the essential drugs programme which started in 2003/2004. These drugs supplement those procured with funds transferred directly to districts and referral hospitals (MOH 2007b). Both government institutions and private not-for-profit units access these funds in form of drugs through the National Medical Stores (NMS) and Joint Medical Stores (JMS) respectively. In financial year 2007/08, credit lines totalled UGX 20.44 billion with an increase of UGX 4.59 over that of the previous financial year (ibid). The utilisation of these drugs per facility-category in 2007 is highlighted in the table below.

Table 2 Summary of Drug Credit Lines

Sub-sector	**Amount in UGX** *(1USD= UGX 1685)*
Government Health Centres	12,335,744,426
Government General Hospitals	3,372,870,662
Government regional referral Hospitals	1,686,435,331
PNFP Hospitals	1,686,435,331
PNFP Health Centres	1,358,517,350
Total	**20,440,003,100**

Source: MOH (2007b:5)

The PNFP hospital credit lines cover 35 districts compared to 48 covered under government hospitals; a significant number (ten) new districts are left out (MOH 2007b).

2.4.3.3 Medical Staff Secondment

Given the inability by PNFPs to attract and retain staff, government embarked on a staff secondment scheme in 2002/2003. According to the desk study this was because whenever government advertised, health workers crossed from the private not-for-profit network to government (MOH 2008).

With the secondment arrangement, 4% of the 10,000 PNFP workforce, are public servants either deployed by the district or posted by Ministry of health (UCMB et al 2007). Under this scheme, Ministry of health reserves 118 posts for deployment though 50 % of these had been filled by 2006 (ibid). Though the government contribution to PNFP staffing is still trivial, there was a slight increase in the number of staff seconded to PNFP units in 2007 due to the central government recruitment exercise. According to bureau statistics there were 111 government posted staff in 24 hospitals with 39% posted by Ministry of health and the rest by local governments (ibid). However, this is inconsistent with the Ministry of health position which notes that 1.146 billion wage subvention is used to support a total of 3 consultants, 22 special grade medical officers and 94 medical officers in the PNFP network (MOH 2007b:15).

Taking the bureaus' (2007) position, under the UCMB network, doctors form the bulk of posting (43%), followed by nurses/ midwives (25%), paramedics (10%) and 12 % of other cadres. 79% of the doctors come from Ministry of health while local governments (LGs) account for 88% of other staff. Of the 3,630 UPMB health workforce, there are 35 medical officers (9.2%) posted by government. UMMB has 8 staff (6 doctors, 1 clinical officer and 1 other) out of 611 health workers which translates into 1.7% of the network staff posted by government (UCMB et al 2007).

2.4.3.4 Equipment Credit Line

Given the national deficiencies shown in the 1999 laboratory needs assessment study, government introduced a credit line where health facilities are able to access laboratory and obstetric equipment and supplies starting 2000/01. The scope of support includes microbiology and basic haematology which according to the 1999 assessment were very limited (MOH 2000:77).

2.4.3.5 Invited spaces for PNFP participation

Further to the various forms of financial support, central government created some forums for PNFP participation in national policy making like the public-private partnership for health working group (PPPH-WG) which is constituted by various partners. In addition it invited PNFP representation on the health policy advisory committee (HPAC) which the highest technical policy making forum in Ministry of health, the joint review mission which is an annual undertaking, national health assembly and integrated disease surveillance committee.

2.4.4 Local Communities

The communities found in PNFP locations are not only recipients of services but also participate in the governance structures of PNFP facilities. They also participate in monitoring and evaluation exercises like the customer satisfaction surveys.

2.4.5 Donors

Donors especially the Italian cooperation and DANIDA play a substantial role in this partnership. They provide financial support to PNFPs in addition to championing this collaboration. From the national health accounts report 1998/1999 to 2000/2001, 60% of the donor project funds were channelled through PNFPs

(Kirunga et al 2007:3). In addition to funds, donors provide in-kind supplies to PNFPs like vaccines, contraceptives and specific drugs for TB and HIV/AIDS (ibid).

2.5 Conclusion

This chapter has shown that partnerships in health are not new undertakings in Uganda since they can be traced to the colonial period. Surprisingly partnerships started without a policy document which indicates that government policies are not what is noted in policy documents but what is practiced. This chapter found that partnering was incremental. At the initial stage only a subsidy was provided; later secondment and credit lines were added. The chapter also highlighted the shortfalls in getting partnerships institutionalised. For instance, while the partners tried to formulate a policy, government failed to commit itself by approving it.

CHAPTER THREE: CONCEPTUAL AND ANALYTICAL FRAMEWORKS

3.1 Introduction

This chapter introduces the main notions of public-private partnerships, from broad definitions to specific concepts commonly used when analysing partnership implementation.

3.2 Public-Private Partnerships

The term 'public- private partnership' draws a multiplicity of meanings from different practitioners. This is consistent with the WHO (2008) benchmark, which comprehends that pubic-private partnerships involve a diversity of arrangements which vary depending on membership, legal status, governance, management, policy setting, contributions and operational roles of partners. Despite the multiplicity in meaning, some common points could be agreed.

Bjorkman and Raman (2008:5), define partnership as a "collaborative effort and reciprocal relationship between two or more parties with clear terms and conditions, well defined partnership structures and specified performance indicators for delivery of a set of health services in a stipulated time period." However, when comprehending such broad definitions, researchers and practitioners should recall the caution by WHO (2008) that some public-private partnerships could be defined as public sector programmes with private sector participation; for example, arrangements between government or NGOs and manufacturing companies as well as government and private for-profit providers.

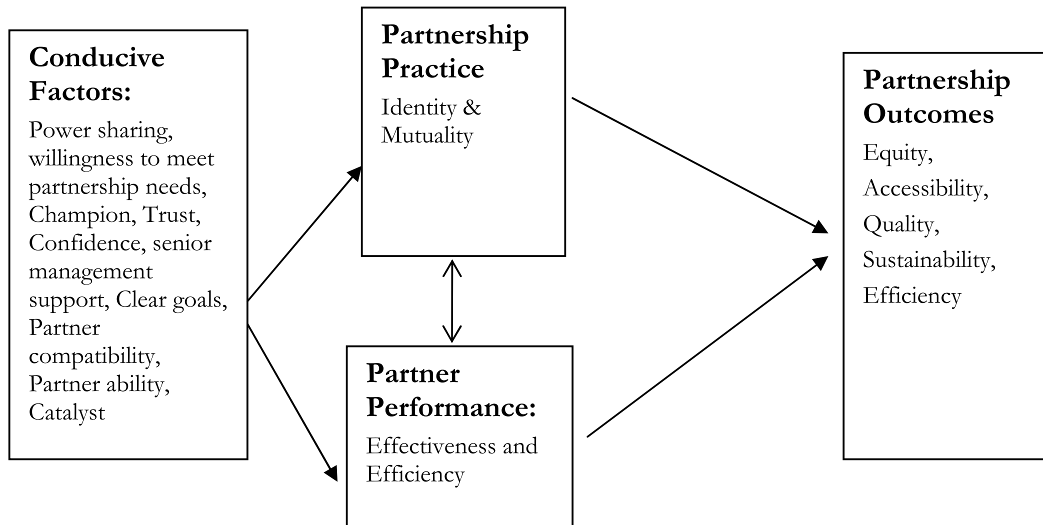
Bjorkman and Raman (2008:7) classify the common types of public-private partnerships as "contracting, franchising, social marketing, joint ventures and tax incentives, vouchers, hospital autonomy, build operate and transfer, philanthropic contributions, health cooperatives, grants in aid, capacity building, leasing, and social insurance." Similar to Bjorkman and Raman's definition, Uganda's Ministry of health takes partnerships to mean "a formal relationship between two or more partners who have agreed to work together in a harmonious and systematic fashion and being mutually supportive towards common goals, including agreeing to combine or share their resources and or skills for the purpose of achieving these common goals" (MOH 2007d).

Within the health sector, public-private partnerships are increasingly pursued as one of the remedies to increasingly challenging health systems. They rapidly grew in response to the perceived failure of health systems in developing countries to address major health problems and perceived failure of the private market to produce needed vaccines and medicines for neglected diseases like malaria and tuberculosis (MOH 2008: 2).

3.3 Analytical Framework

Brinkerhoff (2002b) proposes five assessment areas for any form of government-non profit partnership. These include compliance with pre-requisites and success factors, the degree of partnership practice, outcomes of the partnership relationship and partner's performance as highlighted in the figure below:

Figure 6 Analytical Framework



Causal chain of relationship outcomes adapted from Brinkerhoff (2002) with modifications by the researcher

3.3.1 Conducive Factors

According to Brinkerhoff (2002b:220) any form of partnership requires some conducive factors which she categorises as pre-requisites and success factors. Foregoing these separate categories these factors broadly include: *tolerance for power sharing; willingness to meet partnership needs (which includes receptivity to new solutions, flexibility in taking corrective action, accommodation of special request and responsiveness to unforeseen situations), existence of a champion, trust, confidence, senior management support, ability to meet performance expectations, clear goals, and partner compatibility*.

3.3.1.1 Champions

Among the conducive factors, there is strong emphasis on the existence of legitimate *champions,* which according to Bjorkman and Raman (2008: 6) is associated with strong leadership which is visionary, energetic and enthusiastic. The championship responsibility usually calls for special skills like communication and negotiation given the advocacy roles that come with it (Brinkerhoff 2002b:220).

3.3.1.2 Senior Management Support

Related to championship is *senior management support* which according to Brinkerhoff could directly or indirectly influence the overall performance of any partnership. Directly, senior management support influences the financial and human resources committed and flexibility among partners in accommodating their colleagues' preferences and constraints. Indirectly, the participation and support of senior management symbolizes the organization's commitment to the partnership and its success, contributing to trust building among partner organizations (ibid 224).

3.3.1.3 Trust and Confidence

Of similar importance are five factors advanced by Whipple and Frankel (2000) cited in Brinkerhoff (2002b:223). They include *trust* which is considered to be voluntary

and linked to shared values and *confidence* which according to Luhman (1988) cited in Brinkerhoff (2002b:224) is based on rational expectations, typically grounded in institutional arrangements such as contracts, regulations and standard operating procedures.

3.3.1.4 Ability of a Partnership to Meet Performance Expectations

With regard to the *'ability of a partnership to meet performance expectations'*, focus is put on the efforts undertaken by partners to manage existing constraints beyond the control of any partnership, which inhibit performance. These include legal or regulatory policies and the skills or capacity of partner members (ibid 224). On the other hand is the presence of *clear goals* where there is concern in understanding their influence as an outcome and on the process. For clear goals to influence partnership outcomes, there is a need that all partners understand prescribed goals, share a common vision and that goals are clear to facilitate assessment. However, taking a process perspective of clear goals, it is important that the mission, vision, and goals are mutually determined (Leonard 1998 cited in Brinkerhoff 2002b:224).

3.3.1.5 Partner Compatibility

Lastly *'Partner compatibility'* as a conducive factor takes into account the partner's ability to know and understand each other's mission, track record, operations, and constraints in advance of partnership. This in the process stimulates mutual understanding and trust building which to some extent could depend on the partners' previous experience particularly the absence of conflict (Brinkerhoff 2002b:224).

