An assessment of public private partnerships in the healthcare sector in Uganda: a case of government referral hospitals

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Thesis accepted in fulfilment of the requirements for the degree *Doctor of Philosophy in Public Management and Governance* at the North-West University

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DECLARATION

I, Settumba John Paul, hereby declare to the best of my knowledge that this study **"An Assessment of Public-Private Partnerships in the Healthcare Sector in Uganda: A Case of Government Referral Hospitals"** is my original work; and that all secondary sources of data used, or quoted have been properly in text cited and accurately referenced according to APA format; and that this study has never been submitted for the award of any degree in this University or any other institution of higher learning. This thesis is submitted in fulfilment of a PhD in Public Management and Governance at North West University, Vaal triangle campus, Vanderbijlpark, Gauteng Province, Republic of South Africa.

Settumba John Paul Date: 23rd March 2022

APPROVAL

This PhD thesis has been written under my supervision and has fully fulfilled all the requirements for the award of the degree of a PhD in Public Management and Governance at North West University, Vaal triangle campus, Vanderbijlpark, Gauteng Province, Republic of South Africa.

Signature: 

Professor Lukamba-Muhiya Tshombe

Date: 23rd March 2022

DEDICATION

I, Settumba John Paul, dedicate this study to my family: Dad, the late Willy Sekitoleko Sembatya, Mom Anne Sembatya, my wife Patience Birungi Settumba and children Pertinah Nagawa, Jordan Paulsen Settumba and Paloma Kirabo. You defined my beginning and future. May the Almighty God bless you for all you did in my education journey.

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ABSTRACT

The current study examined the role of Public-Private Partnerships in the Healthcare sector in Uganda: A case study of government referral hospitals. The study determined a sample size of 160 eligible participants, where a purposive sampling procedure was used to collect qualitative data from 32 informants, using interview guides. Whereas, the snowball technique was employed to collect quantitative data from 160 respondents, using survey questions.

The study findings show that the healthcare sector of Uganda is too large, challenging, and demanding for the government to fully finance its programmes and ensure primary healthcare coverage. Accordingly, the study results show that the government of Uganda has embraced PPPs and contracted several private partners to provide improved health facilities through the design, building, and financing of health projects. Thus, the PPPs have helped the government to bridge the financial gaps through funding of many health programmes and infrastructural development, and human resource capacity through recruitment, training, and capacity building of staff.

This study maintains that PPPs provide improved health services and medical supplies such as, ARVs, medical beds, surgical equipment, mosquito nets, and clinical and non-clinical support like, Human Immunodeficiency Virus (HIV) counseling services on time and in an efficient manner. Though the government has taken a general form of the PPPs model in the healthcare sector. With regards to the best health PPP model, the study results indicate that Integrated Clinical Services is the best health PPPs model for the healthcare sector in Uganda.

Although PPPs play a critical role in improving health services and infrastructural development, and health promotion in Uganda, they face some critical challenges along the way. The current study found the following: political interference, bureaucracy in the process of implementing a health project or service, conflict of interest, the parallel working relationship amongst PPPs workers, poor communication and coordination, a discrepancy in compensation structure, advanced equipment provided by private partners that outmatches the users' knowledge, insufficient funding and a poor sustainability plan, collision on the same projects, as well as others that require both policy and administrative solutions.

Keywords: *Public-private Partnerships, Government Regional Referral Hospitals, Healthcare Sector, healthcare service delivery in Uganda.*

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LIST OF ABBREVIATIONS AND ACRONYMS

AAAQ	:	Availability, Accessibility, Acceptability and Quality
ACA	:	Affordable Care Act
ADF	:	Allied Democratic Forces
AI	:	Artificial Intelligence
ART	:	Antiretroviral Therapy
CDC	:	United States Center for Diseases Control and Prevention
CDPA	:	Central Drug Purchasing Agency
CHCs	:	Community Healthcare Centers
CSOs	:	Supporting Civil Society Organizations
CVI	:	Content Validity Index
DBFM	:	Design, Build, Finance and Maintain
DBFMO	:	Design-Build-Finance-Maintain-Operate
DBFO	:	Design, Build, Finance, and Operate
DBOD	:	Design-Build-Operate-Deliver
DBOT	:	Design-Build-Operate-Transfer
DBSA	:	Development Bank of Southern Africa
DGF	:	Democratic Governance Facility
DH	:	Department of Health
DHMT	:	District Health Management Team

EU	:	European Commission
FRU	:	First Referral Unit
GAVI	:	Global Alliance for Vaccines and Immunization
GDP	:	Gross Domestic Product
GHP	:	Global Health Portfolio in Uganda
GoE	:	Government of Ethiopia
GoU	:	Government of Uganda
GUREC	:	Gulu University Research Ethics Committee
HCC	:	Health Care Coverage
HDP	:	High Density Polyethene
HDP	:	High-Density Polyethene
HFSP	:	Health Financing Strategy Policy
HIV	:	Human Immunodeficiency Virus
HPACs	:	Health policy advisory Committees
HPV	:	Human Papillomavirus
HSDP 2015-19:		Health Sector Development Plan 2015-19
HSDP	:	Health Sector Development Plan
HSSIP	:	Health Sector Strategic and Investment Plan
HSSP	:	Health Sector Strategic Plan
HUMC	:	Health Unit Management Committees

IDI	:	Infectious Disease Institute
IFC	:	International Finance Corporation
IFC	:	International Finance Corporation
IFPPP	:	Infrastructure Finance and Public Private Partnership
IMF	:	International Monetary Fund
IoMT	:	Internet of Medical Things
ISER	:	Initiative for Social and Economic Rights
JICA	*:*	*Japan International Cooperation Agency*
JSI	:	John Snow Inc
KOICA	:	Korea International Cooperation Agency
LRA	:	Lord's Resistance Army
M&E	:	Monitoring and Evaluation
MCM	:	Management Contract Model
MCRI	:	Mbale Clinical Research Institute
MDGs	:	Millennium Development Goals
MoF	:	Ministry of Finance
MOU	:	Memorandum of Understanding
MoU	:	Ministry of Health
MPs	:	Members of Parliament
MRH	:	Mulago Referral Hospital
Mug	:	Mildmay Uganda

NACC	:	National Aids Control Commission
NCST	:	Uganda National Council for Science and Technology
NDA	:	National Drug Authority
NDP II	:	National Development Plan II
NDP	:	National Development Plan
NGO	:	Non-Governmental Organization
NHPPII	:	National Health Policy Plan II
NHS	:	National Health Service
NPM	:	New Public Management
NPPPH	:	National Policy on Public Private Partnership
NPPPPH	:	National Policy on Public Private Partnerships in Health
NRHM	:	National Rural Health Mission
NSDGs	:	National Sustainable Development Goals
NWU	:	North-West University
O&M	:	Operation and Management
OPD	:	Out-Patient Department
PATH	:	Programme for Appropriate Technology in Health
PCNE	:	Parliamentary Committee on National Economy
PDSM	:	Participatory Development Systems Model
PEPFAR	:	President's Emergency Plan for AIDS Relief
PFI	:	Private-Finance-Initiative

PFMA	:	Public Finance Management Act
PFP	:	Private-for Profit
PHC	:	Primary Health Care
PHCs	:	Post-Harvest Challenges
PHPs	:	Private Health Practitioners
PHS	:	Private Health Sector
PMO	:	Prime Minister's Office
PNFHP	:	Private Not for Profit Health Providers
PNFP	:	Private-non-for Private
PNPM	:	Private Not for Profit Making
PPDPA	:	Public Procurement and Disposal of Public Assets
PPE	:	Public-Private Engagement
PPFP	:	Postpartum Family Planning
PPIP	:	Public-private Integrated Partnership
PPPH	:	Public-Private Partnership in Health
PPPs	:	Public-Private Partnerships
PPPU	:	Public Private Partnership Units
RHI	:	Rwanda Health Insurance
RHITES	:	Regional Health Integration to Enhance Services in North, Acholi Activity
RMA	:	Rwanda Medical Association

RRHs.	:	Regional Referral Hospitals
SCM	:	Service Contract Model
SDGs	:	Sustainable Development Goals
SHA	:	Strategic Health Authorities
SMC	:	Safe Male Circumcision
SMS	:	Sawai Man Singh
SPEs	:	Special Purpose Entities
SPSS	:	Statistical Packages for Social Science
SPVs	:	Special Purpose Vehicles
SUSTAIN	:	Strengthening Uganda's Systems for Treating AIDS Nationally
TASO	:	The AIDS Support Organization
TB	:	Tuberculosis
TCMPs	:	Traditional Contemporary Medicine Practitioners
TRP	:	Terms of Reference Proposal
UHC	:	Universal Health Care
UHCC	:	Universal Health Care Coverage
UK	:	United Kingdom
UN	:	United Nations
UNICEF	:	United Nations International Children's Emergency Fund
UNMHCP	:	Uganda National Minimum health care package
USAID	:	United States Agency for International Development

VFM	:	Value for Money
VHTs	:	Village Health Teams
WBI	:	World Bank Institute
WHO	:	World Health Organization

CHAPTER 1

INTRODUCTION

1.1. Introduction

The 1990s embraced a concept of Public-Private Partnerships (PPPs) as a necessary tool to act as a public strategy due to the development of New Public Management (NPM). The NPM significantly moved the focus of management from providing public services to ensuring effective and proper service delivery to the beneficiaries (Khanom, 2010). The NPM approach was implemented to lead to more transparent, and more effective management techniques and government implementing incentives of the private sectors (Velotti *et al.*, 2012, p.340). The 1980s experienced considerable stiff in the market mechanism, privatisation, the struggle to delivering public projects, goods, and services and redefining the role of the government became the working words of the NPM. The implementation led to the reduction in public expenditure, where the roles of the private partners and the promoting of voluntary engagement of private actors became a mirror for delivering public goods and services (Khanom, 2010).

Consequently, the NPM promoted and encouraged the implementation of PPPs as a new management tool to deliver goods and services to the population. PPPs have now become key tools suitable for providing public goods and services and developing society in both emerging and developing nations. In general terms, PPPs are recognised as long-term goods and are service-driven between the government and private sector to achieve several goals. PPPs are established when more than one party in the public and private sector build a viable sustainable agreement based on a mutual relationship, which is not based on organisational structure (Naoum, 2003).

PPPs have been broadly recognised and used in the management of the public sector in most governments across the world. These are institutional tools being used for many goals. However, there have been diverse opinions among the researchers concerning the importance of PPPs in general practice. Some scholars have focused on the PPPs as an institutional arrangement between different organisations, in which the concept is being applied as a management and governance tool; and some studies have focused on PPPs as development intervention; while others contend that it is a language game or a discursive concept (Khanom, 2010; Teisman & Klijin, 2005).

This chapter introduces the background information and problem statement of the study. It further presents and discusses the concept of PPPs and the global perspectives of the PPPs. The

chapter presents research questions, objectives, purposes, significance, delamination, limitations of the study, and ethical considerations.

1.1.Background to the Study

PPPs is traced back to the construction of the Italian City-States, which began in the 14th- Century and lasted until the 17th- Century, a period in Dutch history, when the Dutch, traditionally able seafarers, dominated world trade and in which public organisations integrated political interests with the private sectors for economic improvement (Whyle & Olivier, 2016). Later in the 19th Century, the United Kingdom's economic and commercial associations brought together public and private sector interests, which led to unprecedented commercial growth and economic increase that made the Empire of England, the world's "top" global economy. Throughout the 20thCentury, PPPs were greatly considered as central instruments for development in Stockholm, Sweden 1972, at the United Nations (UNs) conference on the Human Environment (Mundial, 2003).

PPPs started being consolidated at an international level as a development mechanism after Agenda 21 was globally adopted in Rio, Brazil, where some new perspectives, in which the UN Conference on Environment and Sustainable Development declared and agreed upon on issues, including the sustainable environment, economy and the social setting (Ríos-Carmenado, Ortuño & Rivera, 2016). To add to this, for instance, in the World Economic Forum in 1998 in Davos, Switzerland, Kofi Annan, who at the time was a UN secretary-general, stressed the significance of PPPs, stating the need for public and private sectors to join efforts to end international extreme poverty. Similarly, in 2002 at the Johannesburg World Summit on Sustainable Development in South Africa, the adaption of PPPs was stressed as a viable mechanism for attaining sustainable social, economic, and environmental development (Lopez-Claros & Zahidi, 2005).

The half of the later 1990s underwent a remarkable increase in the number of initiatives between the public and private sectors with the sole purpose of addressing public failure and market demand of public health, through global Public-Private Partnerships for the improved health system (Buse & Walt, 2000a). The author maintains that financial constraints and the need to have access to technology in a search to secure competitiveness, have encouraged the many governments across the world to co-opt the idea of PPPs in the strategic agenda.

Over the past years, private sectors and different groups have proven to be more effective in supplementing public efforts. Non-government organisations (NGOs) and community groups have in various ways demonstrated their capacities in helping the disadvantaged groups with a number of services including motivational services-to-educational and health-based activities. Private enterprises and organisations have gained reputations in offering high-quality services, which directly respond to the needs and demands in the health sector. The private sectors in many cases have constantly cooperated with the governments in offering successful and efficient services of government-subsidised or financed services (Whyle & Olivier, 2016).

Similarly, the private sector, including not-for-profit and for-profit organisations, have remarkably addressed the market demand by offering considerable services, which improve government or public services delivered to its people. Under normal conditions, forming a partnership between the private and public sectors can eventually establish many opportunities for better service and resource allocations, additional resources, and improved quality in services (Mustaghis, 2016). For instance, the three key sectors have complementary strengths toward public services, which by integrating them can widen the financial for social gains. Based on the theoretical view, the NGO sector is in existence with the sole purpose of social development using people's initiatives, whereas the profit sector is in place for profit-making gains and thus it calls for market-based solutions to the world's social issues.

On the contrary, the public sector seeks to ensure access and equality for all and thus addressing the challenges of the market's limitations. With the disparities in nature and characters of public and private sectors, entering into possible partnerships implies the sharing of information, responsibilities, and benefits in a joint effort to address social development issues. Sharing information and responsibilities of the public sector by the private sector may help to free up some of the government resources to reach the most disadvantaged and poorest groups (Mustaghis, 2016).

1.2.Statement of the Problem

Since the First World War (28 July 1914 to 11 November 1918), the world has over the years experienced some significant challenges, including economic, political, and social problems (Martel, 2014). These consist of access to clean water, food, basic education, proper sanitation, and improved healthcare, which continue to affect mostly the globally deprived populations. Previous studies indicate that in most developing countries, the role of the private sector in

health has become a central part of providing improved public services (Ministry of Health, 2012; Tashobya, Musoba & Lochoro, 2007). The concept of PPPs has been adopted in terms of resource mobilisation and management, such as human resources, finances, and supplies. For instance, PPPs play a very critical role in delivering better services (Kwok-Cho, Beaglehole & O'Byrne, 2005).