Conducive factors take central stage in most studies on partnerships as evident from ADBI (2000) and Reich (2008). Reich (2008) summarises the core success factors as *"mutual respect and trust among partners, leadership and personal relations, clear and realistic goals and a practical recognition of each partner's operating conditions*" (MOH 2008). On the other hand ADBI (2000) which classifies them as 'necessary conditions' summarises them as; *"a clear understanding between partners about mutual benefits, responsibilities and obligations; strong community support, a catalysts at the start of the process, stability of the political and legal climate, regulatory framework, capacity and expertise of government, appropriate organisational and management systems, strong management information system and clarity on incentives and penalties"* (Bjorkman and Raman 2008).

3.3.2 Partnership Practice

In addition to the conducive factors is the degree of *partnership practice* which according to Brinkerhoff (2002a), can be understood with reference to its defining dimensions of *mutuality and organizational identity*. To her *mutuality* is more than mutual dependence among partners since it takes into account other dimensions like, *equality in decision making, resource exchange, reciprocal accountability, transparency, degree of partner representation, participation in partnership activities, mutual respect and even benefits* (Brinkerhoff 2002b:224).

3.3.2.1 Equality in Decision Making

Taking *equality in decision-making* as an aspect of mutuality, Brinkerhoff states that it's a challenge from the start, especially if there is a power imbalance among partners. Such power imbalances could originate from one partner controlling majority of the resources (ibid 224).

3.3.2.2 Reciprocal Accountability and Transparency

With *reciprocal accountability* which is largely sustained by information access, each partner takes responsibility and is accountable to others for expressed actions and their potential impact on the partnership (Commins 1997 cited in Brinkerhoff

2002b:225). *Transparency* on the other hand rests on the availability of formal, timely and accurate information exchange and response to specific information requests among partners. This information exchange, according to Peterson (1997) cited in Brinkerhoff (2002b:225) is both a professional duty and an expression of respect. Taken in this sense, transparency includes availing relevant information in an accessible manner, appropriate language and with minimal use of terminology specific to a particular professional culture that excludes or is inconvenient to one or more partners (Brinkerhoff 2002b:225).

3.3.2.3 Partnership Participation and Mutual Respect

'*Partnership participation'* as another dimension for mutuality can be reflected on with reference to decision making, and other activities like meetings, relevant discussions and program activities (ibid 225). *Mutual respect* involves the explicit recognition of the indispensability of each partner and their contribution. It presumes that all negotiation and agreements are made in good faith, implying full disclosure of actor-specific objectives (ibid 225). According to Brinkerhoff, mutuality not only includes mutual benefit but also risk sharing which is further amplified by Bjorkman and Raman (2008).

3.3.2.4 Identity

Brinkerhoff (2002b:225) advises that though partnerships require some form of adaptation, their success depends on the partners' ability to preserve their *identity*. This is consistent with Bjorkman and Raman (2008:13) who note that the "cornerstone of partnership is the relative autonomy enjoyed by both partners on day to day operations as well as the overall management of the partnership." Key areas of assessment in respect to organizational identity maintenance include the "degree of reciprocal adaptation for the purpose of protecting organization identities while maximizing their benefit to the partnership, maintenance of service quality and responsiveness to partners' constituencies" (Brinkerhoff 2002b). Assessment of the organization's ability to maintain its identity can be approached from understanding its ability to identify its mission, core constituencies, underlying values, and organizational culture (ibid 225).

3.3.4 Partner Performance

Under this dimension emphasis is on understanding if partners perform the prescribed roles *effectively* and *efficiently* (ibid 226). It involves assessment of partner contributions in accordance with the program design and partner agreements as well as mutual assessment among partners of each other's performance (ibid). This assessment raises measurement challenges but one crude criterion could be exploring partners' satisfaction levels with the performance of others.

Brinkerhoff advises that partner performance assessments should note whether a partner acted above and beyond the call of duty in promoting and performing within the partnership. When assessing partner performance, efficiency should be a key ingredient signified by the extent to which there was environmental hostility toward the partnership program and how this was continuously monitored and proactively managed (ibid).

3.3.5 Partnership Outcomes

Partnerships are usually undertaken for specific purposes over which results are expected. Using the Ugandan case, government accepted to go into partnership with the PNFP sub-sector with key aims of increasing; *accessibility & equity* among

vulnerable groups, *efficiency* taken in terms of the amount of inputs used to produce a standard unit of output, *quality* as specified by Ministry of health and World Health Organisation standards and *sustainability* of health care services. It's on this background that the study adopts the five criteria while measuring partnership outcomes.

3.3.5.1 Equity

Taking equity as one of the initial aims of partnership, the study appreciates that it cuts across other parameters of analysis like access and quality. PPPH aims at increasing equity which is to be realised through removal of economic barriers that affect utilisation of services by vulnerable groups. This is possible through reduction of user-fees and provision of subsidised services. This objective seems realistic since majority of PNFP providers are committed to providing services to the neediest people and are located in rural areas.

3.3.5.2 Accessibility

Second, PPPH aims at increasing accessibility through reduction of user-fees with a translated increase in health services utilisation. Accessibility is partly measured by the standard unit of output which includes in-patient and out-patient department attendance, deliveries, immunisation and antenatal care. Accessibility can be attained if there is an increased number of human resources and other inputs. In addition, PNFPs are expected to contribute to accessibility through the provision of services which aren't provided by government-owned units in some areas.

3.3.5.3 Efficiency

Third, PPPH aims at rationalizing public and private sector programs and inputs to ensure maximum benefit from all available resources. Ideally, PNFP sub-sector inputs to service delivery systems and structures should represent cost savings to the public sector and the reverse is true. It's envisioned that partnering will nurture a spirit of complementation and minimization of duplication where possible.

3.3.5.4 Quality

Fourth, PPPH aims at stimulating quality services among partners. This can be possible if individual service providers nurture norms of self-regulation based on the standards set by national and international regulatory authorities.

3.3.5.5 Sustainability

Lastly, the private not-for-profit sub-sector is to contribute to sustainability by maintaining complementary networks of facilities and services that can withstand social, political and economic shocks in case they adversely affect the public sector. By working in partnership with government, the mixed system of public and private services should create a stronger health system and compensate for shortcomings in either of the providers.

3.4 Conclusion

This chapter has described core concepts in analysing partnerships. They include conducive factors, the balance between mutuality and identity, efficiency and effectiveness on partners' performance and outcomes from partnering which depend on the set objectives. These concepts are used to assess the Ugandan experience in the next two chapters.

CHAPTER FOUR: PARTNERSHIP OUTCOMES

4.1 Introduction

This chapter uses the outcome part of the analytical framework illustrated in chapter three to show the outcomes of this partnership namely, accessibility, efficiency, equity, quality and sustainability of health services. Though it would have been interesting to explore the various levels of performance among individual PNFP actors, it was not possible given data limitation. Hence a general position for the entire PNFP sub-sector is provided. The analysis in this chapter looks at the trends in the post partnership period. The findings are based on a sample of 65% of PNFP hospitals, available government reports and interviewed officials as indicated in annex A.

4.2 Accessibility

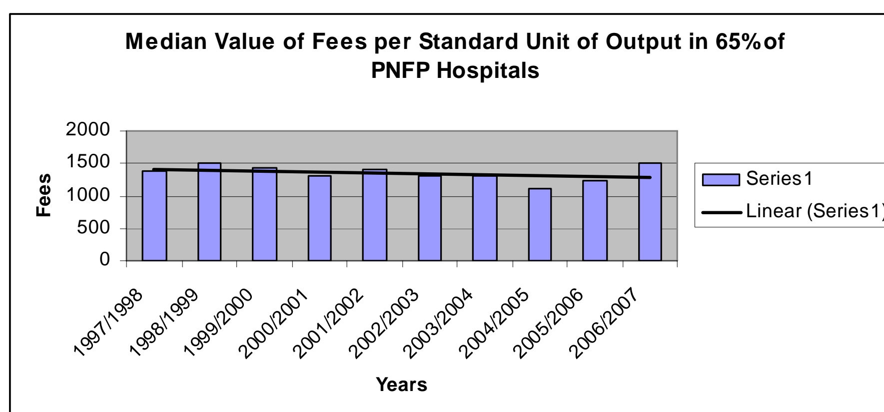
According to the first health sector strategic plan, accessibility was conceptualised in two broad categories namely geographic and financial. Basing on the 2000 health facilities inventory, geographical accessibility which is the percentage of the population living within five kilometres of a health facility was estimated at 49% with only 42% of the parishes having any type of health facility (Konde-Lule et al 2006, MOH 2000). On the other hand, the extent of economic accessibility could be reflected on with reference to the population that lived below the poverty line in 1997/98 which stood at 44% (MOFPED 1998).

With this background, both government and PNFPs had complementary roles in improving accessibility. Government concentrated on removing user-fees in public facilities in order to improve economic accessibility and construction of new facilities to reduce geographic inaccessibility. On the other hand, PNFPs had to make use of the government subsidy to reduce user-fees which would help to reduce financial barriers to the poor hence increasing utilisation.

4.2.1 Economic Accessibility

A review of data from 65% of the PNFP hospitals shows that there was a decline in fees per standard unit of output in specific periods despite the stagnating subsidy that prevailed (UCMB et al 2007: 16). Figure nine, shows that there was a significant drop in fees starting 2002/2003 to 2004/2005 which corresponds with the initiation of the user-fee reduction strategy by the bureaus. Overall, the study noted a decline in fees given that by 2005/ 2006 people were paying less than what they were paying in 1997/1998. From the interviews, the decline was partly due to market comparisons among PNFPs which indirectly aroused equally similar charges and to a greater extent due to PNFPs' faithfulness to their mission.

Figure 7 Median Value of Fees per Standard Unit of Output in 65% of PNFP Hospitals



Source: UCMB data base (2008). The inflation levels in the time period were discounted using Eco Stat (2008) figures

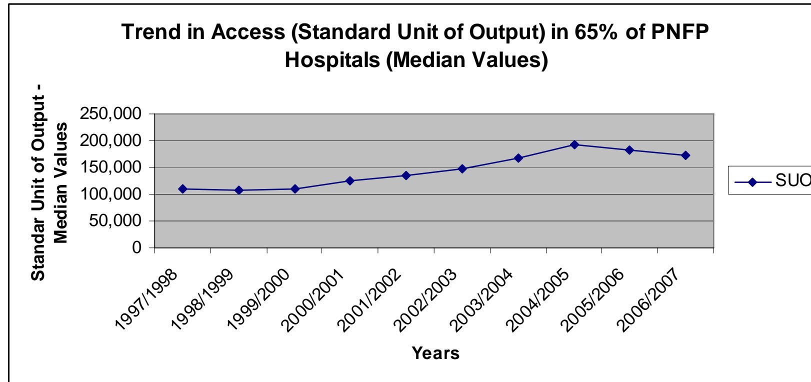
The graph indicates that charges started to increase in 2005/2006 partly due to the stagnation of the subsidy which somehow affected the attendance of children and women as highlighted in figure eleven. The drop in children and women admissions warrants the need to reduce charges, if not for all people, at least for vulnerable groups.

Despite the 2005/2006 setback PNFPs still provide better rates compared to the private sector. The interviews found that PNFPs only charge a half of what is required in private for-profit facilities. For instance, Uganda Protestant Medical Bureau network charges UGX 10,000 and 3,000 (1 USD = UGX1700) as medical consultation fees in rural and urban areas respectively while the private for-profit counterparts charge UGX 30,000. Similarly it charges UGX 30,000 for caesarean operations compared to the private for-profit providers who range between UGX 800,000 – 1,500,000.

4.2.2 Utilisation of PNFP Facilities

Analysis of economic accessibility was supplemented with a reflection on the actual utilisation of PNFP facilities. This was done using the standard unit of output as a proxy of access and utilisation, which is a composite index of in-patient and out-patient department attendance, antenatal care (ANC), immunisation and deliveries, over a sample of 27 hospitals (65% of PNFP hospitals). The analysis reveals that there was a progressive increase in access and utilisation of PNFP hospitals till 2004/ 2005 as shown in figure eight.

Figure 8 Trends in Access in 65% of PNFP Hospitals

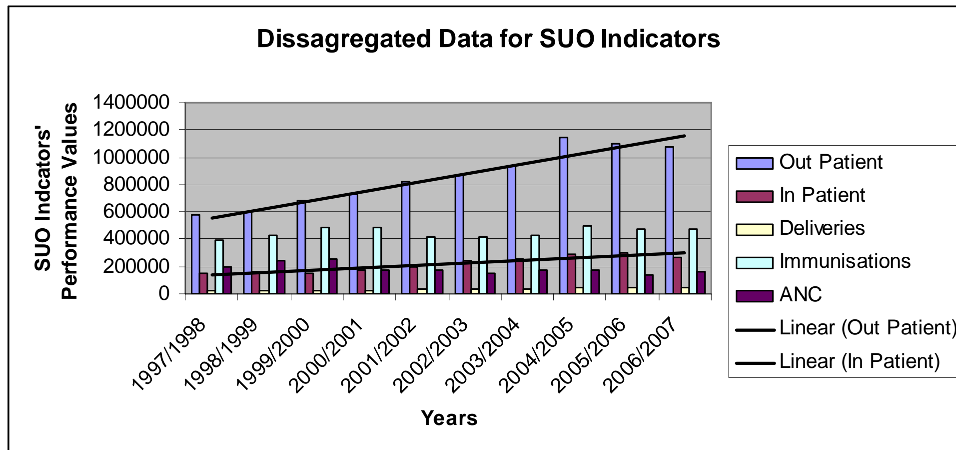


Source: UCMB data base (2008)

4.2.2.1 In-Patient and Out-Patient Admissions

Taking a disaggregated picture of the various indicators constituting the standard unit of output, the study notes that the post-partnership period was characterised by an increase in the number of admissions in the in-patient and out-patient departments as shown by the trend lines in the graph below. However, the number of in-patients didn't grow at the same level as that of out-patients given that the growth on this indicator partly relies on the increase in the number of beds in hospitals.

Figure 9 Disaggregated data for Standard Unit Output Indicators

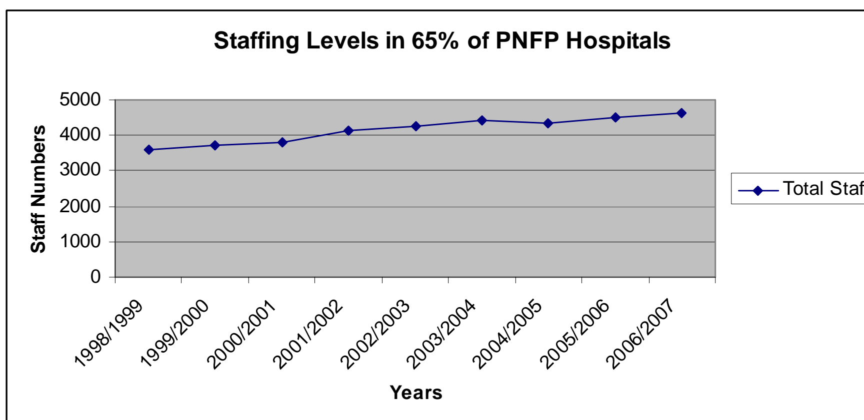


Source: UCMB data base (2008)

4.2.3 Staffing Levels

The improvement in the standard unit of output illustrated in the figure above could have been due to the progressive increase in staffing levels which took place in the same period as shown in figure ten.

Figure 10 Staffing Levels in 65% of PNFP Hospitals



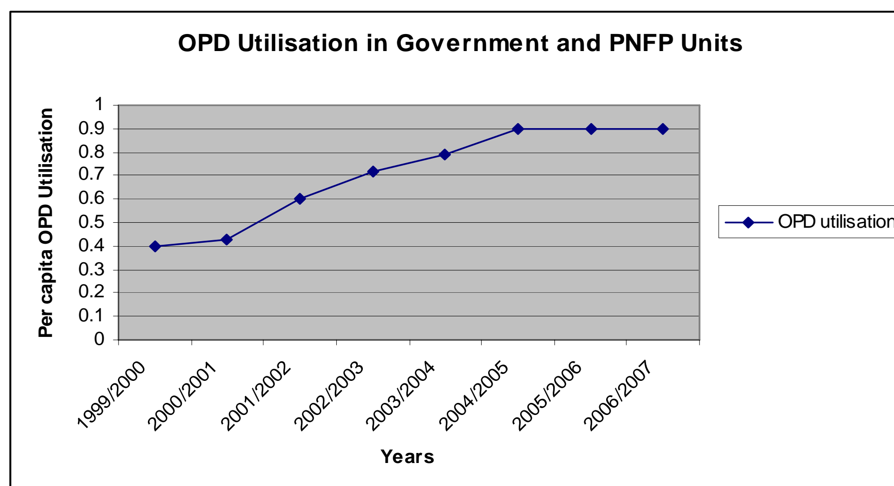
Source: UCMB data base (2008)

However, these staffing levels do not explicitly explain the drops in 2005/2006 which justifies the need to re-emphasise the effect of stagnation of the government subsidy starting 2004/2005.

4.2.4 Out-patient Department Attendance at National Level

The out-patient department utilisation in PNFP hospitals is consistent with the national trends whereby per capita attendance rose from 0.4 in 1999/2000 to 0.79 in 2003/04 which represents a 97.5% increase over the period (MOH 2007a:7). This increase is more apparent using absolute figures where new out-patient department attendees increased from 9.3 million in 1999/2000 to 20.1 million in 2003/2004 (116% increase). However, there was a stagnation in the last three years as shown in the figure below which matches with the fall in out-patient department utilisation in PNFPs (ibid 9).

Figure 11 Out-Patient Department Utilization in Government and PNFP Units



Source: MOH (2007a)

4.2.5 PNFPs as referral points

With regard to the role of partnership in availing specialised services to areas under-served by government facilities, the study notes positive results. According to one of the interviewees, this partnership has led some of the PNFP facilities to be referral points for specialised services in some areas like Kumi and Arua (Kuluva Hospital) where government facilities are out of reach.

4.2.6 Accessibility to HIV/AIDS services

During initiation of this partnership, there was emphasis on provision of essential health services especially primary health care (PHC). However, following several incremental changes, there have been added advantages in rolling out TB and HIVAIDS services like prevention of mother to child services (PMTC), HIV counselling and testing and anti-retroviral therapy (ART) coverage. This is because PNFP facilities were incorporated into sites providing HIV/AIDS services.

Overall, it is noted that there have been improvements in economic accessibility as shown by the figure on user-fees matched with increased utilisation in PNFP facilities. In addition, there have been gains in geographical accessibility given that by 2004, 72% of the population were living within 5 km of a health facility from 49% in 2000 (MOH 2005).

However, despite these improvements, geographical accessibility remains a challenge with majority of the rural population still constrained by distance and geographic physical features like rivers, marshes and hills (MOH 2000:11). There are persisting inequities in access, with coverage ranging from 7.1% in Kotido to 100% in Kampala. Further, there is a mismatch in facilities constructed and their actual functionality with majority being closed for a long time due to lack of staff, basic equipment and drugs (MOH 2005:6).

Also, questions can be raised on the comprehensiveness of the data especially if variations in district performance are taken into account. From the desk review, the study noted that not all units are operating at 0.9 per-capita attendance. For instance, Kiboga district with a population of 231,718 operated at 0.1 while five other districts operated below 0.6. Furthermore, not all the bureaus are well represented in all parts of the country. For instance, Uganda Muslim Medical Bureau has very few facilities in northern and north-eastern Uganda.

4.3 Equity

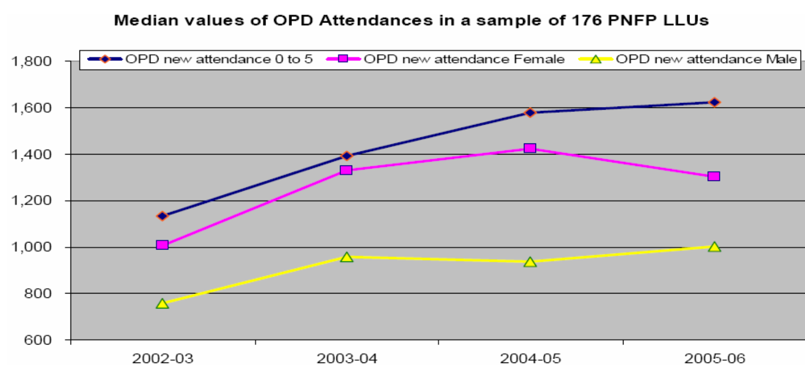
Considering that vulnerable groups *(poor, children, women, elderly, orphans, displaced persons, nomads, conflict affected persons)* constitute a significant population excluded from formal health services and that by 1995 pre-natal and maternal related conditions accounted for 20.4% of the disease burden, this partnership has one of its aim as that of improving equity. In this context, equity is taken to mean the reduction of the disproportionate amount of the burden of ill health borne by vulnerable groups. This aim is further justified by the fact that a significant percentage of the Ugandan population lives below the poverty line which was 44% in 1997/98 and currently at 37.7% with 96% of the poor living in rural areas (MOFPED 2008, MOH 2005:1).The study didn't take into account the whole spectrum of vulnerable groups but focussed on understanding how partnership has helped in improving the health care of women and children. In this regard attempts were made to understand levels of utilisation of PNFP facilities by the young and female sub-populations.

4.3.1 Utilisation of PNFP facilities by women and children

Considering the overall utilisation of PNFP facilities by women and children, there was a progressive trend till 2004/2005 as shown in the figure below. However, this was followed by a significant drop in 2005/2006 of new out-patient department attendance for the female sub-population and relatively low growth in attendance of the under-fives. These drops correlate with the increase in user charges hence confirming the feedback from interviews that "with an increase in user-fees, children and women start disappearing from the hospital clientele" (UCMB respondent).

Overall, there has been increase in out-patient department use by the poor segments of the population as evidenced by the various studies done by Ministry of Health, World Health Organisation, World Bank and the 2003 household survey (MOH 2005, MOFPED 2008). Interesting is that unlike in government facilities, proportionately more children are utilising out-patient department services in PNFP facilities (ibid). However, there is an unanswered question of whether orphans are served more than other children.