Since the introduction of PPPs in 2001, the Government of Uganda has experienced significant challenges within the different aspects of this partnership including difficulties in policy development and conceptualisation of the PPPs in healthcare, information sharing, resource mobilisation, and provision (Tashobya, Musoba & Lochoro, 2007). However, there is insufficient literature that has discusses the role of PPPs in improving healthcare service delivery among the population. For instance, providing quality healthcare services to the most world's impoverished population is one of the social issues that needs urgent partnerships for better care.

Although most governments around the world have tried to resolve such problems, many have failed due to resource constraints including human resources and finances (Aggarwal, Angrish & Bansal, 2015). The healthcare organisations, which are involved in ensuring improved health services, have come up with significant innovations in the healthcare sector for emerging and developing countries, such as restoring failed health systems, improving child and maternal health, and fighting infectious diseases including malaria, tuberculosis, and HIV/AIDS, using cost-effective methods (Steinwald, Sloan & Edmunds, 2012; World Health Organization, 2017). The 2018 report by the World Health Organisation adds that all health facilities must have proper sanitation, be connected to clean water and stable electricity, have waste disposal systems that are functional, safe, and work 24/7 (World Health Organization, 2018).

Therefore, providing improved health care services to the patient has become a major concern for all healthcare organisations and care service providers with the general goal of achieving a high level of patient satisfaction (CARE, 2002). However, the government of Uganda also lacks enough resources to provide quality healthcare for its population, and some of the profit-motivated private organisations are often not willing to be engaged in most of the public programmes that seek economic and social returns in improving healthcare (Tashobya, Musoba & Lochoro, 2007).

The government of Uganda has received insufficient information about the importance of implementing PPPs to get relief from financial burden and a low level of experts in the public sector (Tashobya, Musoba & Lochoro, 2007). This means that the previous studies have not fully examined the primary role of Public-Private Partnerships in the healthcare sector. As a result, this presents a gap between the previous pieces of literature and the current study. Based on the above background, the study seeks to examine the role and impacts of Public-Private Partnerships in improving the quality, delivery of services, and financing of the healthcare sector in Uganda.

1.3.Research Questions

This research was interested in answering the following main and sub research questions (RQs)

RQ1. Why have PPPs become such an important concept for governments?

RQ2. What roles have PPPs played in improving the quality and delivery of healthcare services in Uganda?

RQ3. What are the challenges affecting the successful implementation and performance of PPPs in the healthcare sector in Uganda?

RQ.4. What type of healthcare PPPs model should exist for healthcare in Uganda?

1.4.Objectives of the Study

The present study seeks to investigate the role of PPPs in addressing the challenges in the health sector in Uganda. To help achieve this, the four (4) research objectives below were advanced and informant(s) data was collected from the field:

- To establish the importance of the PPPs concept for governments.
- To examine the roles played by PPPs in improving the quality and delivery of healthcare services in Uganda.
- To establish the challenges affecting the successful implementation and performance of PPPs in the healthcare sector in Uganda.
- To identify the best type of PPPs model for the healthcare sector in Uganda.

1.5.Purpose of the Study

This study investigated the roles of PPPs in addressing the challenges facing the health sector in Uganda. The purpose was to provide an institutional mechanism to help the government of Uganda to manage public-private projects, provide advisory and financial services, and to deliver improved health projects, equipment and services through the arrangement of PPPs.

1.6.Significance of the Study

The PPPs are largely considered as a mechanism through which a government can mobilise and utilise public resources to effectively and efficiently deliver services to its people (World Bank, 2015). The health sector in Uganda lacks the capacity to meet the health goals of the population (The guardian, 2009). This calls for urgent effort to develop a supportive mechanism, which can help to fulfill the unmet health needs of Uganda's population. This supportive mechanism in the form of Public-private Partnerships seeks to improve quality and healthcare service delivery which is a burden to the government of Uganda. This study aimed at examining the role of PPPs in improving quality and service delivery in the health sector in Uganda, and the significance includes the following:

1.6.1. Contribution to the Theory

The study explored several previous works of related literature, providing diverse definitions to the concept of PPPs. For instance, the World Bank defines the concept of PPPs as a long-term arrangement between the government and private organisations, that establishes a meaningful way of providing public services and assets, in which the private sector has a legal responsibility of taking all risks and management roles (Buse & Walt, 2000a; World Bank Institute, 2012). Other studies indicate that PPPs is an official agreement between two or more parties that allows them to work toward achieving a common objective but with a certain level of mutual responsibility and benefits, shared authority, resources, and risk-taking (Great Britain Treasury Taskforce, 1998).

Some scholars have identified PPPs as a cooperation of a long-term working relationship between the public sector and private parties in which they come together to develop products as well as services, share probable risks, and contribute both advisory and monetary resources which are associated with this main purpose of the arrangement (Van Ham & Koppenjan, 2001). The current study adds that forming a long-term working partnership between the public and private sectors could establish some significant avenues to craft some employment

opportunities, proper resource mobilisation and allocations, improve livelihoods, and quality care services delivered to the citizen.

This study has determined that PPPs is a cooperative initiative between the government and private actors based on the resources and expertise of each party joined to meet the growing public demand through a proper allocation of resources, rewards, and projected risks. Public-Private Engagement (PPE) is being used as the model for furthering health goals. The current study adds that the best PPP model arrangement should be people-centred, based on the priority and urgent needs of the beneficiaries. Therefore, entering into a partnership with the private sector, such as non-governmental organisations, international donors, for-profit service providers, and traditional-local leaders would significantly transform the service delivery and improve the financing of healthcare programmes.

1.6.2. Contribution to the Practice

PPPs can be designed to achieve resourceful and high-quality healthcare goods and services. The information reported in this study can be used by governments and the Ministry of Health for proper resource mobilisation, planning, and designing holistic health-related projects to improve healthcare services delivery for the entire population through health PPPs business models. The models can take different forms and understanding the limitations of these models is crucial (Whyle & Olivier, 2016). The current study identified *ñ I n t e g r a t e d C l i n i c PPP business modelò as* the best PPPs model, and its related features that can be adopted to improve the performance of the entire health sector. More importantly, the current study adds that the best PPP model arrangement should be people-centred, based on the priority and urgent needs of the beneficiaries.

1.7.Delimitations of the Study

The study scope was limited to the problem under investigation and examined the role of PPPs in addressing the challenges in the health sector of Uganda. The study did not examine issues outside the PPPs in the health sector in Uganda.

1.8.Limitations of the Study

Lack of reliable data: lack of reliable data was a critical limitation in investigating the problem. For instance, there are some previous studies conducted about PPPs, but title researches have been carried out in Uganda's context which made it hard to find reliable data. To overcome

this obstacle, the study visited and consulted with the librarians, google search and retrieved some databases to find out whether the topic to be investigated has been studied and has relevant information to depend on. Also, more sources, including newspapers, magazines, Government reports, and key stakeholders were consulted to gather more reliable data for analysis and reporting.

COVID-19 outbreak: coronavirus greatly impacted the current study. It should be remembered that COVID-19 was declared a pandemic at a time when this study was about to take place. However, due to effects, and rapid changes which were brought on by the coronavirus pandemic on a world scale, the current study could not continue as per the timeframe.

For instance, it came with certain restrictions including lockdown, social distancing, the wearing of masks, and regular hand washing. Some of these guidelines especially the lockdown did not allow the study to continue because all persons and animal movements were prohibited to curb the spread of the disease. Also, the closure of institutions of learning hindered the coordination between the researcher and project sponsor, and gatekeeper. It was also hard to physically connect with the study participants to obtain their consent. This delayed the data collection process.

1.9.Ethical considerations

The study was conducted based on the NWU ethical standards. Confidentiality and consent of study participants was crucial during data collection and reporting the final results. Ethical approval was obtained from Gulu University Research Ethics Committee (GUREC), and the study was registered with the Uganda National Council for Science and Technology (UNCST). Similarly, another research ethical clearance certificate was obtained from the NWU before visiting the field as this helped the research team to identify immediate/contact persons, relevant information, and key stakeholders to take part in this study.

Therefore, both permission and an introductory letter were obtained from NWU, which was presented to Uganda's Ministry of health and the implementers of healthcare, who also allowed the study to be conducted about the role of PPPs in improving quality and service delivery in the health sector of Uganda.

A letter was obtained from a gatekeeper, the Ministry of Health that allowed this study to be under their support, which, again was presented to the North-West University when seeking ethical clearance.

Informed consent was sought to recruit the eligible participants. Study subjects were contacted and were involved voluntarily. They were informed of the reason for being selected to participate, the purpose of the study, and permission for access to the study field.

Some of the relevant documents for the study were fully explained to the participants. These included a cover letter, discussion of the possible risks and benefits associated with their participation, integrity, confidentiality, and openness of the researcher was highly considered.

Participant's information was handled in a manner that protects their privacy and was only used for the purposes of data analysis. Bias was generally controlled by selecting, training, and deploying research assistants during data collection exercises.

1.10. Summary of the Chapter

This study examined the role of PPPs in the Health sector in Uganda. The available literature shows that PPPs are the best for mobilising and allocating resources to improve public service delivery to the population. However, since the introduction of PPPs in 2000, the study found that Uganda has experienced significant challenges within the different aspects of this partnership including difficulties in policy development and conceptualisation of the PPPs in healthcare, information sharing, resource mobilisation, and provision. The available works of literature indicate that the government of Uganda has received insufficient information about the importance of embracing health PPPs to get relief from financial burdens and the low level of experts in the public sector (Tashobya, Musoba & Lochoro, 2007).

Chapter One presented the research problem and an overview of the study. In addition the chapter discussed the background to the study, problem statement, objectives of the study, significance of the study, limitations to the study, theoretical perspective, research methods, and ethical considerations. Consequently, Chapter Two presents the works of related literature about the roles and impacts of Public-private Partnerships in improving the quality, delivery of services, and financing of the healthcare sector in Uganda.

CHAPTER 2

LITERATURE REVIEW

2.0.Introduction

This chapter conducted several related literature reviews to which their findings have been published about the concept of PPPs, and how this concept has been implemented as a means to improve public service delivery on a global scale and in Uganda.

2.1.Global Motivation for Implementing Health PPPs

Governments all over the world are struggling with the increasing demand for providing better healthcare services in the event of ongoing budget constraints. As governments grapple to meet their healthcare funding and to have better and desirable health outcomes, many are constantly implementing PPPs to deliver these services to the population. Below are the key critical factors motivating the governments globally to use the health PPP Models (The World Bank, 2013).

i. Opportunity to leverage the private investments with not-for-profit-making actors that produce a significant share of public services.
ii. The desire to enhance operations of public hospitals and health centres, and to improve access to better quality care services.
iii. The need for potential partners for governments to develop the private healthcare sector.
iv. Desire to formalise the available structures with not-for-profit-making partners that produce a critical share of public services.

The World Bank Group indicates that the healthcare system is a fundamental sector that every government needs to develop as a strong mechanism to deliver quality services for the wellness of its citizens (The World Bank, 2013). The World Health Organisation (WHO) shows that health means the complete physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 1948: 2, p. 100). However, this remains a big challenge to many governments in developing countries due to limited resources, including finance and human capital resources. Many developing countries face several challenges in delivering quality health care for individuals and community health.

Therefore, the definition of health and its challenges creates collaboration approaches and interactions among the Public-Private Partnerships (PPPs) that are widely considered as a

mechanism for mobilising possible resources to improve the quality of health (Roehrich, Lewis & George, 2014). This has attracted a massive involvement of the private sectors, including charitable philanthropic and non-government organisations (NGOs), finance and management of services, communities, corporations, parents, and families (Galea & McKee, 2014). PPPs entail a broad range of diverse components and are engaged in various activities. Nevertheless, few scholars and researchers agree on what exactly PPPs mean, and their definition as well. This means that there is no precise and generally distinctly recognised definition of Public-Private Partnership and the whole idea of PPPs is still under debate (Khanom, 2010).

The World Bank defines PPPs concept as a long-term sustainable agreement between the government agency and a private organisation, which identifies a means of providing public services and assets, in which the private organisation should bear all risks and management roles (World Bank Institute, 2012). However, it has been a challenge applying the term "partnership" to mean the mutual relationship between Non-Governmental Organisations (NGOs) players and government agencies because the term creates an equal authority and status for the parties involved (Martens, 2003).

Consequently, WHO explains this partnership in the health system as a method to bring together some key stakeholders for the shared goal and individual benefits of enhancing the health system based on the agreed principles and roles (Kickbusch & Quick, 1998). Based on the WHO's definition of PPP, mutual agreement on critical principles and roles remains central and maintains the power of the parties involved to allow each to retain its status and core values (Buse & Walt, 2000a). As a result, this study examined the primary role of PPPs in the Healthcare sector in Uganda.

2.2.Theoretical Statement

Galea & McKee (2014) show that although PPPs is traced back to Italian City-States, that began in the 14thCentury and lasted until the 17thCentury, a period in Dutch history, when the Dutch, traditionally able seafarers dominated world trade, and in which public organisations integrated political interests with the private sectors for an economic boost. The concept of PPPs was again promoted in 1997 by the group members gathered at Neil Kinnok in a publication report on the question of financing various projects of the Trans-European transport network through mutual collaborations between the public and private sectors (Levai,

2012). The PPP notion represents considerable cooperation between the public agencies and private actors and between business people associations and NGOs (Mustaghis, 2016).

The different forms of cooperation between the government agencies and private sector makes it challenging and at the same time, it does not clearly provide a uniform definition of PPPs. Various perspectives exist concerning this form of partnership, in so far as there are different types of public services and administrative organisations, which can be identified in a diversity of political, economic, religious, and social settings. The idea of arranging the government administrations known as (centralized-decentralized services) and the features of the public programme as well as project—which is about to be implemented (sectorial forms with local or countrywide implementation) are central components that define the centralised or decentralised/ mixed or integrated approaches in determining the type of PPPs (Levai, 2012).

Nowadays, PPPs has become a concept more and more common within political discourses, international institutions, in the economic mass media, judicial systems, economic and financial publications. Under various forms of PPPs, the subject is being used in most of the marketing official papers or channels and in the name of providing the products and services of consulting and audit firms of banks and international judicial firms. Consequently, the PPPs notion denotes any form of cooperation or collaboration between the public or government agencies and private sectors. In this case, the private sectors stand out from an idea of partnership with the public agency, by providing a considerable contribution toward the process of addressing public problems including economic, political, and social issues (Levai, 2012; Osborne, 2002).

A partnership is a type of collaboration, whereby information, benefits, roles and or responsibilities, risks, profits, and costs are equally shared among the parties involved. The main reason for collaborating varies but it generally involves the planning, financing, operationalising, and maintaining the public infrastructures and services and offer some cost-effective approaches to providing better and sustainable public services to the citizens (Osborne, 2002). Similarly, each party contributes to mobilising and planning necessary resources to acquire shared goals. Each partner enters the agreement voluntarily and brings their resources, such as materials, financial, human resources, symbolic, and authority (Levai, 2012).

2.3.Different PPP Models Applicable to Public Services

PPPs in health sectors show positive progress towards successful financing of healthcare innovations and improved care quality with combined efforts between public and private sectors, with a practical concept on partnership structures, arrangement and common goals for timely delivery of health services offered to the public (Adhikari, 2019). Consequently, it is important to identify and assess the different PPP models of engagement being used and suggest the best models which would address the challenges and speed the development and improvement of the health care sector.

Some of the PPP models adopted include build-operate-transfer (BOT), build-lease-transfer (BLT), design-build-operate (DBFOT), among others. Most of these PPP models operate differently in the private sector concerning levels of funding, ownership control and management, risk sharing, technical collaboration, project duration, investment approach, tax arrangement, management of cash-flows, etc. The following are the main PPP models being used in different countries (Adhikari, 2019; Indian Economy, 2016).

2.3.1. Build-Operate-Transfer (BOT)

BOT is one of the simplest and conventional PPP models, where the private party takes the role to design, build, operate and transfer back a project or contract to the government. Under this model, the private company brings the finances and takes the role to build and maintain the health project during the contracted period. In return, the public sector gives the power to the private partner to collect revenue from the users (Adhikari, 2019; Indian Economy, 2016).

2.3.2. Build-Operate-Lease-Transfer (BOLT)

Under this model, the public sector gives the mandate to a private company to design and construct a project, own a facility, lease it to the public sector, and at the end of the contract, the ownership is transferred to the government.

2.3.3. Build-Own-Operate (BOO)

The BOO model is another version of the BOT model and the only difference is that the ownership of the facility will lie in the hands of the private party. The public sector agrees to purchase the goods and services produced by the project on agreed terms.

2.3.4. Build-Own-Operate-Transfer (BOOT)

This model also lies in line with the BOT model after the contract, the infrastructure or project asset is transferred to the public sector partner or private actors. The BOOT model is used for the development of roads and ports.

2.3.5. Lease-Develop-Operate (LDO)

Under the LDO model, the public company retains the ownership of the newly developed facility and receives revenues in terms of a lease agreement with the private actors or promoters. This model can be implemented in the transport and health sector etc.

2.3.6. Rehabilitate-Operate-Transfer (ROT)

Under this PPP model, the government and local authorities allow private actors to rehabilitate and operate a contracted facility during an agreed timeframe. At the end of the contract, the facility is transferred back to the government or local authorities.

2.3.7. Design-Build-Finance-Operate (DBFO)

Under the DBFO model, the private company assumes full responsibility to design, build, finance, and operate the project for the agreed period (Kurniawana, Mudjanarkoa, & Ogunlana, 2015; Odhiambo, 2019).

2.3.8. Management Contract Model (MCM)

Under this model, the private actors have full responsibility for all the investment activity, operation, and maintenance roles. The private partner has the full power to make day-to-day management decisions under a profit-sharing as well as a fixed fee agreement.

2.3.9. Service Contract Model (SCM)

This model is less focused than the management contract. Under this model, the private actor performs a certain operational and, or maintenance role for a fee over a specified time. Odhiambo (2019) indicates that the health services model is implemented where the entity is given full power to operate and deliver public-funded services to the beneficiaries in the public health facilities.

2.4.What is already known about PPPs?

Public-Private Partnerships are commonly used political tools for developing society and delivering health care services in both developed and developing nations. At the topmost levels, PPPs are being accepted as long-term cooperative organisational arrangements among the public sector and private partners to accomplish different health care purposes (Bastani, Barati, Sedeghi, Ramandi, & Javan-Noughabni, 2019). The World Bank Institute defines the PPPs concept as a long-term agreement between the government agency and a private company, which identifies a means for providing public services and assets, in which the private organisation should bear all risks and management roles (World Bank Institute, 2012).

2.5.What this research adds to the current body of literature?

This study reviewed the current PPP models that have been used in the health sector and other government departments. The findings offer a significant contribution to the understanding of the Public-Private Partnerships, offer appropriate guidance on the implementation of PPPs in the Healthcare sector, including the PPP models in Uganda. Thus, it also offers policy makers robust criteria for implementing the best PPP models for improved healthcare service delivery and health system in Uganda. Such PPP models can work as a collaborative approach for the first time in Uganda's history and will bring positive effects on hospital indicators. By accepting and implementing such models to Uganda's current situation, the best development in the health sector can be achieved.

2.6.The Components of the Health Sector Industry

The structure of the healthcare sector does not operate as a single entity, but it includes industries and different varieties of companies. Ledesma *et al* indicate that any industries engaged in the production of medical care products and services are largely in the health sector and further arranged under six major industries. Such industries consist of pharmaceutical industries, biotechnology, facilities, managed health care, and distribution centres (Ledesma *et al.,* 2014).

2.6.1. Pharmaceutical Industries

Pharmaceutical is a sub-industry of the health sector that discovers new medicine, and takes the design roles, develops, produces, and markets pharmaceutical drugs for health use, that is

administered to patients to cure or relieve pain, vaccinate people, or alleviate the diagnosed symptoms (Bozenhardt & Bozenhardt, 2018). Pharmaceutical firms may also deal in medical devices, generic products, and brand medications. However, they follow some government regulations and laws that govern the efficiency, marketing, patenting, testing, and safety of drugs (McGuire *et al.*, 2007).

2.6.2. Biotechnology Industry

Biotechnology is a sub-industry that generates its values and benefits from its capacity to design, develop, produce and produces patented medicines that ultimately generate revenues to the governments (Wang, 2014). Unlike pharmaceutical industries, biotechnology companies are considered as one of the fast-growing and innovative firms. Similarly, biotech industries differ from pharmaceutical firms because they design and develop new drug therapies, which use biological processes rather than chemical processes.

Biological processes use cell lines as well as microbes that are genetically modified (GM) to produce treatments. These treatments can be common treatments, such as the injection of insulin, and are as complex as administering gene therapy to replace defective genes in patients (Ledesma *et al.*, 2014). With the increasing number of equipment and drug companies confined to manufacturing different medical products, there is a need for a distribution sector in the market to significantly improve healthcare service delivery.

2.6.3. Equipment Industry

In addition to drug or pharmaceutical firms, equipment is also part of the health sector to improve quality care and services. The equipment sector comprises of medical devices and healthcare equipment, medical instruments, and products like drug delivery systems, diagnostic equipment, orthopedic, and cardiovascular devices (Investing, 2014). Such medical products are provided to hospitals and health centres, and are used in medical treatment settings. For instance, Medtronic is a product from the equipment sector that specialises in the production of implant devices (Ledesma *et al.*, 2014).

2.6.4. Distribution Industry

In healthcare, the distribution sector plays a key role in the supply chain. It consists of wholesalers and distributors of healthcare products. The distribution sector can entail

companies from pharmacies to wholesalers of medical equipment. With the increasing production of medical equipment and drugs, the distribution sector is rapidly growing. For instance, AmerisourceBergen is one of America's leading and largest distributors of medical equipment and drugs, with a 48% increase in stock price (AmerisourceBergen Corp, 2014). With such an effective distribution industry, equipment firms and pharmaceutical industries can effectively deliver their products to all target hospitals and health facilities.

2.6.5. Facility Industry

The Healthcare sector also consists of facilities serving as health care providers. It is a destination as well as a place where medicines are delivered to doctors practicing medicine and needing patients. In the facility sub-sector, companies come in to offer some social and healthcare services through hospital and other health facilities.

2.6.6. Managed Healthcare Industry

The managed healthcare sub-sector consists of techniques designed to minimise the costs of providing health services and improve the care quality and make delivery effective that can be called the health insurance industry. Compared with other sub-sectors within the healthcare industry, managed healthcare shows a greater rate of growth. This is because the healthcare act reform in some countries, like the United States, requires that every citizen must be insured and this creates a great opportunity for insurance firms (Ledesma *et al.,* 2014).

2.6.7. Sector Sensitivity Industry

The health sector offers both defensive and secular features of operation in regards to the public health concerns and global economy. The medical products, such as equipment, drugs, medical supplies, and facilities is important to the wellness of patients. Similarly, the sector undergoes a tremendous growth as hi-tech products are produced to treat a wide range of health conditions, disorders and diseases in patients. It is important to note that the growth projections of the health sector is filled with increased unpredictability because of the sensitivity and compliance issues of their business cycle.

Whereas most of the health industries are susceptible to changes in government policy, the pharmaceutical and biotech industries operate in a difficult governing setting coupled with a competitive environment (Ledesma *et al.,* 2014). Pharmaceutical and biotech firms face some

potential risks that increase their sensitivity. As these companies produce products and services to health facilities, they heavily depend on distribution and reimbursement from insurance service providers to generate revenue.

Since pharmaceutical and biotech firms have to wait to receive their imbursement until after the insurance providers are paid, this greatly increases the amount of time taken between production and receiving payment for such products. Similarly, reliance on third-party partners to generate sales, pharmaceutical and biotech industries undergo amplified sensitivity because of tough governing oversight (Ledesma *et al.*, 2014).

2.7.Global Healthcare Outlook: The future of Global Healthcare—Six Trends

This section reviews the current state of the global health sector and examines key trends and critical issues, affecting health care providers, governments, patients, payers, and other stakeholders. With the current digital transformation, financial sustainability, patient centricity, healthcare delivery, and regulatory compliance is the main agenda. Leaders of the health sector need to work together with all stakeholders both within the healthcare system and those in the converging sector as they look, or they navigate to shape the future of the health-care industry and build a sustainable smart health community (Allen, 2019).

The global healthcare sector shows a significant sign of growth. Aging people and growing populations, the high rate of chronic diseases, and exponential improvement in an innovative way, but costly, digital technologies continue to increase healthcare expenditures and demand. Health-care providers and all stakeholders are continuously working towards managing financial, clinical, and operational challenges, foresee an industry in which innovations and new business models, supported by digital technologies may help to address today's problem and to establish a foundation for accessibility, affordability and high-quality care. This projection may generate a high probability of becoming a reality if all care providers and stakeholders actively contribute in harnessing the future of the health sector. This can be done by shifting their focus from a sick care system to a health system that supports well-being, prevention, and finally early prevention. (Burrill & Beaudoin, 2019).

2.7.1. Building Financial Sustainability in a Volatile Health Economy

The emergence of increased use of exponential biotechnologies, personalised medicine, the demand for expanded care delivery, public funding models and revamped payments, non-

traditional competitors and entry disruption are all impacting the financial performance of the healthcare system. It is estimated that the expected rise between 2017 and 2020 will be 5.4% annually to just over $10 trillion. Healthcare stakeholders and care providers are improving financial management efforts, outcomes-based care, efficient operational performance, and innovative solutions to help address the increase in expenditure. Establishing and implementing PPPs, investing in prevention and well-being, and learning from firms outside of the healthcare sector will also be key for health improvement (Allen, 2019).

2.7.2. Adopting New Care Delivery Models to Enhance Access and Affordability

Transiting from volume to value will need creating an outcomes-based financial model and data infrastructure to increase value-based care reimbursement pathways—which will remain fundamentals to most of the health ecosystems' sustainable growth. This trend is most apparent in the U.S., where the Medicare Access and CHIP Reauthorisation Act of 2015's regulations have led to payment adjustments and incentive payments in 2019 (Burrill & Beaudoin, 2019). Government programmes payment policies, patients' preferences and clinical innovations are significantly promoting hospitals to modify specific services to alternative points of healthcare and even to virtual environments that benefit from a cost and access viewpoint. This can be perceived as a social determinant of health as having a greater impact on care outcomes (Allen, 2019).

2.7.3. Adapting to Changing Consumer Needs, Demands and Expectations

Allen indicates that healthcare stakeholders, including patients and caregivers like nurses and doctors, are dissatisfied with the lack of transparency about price, poor care quality, service, and safety, and are demanding healthcare improvement and sustainable solutions that are systematically coordinated, accessible, convenient, and customised, as well as personalised (Burrill & Beaudoin, 2019). With the current trend in healthcare becoming "a shopable product" and increased costs for patients in a cost-sharing model, improving the patient experience becomes a potential area for fundamental change.

Non-traditional firms, for instance, from wholesale, retail, consumer, and biotechnology industries are also creating significant attempts into making a healthcare value chain with solutions that are disrupting the standard. As protective healthcare takes a central role, "nudging" is widely seen as a significant alternative to help with patient adherence (Allen, 2019).

2.7.4. Investing in Digital Innovation and Transformation

The healthcare sector is experiencing a rapid increase in pace and scale with which m-health care and technological innovations are continuously emerging. Digital technologies, for instance, are significantly supporting health to transition to new models known as patient-centred care to help them develop smart health mechanisms to improve access and affordability, care quality, and lower costs. For instance, from Blockchain technology, robotics, RPA, and Artificial Intelligence (AI), to the internet of medical things (IoMT), virtual and digital reality are some of the approaches in which technology is increasingly disrupting healthcare. These technologies are significantly helping with clinical diagnosis and treatment, supporting with speed, accuracy, quality, and improving the general care outcomes (Burrill & Beaudoin, 2019).

2.7.5. Maintaining Cyber Security Requirements and Regulatory Compliance

Allen indicates that as data increasingly becomes the new healthcare currency, protecting it also becomes a major concern in the sector. Health innovations, networked medical devices, and market complexity have increased the continued need for unstable government regulatory oversight, policies, and risk management in the sector. The continued growth of consumptive health services like prescription drug pricing in the U.S has received stiff regulatory attention. Cybersecurity has also become a major concern to the industry. It has become a concern of high-value data and increasing demand for interconnected IT ecosystems that make healthcare a target for cyberattacks.

2.7.6. Hiring, Training, Developing and Retaining Top Talent

An aging labour force, increasing demand for healthcare services, moral values, and well-being are continuously driving a shortage of skilled medical personnel in both wealthy and poor economies. However, many dimensions are shaping the future of work. In other words, automation is seriously impacting many administrative processes, digital medicine and telehealth tools are enabling a model known as “A care anywhere.” Organisations are constantly developing and deploying new staffing models, such as allowing a nurse to work remotely, while still creating strong doctor-patient relationships (Burrill & Beaudoin, 2019).