Figure 12 Median Values of OPD attendance for under-fives, female and male in a sample of 176 Lower Level Units



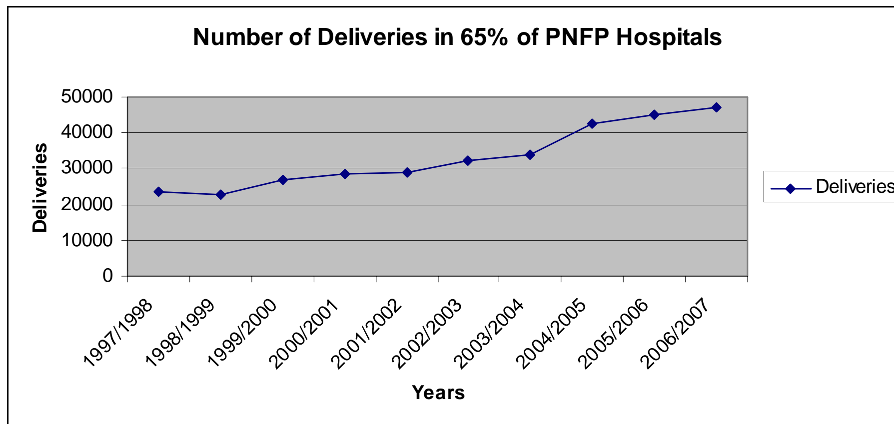
Source: UCMB et al (2007:15)

4.3.1.1 Deliveries

Taking into account the maternal health indicators, the study focusses on the utilisation of health facilities for delivery. Figure nine shows that the proportion of women delivering in PNFP hospitals has been increasing since the early stages of partnership with an exception of 1998/1999. These growth rates correspond with the changes in user-fees noted in figure seven. Since 2004/2005, growth levels have significantly dropped, which further emphasises the effect of the stagnation of the subsidy and rise of user-fees.

Generally, there is an improvement on this indicator among PNFP units which could be associated with the different initiatives undertaken by partners to improve maternal health. For instance, Uganda Protestant Medical Bureau network introduced an arrangement whereby expectant mothers only pay UGX 10,000 charge on the first antenatal care and subsequent ones are free. It also provides free iron supplements and a minimal fee for some drugs. On the other hand, the Uganda Muslim Medical Bureau network offers free delivery for those who make three antenatal checks. Other significant contributory factors include increase in qualified staff, regular supply of contraceptives through credit lines and *partner ability* which is signified by government introduction of safe delivery kits (mama kits).

Figure 13 Number of deliveries in 65% of PNFP Hospitals



Source: UCMB database (2008)

Nationally there is low performance on maternal health indicators, given that access to basic emergency obstetric care, the main determining factor for improved maternal and neonatal survival remained at 5.1% compared to the UN recommended rate of 15%. Only 14% of the 592 randomly surveyed facilities in 2003 and 2004 offered obstetric care services (MOH 2005:6). In addition only 24.4% of births took place in a health facility at national level with 38% of deliveries occurring under the supervision of qualified health worker by 2005.

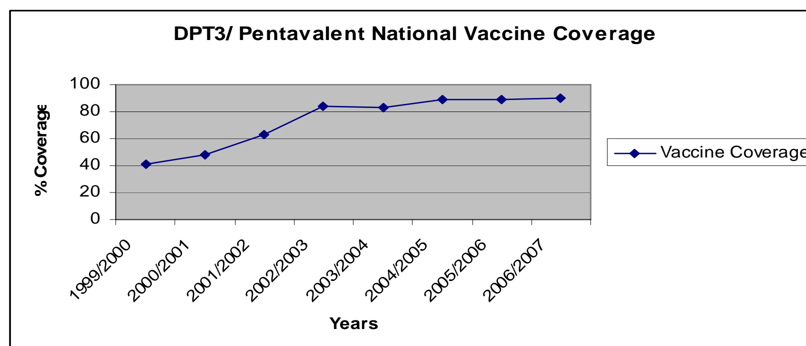
The low utilisation of maternal and child health services could be associated with the low levels of female education and cultural practices including power dynamics at household and community levels (MOH 2005:35). In addition are perceived poor quality, cost and rudeness of midwives (MOH 2007a:11).

4.3.1.2 Child Health Indicators

With regard to child health, the study considers the performance on immunisation and other child health indicators. It was noted that between 2002 and 2006 fully immunised children by twelve months at national level increased from 37% to 46%, whereas those who received none of the basic vaccines declined from 13% to 7% (MOH 2007a). Children's access to treatment/ professional advice following a diarrhoea episode increased from 45% to 70% in the same period (ibid).

Overall DPT3/ Pentavalent vaccine coverage which is usually taken as a proxy for immunisation at national level increased as shown in figure 14.

Figure 14 DPT3/ Pentavalent National Vaccine Coverage

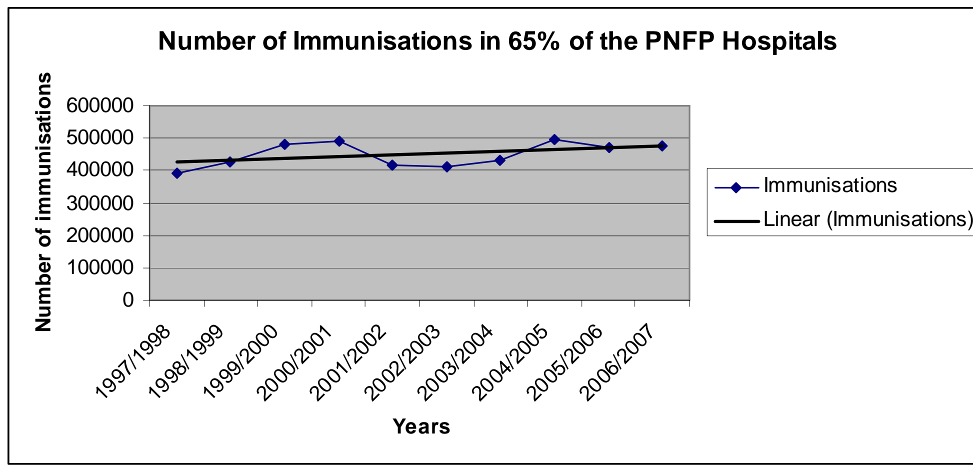


Source: MOH (2007a)

4.3.1.3 Immunisation in PNFPs

The initial increase at national level comfortably corresponds with the immunisation incidence in the PNFP network as shown in figure 15. However, surprisingly, national levels continued to significantly grow between 2001/2002 and 2003/2004 despite the slump in PNFPs. This could be explained by the effect of the national immunisation campaigns whereby mobile immunisation clinics were established on immunisation days. On the whole, PNFPs have recorded increases in absolute numbers of children immunised in their facilities as noted in the figure below. Even with the drops in years 2001/2002 - 2003/2004, there were still more children immunised in PNFP facilities than they were in 1997/1998. The drop in 2005/ 2006 re-echoes the effects of stagnation of the subsidy.

Figure 15 Number of immunizations in 65% of PNFP Hospitals



Source: UCMB data base (2008)

The national immunisation data should be taken with caution given that it's based on pentavalent vaccine coverage which takes into account antigens for only five diseases namely, Diphtheria, Tetanus Toxoid, Pertussis, Hepatitis B and Haemophilus Influenza (Hib) and leaves out others like measles which still claim many infant lives. In addition, not all districts are at the same levels of administration of the vaccine with seven districts performing below 70%, which is far below the usually communicated national average of 90% (MOH 2007a).

4.3.2 Community Participation and Subsidisation of the Poor

Besides child and maternal health performance levels, the study examines norms of subsidisation initiated by individual facilities for the poor and their participation in governance of health facilities. With regard to subsidisation, the study notes that arising out of partnership, private and general wings were established in government and PNFP hospitals with different pay charges. For instance, among the Uganda Protestant Medical Bureau network, caesarean operations cost UGX 30,000 and 300,000 in the general and private wings respectively. From the interviews it was noted that some people prefer to use the private wings which in the process creates more subsidised services in general wings which are largely used by the poor. In addition, the money collected from the private wings is used to meet operational costs in both wings which could imply that the poor are further subsidised with funds from private wings.

With regard to community empowerment and participation in health facility management, it is noted that communities are represented on the governance boards of lower level units in form of health management teams. They also participate in monitoring and evaluation of PNFP activities through customer satisfaction surveys.

4.4 Sustainability

Partnership aims at increasing sustainability measured in terms of maintenance of the PNFP infrastructure and their ability to provide a cover in case the public health units experiences severe shocks. However, on the contrary, this hasn't been the case as elaborated in this sub-theme due to the nature of government and donor support.

4.4.1 Vulnerability to Economic Shocks

Data in chapter four indicates that PNFPs are vulnerable to economic shocks and are unable to provide the envisioned cover. For instance, arising out of the reduced proportion of national budget allocated to the health sector, the amount of the subsidy to PNFPs was reduced which adversely affected their registered gains (accessibility, quality, equity and staff productivity). PNFPs were unable to cope with this shortfall. In addition, arising out of a wage difference between government and PNFP units, the later experienced severe attrition rates which affected productivity.

4.4.2 Weakness in Human Resource Management

The interviews noted a shortfall in human resource management in PNFPs which could explain the low sustainability. Most PNFP units lack salary structures and staff development plans.

4.4.3 Short Falls in Government Support

The vulnerability explained above is partly due to the nature of government contribution. Government subsidies are delayed, inconsistent and declined in real terms. Hence they couldn't nurture sustainability.

4.4.4 Short Falls in Donor Support

As expressed in figure three, donor support has been contributing a big proportion of PNFP income but it has failed to contribute to sustainability given that it's weak on health systems strengthening. In addition, most of it is spent on administration, is unpredictable, specific, short term, and disease oriented (UCMB et al 2007:10). This confirms Buse et al (2006:262)'s findings that "irrespective of their laudable intentions, most of the funds from global health partnerships are by design issue specific and quick results oriented." Therefore, donor support has most likely created volatility and dependency rather than sustainability.

4.4.5 Low Prioritisation for Infrastructural Maintenance in District and PNFP budgets

Low sustainability is further sustained by the low prioritisation accorded to facility maintenance in budgeting. Limited funds are allocated for maintenance of health facilities despite the government guidelines that 5% of the non-wage grant should be used for maintenance.

However, the highlighted gaps don't discount some aspects of sustainability that were noted during the study. For instance, it is well known that PNFPs have stood the test of time by being in business since 1950s. Similarly from the interviews it was noted that UMMB has been able to increase the number of units under its coordination from forty eight in 2005, to sixty two by 2008. Though some of these are newly constructed, others had existed but had never been accredited. There is also an increase in the number of beds in some facilities for instance Kibuli hospital

had 100 beds by 2003 but by the time of the research it had 180. In addition, there is increasing number of NGO facilities. Lastly some proportions of donor support have been used to support construction and maintenance of information, communication and technology infrastructures.

4.5 Quality

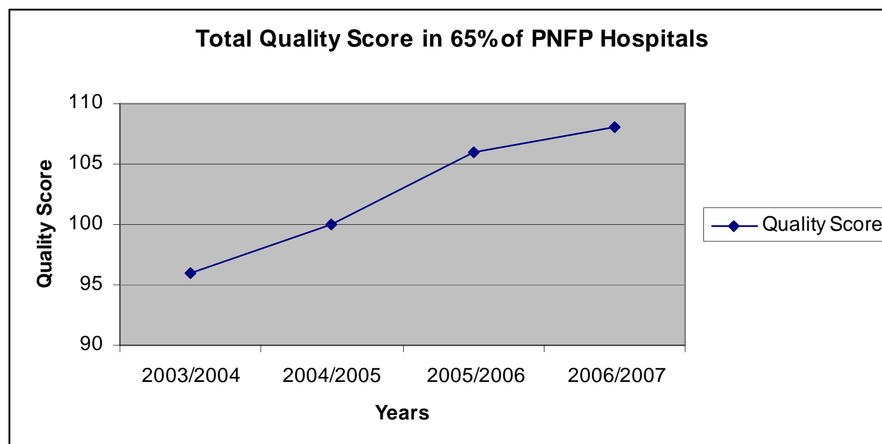
In order to evaluate the role of partnership in ascertaining quality of health services, the researcher was guided by the expectations of two broad groups namely; the customer and provider. For instance, usually providers are concerned about issues like availability of a service and equipment while customers are interested in issues like waiting time, responsiveness and fairness of the fee. In this regard, three parameters are used: quality assessments in PNFPs, essential drug stock out and proportion of qualified staff.