2.8.The U.S. Healthcare System

The United States health sector is run by different health organisations. Hospitals and other health facilities are largely owned and run by private sector organisations. It is estimated that 58% of community health facilities are not-for-profit making, 21% are government owned, and 21% are for-profit making. The World Health Organisation (WHO) indicates that the U.S. spent $9,403 on only healthcare per capita, and 17.2% on care as its gross domestic product (GDP) in 2014 (Rosenthal, 2013).

The U.S. health sector offers unique features among the developed countries around the globe. The U.S. passed legislation mandating healthcare coverage for almost every citizen. The National Health Expenditures indicates that in 2014, 48% of America's healthcare expenditure came from private funding, with 28% from households and 20% as private business shares. The Federal government accounted for 28% as expenditure, whereas 17% for states and local governments (National Health Expenditures, 2014). Most of the U.S. health systems are financed by the federal government and are delivered privately (Department for Professional Employees. 2016).

The National Health Expenditures report adds that in 2014, nearly 283.2 million people in the U.S., about 70% of the U.S. population had acquired some forms of health insurance, amounting to 66% of workers covered by a private insurance policy. It is shown that among those who were insured in 2014, 115.4 million people, 37% of the population were insured by the government through Medicaid (61.65 million), Medicare (50.5 million), and Veterans Management or other military care (14.14 million). By 2014, about 32.9 million people in America had no health insurance (Jessica & Medalia, 2014).

The U.S. spends much on health care as compared to other countries and it is expected to grow every single year. As a result, the challenge for stakeholders and care providers lies in containing the costs and reducing them persistently. However, the 2010 Affordable Care Act (ACA) has significantly transformed both healthcare funding and insurance coverage. Health insurance plans became compulsory with the main reason centred on the slowing-rise in healthcare costs. Nevertheless, despite this intervention, consumers are still paying a big percentage for their health coverage and even higher for different healthcare services.

2.8.1. Key trends in the U.S. Healthcare Market

Transitioning to value-based health care services: The U.S. is currently transitioning to value-based care from volume-based healthcare in an attempt to control and cut costs, enhance clinical outcomes, and get more value for money spent. Consolidation among health-care providers: The exponential consolidation approach among care providers has been seen in the U.S. healthcare system due to the changes in technological innovations, regulations, financial pressure, and market dynamics (Alliance Experts, 2019a).

Health practitioners are constantly shifting from private practice to being employed by health systems. This means that health plans will be providing more clinical services. Similarly, regulatory pressure and privacy: The U.S. regulatory systems that control the health sector are constantly changing and as a result, they should consider reassessment of the compliance initiatives and be given priority for investment. Finally, privacy and safeguarding security bring significant challenges with the evolving healthcare ecosystem.

This has been due to the increased amount of medical data being shared and is a potential risk of being maliciously hacked. The U.S. healthcare market is growing but with significant threats to its integrity (Alliance Experts, 2019a). However, the stakeholders need to be mindful of the growing trends that seem to greatly influence the growing healthcare sector.

2.8.2. The U.S. Health Insurance

By early 2019 the U.S population that was not covered by insurance significantly decreased after the inaction of the 2010 Affordable Care Act (Gill, 2019). A report from the U.S. Census Bureau indicates that a decline was due to a 0.7% drop in Medicaid applicants. There was no change in those with private insurance, but Medicare participants increased significantly by 0.4%. Initiative for Social and Economic Rights Health News reported that n=574,000 (2.3%) of the people that lost coverage were not American citizens, showing that President Trump's anti-immigration rhetoric and policies may have contributed to the decline (Galewitz, 2019).

The U.S. Tax Policy Centre indicates the statistics of where non-elderly had acquired their health coverage in 2016. The centre shows the following percentage of the population: 56% got insurance through their employers, 8% were covered by the private market with 22% through Medicaid, 4% by other public sources, and uninsured were10% (Tax Policy Centre, 2016). Medicare provided health care to most of the American senior citizens and the

population with low incomes receives assistance through Medicaid (Gill, 2019). The report shows that U.S. health systems have a combination of public health coverage and private health insurance. The U.S. lacks a universal health coverage like other countries. (Fisher, 2012).

2.9.United Kingdom Health Sector

In the United Kingdom, the Government's Department of Health (DH), is responsible for the general National Healthcare Services (NHS). The UK's department of health has the full mandate to control England's ten Strategic Health Authorities (SHA), which oversee all the NHS projects in England (National Healthcare Services, 2012). As a result, each SHA is responsible for monitoring and supervising all the NHS facilities within its area, whereas the secretary of state for health oversees the DH and reports directly to the Prime Minister's Office (PMO) (Muza & Sapsead, 2013).

The National Healthcare Services was established in 1948 to become the globally largest publicly funded health system. The UK's NHS operates within the scope and guidance of the NHS legislation that sets out the values and principles of NHS in England. It indicates the rights to patients, public and medical staff are entitled, and duties that the NHS is mandated to perform, in addition to the roles with the public, patient, and medical staff owe to one another to allow the NHS to run smoothly, fairly and effectively. The NHS sets out the code and standards and stipulates the staff and patient's rights and roles of practitioners. The legislation of NHS also sets out the services offered to the patients, staff, and the general public. Similarly, the NHS constitution defines the individual's opportunities to offer support to have the efficiency and effectiveness of NHS (National Healthcare Services, 2012).

2.10. Indian Health Sector

India is comprised of a mixed health system that embraces both public and private healthcare service providers (Chokshi *et al.,* 2016; IBEF, 2019). Nevertheless, the majority of India's private healthcare service providers are largely concentrated in urban areas, providing both tertiary and secondary care healthcare services. The public health infrastructure in rural areas have been established as a three-tier sector that is proportional to the population standards (Chokshi *et al.,* 2016).

Health industry is one of India's largest sectors both in terms of employment and revenue. India's healthcare is comprised of hospitals, clinical trials, medical devices, telemedicine or m-

health, medical tourism, outsourcing, medical equipment, and health insurance. The healthcare sector in India is constantly growing due to its strengthening services, coverage, and increasing expenditure by public and private actors (IBEF, 2019).

2.10.1. Indian Healthcare Sub-centres

Healthcare sub-centres are strategically established in areas with 5,000 people and in hilly and hard to reach areas, such as tribal places with a population of 3,000, and it is the immediate connection between the community and primary healthcare system. Each sub-centre is required to have strong staff by at least one male medical worker and one auxiliary nurse midwife female medical worker. Under the National Rural Health Mission (NRHM), one extra auxiliary nurse midwife is added on a contract basis (Chokshi *et al.,* 2016).

In India's healthcare setting, sub-centres perform duties concerning interpersonal communication to bring about behavioural changes and offer healthcare services concerning family welfare, maternal and child health, immunization, nutrition, control of communicable diseases, and diarrhea control programmes. The Indian Ministry of Health & Family Welfare offers 100% support to all the sub-centres since 2002, in the form of rent, salaries, and contingencies in addition to medical equipment and drugs (Chokshi *et al.,* 2016).

2.10.2. Indian Primary Healthcare Centres

India's PHC is established in an area with a population of 30,000 and in hilly and hard to reach places, and is the immediate contact between the medical officer and village community. The PHCs are established to offer preventive health care and integrated curative care to the rural population with the main focus on preventive and promoting healthcare. They are operated and maintained by the Governments under the Minimum Needs Programme or Basic Minimum Services Programme. With regards to the minimum requirement, a PHC is to be staffed by a health officer who is supported by fourteen paramedical and other staff (Chokshi *et al.,* 2016).

2.10.3. Community Healthcare Centres (CHCs)

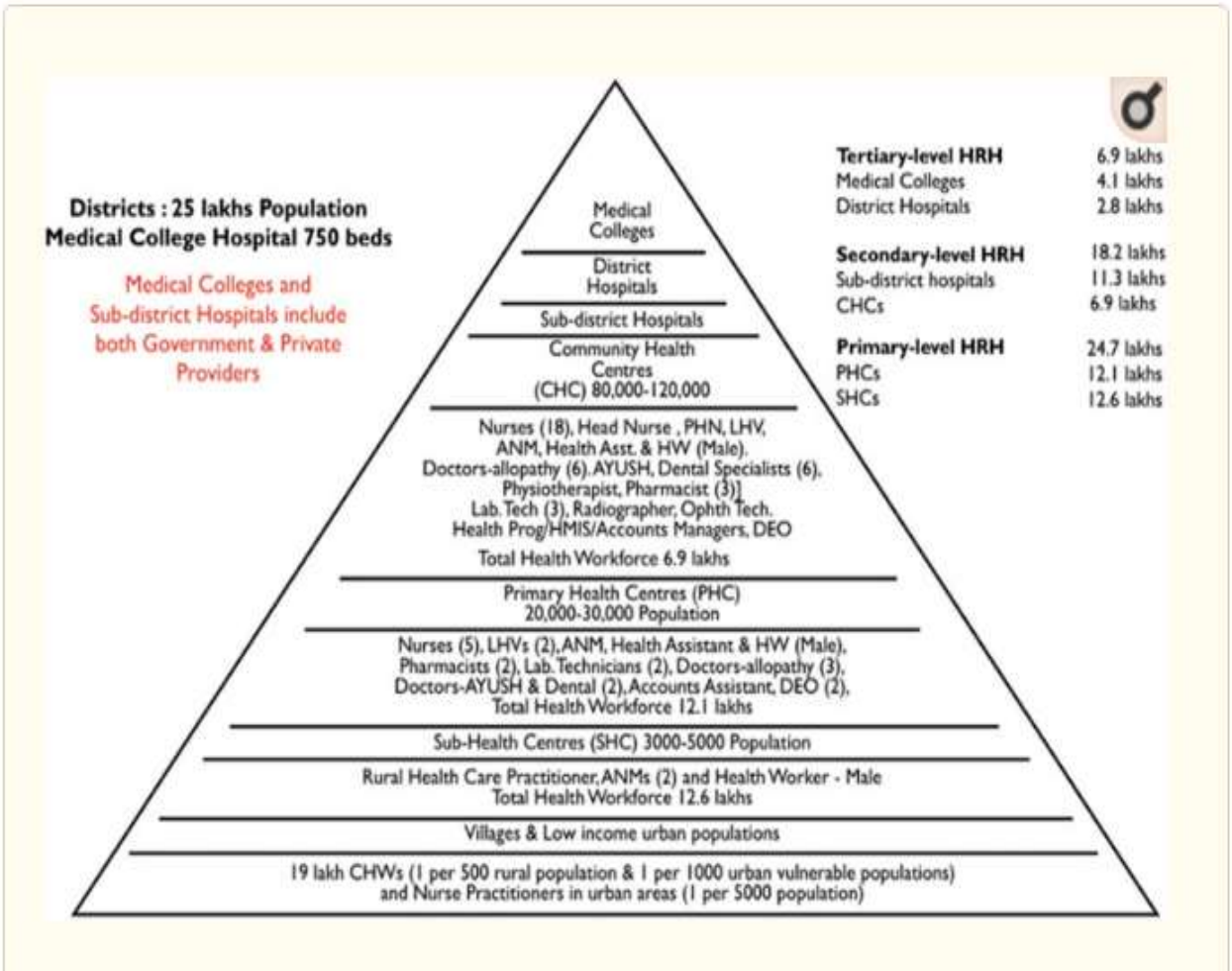
Just like PHC, also CHCs are strategically established, operated, and maintained by the Government under the BMS or MNP programme in places with 120,000 populations and in difficult-to-reach areas with 80,000 populations. As per minimum standard, CHCs are required to have a staff of at least four medical specialists, such as physicians, a surgeon, an obstetrician

as well as a gynaecologist and pediatrician supported by 21 paramedical and other medical staff. It is equipped with 30-beds with a laboratory facility, labour ward, X-ray, and an operating theatre. The CHC serves as a referral health centre for PHCs and also offers facilities for obstetrics, or gynaecology care, and other professional consultations.

2.10.4. Indian First Referral Units (FRU)

India's referral system includes district hospitals, sub divisional hospitals, and CHCs are fully operating as FRUs, equipped and well-staffed to offer round-the-clock services for newborn care and emergency obstetric care, in addition to all care emergencies that any facility is required to provide to the population. In addition, there are three key determinants of a hospital being stated as First Referral Units, including; 1) care for small and sick new-bornes, 2) blood storage facility on a 24—basis, and 3) emergency obstetric health care, such as surgical interventions like caesarean sections (Chokshi *et al.*, 2016).

Figure 2.1: A Representation of the Indian Public Health Standard (IPHS)



Source: *Chokshi et al., (2016). Health systems in India. Journal of Perinatology, J Perinatol. 36(Suppl 3): S9ï S12.*

Figure 2.1 demonstrates the formation of the Indian Public Health Standard (IPHS)

2.11. South Africa Healthcare Sector

South Africa also operates a mixed healthcare system, such as the public and private health system, and is rapidly growing. The public hospitals serve the biggest percentage of the population, though it is chronically understaffed and underfunded. The wealthiest community is about 20% of the entire population that uses private healthcare systems and is well served.

The country's expenditure on health as of 2017 is 9% of its gross domestic product (GDP), which is 4% higher than the recommended expenditure by the World Health Organisation for a country of its socio-economic capacity. Although the country is experiencing a high expenditure, health care outcomes are still moving slowly and are not promising compared to other middle-income nations, this is due to the disparities among the private and public sectors (Informa Markets, 2019).

2.11.1. Organisational Perspective of the South African Health Sector

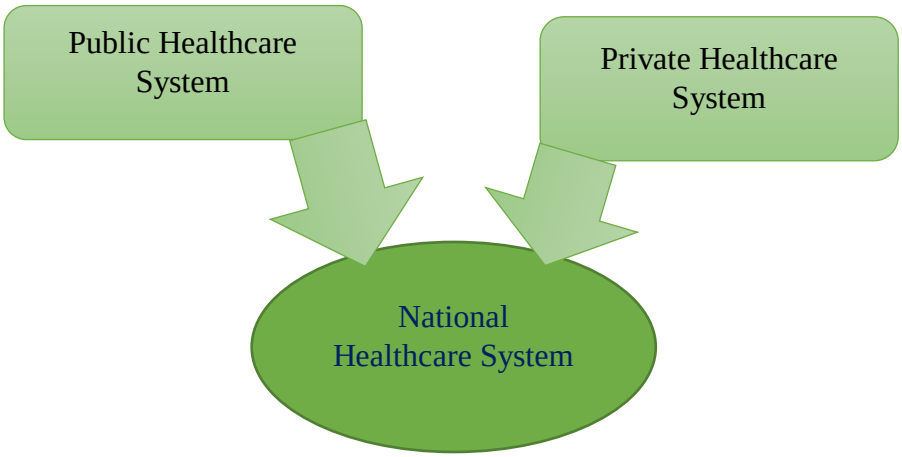
South Africa is estimated to have a population of 54,956,900 people (Statistics South Africa, (2015), of which the biggest percentage access healthcare services through the hospitals run by the government and public health centres. The public health sector consists of primary, secondary, and tertiary health through hospitals located in and run by the provincial departments of health. Ministry of Health is a direct employer and tasked with coordination and policy development roles (Mahlathi & Dlamini, 2015).