4.5.1 Quality Assessment and Self regulation norms in PNFP Units

The study notes that there have been institutional attempts among PNFPs in measuring and improving the quality of services provided. For instance, Uganda Catholic Medical Bureau developed a quality index which consists of seven weighted indicators namely; *fresh still births, maternal death rate, recovery rate, infection rate* (takes into account if mothers get new infections arising out of the caesarean section), *proportion of qualified staff, patient satisfaction survey and drug prescription practice survey* (takes into account if clinicians are prescribing not more than the required medication).This index should be credited for its sensitivity to newborn health survival given that half of infant deaths in Uganda occur in the neonatal period (first 28 days i.e. two thirds die in the first week of life and two thirds in the first 24 hours) (MOFPED 1996, MOH 2005:37).

Each indicator within the index can score a maximum of twenty points and a minimum of one. The weights are based on the WHO standard with the highest score for any unit being 140. With this index, data have been collected for the last four years which shows a positive trend in quality as highlighted in the figure below.

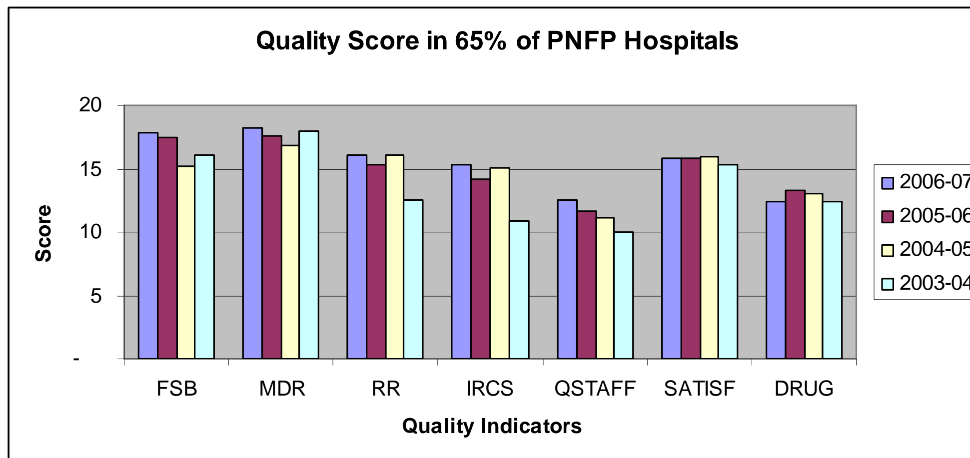
Figure 16 Total Quality Score in 65% of PNFP Hospitals



Source: UCMB data base (2008)

From the disaggregated data depicting indicator specific unit scores, there is an improvement as shown in the figure 17 apart from the drug prescription practice indicator.

Figure 17 Quality Unit Score in 65% of PNFP Hospitals



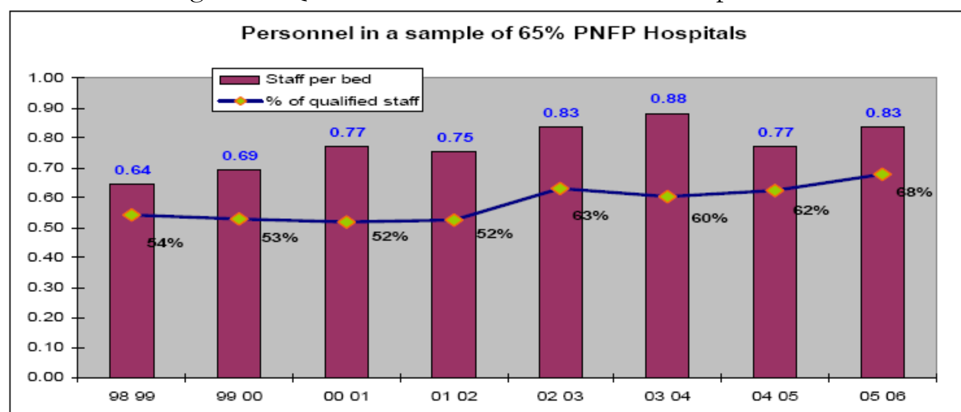
Source: UCMB database (2008)

Focussing on Uganda Muslim Medical Bureau (UMMB), it emphasises quality through its support supervision activities under which it criticises, threatens and gives credit depending on the performance of the facility. During the supervision visits, UMMB takes pictures of units in appalling situations, publishes them and gives a feedback report to the facilities. It was also noted during the interviews that UMMB had applied to Ministry of health, to have its unqualified staff that had on-job training get qualified.

4.5.2 Qualified Staff

Further to the total quality score highlighted above, the qualified staff indicator was singled out for further analysis. This is because there were available data on it since the launch of this partnership and had been used by some previous studies like Giusti (2002) as a proxy for quality. From the statistics provided by Giusti (2002:4), the number of qualified staff stood at 1,820 in 1995/96 but had fallen to 1,764 by 1996/ 1997. However, with the initiation of partnership, the figure rose to 1,835 in 1997/1998 and 1,890 in 1998/1999. In general, partnering could have played a role in solving the qualified staff drop of 1996/ 1997 and registered growths as noted in figure 18.

Figure 18 Qualified Staff in 65% of PNFP Hospitals



Source: UCMB et al (2007: 19)

Though there is an increase in qualified staff, they are unequally distributed given that majority of the personnel favour urban areas despite the fact that 80% of the population is found in rural areas (MOH 2000:13). Also different districts have different capacities in attracting qualified staff. In addition, there is an inappropriate skills mix, inadequate staffing levels and heavy work load as shown in figure 18 (UCMB et al 2007:19)

4.5.2.1 Attrition

The qualified staff indicator is being undermined by high turnover in PNFP units as indicated in the table below. This is due to the rural location of most facilities and pay difference with the government units.

Table 3 Attrition rates for selected staff categories in 65% of PNFP Facilities

Staff Category	2003/2004	2004/2005	2005/2006
Medical Officers	28%	21%	30%
Clinical Officers	22%	21%	36%
Enrolled Nurses	16%	17%	26%
Enrolled Midwives	15%	10%	34%
Registered Midwives	9%	11%	27%
Registered Nurses	5%	14%	11%

Source: UCMB et al (2007: 19)

These attrition rates are higher in lower level units. For instance, taking the 2005/2006 data, lower levels units had attrition rates of 30% among clinical officers, 45% among enrolled nurses and 46% among enrolled midwives. To show the magnitude of attrition, Uganda Protestant Medical Bureau indicated that it approximately runs three job advertisements for medical officers in a year.

4.5.3 Essential Medicines Availability

Under the second health sector strategic plan, the availability of essential medicines in health facilities for patients is taken as a proxy for quality. In this regard, the study

incorporates this dimension by considering the percentage of health units without any stock outs.

Taking a trend analysis of 35% of the health units, the study established that the proportion of health facilities without stock out of five tracer medicines and supplies performed at 35% in 2004/05, dropped to 27% in 2005/06 and bounced back to 35% in 2006/07. During literature review the researcher noted that 42 districts (54%) were able to spend their 'essential medicines and supplies' budget on procurement of drugs, 25 (32.4%) operated at less than 40 % while 10 (12.9%) operated at less than 20% (MOFPED 2007, MOH 2007a). The low performance could be associated to the stagnating essential medicines budget, logistical challenges at National Medical Stores and low expenditure on essential medicines by local government and hospital budgets (MOH 2007a:15).

Like noted in chapter two, some new districts are not accessing essential drugs. Similarly, though there is information of how much of the district essential medicines budgets spent at National Medical Stores and Joint Medical Stores there is no specific district information on medicine stock outs since findings were based on a survey (ibid). Also, although some districts performed at 100% and ten districts even reached 120% performance, 25 districts spent less than 40% while 10 spent less than 20%. Interesting are three districts that spent less than 0% (ibid). There are also data gaps at national level on the proportion of the population expressing satisfaction with health services.

Within the PNFP sub-sector the Seventh Day Adventist (SDA) and Pentecostal facilities are slow in adapting to the quality standards. In addition, there is low commitment to the UCMB index and as a result, there is preference on tracking hospital quality on single indicators like fresh still births rather than aggregated results.

Similarly the accreditation system is mainly linked to the process and isn't totally integrated with quality enhancement (UCMB 2008). Accreditation is largely limited to managerial process whereby the mere fact that an institution is assessing quality is enough criteria for getting accredited with the quality of data never being an issue. On the overall, there could have been more focus on accessibility than quality in the first stages of partnership and this could be the reason why most quality indicators were not tracked in the first five years of partnering.

4.6 Efficiency

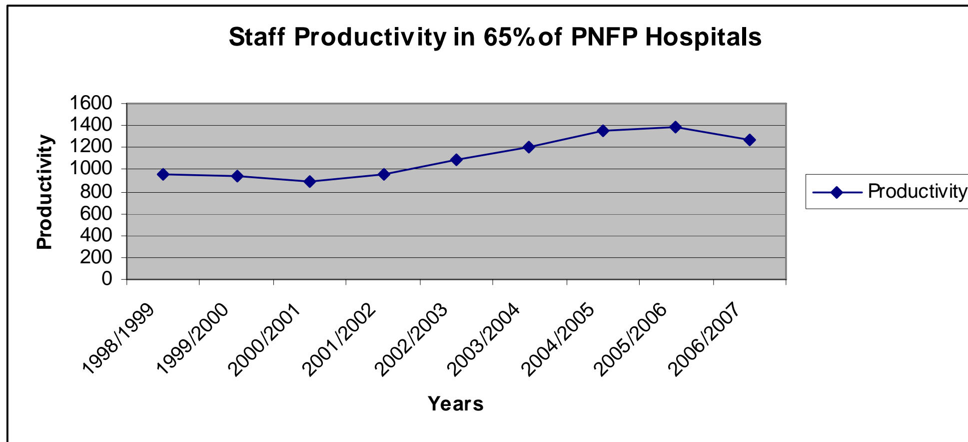
Given the financing gap that faces the health sector, this partnership has one of its aims as that of maximising efficiency taken in the sense of either producing desired outputs at least cost or producing the maximum quantity from a fixed budget (MOH 2005:84). Of central focus are the use of beds, staff, and funds (MOH 2007a:74). Taking the 2007 national performance, there is fairly high utilisation of hospitals with bed occupancy rate (BOR) averaging 85% in district hospitals and 75% in ten regional referral hospitals including four PNFP units (ibid 77). With regard to staff productivity, each staff member on average is in charge of 1,571 units of output in district hospitals and 1,395 in the ten regional referral hospitals including the four big PNFP hospitals (ibid).

4.6.1 Staff Productivity in PNFPs

The study uses staff productivity as one of the indicators for efficiency in PNFPs which literally takes into account the number of patients seen by a medical officer

amidst the available time. Using this conceptualisation, the study notes that PNFPs have registered continuous gains in staff productivity measured in terms of standard unit of output produced per staff (SUO/Number of staff) as shown in the figure below. From the interviews, the increase in staff productivity is due to the accreditation system adopted in PNFPs. Under the accreditation system each medical officer is expected to serve at least six patients a day (UCMB 2007b). However, from the same interviews, it was also noted that there was a danger in concocting data with regard to efficiency which was being handled by nurturing a culture of true information.