The constitution of the government of South Africa states that every citizen has full access to all healthcare-related services across the country (section: 27 of the Bill of Rights). Nevertheless, every citizen has access to both private and public health services, with access to private health services based on the person's ability to pay their hospital bills. The private sector offers healthcare services through individual physicians or doctors who operate or perform private surgeries as well as through private hospitals, usually located in urban areas.

Statistics show that South Africa's healthcare system took nearly 8.8% of the country's GDP in the financial year 2012 (Organisation for Economic Co-Operation and Development &

Health Statistics, 2014). The biggest percentage of patients have access to healthcare services through the District Health System, recognised and preferred by the government as a means for health care providers to offer satisfactory PHC to the population. The private sector serves 16% of people, while the government hospitals serve 84% of the country's population (Naidoo, 2012). South Africa's population distribution indicates that nearly 67% live in typically rural areas and settings of the provinces. Although the majority of the population lives in rural communities, most of these rural areas are large cities (Mahlathi & Dlamini, 2015).

Figure 2.2: The Organization of South Africaôs Hea



2.11.2. South African Healthcare Workforce Context

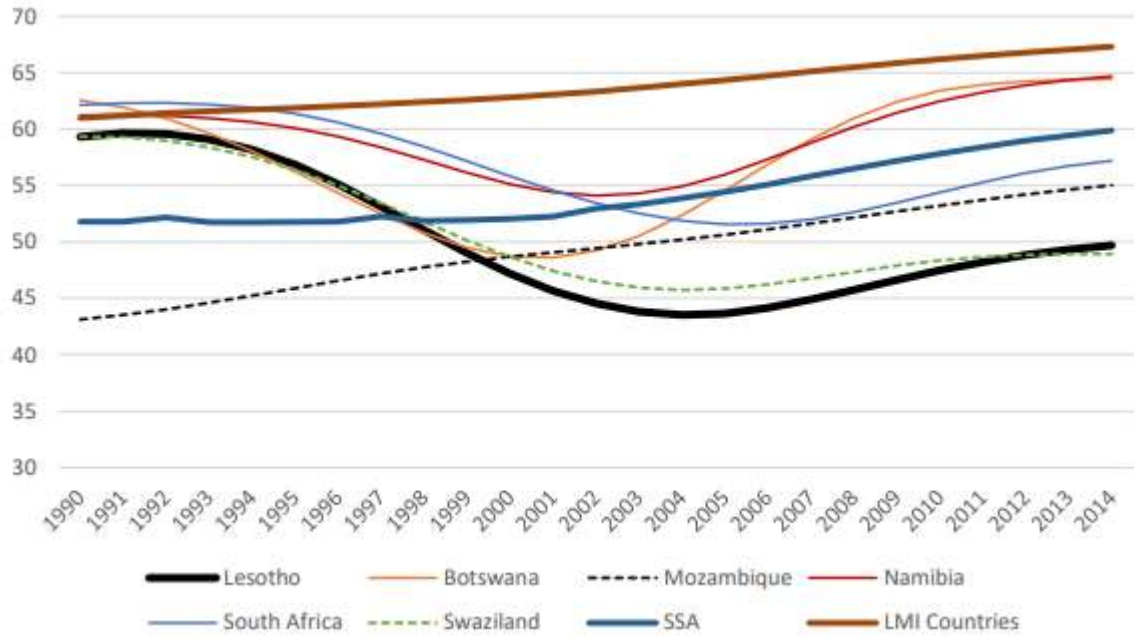
The responsibility to make health worker policy lies in the hands of the Department of Higher Education and Training and the National Ministry of Health; for the output of trained personnel and the Department of Public Service and Administration for employment conditions. The country has twenty-three (23) universities and a total of eight schools of health sciences and one medical school.

India also has nine provincial nursing institutes and some private nursing schools. Overall, the medical schools have an annual output of between 1,200 and 1,300 medical graduates. This is seen as grossly not enough for the country's population size of 55 million. The staffing of doctors, nurses, physicians, and caregivers is enhanced by the training of doctors in Cuba through government-to-government partnerships (Mahlathi & Dlamini, 2015).

2.12. Lesotho's Healthcare sector

In Lesotho, life expectancy at birth was 55 years for women and 51 years for men in 2015/2016. The infant mortality rate is nearly 8.3%. By contrast, in 2006, Lesotho's life expectancy was about 42years for both women and men. This trend follows the 1990s-2005 when Lesotho's life expectancy at birth significantly dropped from 60years to below 44years. The World Bank observed this trend while comparing with Lesotho's neighbouring countries or South Africa, Botswana, and Swaziland that correlated to a high incidence of HIV/AIDS in Southern Africa as the Figure 2.3 demonstrates:

Figure 2.3: Lesotho's Life expectancy at birth 1990-2014



Source: *World Bank Group and World Bank Open Data*

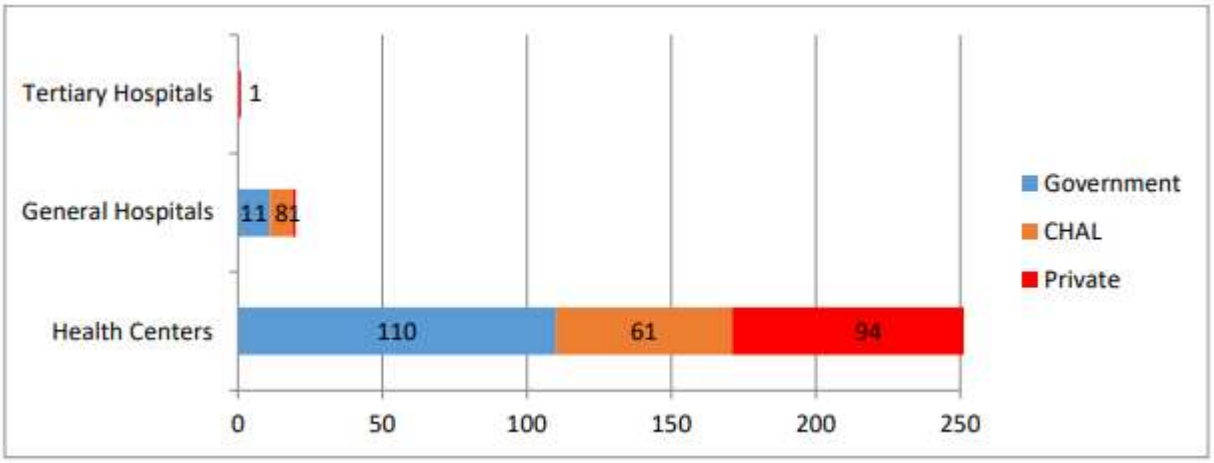
2.12.1. Healthcare Infrastructure in Lesotho

The government of Lesotho is responsible for the maintenance and operation of the general healthcare system, and Lesotho's Ministry of Health develops and implements health guidelines, policy, standards, and mobilise the necessary resources for the health sector. The delivery and distribution of health care services are done at three levels, such as primary, secondary, and tertiary/referral levels. By 2017, Lesotho had 286 health facilities. Of these, a total of 265 were primary healthcare facilities, 20 were district hospitals, and one was categorised as a referral or tertiary hospital located in Maseru (World Bank Group, 2017).

Patients seeking care services beyond what is provided at the referral hospitals are referred to Pelonomi and Universitas hospitals in South Africa at the expense of the Government.

The government of Lesotho is the largest healthcare provider in the country, operating over 110 primary health facilities and 11 public hospitals. The CHAL runs 61 primary healthcare facilities and 8 public hospitals and is fully financed by the Ministry of Health through a method known as the Subvention payment. Tsepong runs only referral hospitals, the QMMH, together with 4 clinics (World Bank Group, 2017).

Figure 2.4: Healthcare system pyramid, split by government, CHAL, and private healthcare providers



centres

Source: (World Bank Group, 2017).

2.12.2. Human Resources for Healthcare in Lesotho

Deploying well-trained medical workers is central to the delivery of high-quality care services, and this section describes the nature of human resources for health in the Lesotho system. The percentage rate of physicians or doctors is 0.9 per 10,000 people. For nurse-mid-wives, the rate is 10.2 per 10,000 people. Both rates are relatively below the World Health Organisation Afro Regional average of 2.6/3 and 12.0, which, in turn, produces poor results that harm the capacity of the government of Lesotho to deliver high-quality health care services.

The staffing procedures for the public hospitals are directly guided by the Ministry of Public Services that is responsible for producing a list based on the number of facilities. All primary health facilities are comprised of between 4 and 6 nursing positions, and a fixed number

irrespective of the demand of the health care services. The public or national referral hospitals have more variability in their staffing of the listed positions, and they may not comply with any bed-based methods, but the hospital staffing does not depend on the demands of service for either.

Figure 2.5: Lesotho government health workers

Source: (*World Bank Group, 2017).*

2.13. Ethiopia's Health Systems

Ethiopia is one of the fastest-growing African nations, with over 104 million people, making the country the second populace in the region. Developing countries are challenged by public health concerns, including communicable diseases like Malaria, Tuberculosis, HIV/AIDS, maternal and child health-related problems, such as Neonatal cases, pneumonia, dehydration and diarrhea; and malnutrition also contributes to the biggest percentage of public health problems, but there is also importantly growing non-communicable diseases, like cancers, cardiovascular syndromes, mental illness and injury.

2.13.1. Ethiopia's Health and Welfare

The general healthcare sector in Ethiopia comprises of primary health facilities, clinics, and public hospitals. Only hospitals in major cities have full-time medical workers like surgeons, doctors, physicians, and nurses, and most of these hospitals are located in the capital of Addis Ababa, the country's largest city. It is reported that affordability and access to modern health care are limited, and in most of the rural areas is remotely non-existence (Britannica, 2019).

The new-born and child mortality rate are nearly double that of the world's average. Public health concerns include lower respiratory infections, diarrhea, and HIV/AIDS. The country's HIV adult incidence is above the world's average and slightly above that of Ethiopia's neighbouring countries, though it is lower than that of most other African nations. It is reported that the prevalence is higher in town areas and among females. Most of the health centres are owned and run by the government. Progress in healthcare declined during the Derg period when most of the medical workers either immigrated or did not return from specialised training abroad.

Notwithstanding the downfall of Derg's reign in 1991, this trend has remained. For instance, the country's medical schools continue to produce practitioners, specialists, and nurses, but the scale of output does not match the country's increasing demand for health services. Lack of drugs and shortages of medical equipment are continuous health problems in the country. The widespread use of traditional treatment, including minor surgery, like circumcision continues to spread in the country (Britannica, 2019).

2.13.2. Ethiopia's Healthcare Progress

Ethiopia's healthcare sector has seen tremendous progress including several health improvements like nutrition, and population indicators as shown in the table below:

Table 2.1: Statistics of Ethiopiaôs Healthcare Pr

Total population as of 2016	**102,403,000**
Gross-national-income per capita (Int $-2013)	1,350
Life expectancy at birth male/female (years, 2016)	64/67
Likelihood of dying under 5years of age (per 1 000 live births, in 2018)	55
Likelihood of dying between 15 and 60years m/f (per 1,000 population, 2016)	246/194
Total spending on healthcare per capita (Intl $-2014)	73
Total spending on health % of GDP (2014)	4.9

Source: *(World Health Organization, 2019).*

There is a significant improvement in Ethiopian public health. The effort for modern medicine beyond traditional practice begun in the 15th Century during Emperor Lebnedingil's reign, when the king appealed to the Portuguese King for medical workers, like surgeons and

physicians to cure various diseases. Ethiopia's first public hospital was established in 1897, the country's Ministry of Health was implemented in 1948, and the first medical school was opened in 1964. It was not until the reign of Emperor Menlik between 1889 and 1913 that the country received the first foreign-trained Ethiopian physician, Hakim Workneh Eshete, who began practicing medicine in Addis Ababa—Ethiopia (Kidane Mariam & Moen, 1972).

2.14. Rwanda's Healthcare Sector

Rwanda's health systems have a history of poor quality, but in the most recent decades has experienced great improvement in the care services. The country operates a system known as a universal healthcare system and is widely considered to have one of the best healthcare systems in Africa (Evans, 2014). In the pre-genocide period, the Rwandan healthcare system was supported by the Bamako Initiative that was financially supported by the WHO and UNICEF and later in 1987 adopted by the African minister of health (Bamako initiative, 2006; Kayonga, 2007). The country embarked on significant progress towards decentralising the management of the healthcare system as it was first implemented on the Province Level and then later to the district level.

However, this was disrupted by the 1994 internal conflict, known as "Rwanda Genocide of 1994", which damaged the whole healthcare system and the entire economy. During the post-genocide period of Rwanda, the country has had a difficult time in the restoration of its healthcare system and its economy. Nevertheless, it has built one of the best healthcare sectors in Africa. In 2008, the government spending on healthcare was 9.7% as compared with 3.2% in 1996 (WHO, 2009). The healthcare services in Rwanda are provided through public hospitals, government-assisted health hospitals, private health facilities, and traditional healers.

The following key actors take part in the provision of the highest-quality social services and the promotion of healthy people include Ministry of Health, National Drug Authority (NDA), Rwanda Medical Association (RMA), Rwanda Health Insurance (RHI), National Aids Control Commission (NACC), and Central Drug Purchasing Agency (CDPA) (Fortune of Africa, 2016).

2.14.1. Healthcare Insurance System in Rwanda

By 2008, health insurance coverage became mandatory for all citizens in Rwanda (WHO, 2008), where in 2010 more than 90% of the country's population was covered. It is reported

that in 2012, only 4% were uninsured (McNeil, 2010). President Kagame made healthcare one of the national priorities for the Vision 2020 development strategic plans (Evans, 2014), by boosting spending on health-care to 6.5% of the national gross domestic product in 2013 (World Bank, 2010), as compared with 1.9% in 1996 (World Bank, 1995).

The central government of Rwanda decentralised the management and financing of healthcare to the local communities, through a system known as health insurance, providers known as *mutuelles de santé*. The mutuelles acting as government interventions to improve healthcare, were implemented in 1999 and made accessible countrywide by the mid-2000s with the support of international development actors (WHO, 2008). The *mutuelles* systems are operating and managed at the level of Rwanda's thirty districts. There are many separate national health insurance schemes for the army and public servants as well as for citizens (Jones, 2018).

Premium insurance coverage operating under the system was initially at $2 US dollars per annum, however, since 2011 the rate has changed on a sliding scale based on the wealth distribution, with the wealthiest citizens paying a premium of $8 US dollars per person and the poorest population entitled to free health care insurance (11). By 2014, over 90% of the entire population was covered by the system (USAID, 2014).

Training institutes, such as the Kigali Health Institute (KHI), which was established in 1997 by the government of Rwanda, and became part of the University of Rwanda. It is reported that in 2005, President Kagame also embarked on a health intervention called the President's Malaria Initiative (United Nations in Rwanda, (2016). The main aim of this initiative is to help get the most basic health materials for the prevention of malaria to the most remote areas; these include medication services and mosquito nets.

The government of Rwanda uses a universal healthcare model that offers a health insurance policy through a scheme known as Mutuelles de Santé (WHO, 2008). The system serves as a community-based healthcare insurance scheme, whereby residents of certain locations pay premiums and are charged copays for treatment. It is reported that in 2012, nearly 45% of the activities of the scheme were financed by premium payments, with the rest of the projects funded by the government and international donors ((Jones, 2018).

2.14.2. Characteristics of Rwanda's Healthcare Sector

- ¶ The country's population has been increasing at an annual rate of nearly 2.2% and this has caused the fertility rate to be relatively high.

- ¶ The overall donor supports, account for over 70% of the healthcare sector funding.
- ¶ Malaria morbidity rate has greatly reduced and greater use of clinics has helped cut down cases.
- ¶ There is health insurance in Rwanda that is open to the community.
- ¶ The government of Rwanda has established the Kigali Health Institute, which is tasked with the training of medical technicians and nurses for the health sector.

2.14.3. Current Situation of Rwanda's Healthcare Sector in East Africa

The Fortune of Africa reports that the Rwandan healthcare sector is ranked top in East Africa due to its strong healthcare insurance policy cover that makes the sector stand out. Most importantly, it is reported that most of Rwanda's healthcare insurance services are provided by the central government to cover medical services for its population, in particular the vulnerable groups. This translates to some significant improvement in the healthcare sector of Rwanda. There is an ongoing campaign against HIV/AIDS and there has been significant improvement in the prevalence of these diseases, as the current prevalence is only 2.9% (Fortune of Africa, 2018).

2.14.4. Healthcare Infrastructure in Rwanda

The Access Project functions on the basis to sustainably enhance the health care outcomes, to ensure that each community has access to a permanent local health centre that is equipped to offer a wide range of health services, such as treatment programmes, HIV prevention initiatives, prenatal care, TB treatment, family planning and maternity care for mothers. The Ministry of Health in Rwanda has declared that one health facility must be established for each sector with an estimation of 15,000—25,000 people, although other sectors require such infrastructure today (Fortune of Africa, 2018).

2.15. Kenya's Health Sector

At the time of Kenya's independence, the country inherited a 3-tier healthcare system. For instance:

- ¶ The central government operating at the district, provincial, and national levels.
- ¶ Missionaries operating at the sub-district levels.
- ¶ Local government operated in the urban places.

In 1965, the National Hospital Insurance Fund (NHIF) was introduced as the government state corporation and was mandated to offer healthcare insurance to all citizens over 18 years of age in Kenya. The central mandate and aims for NHIF is to offer an affordable, accessible, quality, and sustainable healthcare insurance system for all citizens living in Kenya, who are 18 years and receive a monthly income of KES1,000 and above (National Hospital Insurance Fund, 2019).

In 1970, the government of Kenya established a comprehensive rural health service system, whereby health facilities became the central points for promotive, preventive, and limited curative health services. In 1989, the government introduced user fees (known as Facility Improvement Fund or Cost Sharing). In 2004, 10/20 guidelines in the health facility and dispensaries were introduced (Alliance Expert, 2019).

Most importantly, Kenya has established a promising stage for key improvement in its healthcare sector. The country has designed a long-term development plan known as vision 2030 to significantly transform the nation into a middle-income status in Africa. To achieve this; the government has designed three major pillars, such as economic, social, and political development with a central focus on the following deliverables:

- Attain an average economic growth of 10% per annum;
- Establish equitable and fair social development in a safe and clean environment; and
- Achieve and practice a democratic system that focuses on people's problems, and is result-oriented and Accountable (Alliance Expert, 2019).

Kenya's healthcare policy is generally based on goals listed in the vision 2012—2030. Consequently, the private sector is in more demand than the public actors for some reasons, but not limited to the poor-quality service offered by the public; healthcare insurance growth remains low at only 4%; healthcare infrastructure is unequally distributed, and private medical clinics and hospitals concentrate more on urban places than villages or rural areas. As a result of these reasons, approximately 47% of the poorest population use private health facilities or medical clinics.

2.15.1. Components of Kenya's Healthcare Sector

The following healthcare sub-sector has significantly contributed to the development of a wider range of business opportunities in Kenya for both local and international actors:

Pharmaceuticals:

- The international include Merck & Co, GlaxoSmithkline, Pfizer, and Novartis
- The local players include Beta healthcare

Hospitals:

- Government-Owned and operated ones include Moi Teaching and Referral Hospital and Kenyatta National Hospital (KNH).
- Privately owned and operated include Aga Khan University Hospital and Nairobi Hospital.

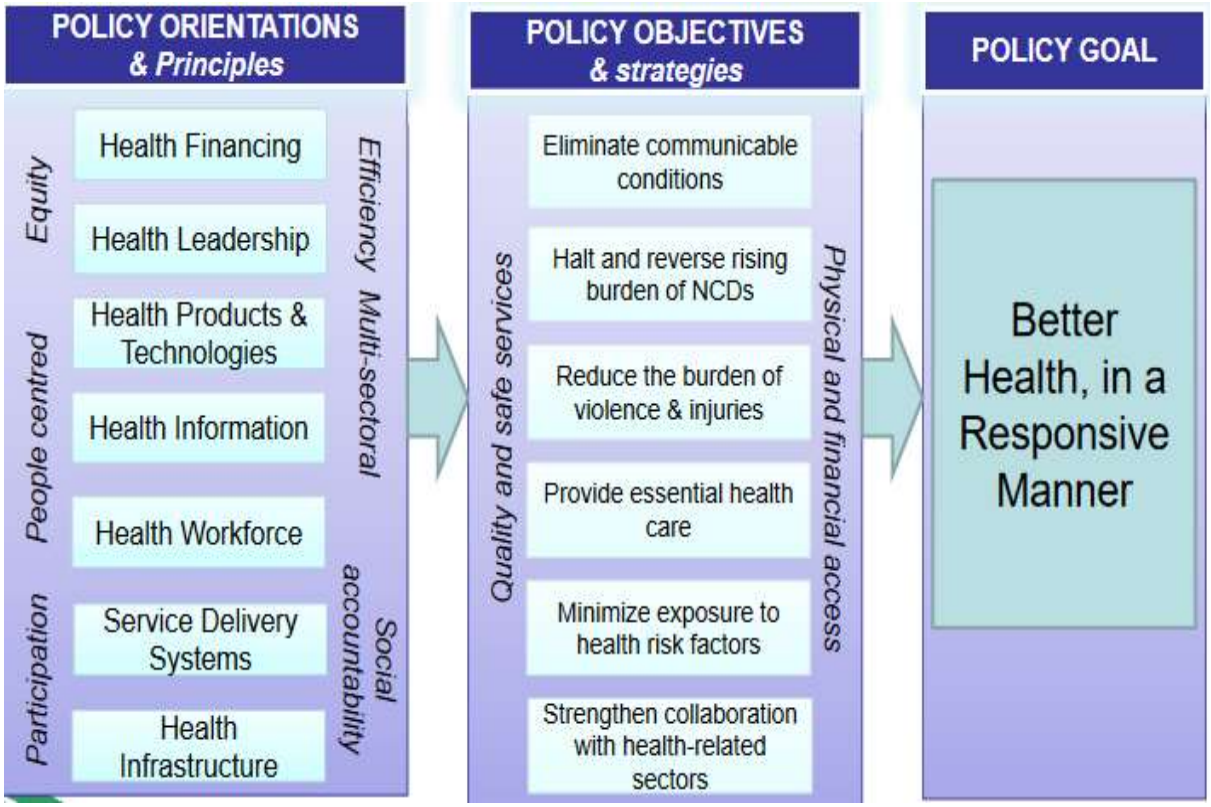
Medical Equipment:

- GE Africa
- Guided Therapeutics
- Philips

Diagnostics (Insurance Firms):

- AIG insurance
- Insurance company of East Africa (ICEA)
- Jubilee Insurance company
- UAP insurance company

Figure 2.6: Kenyan Healthcare Policy 2012-2030: Key Policy Directions



2.16. Uganda's Healthcare System: General overview

Between the 1980s and 1990s, Uganda was operating one of the worst health sectors across the world. However, that story has significantly changed today. For instance, Bulamu healthcare indicates that the HIV infection rate has reduced up to 30% of the country's population and has significantly fallen to 6.5% than before in the history of Uganda's healthcare performance. Today, the maternal death rate has also dropped by 40% from a 561 mortality rate per 100,000 people to 343 live births (Bulamu Healthcare, 2019).

Table 2.2: Uganda compares to Africa, the U.S., and the rest of the World on Key Public health measures

Uganda Key Public Health Statistics vs. Arica, U.S, and the World					
Statistic	Uganda	Africa	U. S	World	Population
Life Expectancy	62.3	60.0	71.4	79.2	
Malaria Cases	218.3	245	11	14.3	1000 at risk population
Maternity Mortality Rate	343	542	216	69	100,000 live
Neonatal Mortality Rate	19	28.0	19.2	3.6	1000 live
Suicide Mortality rate	7.1	9	11	14.3	100,000
Skilled Health Professional Density	15	14.1	46	119	10,000

Source: *(Bulamu Healthcare, 2019).*

2.16.1. National Health Systems in Uganda

Uganda's healthcare sector has been organised into a national health system and provision of healthcare projects and services within a recognised framework. For instance, the national healthcare system consists of both public and private sectors. The system operates on a referral basis. For instance, if health centre III lacks the capacity to handle a certain case or patient, it refers it to the next level up. Health care services in public hospitals are meant to be free, though it is not the case because some health workers have been highlighted to extort money from the patients desperate for services. It has been reported that in most cases these units lack essential drugs and equipment that are helpful for practitioners, forcing the patients to buy them from pharmacies (Kavuma, 2009).

The private healthcare sector is composed of Private Health Practitioners (PHPs), private Not for Profit making, (PNPM), and Traditional Contemporary Medicine Practitioners (TCMPs) (*The World Bank, 2010)*. These examples of the private sector contribute to nearly 50% of the healthcare service delivery. On the other hand, the public sector is comprised of Health services departments of different ministries and Government health facilities. The Ministry of health has many functions, which have been delegated to National Autonomous Institutions, including the national drug authority (NDA).

Healthcare service delivery is generally decentralised within the national, districts, and sub-health districts. The lowest level is typically the Village Health Teams (VHTs), volunteers in the village at grassroots facilitating health care promotion, community participation, healthcare service delivery, and community empowerment (Nakisozi, 2014).

2.16.2. Village Health Teams (VHTs)

VHTs are the first contact for the local population, also known as community medicine distributors. In Uganda, each village is meant to have a team of these volunteers. However, in most cases, some villages do not have them or they lack basic drugs for diseases like malaria, typhoid among others. For instance, in Katine village, the African Medical and Research Foundation (Amref) intervention project has empowered the VHT structure at grassroots, through providing members with bicycles to assist their transport and training them. Nevertheless, they still lack necessary medicine, though they can counsel and give advice to patients and possibly refer them to health facilities (Kavuma, 2009).

2.16.3. Health Centre II and III

Uganda's healthcare structure at the district levels is composed of health centres II and III; with health centre II offering the first level of intervention services between the community and formal health sector. These are supposed to provide care services to outpatients and engage in community outreach services. The health centre III at the district level is established to provide basic promotive, preventive, and current services to the community (Nakisozi, 2014).

The government of Uganda has a health policy that stipulates that every parish must have at least a health centre (Kavuma, 2009). For instance, a health centre II is meant to serve a few thousand people and should be equipped to treat common diseases like malaria and typhoid. The facility is supposed to be managed and led by a qualified enrolled nurse, serving with a midwife; and with the help of two nursing assistants and a health assistant. Nakisozi adds that health centre II is equipped to run an outpatient clinic, treat common diseases and provide antenatal care to mothers (Nakisozi, 2014).

2.16.4. Health Centre III

The next levels to health centre II are general or referral hospitals, which are equipped to provide Health Centre III with a wide range of services, including treatment, surgeries, and

blood transfusions. They are also established to conduct different research projects and training. The Regional Referral Hospitals (RRHs) offer relatively greater levels with some specialised clinic services and also engage in research and training initiatives (Nakisozi, 2014). It has been indicated that each sub-county in Uganda is supposed to have a health centre III facility; and they should have approximately 18 medical workers, led by a senior clinical officer, who is responsible for running a general maternity ward and out-patient clinic. It should be equipped with a functioning medical lab (Kavuma, 2009).

2.16.5. Health Centre IV

A health centre IV is considered a mini-hospital. It is supposed to have health services that are found at the health centre III; and it should be designed to have men's wards, women's wards, children's wards, and should have the capacity to admit patients. A senior medical officer, doctor, and a functioning theatre for performing any emergency operations must be present at health centre IV. An example is Tiriri Health Centre which has 34 beds and it has a theatre (Kavuma, 2009).

2.16.6. General Hospitals

Formerly, each district in Uganda is meant to have a hospital that must have all the healthcare services provided at a health centre IV, with several specialised clinics, including those for consultant physicians, dentistry, and mental health. For instance, Soroti district has a RRH, which caters to the Karamoja and Teso regions, implying that it receives some cases referred from another district hospital (Kavuma, 2009).

Uganda's national hospitals are more comprehensive because they offer the highest level of specialised care in addition to clinical services. The structure of referral is from the lowest level to the highest level of healthcare in Uganda's healthcare sector (Nakisozi, 2014). Mulago Referral Hospital (MRH) is the national referral hospital located in Kampala, Uganda's capital city. It has most of the best doctors and nurses (Kavuma, 2009).

2.16.7. Uganda's Healthcare Financing

The World Bank reports that the total private and public health spending per capita is $59 US dollars (The World Bank, 2014). Public financing for general healthcare, 4.3% of the national GDP in 2013 (The World Bank, 2019), which is below the target of 15% set in the 2001 Abuja

Declaration (World Health Organization, 2011). As Ethiopia's socio-economic, and literacy status continues to improve, the demand for quality care services is also increasing.