Figure 19 Staff Productivity in 65% of PNFP Hospitals

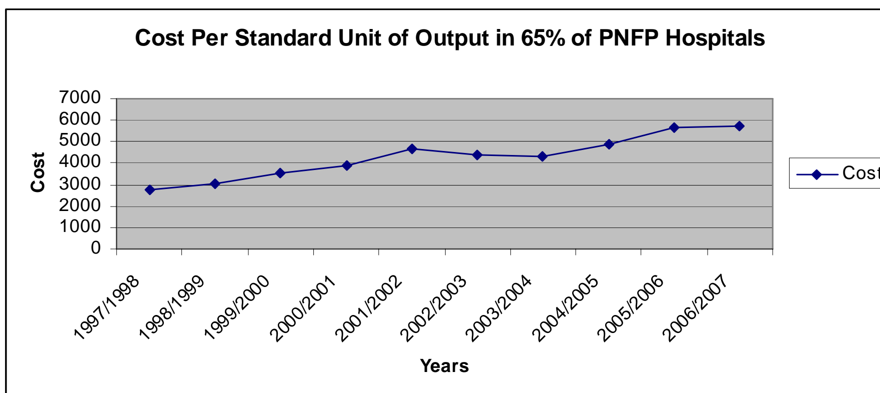


Source: UCMB database (2008)

4.6.2 Economic Efficiency

Economic efficiency, which is the average cost per standard unit of output (Cost/SUO), was also explored within the PNFP network. From the data available, average cost steadily increased starting 1997/1998 to 2001/2002 and started dropping till 2003/2004 with a marked increase starting 2004/2005. Basing on the reviewed literature, the rise in average cost was due to the impact of labour costs.

Figure 20 Cost per Standard Unit of output in 65% of PNFP Hospitals



Source: UCMB data base (2008)

Despite the ascertained levels of efficiency with regard to staff productivity, there are persisting inefficiencies especially duplication as highlighted in the next chapter.

4.7 Other Factors

As expressed in the introduction, it would be unrealistic to attribute all the outcomes to this partnership. Other factors could have been influential. For instance education, especially that of women, could have influenced accessibility to services and quality demanded. Related could have been the effects of decentralization especially the fiscal decentralization strategy and revitalization of the Uganda expanded programme for immunization. However, most of these reforms could have significantly influenced outcomes in government controlled facilities where services are free and not PNFPs. In addition several of these reforms had implementation shortfalls like underlined by Okuonzi (2004).

4.8 Conclusion

This chapter has shown that PNFP hospitals play a major role in provision of health services in Uganda. The figures indicate an increase in most of the indicators like accessibility, staff productivity, user-fee reduction and qualified staff between 1997/1999 and 2004/2005 as shown in Annex B. However, these gains which were largely due to the proportionate increase in the subsidy began to erode since 2005/2006 amidst attempts by hospitals to remain in operation given the escalating costs especially labour (MOH 2007a). Surprisingly, instead of government positively reinforcing the gains registered by 2004/2005, it compromised PNFP virtuous behavior and partnership objectives by reduction and stagnation of the subsidy. As a result, there has been a drop in most indicators since 2004/2005. For instance, outpatient attendance decreased by 2%, inpatient by 10%, overall volume of out puts measured by standard unit of output decreased by 5% and expenditure per unit of output continued to rise by 5% between 2005/06 and 2006/07 (ibid). With this compromised status quo, PNFP hospitals may be taken to the pre-partnership state of underutilization, use of lowly qualified staff, loss of efficiency for staff and bed use (ibid).

CHAPTER FIVE: TRIGGERS, CONDITIONS, CHALLENGES

5.1 Introduction

Having highlighted some of the outcomes of partnership, this chapter emphasizes the triggers, conditions and handicaps that could explain these outcomes using the theoretical framework in chapter three.

5.2 Triggers and Conditions

5.2.1 Power Sharing Arrangements

Powers sharing among all partners is a contributory factor for the positive outcomes highlighted in the previous chapter. Central government allowed the three bureaus to be represented on the health policy advisory committee. Similarly, bureaus allowed government representation on their boards including those of the health facilities. Furthermore, there are other forms of power sharing among the bureaus. For instance, the interviews found that both Uganda Protestant Medical Bureau and Uganda Catholic Medical Bureau have an arrangement under which they share the leadership of joint medical stores.

5.2.2 Receptivity to new solutions

Receptivity to new solutions could have influenced the outcomes in chapter four. For example, the bureaus endorsed a decentralized structure of central government transfers and rejected the 1950 approach for centralized administration and disbursement of subsidies (UCMB et al 2007:26). This receptivity among bureaus came with a sacrifice since with the new arrangement, they were to lose 4% of the levy they would have charged on disbursed amounts as administrative fee, like it had been in the 1950's and 60's. With this levy, they would have been able to sort out their financial problems rather than relying on donor support and subscription fees.

Receptivity was also expressed by partners when they endorsed the district and hospital league tables which are designed to improve quantity and quality of outputs by stimulating comparisons. These tables provide an opportunity for hospital and district leaders to question why they perform poorly and the ways in which they can improve performance. They include both management and service delivery indicators like management of the primary health care conditional grant measured by the amount received and spent, expenditure on key inputs, flexibility in using the fiscal decentralisation strategy (FDS) in favour of the health sector, new out-patient attendance, immunisation coverage, hospital deliveries, magnitude of hospital outputs, efficiency and quality of services.

5.2.3 Partner Compatibility

Of great significance is the *compatibility* between the PNFP sub-sector and government. Given that the two partners have worked together since the colonial period, they know each other's track record, mission, operations and constraints which in a way could have promoted mutual understanding in the first five years of collaboration.

This compatibility is further reinforced by the fact that both government and the PNFP sub-sector have almost similar objectives of serving the public especially the poor and rural people at low or even no fees. This is consistent with the findings of Lochoro et al (2006) who note that in some countries PNFPs can be taken as part of the public health system. From the literature, it was noted that the central aim of PNFPs is ensuring equity and social justice and as a result they have no plans of re-orientating towards pure business and neither do they distribute surplus to their directors or owners (UMCB et al 2007). This commitment to serving poor people is substantiated by the fact that a majority (85%) of the PNFP hospitals and dispensaries are in rural areas (MOH 2000). This illustrates consistence with their original plan whereby most of the PNFP facilities were built by their founding members among the poorly monetized population though over time towns were built in their surrounding (UCMB et al 2007: 3). From the analysis it was noted that religious values helped in promoting the mission of serving poor people, since bureaus hold that health care delivery is central to spiritual healing. Indeed one of the interviewees emphasised that "Jesus cured diseases during the spiritual healing missions" (UPMB respondent).

However, the researcher noted that serving poor people faced challenges of 'affordability' especially in areas where 80% of the population was below the poverty line, since more patient admissions didn't imply added financial returns to PNFPs. From the interviews it was noted that more admissions amidst decreasing government subsidy coupled with a commitment to lower user-fees translated into a double burden to PNFPs given that they had to mobilise resources in addition to actual provision of services.

Partner compatibility could further be substantiated by the fact that like government, PNFPs have well established health infrastructure especially in hard-to-reach areas. In addition, both institutions have coordinating structures at local level represented by dioceses and at the centre through the three bureaus (UCMB et al 2007: 23).

However, though compatibility made it easier to engage this sector, like experienced in India there was potential for dubiousness whereby some NGOs could be established by political personalities to garner funds (Bjorkman and Raman 2008:7). This fear was re-echoed during the interviews whereby within Ministry of health, it is thought that some of the PNFP facilities don't actually exist which indicates a weakness in government monitoring, inspection and verification.

5.2.4 Confidence

Further to compatibility, there was a high level of *confidence* between both partners. From the government side, it showed confidence in the PNFP sub-sector when it opted for a shared vision based on rational expectations. As a result it included the sub-sector outputs as part of the whole sector outputs, monitored by the second health sector strategic plan and the poverty eradication plan (PEAP) indicators and accounted for in the health sector performance report (MOH 2007, UCMB et al 2007:30).

However, this confidence was later undermined by *mistrust* on both sides. For instance, local leaders thought that PNFPs received more funds than government units through user-fees, donations and government subventions. There is also a misconception by local government leaders and their constituency that the government subsidy is adequate to replace user-fees. Surprisingly, local government

officials also mistrust central government and hold it responsible for the status of this partnership.

There was also an unfounded assumption by government officials that PNFPs didn't have ability to attract and retain staff which as a result prompted secondment. This was based on pretext that whenever government advertised, health workers crossed from PNFPs to government. This point can only be valid if reflected on in relation with the overall government recruitment policy whether by design it encourages equal remuneration between the staff employed by both sub-sectors.

5.2.5 Partner Abilities

Another factor which triggered the positive results was that *partners exhibited abilities in meeting performance expectations* which was expressed in form of the efforts undertaken in managing constraints beyond partnership boundaries. For instance, local governments undertook initiatives for seconding staff including security guards and recommending potential donors to PNFPs.

Central government distributed safe delivery kits (mama kits) in government and PNFP hospitals with a view of increasing the proportion of expectant mothers delivering in health facilities. Other initiatives were undertaken by some districts for example in one district with assistance from CUAMM project there was formation of a PNFP coordination committee comprising of all religious based PNFPs.

However, some of the initiatives undertaken have limitations especially secondment given that it led to discontent between government employed staff and those of PNFPs (UCMB et al 2007:18). This is because the posted staff, receive a government salary which is relatively higher than that paid to their PNFP colleagues. In addition the seconded staff get a variable top-up constituted as a hardship allowance (because most of these hospitals are in rural areas) from the PNFP employer almost equivalent to the pay to locally recruited workers which creates further imbalances (ibid).

Also most of the seconded staff are located in urban areas which defeats the objective of partnering in improving equity. For instance by 2007, of the 119 seconded staff, Kampala city commanded 53 personnel (44.5%). Of the three consultants two were resident in Kampala which shows a big gap in rural and semi-urban areas (MOH 2007b:15).

Furthermore, there is delayed payment of the seconded staff which in the process leads to neglect of duty. Related to this point, the seconded staff take long to access the payroll than those posted in government hospitals and as a result abandon duty.

There is also a difficulty in managing and supervising seconded staff since they tend to pay more allegiance to government institutions which pay their salaries. During literature review, it was noted that Ministry of health and district officials invite seconded staff for activities without informing PNFP managers who only notice their absence after abandonment of duty (MOH 2008:34).

It's also alleged that the seconded staff incite other PNFP workers into protesting about working conditions especially with regard to pay and working hours which in the process destabilizes the PNFP workforce. In summary, re-echoing the comments from Ministry of public service and the bureaus, secondment is failing because of supervision and monitoring difficulties and the questions it raises about liability.

5.2.6 Mutual Dependence

Mutual dependence between government and PNFPs was another influential factor. The study noted that government needed PNFP outputs to improve its performance in the health sector while PNFPs needed government support to survive the economic crisis especially high inflation and labour costs. Indeed during the interviews all parties expressed their happiness of the existence of this partnership.

This norm of mutual dependence is replicated at grass root levels by individual health facilities. For instance, Ngora hospital a UPMB affiliated facility which started as a health centre had for long wanted to upgrade into a hospital. However, it had to offer maternity services for it to be upgraded and as a result went into partnership with a nearby government grade three health centre rather than constructing its own maternity ward. Arising out of this collaboration, medical officers from the hospital were able to undertake routine ward rounds and reviewed complicated cases at the government health centre (MOH 2008).