Despite the changes in demographic trends, increasing urbanisation and epidemiology needs more comprehensive services that cover a broad range and quality of promotive, preventive, and curative services. In the last decade, Rwanda's healthcare sector has significantly seen a remarkable improvement. Major improvements in medical technology have been registered, healthcare insurance, community-based healthcare has been improved, and the mindset of the citizens about the healthcare issues has been significantly changed.

In Kenya, based on the International Finance Corporation (IFC), it shows that Sub-Saharan Africa has nearly 11% of the world's population, but it experiences 24% of the global disease burden in finance and manpower costs. Almost half of the global death of children in fewer than 5 years, happens in Africa. However, based on the Kenyan Healthcare Policy 2012-2030—Key Policy Directions, the Kenyan healthcare market will receive significant growth over the 2020- 2030 period.

With respect to Uganda's healthcare sector, both public and private actors offer healthcare services to the population. The Ministry of Health indicates that the central government contributes nearly 66% of the health care services delivered to the community. These services include regional and national hospitals, such as the tiered scheme of health centres, which generally handle a wide range of health services.

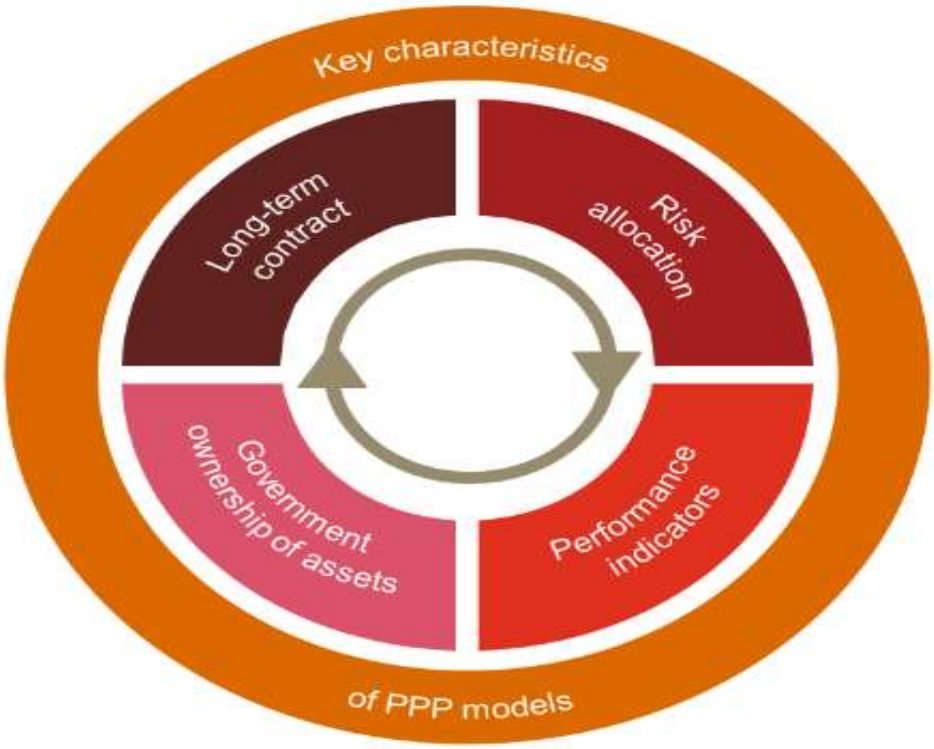
2.17. Global Experiences of PPPS

In more present times, PPPs have become a common tool for developing society and delivering public services in both developed and developing nations. At the topmost levels, PPPs are typically accepted as long-term cooperative organisational arrangements among the public sector and private actors to accomplish different purposes (World Bank, 2013). This subsection entails works of related literature conducted on the global experiences of PPPs. The subsection presents a discussion of PPPs in the U.S., Canada, United Kingdom, India, South Africa, Ethiopia, Kenya, and Uganda at large. The focus in this section is based on the country's success in the implementation of PPPs. This section only includes a literature review of experiences of PPPs in the healthcare sector.

2.17.1. Characteristics of PPPs in the Health Sector

In more present times, PPPs have become a common tool for developing society and delivering public services in both developed and developing nations. At the topmost levels, PPPs are typically accepted as long-term cooperative organisational arrangements among the public sector and private actors to accomplish different purposes.

Figure 2.7: Features of PPPs in the Health Sector



Source: (Abuzaineh *et al.*, 2018)

These characteristics of healthcare PPPs distinguish them, (long-term contract, risk allocation, performance indicators, and government ownership of assets) from other forms of PPP engagements.

a) The PPPs long-term arrangement is a contract of normally 15+ years, and at least more than five years;
b) Risk transfer from the public to the private sector, where both actors contribute to toward the design and implementation of a contract;
c) A PPP contract is based on agreed performance indicators; and

d) Government owner's assets, including medical equipment and facilities at the end of the contract.

It should be noted that PPPs have become a remarkable approach in delivering public services in most developed and developing countries. Nevertheless, even with wide adoption, the definition of the term "PPP" remains unclear. Many scholars, international organisations, and government agencies have defined the term "PPP" (Savas & Savas, 2000).

PPPs is an official arrangement between two or more parties that allows them to work toward achieving a common objective but with a certain level of mutual responsibility and benefits, shared authority, shared resources, and risk-taking (Great Britain Treasury Taskforce, 1998). The World Bank defines PPPs as a long-term sustainable agreement between the government agency and a private organisation, as a means of providing public services (Roehrich, Lewis & George, 2014; World Bank Institute, 2012).

Bovaird (2004) has also defined PPPs as an arrangement between two or more entities, who have agreed to work together toward the common objectives, in which there is shared responsibility and authority, shared resources, mutual benefits, and obligation to take risks and liabilities. A Public-Private Partnership is considered as a cooperative initiative between private sectors and the government, based on the expertise of each party involved, defined public demand through the appropriate distribution of the available resources, rewards, and risks (Canadian Council, 2003).

Similarly, the World Health Organisation asserts that this partnership in the health system is a collaboration of a "set" of actors for shared objectives of enhancing the health system based on the agreed principles and roles (Kickbusch & Quick, 1998). Based on the WHO's definition, mutual agreement on critical principles and roles remains central and maintains the power of the parties involved to allow each to retain its status and core values (Buse & Walt, 2000a).

2.17.2. Health PPPs in the United States

The U.S. ranks number one in the world for healthcare spending in terms of GDP. This is central in the move to improve care delivery; however, for example, Texas ranks number 11 worldwide when it comes to healthcare performance, which is credited to access to healthcare facilities and services (Nabers, 2018). The government achieves this through implementing alternative funding in form of PPPs engagement. Implementing the PPPs healthcare model in

the U.S. has helped the hospitals to secure immediate funding and use private sector expertise, and suitable mechanisms while transforming all the potential risks.

PPPs in the U.S. are still at their infant stage, it shows promise and their success has been related to key healthcare infrastructure projects. For instance, 48 major PPPs project infrastructure transactions worth $61 billion were registered in the U.S. between 2005 and 2014 (Wharton University of Pennsylvania, 2017). It is now believed that collaborative efforts are a norm and healthcare PPPs are likely to become common practice across the United States.

2.17.3. Health PPPs in Canada

PPPs have been successful in Canada, especially where they collaborate well with the country's single actor health system. Unlike the U.S., that promising success is reflected in Canada's willingness to partner with the private sector in delivering the best services, with a success story on the PPPs, and the most recent standout in Montreal. For instance, the Canadian Council for Public and Private Partnerships (CCPPP) indicates that PPPs provide critical advantages over traditional funding arrangements, such as:

- confidence on the project scope, timeframe, and budget of the project;
- a single project, with all attributes including scope resolved at the outset;
- annual service fees paid based on the performance, with a managing contractor only compensated when the project is delivered as agreed on the terms and conditions of the contract.

Canada has registered a strong record in PPPs in the healthcare sector. For instance, it is reported that between 2003 and 2011, over 50 public-private hospital projects worth nearly 18 billion Canadian dollars ($12.3 billion), were spent in British Columbia, New Brunswick, Quebec, and Ontario. These PPPs have enabled a community to join the available resources and equipment, medical expertise of the public sector with the environmental and operational expertise of the private-sector. All combined, they have created a sustainable infrastructure, providing the population with more efficient services that also help to place Canada in a good position to tackle all healthcare challenges (Wharton University of Pennsylvania, 2017).

2.17.4. PPPs Healthcare in the United Kingdom

The United Kingdom is one of the first nations to officially develop and implement PPPs, formerly known as the Private-Finance Initiative (PFI). The concept of PPPs started in the UK in 1992, and later extended from the late 1990s across all parts of the government spending, such as education, healthcare, and military (Healthcare UK, 2013). Through joint efforts, PPPs have enabled the delivery of cost-effective, efficient, and measurable public services within the improved infrastructures whilst reducing the financial costs (Jubilee-Debt, 2017).

The UK is the world's leader in healthcare PPPs, combining the best public and private sector innovation and expertise to generate outstanding healthcare facilities. The government has successfully implemented a broad range of PPP programs for mental health, acute, primary, and community facilities with the highest level of engagement being with the public and practitioners. The projects range from the massive Royal London Hospitals and St. Bartholomew's project, which is the largest PPP public hospital contract in the United Kingdom at £1.1 billion, spent on a residential health care home costing £2.8 million (Healthcare UK, 2013). The Calderdale Royal Hospital is an example of a PPP, health facility in the West Yorkshire region of northern England, built through a PPP framework between 1998 and 2001.

Moreover, it was reported that the initial budget of the hospital was $42.5 million, but this almost doubled to $81 million at its completion. This project deal was negotiated by the Conservative government in the 1990s and passed by the labour government in 1998 (Jubilee-Debt, 2017). The UK's combined PPPs provide necessary means that can serve as a one-stop-service centre on projects, offering everything required for successful completion from advice and project management to fundraising and securing the finances.

Since 1991, the National Healthcare Services (NHS), working together with British advisors, has established practice expertise in supervising the entire process of procuring, specifying, contracting, and implementing a PPP project. This entails developing effective procurement, with the most acceptable form of contract set to minimise costs. Similarly, the UK's Private Sector has remarkable experience in bringing together consortia consisting of engineers, planners, architects, facilitates managers, building contractors, medical suppliers, and financiers. The UK government provides an in-depth understanding of how to combine a deal to manage the tenders; to arrange delivery of the new equipment during the construction phase,

and to manage and supervise the services being offered by the contractor during the delivery phases.

This means that the UK has excelled in the complex working relationships that are common in the present PPPs. As a result, it has promoted innovations, efficiencies, and creativity not readily found in extremely restricted practices in many countries across the world. For instance, the financial knowledge that the United Kingdom professionals offer, a more comprehensive knowledge of the needs of the investment community, and the capacity to understand this knowledge within the local structure of the individual nations in which they operate (Healthcare UK, 2013).

2.17.5. PPPs Healthcare in India

The government of India has adopted many types of PPPs, such as Performance-based management, User-fee based Model, and modified design-build contracts. There are several PPP projects in different stages of implementation in India, where not only health facilities have been developed and significantly improved by the concessionaire but also services are being offered (The World Bank, 2019). This approach is credited to the idea of private hospitals built on public or government land with a need to make a specific number of beds and offer treatment to publicly funded patients. The World Bank adds the rest of the hospital facilities which are used for private patients.

In addition, the concessionaire pays the government a fee for the right to run the concession, and this requires funding. Generally, when there is a contract tendering, the bids are assessed based on the lowest and fair cost to the government (World Bank Group, 2019). In India, PPPs offer access to a healthcare facility. For instance, PPPs took 24 districts in Jharkhand (Jharkhand, is a state in eastern parts of India) to provide its citizens with better healthcare alternatives. To achieve it, the state adapted to the "Hub and Spoke" PPPs model, in which healthcare services are distributed and routed into and out of a central location.

Below-poverty-line patients get free pathology and radiology care services from the district-level hospitals and village health facilities, commonly known as Spokes. It is designed in a manner that the patients that need more thorough check-ups, careful attention, and treatment are referred to the district hospitals and three state-operated medical colleges, commonly known as Hubs. This model helps practitioners in the most remote locations and small towns

to offer accurate and quick diagnoses, cutting off unnecessary medication and travel, and maintaining the costs low for patients and medical facilities (IFC, 2017).

2.17.6. PPPs Healthcare in South Africa

South Africans embraced the concept of PPPs in 1999 to help the government improve its public services. Since 1999, South Africa monitored private projects under the regulated 16 to the Public Finance Management Act, 1999 (PFMA), offering a systematic and transparent framework for public actors and private partners to have a mutually profound commercial agreement, for the interests of the public. The government has incorporated the trend in the implementation of PPPs by using imperative formal PPPs framework in the National Treasury since 1999 (Fombad, 2014). Even though South Africa had PPPs in place, these frameworks did not have a formal and standardised process as PPPs in the National Treasury.

Nevertheless, following the launch of the PPPs in 1999, the South African government established a formal and standardised framework to allow parties to take part, which served as a mutual contract between the government institutions and the private actors, in which the private actors conducted an institutional mandate and role to use the government property in forms of output; considerable project risk including technical, operations, and financial risks are transferred to the private partners, of which the private actors can only benefit through unitary payments from the user fees and the state budgets (Walwyn & Nkolele, 2018).

South Africa is one of the leading countries around the world in the policy, law, and systems developed for PPPs. Its public service delivery has been improved through PPPs over the most recent years. South African has continuously increased the number of PPPs involvement and the number of projects continues to grow in health, social development, mineral, eco-tourism and transportation, among others, and in an innovative way (Walwyn & Nkolele, 2018).

In preparation to host the first South African National Health Summit in 2001, the concept of PPPs became a general model used in the context of the South African government. In South Africa's healthcare sectors, this concept is being used particularly to imply that all forms of engagement between the two sectors should be of the main focus, rather than simply focusing on certain PPPs, which offers a much narrower meaning. South Africa's recent healthcare policy documents all emphasise four key goals, including coherence, quality of care, health efficiency, and equity (Toit, 2003), which all offer a considerable basis for decision-making approaches about the public-private engagements (PPEs).

The depths of PPEs that may constrain or support the South African healthcare system's development are established within the overall PPPs of the country. To develop an efficient, coherent, equitable, and high-quality health sector in South Africa, there is a considerable benefit for constructive interaction (co-operation and collaboration) between the public and private players in South Africa.

Both players need to embrace this approach, and thus, it is important to suggest specific basic policies for this engagement based on the mission and vision statement of the national healthcare system. In debating whether or not to embrace any new PPEs within the healthcare sector or in assessing whether an existing PPE can continue or be revised, it is also essential to assess its merits about the success of the healthcare mission and objectives (Toit, 2003; Thomason & Rodney, 2009).