Similarly, there are strong levels of mutual dependence between the two bureaus. For instance the diocesan health coordinator for Uganda Catholic Medical Bureau in Lugazi catholic diocese was delegated to act as a coordinator for Uganda Protestant Medical Bureau in Mukono district. Also in Moroto district, when the community requested a health centre from an inadequately funded NGO, the sub-county intervened and offered a building while the NGO hired staff, provided medicine and supplies. The health centre (Nadunget HC 11), was later transferred to the district (MOH 2008).

During the interviews the researcher was informed that non facility-based PNFPs like Joint Clinical Research Centre and Catholic Relief Services are accommodated at the PNFP facilities. Another aspect of mutual dependence was noted when the new Ministry of health permanent secretary wanted to revise the health policy advisory committee representation but all bureaus jointly reacted against it and the decision was reversed.

The noted cases not only depict mutual dependence but also efficiency considering that there are multiplier effects in cost saving. However these experiences are threatened by lack of commitment in Ministry of health as evident from its failure to get the policy approved.

5.2.7 Resource Exchange

The positive outcomes can also be associated with the norms of *resource exchange*. For instance, there is a partnership between Uganda Catholic Medical Bureau and Uganda Protestant Medial Bureau at joint medical stores through which they coordinate and manage logistics like drugs and equipment. Arising out of this partnership, the three bureaus are able to get subsidised prices on most drugs and equipment. Though Uganda Muslim Medical Bureau isn't a core owner in this arrangement, it benefits from subsidised procurement. During the interviews it was noted that partners share theatres during emergencies and doctors work in all hospitals though this is not encouraged by Ministry of health especially among government workers.

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5.2.8 Mutual Respect

Mutual respect among all partners is another fundamental factor. The three bureaus respect each other given their religious values. On the other hand, government respects PNFPs because of their reputation in the health sector.

5.2.9 Even Benefits

The presence of even benefits among partners is another significant factor. This is sustained by the compatibility in mission statements between government and PNFPs given that both are interested in providing public goods. However, the presence of even benefits is threatened by uneven risk sharing. For instance while government encouraged user-fee reduction, it didn't provide a safety net for PNFPs that could be adversely affected by the policy implementation.

5.2.10 Autonomy and Identity

This partnership was able to record some of the achievements because members preserved their *identity*. PNFPs maintained their original mission and there was no intrusion by government on their operational decisions. PNFPs controll decisions of whom to serve, whom to partner with, charges to levy and employees to recruit, though this is threatened by staff secondment.

It's on the basis of protection of their identities that bureaus recommended the provision of a wage subvention rather than secondment and are against the constitution of one PNFP coordinating bureau for all networks which could raise questions of ownership and replication of some models. From the interviews, the bureaus objected having one coordinating entity because they believed there are areas they don't agree on and hence need to operate as separate entities. A commonly cited example is the Maputo protocol championed by the United Nations Population Fund which was meant to legalise abortions as a mechanism for family planning. However, given that it contradicted Catholicism, Uganda Catholic Medical Bureau distanced itself from it.

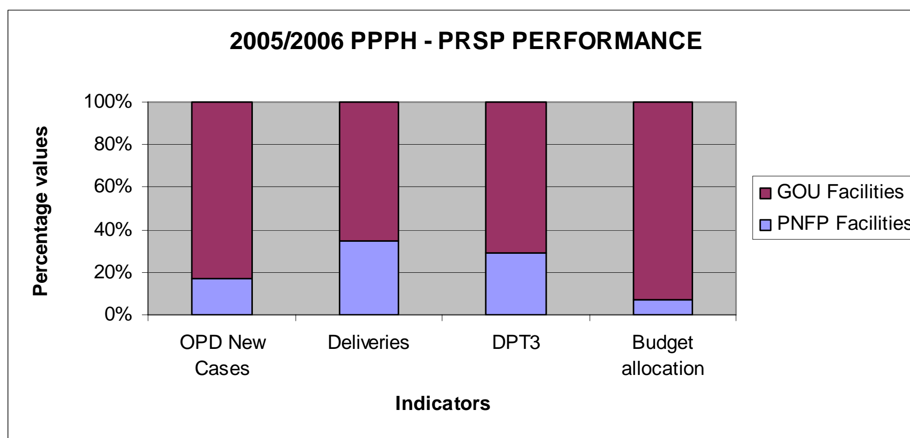
In addition, because of the need to preserve their identity, bureaus argue against the principle of bringing private health practitioners and traditional and complimentary medicine practitioners under the same policy and instead advocate separate policies for these entities. This identity has been preserved because each bureau is represented as an individual entity in government forums.

However the study noted the prevalent mistrust by PNFPs towards government intentions which could hurt autonomy and identity. PNFPs fear that with full institutionalisation of the partnership, they could lose autonomy like it happened in the 1960s when government took control of missionary schools. This study also provided insights on the shortfalls of identity in partnership. Though identity helped in realisation of set objectives, it was a barrier to partnership institutionalisation since by protection of each entity's identity; there was an intuition to recognise its uniqueness and difference with the 'other'. From the PPPH case, bureaus prefer their respective religious-based coordination networks rather than a single body and are against the principle of including private health practitioners and traditional and complementary medicine practitioners into the same policy. Such differences could prevent meeting high-end objectives and could hurt the small members like Uganda Muslim Medical Bureau in any partnership given their low bargaining power and expectation to learn from their powerful colleagues.

5.2.11 Partner Performance

The level of the partner performance was a significant factor in attaining the outcomes despite constraints in under-funding and attrition rates of qualified staff. Using Brinkerhoff's yardstick, the study established that the three bureaus are satisfied with each others' performance. From the interviews, there was a general attitude that the level of performance in PNFP units is better than that in government units and that PNFPs have been effective in meeting some of the set targets as shown in the figure below. Out of 7% of the total health budget allocated to PNFPs, they were able to record 17% of all new out-patient department cases in the country, 35% of deliveries and 29% of immunisations by financial year 2005/2006 as shown in the figure below. Indeed government got more outputs from its money (MOH 2007a).

Figure 21 PPPH- PRSP Performance (2005/2006)



Source: MOH (2007a)

The level of partner performance in PNFPs is partly ignited by what the respondents termed as 'the power of results.' PNFPs have forced themselves to deliver because of the general belief that with numbers it will be hard for them to be ignored by government.

However, this doesn't discount the noted shortfalls especially with the central and local government. For instance, while Ministry of finance improved timeliness and completeness in release of funds to local governments, some districts delay their disbursement from collection/ sector accounts to implementers (MOH 2007a:19). In addition, there is inadequate and low quality information flow from the district to Ministry of health on primary health care conditional grant releases, monthly health management information system (HMIS) and annual reports.

Also, Ministry of health and local governments take long to approve new PNFP units that applied for funding and credit line support. For instance, of the sixty two units belonging to Uganda Muslim Medical Bureau, it was noted that ten were not on credit line by August 2008 despite that applications were made in January. In fact some of these applications were made two years ago and had never been approved. Partly this was due to the long procedure since districts were expected to endorse the applications. This variance created discontent between the approved and non-approved units.

It was also noted that at times Ministry of health performs routine mistakes. For instance, it approves units under Uganda Muslim Medical Bureau yet they belong

to another entity and sometimes it gives more money to lower level units than hospitals. In addition, though some units made applications to be upgraded to [1]health centre grade four, they were never considered and left at health centre grade two level.

5.2.12 Existence of catalyst at the start of the process

In relation with ADBI (2000) cited in Bjorkman and Raman (2008), the study emphasises the *existence of a catalyst at the start of the process* as a contributory factor. This partnership was undertaken at the appropriate time when PNFPs were facing a crisis to maintain their facilities and when there was a new political regime committed to implementing socio-economic reforms. It ought to be noted that prior to the 1970-80s political upheavals, Uganda had the best health indices in the East African region (MOH 2000). With the crisis there was a collapse in the sector. The collapse in the socio-economic system led to a political movement with the ascendancy of a new regime in 1986 which was committed to socio-economic reforms.

5.3 Shortfalls and Dilemmas

Beyond the earlier mentioned factors which precipitated some of the recorded levels of success, the study was able to pick up some dilemmas and shortfalls facing partnership using the same framework.

5.3.1 Low Accommodation of Special Interests

Taking into account the *conducive factors*, several shortfalls were observed especially with regard to *accommodation of special interests*. For instance, though there is an agreement between government and PNFPs not to open new health units where the other partner is already offering the same services, it was rarely observed by both sides. For example, a new hospital (Buikwe Hospital) was constructed in Mukono district with the help of donors through Lugazi catholic diocese following a request by local people and politicians next to a government owned health centre grade three. Although the health centre facilities and staff were later allocated to the hospital, it was against the principle of building a facility where the other partner had one which in someway created resource wastage. From the interviews, this was due to political promises and different levels of understanding of this partnership. Other incidences of duplication were reported in Kumi district.

Another gap in accommodation of special interests was when PNFPs requested government to integrate their health management information system with that of Ministry of health. However, this request was turned down by government which in a way created shortfalls in transparency and accountability. This was self defeating given that if government had accepted the request there would have been improved accountability.

5.3.2 Government Inflexibility in taking Corrective Actions

This partnership is impeded by government's *inflexibility in taking corrective actions*. The researcher noted that arising out of government's successful negotiation of a World Bank loan, salary increments were made to government medical staff despite the advice that came from PNFPs. The salary difference almost made the government-PNFP relationship to look like a competition given the associated attrition rates whereby most PNFP workers left their work for the better pay in government units.

With this situation PNFPs made a salary harmonisation proposal to government which was rejected

5.3.3 Absence of Legitimate Champions

The absence of a champion in Ministry of health is another factor that could explain the reversal in outcomes noted in the previous chapter. It ought to be noted that the start of this partnership was championed by then Minister of health (Dr. Crispus Kiyonga). However, following his departure from Ministry of health, this partnership lacked a political champion. The interviews indicated that very few Ministry of health technocrats are interested in PPPH. With this gap, development partners represented by the Italian cooperation have been motivated to take up the responsibility through various forms like provision of financial support and technical guidance for development of the PPPH policy document and operation of the desk office. However, given that the Italian cooperation is outside Ministry of health, it faces shortfalls in leadership particularly with garnering legitimacy which is consistent with Bjorkman and Raman (2008:6)'s findings that partnerships require governmental leadership.

5.3.4 Low Senior Management Support

Related to the above point, low senior management support is a hindrance and could be the reason for the declining resource commitment into this partnership starting 2004/2005. This is evident basing on a number of factors like the small position given to the PPPH desk in the Ministry of health structure. In this structure, the PPPH desk falls under the directorate of planning, headed by a director who usually delegates such functions to one of the officers in the directorate. So in essence there is no permanent PPPH technical team in the Ministry. For instance by the time of the interviews, the PPPH work was handled by the senior health planner who was shouldering this in addition to other responsibilities like coordination of global fund activities which appeared to be more of a priority to him than PPPH work.

In addition, none of the Ministry of health senior management staff member is represented on the PPPH working group nor attends its meetings. This low senior management could be associated with the perception of majority of the ministry staff who think that the PPPH working group is largely to do with the private sector and not government i.e. 'their thing' syndrome. Ironically, the only representative of the Ministry on the working group (chair person) comes from the clinical services directorate rather than planning where PPPH structurally belongs.

5.3.5 Inadequate Goal Clarity

Though some of the goals are specified in the health sector strategic plan, there are shortfalls in their specificity. This is partly because of lack of an approved policy document amidst the incremental changes which were happening to partnership implementation. Inadequate goal specificity hindered critical inputs and outputs. For instance there were delays in measuring quality. Similarly there were gaps in monitoring and specification of the proportion of the health budget to be allocated to PNFPs. These findings are consistent with Buse et al (2006: 264) who notes that "poor specificity can lead to failure to deliver critical inputs as well as misunderstandings, both of which undermine the partnership and impede performance monitoring and accountability."

5.3.6 Low levels of Reciprocal Accountability

The study established a weakness on reciprocal accountability. For instance, during the interviews government officials expressed their dissatisfaction with PNFPs for not providing financial accountability. Ministry of health and finance officials informed the researcher that they didn't know the resource envelope of PNFPs and hence relied on one-off studies covering a few units in order to estimate the total resources of the PNFP sub-sector. This was re-emphasised by one of the bureau respondents who argued that planners are doing case work and as a result financial allocations are not based on facts. Surprisingly, this was refuted by the PNFP executives who noted that they have always provided the information to Ministry of health and that these are new incidences of mistrust.

Other episodes of low levels of reciprocal accountability include shortfalls in submission of work plans and reports by both local governments and PNFP facilities. Most of the reports are never submitted and in case it is done, they were delayed and include only the primary health care grant and not the full PNFP units' budgets. This finding is further substantiated by data from the annual health sector performance report (2007) which indicate that the proportion of districts submitting quarterly reports stood at 20% since 2005 while the those that submitted timely monthly reports to Ministry of health declined from 75% to 68% (MOH 2007a: 7). From the analysis, partly the deficiency is due to the failure by Ministry of health to request for the information especially from PNFPs and its low participation in the PPPH working group.

Despite the above highlighted gaps, the researcher noted that there is a good level of reciprocal accountability among the bureaus. From the interviews, it was noted that the bureaus have a high level of accountability among themselves emanating from the existing information exchange arrangements like annual reports, inter-bureau meetings where common issues are discussed and joint advocacy initiatives.

5.3.7 Transparency Deficiency

The study noted a deficiency on the level of transparency exhibited by government. Government is viewed as not transparent with regard to resource allocation and decision making. For instance there are questions on how some private for-profit units like; Mayanja memorial, Mbarara community, and Gulu Independent hospitals, were able to access the PNFP grant without sound criteria and consultation with the bureaus. In addition, bureaus cited a deficiency in government units for their failure to emulate them in showing the relationship between the funds received and outputs delivered.

5.3.8 Partner representation and Participation

Though this partnership is credited for PNFP representation on the health policy advisory committee, joint review mission and joint annual review, it fell short in actual participation. Indeed representation hasn't translated into participation especially with regard to the PPPH working group and health policy advisory committee. From the interviews it was noted that the working group is crippled by its chairperson and as a result most of the issues aren't taken up by Ministry of Health. Partly this is because she is from the traditional medical practice and lacks skills in partnership steering. It was noted that the chair lady is an academician who doesn't have the calibre to bring other people on board especially since the

partnership broadened and took on private-for-profit providers and civil society organisations. Borrowing from Brinkerhoff, the problem isn't with the personality of the chair lady but her lack of necessary skills. As head of the working group she should have advocacy skills if she is to win more for this partnership in the Ministry.

Similarly, the Health Policy Advisory Committee as a representation forum has shortfalls given that it mainly focuses on Global Fund activities ever since it was assigned the extra mandate of functioning as the Central Coordinating Mechanism.

5.3.9 Inadequate Decision Making

Though the researcher wasn't able to fully measure this indicator given that he didn't attend some of the meetings where decisions are made, some insights were drawn basing on the interviews and literature. From these insights, it was noted that the coordinating bureaus have a shortfall in influencing decisions in affiliated health units given that by design they don't have jurisdiction over them and only rely on their perceived usefulness. It's on this basis that implementation of the user-fee reduction strategy was left at the discretion of individual units which led to varied implementation.

5.3.10 Low Incentives and Penalties

The shortfalls in designing and implementing an incentive and penalty system also hindered some of the outcomes. For instance while it would have been adequate for Ministry of health to reward the virtuous behaviour of PNFPs in 2004/2005 when they scored high gains in most indicators, it instead compromised them by reduction in subsidy. In addition nothing was done to local governments for their delayed release of funds to PNFPs and their failure to provide relevant information to Ministry of Health.

5.4 Conclusion

This chapter has highlighted factors that could have led to the positive outcomes underscored in chapter four. Of special significance are compatibility between partners, preservation of partner identity, effective and efficient performance from PNFPs, power sharing and mutual dependence. However, several shortfalls compromise these achievements like lack of a political champion and senior management support in the Ministry of health, inadequate reciprocal accountability and low accommodation of special interests by government. Lack of a political champion and low senior management support could explain the reduction in resources committed and failure to institutionalise the partnership through approval of the PPPH policy.

CHAPTER SIX: CONCLUSION

6.1 Introduction

This study underscores the potential of public-private partnerships in increasing health care in Uganda. Getting to specifics, PPPH increased accessibility measured by the increased number of patient admissions and reduced user fees, staff productivity, quality especially qualified staff and equity with regard to increased utilisation of services by women and children. This was due to a number of success factors like partner compatibility, high level of partner performance especially among PNFPs, preservation of partner identity, power sharing and mutual dependence.

However there were shortfalls with regard to sustainability as evident from the vulnerability of PNFPs to economic shocks. PNFPs have low performance in human resource management, infrastructure maintenance and high dependence on government and donor support.

In addition, two questions remain unanswered on why the gains attained by 2004/2005 couldn't be sustained over time as evident from the significant drops in most indicators starting 2005/2006. Second, if all parties are impressed with the existence of this partnership and are convinced that it is delivering the intended results, why is there low commitment for its institutionalisation? These broad issues require further research; however, the study did them some justice by drawing on the interviews and literature.

6.1.1 Why PPPH couldn't sustain the gains

Chapter four emphasises the effect of low senior management support on sustainability of the outcomes. Because this partnership doesn't have strong support from the senior management team in Ministry of health, it's a victim of reduced resource commitment amidst other competing health priorities and declining proportion of the health sector budget. The presence of the Italian cooperation as a champion isn't that helpful given that it's not part of government.

Poor incentives and penalty schemes hindered sustainability of the recorded gains. Starting 2004/2005, government failed to increase the subsidy to enable PNFPs provide more outputs. In addition nothing was done to poor performers especially local governments.

6.1.2 Failure for institutionalisation

Partnership institutionalisation in form of an approved policy is central if PPPH is to remain a priority amidst reducing proportions of the health sector budget and pronouncement of the fiscal decentralisation strategy where local governments have discretion to re-allocate funds. However institutionalisation remains a challenge due to the fears and actions of both the government and PNFPs. As a result decisions continue to be based on mutual understanding (gentleman's agreement). In the subthemes below, the effects of autonomy, identity and senior management support on partnership institutionalisation are discussed.

6.1.2.1 Effects of Autonomy and Identity on Institutionalisation

Unlike the usual norm of praising *'preservation of partner identity'* as a success factor, this study found that it could be a hindrance to partnership institutionalisation, especially in situations where more than two partners are involved. As evident in the Ugandan PPPH case, each bureau was concerned about preserving its identity. As a result

common goals like having a single coordinating bureau which would have helped in improving their bargaining position were jeopardised.

Similarly, fears for loss of autonomy has hindered institutionalisation. PNFPs are sceptical of government intentions given their past experience. They are scared that with full institutionalisation, government may take over the privately owned institutions like it did to missionary founded schools in the 1960s (Kirunga et al 2007).

6.1.2.2 Low senior management support

Low senior management support has had tremendous impacts on partnership. Not only did it create the drops in 2005/2006 but also hindered institutionalisation. Because the policy didn't have strong support from Ministry of health senior officials, it wasn't forwarded to cabinet for approval. This is consistent with the information from the interviews that found a lack of will in the Ministry of health.

6.2 Suggestions for Future Research

Though this study tried to show PPPH performance on a number of parameters, some of the indicators and data used had gaps. Therefore, possibilities for further research are suggested below.

6.2.1 Quality

In order to get a deeper meaning on quality, a survey should be undertaken on the proportion of the population expressing satisfaction with health services and percentage of fever and uncomplicated malaria cases correctly managed at health facilities.

6.2.2 Sustainability

There is need for research on the impact of donor support on health priorities particularly with regard to primary health care and partnership.

6.2.3 Equity

Given the low performance on maternal health there is need for a detailed study investigating the supply and demand aspects affecting the health seeking behaviours of women in PNFP facilities. These could include aspects like the women's lack of financial leverage, decision making in households, time spent at health unit, education, nature of staff, equipment, drugs and supplies in PNFP facilities.

There is also need to explore utilisation among specific communities particularly nomads in the north-eastern part of the country who have specific cultural beliefs, fisher-men and their families and people living in conflict areas especially the northern region which accounts for 20% of the country's population.

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Notes

[1] Lower level units are graded as HC II, HC III and HC IV depending on the administrative zone served by the facility (parish, sub-county and health sub-district) and services provided. Grade II centers serve a parish and provide outpatient care, ante-natal care, immunization and outreach. They are manned by one enrolled nurse, one enrolled midwife and two nursing assistants. Grade III centers, serve a sub-county and provide all the services of Grade II centers, plus inpatient care and environmental health. They are manned by one clinical officer, one enrolled nurse, two enrolled midwives and one nursing assistant, one health assistant, one laboratory assistant and a Records Officer. Grade IV centers serves a health sub-district and provides all the services of Centre III, plus surgery, supervision of lower level units, collecting and analyzing data on health and planning for the health sub-district. They have one medical officer, two clinical officers, one registered midwife, one enrolled nurse, one enrolled midwife, one comprehensive nurse, two nursing assistants, one laboratory technician, one laboratory assistant, one health inspector, one dispenser, one public health dental assistant, one Anaesthetic Officer, one Assistant Health Educator, one Records Assistant, one Accounts Assistant and two support staff (MOH website: http://www.health.go.ug/health_units.htm)

Annex

Annex A- Interviewed Officials

1. Executive Secretary; Uganda Catholic Medical Bureau
2. Statistician; Uganda Catholic Medical Bureau
3. Executive Secretary; Uganda Muslim Medical Bureau
4. Health Coordinator; Uganda Protestant Medical Bureau
5. Finance and Administration Manager; Uganda Protestant Medical Bureau
6. Health Training Institution Programme Officer, Uganda Protestant Medical Bureau
7. Health Desk Officer/ Senior Economist; Ministry of Finance, Planning and Economic Development
8. Senior Health Planner; Ministry of Health
9. Senior Economist; Ministry of Health
10. Assistant Commissioner - Planning; Ministry of Health
11. Health Project Assistant; Italian Cooperation
12. Assistant Commissioner, Ministry of Public Service

Annex B - Summary Matrix of PPPH Outcomes

Goals	Expected Outcome	Actual Performance
Access	Increased Physical and Financial access	1. Increased financial access due to reduced user-fees 2. Increased out-patient and inpatient admissions
Equity	Increased Equity	1. Increased utilization by women and children (Deliveries and immunization)
Quality	Increased technical quality	1. Increased Quality in PNFP Units (qualified staff) 2. Reduced stock out of essential drugs 3. Low quality monitoring 4. High attrition rates
Efficiency	Increased output/outcome for a given input	1. Increased staff productivity & cost per unit of production due to high labor costs
Sustainability	Increased proportion of internal financing of public services	1. Donor and government dependence 2. Vulnerability to economic shocks 3. Low infrastructural maintenance