2.17.7. Health PPPs in Lesotho

The government of Lesotho has embraced the concept of PPPs for the delivery of improved healthcare services, equipment, and facilities. The concept is being used as a long-term contract between the public and private actors, in which the latter takes on the roles for delivering new healthcare services and equipment (Hellowell, 2019). For instance, in 2007, the government of Lesotho announced a tender to improve the aging Queen Elizabeth II Hospital. In 2008, the contract was approved and signed with Tšepong, a consortium led by a Netcare firm headquartered in South Africa, to design, build, finance, and operate a 425 bed referral hospital (The Queen Mamohoto Memorial Hospital) located in Maseru, the capital city of Lesotho, and a gateway clinic adjacent to the hospital.

This project was re-equipped and refurbished 3-filter clinics, which are located in the capital at Qoaling, Likotsi, and Mabote to handle patient referrals to the hospital (Grabowski et *al.*, 2013). The partnership agreement was signed, and the upfront capital cost of this project was projected to be $84 million US dollars. The construction lasted for a period of two years and was followed by a period of 16 operational years, in which the Tšepong is responsible for maintaining the facilities and managing all clinical and non-clinical services.

Throughout this period, Tšepong continues to receive a "Unitary fee" from the government and is meant to cover all the anticipated operational expenses plus a return to equity and debt. The fee was nearly $18.4 million US dollars in 2007. The health facilities were completely free for

patients, except for a small co-payment for the specific healthcare service, 90% of the revenues are transferred to the Ministry of Health (Government of Lesotho, 2009).

This Public-Private Engagement required that the Tšepong and the government contribute to the capital costs. The government, therefore, contributed capital of M400 million, and the private (Tšepong) actor contributed M765 million to the project. As this is an approach for any PPPs, the highest capital cost, financed by the private sector did not score in the measures of the government expenditure (The World Bank, 2007). The amount that was privately funded, a loan financed by the Development Bank of Southern Africa (DBSA), accounted for the biggest percentage, at an interest rate of 11.65% (Hellowell, 2019). The Government of Lesotho has shown that Netcare and the DBSA also offered loans at a minimal rate of 13.1% Health (Government of Lesotho, 2009).

Finally, a group of local investors and Netcare provided a share capital (e.g., equity) of M10.41 million. The Netcare firm was the largest individual shareholder. It is reported that when the project contract was signed, the anticipated internal rate on return equivalent to an annual interest rate, on shareholder capital was valued at 25.2%. It is noted that the actual returns may have been lower or higher than this rate (Hellowell, 2019).

2.17.8. Health PPPs in Ethiopia

The Ethiopian government is working towards improving its healthcare sector to align it with the Millennium Development Goals (MDGs) (US Embassies Abroad, 2019). Thus, the Government of Ethiopia (GoE) has embraced the concept of PPPs to provide better health care services and facilities through concession, lease, and integrative agreements. The country has used PPP models like hospital PPPs to build and maintain health facilities.

Broadly used across the country, including social marketing, which has made tremendous contributions to increasing coverage and access to basic health services and products, such as contraceptives. On the other hand, financing has been effectively applied in different contexts, however, successful cases seem to me small, with a lack of equity and cost-effectiveness causing challenges for wider coverage of health care (Harvard School of Public Health & HECPAPS, 2015). Influencing non-state resources through PPPs serves as a practical approach for the GoE to bridge the gaps caused by the resource constraints and enhance coverage and access to quality health care services.

Considering this approach, Ethiopia's Ministry of Health reviewed all the existing PPP practices in its health sector and compared them with the rest of the world to better understand the current experiences, framework, and practices. The idea was how to apply the review to design possible PPP policies that could significantly help to improve PPPs for Ethiopia's health in the future. The Government of Ethiopia (GoE) has implemented sixteen PPPs across the country, and the majority of these are contracting engagement between the government and private- for-profit or private not-for-profit organisations as described below:

Contracting engagement between the government and private not-for-profit and/ or private-for-profit making organisations for the provision of comprehensive primary healthcare services for people living in the rural areas, have shown remarkable improvement in reaching the needy groups with the best quality health care services. Certainly, engagement with the health organisations have been operating under the Ethiopian Catholic Church Development office, such as St. Luke Catholic Primary Hospital and School of Nursing, Wasera Health Centre, Dubo St. Mary Catholic Primary Hospital, are some of the best examples, where Ethiopia has implemented PPP models (Harvard School of Public Health & HECPAPS, 2015).

Harvard School of Public Health & HECPAPS notes several contracting partnership engagements between the government and private-for-profit making health organisations for the provision of non-clinical products and services. These include Mizan Aman Hospital's patient registration and outsourcing of daily cash contributions, and clinical diagnostic services, like Debre Berhan hospital's outsourcing of improved clinical laboratory services, offer good examples of outsourcing mechanisms by the public referral hospitals (Harvard School of Public Health & HECPAPS, 2015).

Infrastructure-based hospital PPP engagements have been implemented in specialised medical care services, including eye care (e.g., OIC eye care centre at Zewditu Memorial Hospital in Addis Ababa), dialysis (e.g., Meles Zenawi Dialysis Centre in Mekelle), within the public hospitals have registered some improvement in terms of affordability, accessibility, and conveniently located care service.

The OIA Eye Care Centre established at the Zewditu Memorial Hospital is meant to support an average number of eye patients between 80 - 100 daily, including 10 to 15 major and minor eye surgeries every day, being the second advanced eye care facility within a public hospital in Ethiopia. The Dialysis facility at Mekelle University Hospital is serving patients who would

have been forced to travel more than 700 kilometres to Addis Ababa to get medical service (Harvard School of Public Health & HECPAPS, 2015).

2.17.9. Health PPPs in Kenya

In December 2011, the Government of Kenya embraced a policy statement on PPP operations. Later on December 5, 2012, the World Bank awarded credits to the GoK for the Infrastructure Finance and Public-Private Partnership (IFPPP) Project (Fortune of Africa, 2016). Kenya has implemented several projects under the Public-Private Partnerships agreement. PPPs in Kenya are considered to be a *performance-based agreement,* in which the private party supplies public services over an agreed period and is financially supported by the public actors and end-user or both.

The PPPs' output is defined by the contracting authority and the input is the sole responsibility of the private actors (Ministry of Finance Kenya, n.d.). In Kenya, PPPs are named the Public-Private Partnership Unit (PPPU), which is created under Section 8 of the PPPs Act -2013, to serve as a distinctive Unit in the National Treasury of the Kenyan Government. The PPP Unit's goal is also to serve as the Secretariat and Technical body composed of an independent committee, with the ultimate mandate of assessing and approving the implementation of the PPP projects in Kenya.

The PPP Unit plays an important role in identifying specific problems, making recommendations to the PPP committee about possible and sustainable solutions, and making sure that all projects meet the quality requirements, such as value for money, affordability, and suitable transfer of likelihood risks (The National Treasury, 2018). In 2017, Kenya Healthcare Federation (KHF) through its PPP committee and collaboration with the Permanent Secretary of Kenya, met and their focus was on scaling up suitable PPPs establishment between the Ministry of Health and KHF.

Health-care financing towards particular health coverage for business models for the underserved, towards universal health care, is the three key PPP areas that the KHF committee, through the health communication and marketing programme under the PPP model of work. The target of the committee was to engage the central government to embrace the PPPs in the country's health sector (Kenya Healthcare Federation, 2018).

In addition, the government of Kenya launched a national long-term development plan, known as vision 2030 in 2008 with the major aim of transforming Kenya into an industrialised and middle-income nation, with a high quality of life for its population, clean water, and a secure environment by 2030. The government injected in an effort to ensure constant change and improvement of the healthcare system and to increase affordability, access to quality care, and prevent the causes of non-communicable diseases that affect the continent (Patolawala, 2017).

Consequently, as a move to implement and achieve its vision in 2030; in 2015, GoK engaged with GE healthcare organisation as one of its key partners to deliver a 7year Managed Equipment Service Partnership (MES) to finance Kenya's 46 million population with access to tele radiology services in 98 hospitals across Kenya's 47 counties. The MES serves as a form of PPP to enable the population to adopt a "pay for service" expense plan and cover some of the financial benefits, including; what is meant to cover maintenance, equipment, and other project costs like training.

This PPP approach enables the Kenyan government to budget for health expenses over 7years by deferring up-front capital expenditure. Thus, the Ministry of Health can assign some funds to address most of the key challenges in the healthcare system. This engagement represents one of the country's programmes to deliver visible benefits for the citizens remotely by decentralising specialised care services from the government referral hospitals to the national level. The main aim of this partnership is to effectively increase access to affordable care for citizens and enable earlier diagnosis and treatment of different diseases (Patolawala, 2017).

There have been tangible benefits from this programme, including improved workflow efficiency, increased skillset of medical workers, and improved access to specialists in radiology training for medical staff. For instance, local availability of formerly non-existent specialised diagnostic equipment has significantly led to greater efficiency in the number of patients and a remarkable reduction in average scan time from the analogue to digital, making the monthly number of digital diagnoses scoring more than tenfold across the modernised hospitals. Also, sustainability and increased equipment reliability are other strengths of the MES model.

More importantly, patient referrals have significantly reduced due to locally improved access to radiology services, with a 50% improvement in access to radiology services registered from the three pilot hospitals in the first five months after the installation of new health equipment.

It is reported that the cost of scans has significantly dropped, and thus improving the accessibility and affordability of specialised healthcare services, and has greatly strengthened Kenya's health system (Patolawala, 2017).

2.17.10. Health PPPs in Uganda

With regards to Uganda, the county's PPP Act of 2015 defines this partnership as a commercial "engagement or transaction" between a private party and a government contracting agency. Under this arrangement, the private actor acquires the use of public property, equipment, and/ or other national resources of a contracting agency. It assumes substantial technical, financial, and operational risks per the function, performance, and use of the property.

In addition, the PPP Act of 2015 indicates that private actors may receive all the benefits and risks of performing a role through payment by the government agency or by charging a fee collected by the private actor from the users of the service or infrastructure or both (Government of Uganda; Public-Private Partnership Act, 2015). As a result, Uganda's definition of PPPs suggests that Uganda's PPPs arrangement is designed for large-scale infrastructure investment (Initiative for Social and Economic Rights, 2019).

Many reforms have been made in Uganda's Health sector and one of the main reforms has been the Public-Private Partnership for Health (PPPH) (Tashobya, Musoba & Lochoro, 2007). The first official form of PPPH in Uganda is the mutual relationship between private actors and the Ministry of Health, which is traced back to the early 1960s, general-notice 245 of 1961, serving as a government tool used to offer possible support to the Private-non-for Private (PNFP). However, this initiative declined and ultimately stopped during the 1970s economic crises (Bataringaya & Lochoro, 2002).

The PPP in Uganda's Health sector, known as (PPPH), begun in 1997 by the Ministry of Health (Ministry of Health) in Uganda, the private sector is widely characterised as Private-non-for Private (PNFP) and Private-for Profit (PFP) player. The recommendation for the integration of the private sector into a public health system can be done after the 1987 Health Policy Review Commission Report that highlighted the importance of PPPs in healthcare settings. The report created the foundation for the 1993—government White Paper on Health Policy that stressed the need for the private sub-sector in the health care system.

Nevertheless, it required that this issue be aligned squarely on the government health policy agenda. This has been widely due to a more sympathetic political leadership or actors during the process, and the economic crisis that had struck many of the PNFP institutions or NGOs that led to various meetings between these institutions and the Ministry of Health (Tashobya, Musoba & Lochoro, 2007).

2.17.11. Motivations for several forms of PPPH in Uganda

Under the concept of PPPH, its advocates have provided numerous reasons for its implementation in Uganda's healthcare context. The USAID's private sector within health has defined the effective mobilisation of the private health sector (PHS) to enhance health care outcomes. It also complements the Ministry of Health's effort towards achieving Universal Health Care (UHC), required practical policy and working environment that enabled public-private engagement, public-private dialogue, and public-private partnership (USAID, 2016). The most critical motivations for designing the policy documents and interviewees are described below:

2.17.12. PPPHs increase access by combining private sector efficiency and work ethic

The national policy on PPPH focuses on the "capacity building" potential of the private sector and claims that working in the private sector would increase sustainability, efficiency, access, and quality. On the other hand, it only provides an in-depth understanding of how PPPHs can help to achieve these goals. The Health Sector Development Plan (HSDP) stipulates that the Ministry of Health should also increase access to health services, by utilising private sector efficiency, work ethic, geographical coverage, personal, financial mobilisation, and physical facilities (Government of Uganda & Health Sector Development Plan, 2016).

The guidelines for the proper implementation of the National PPPH policy also put more emphasis on that, "joint planning and management" between public and private subsectors will 'increase fair access to health-care by optimising the use of available resources persistently with the standard of complementarity' (Government of Uganda & NPPPPH, 2012). This partnership seeks to promote harmony in reporting, procedures, standards, decision making, implementation processes, and efficiency in the utilisation of available resources (Initiative for Social and Economic Rights, 2019).

2.17.13. Quality Regulation and Better Price for Ugandans

Likewise, the Health Financing Strategy Policy (HFSP) suggests that PPPH can allow for quality regulation and better prices for health services than an unregulated private sector (Initiative for Social and Economic Rights, 2019). Under the private sector interactions, payment of health care services by the patients is mainly on a fee-for-service approach. This fee-for-service payment basis might cause cost escalation and thus increased out-of-pocket payments while considering that PFPs and PNFPs are left separately to decide the service fee rates.

However, the Government of Uganda has not yet developed institutional capacity for procurement and regulating prices of services within the private sector. Similarly, the current quality of health services sold by the private sector providers remains undocumented and not measured at all. The proponents of this partnership contend that PPPHs arrangement for engaging with the private sector will significantly help the public sector to achieve a more functional results-based financing model (Initiative for Social and Economic Rights, 2019).

2.17.14. The private sector bears all risks and offer funding to Uganda's health sector

Uganda's Health Financing Strategy Policy (HFSP) indicates that the current input-based memorandum of understanding (MoU) system, where funds are provided to support certain projects regardless of the services being offered, is not fully flexible, and thus might require revising and replacing with an output-based PPPH engagement. HFSP shows that within the public sector, procurement of healthcare services relies typically on the traditional input-based method, in which the government outsources health services from Private-non-for Private (PNFP) health centres through the provision of grants for certain health services based on the terms and conditions as stipulated in the Ministry of Health. This method seems to be problematic due to the growing need for increased flexibility in the distribution of the available funds as needs increase (Ministry of Health, 2016).

The well-known input-based approaches being used have a built-in inflexibility, which cannot allow the available funding to be redistributed based on the needs of the population. In other words, output-based engagement emphasises the practice of reimbursement for the health services offered, including fee-for-care services, voucher schemes, and/or results-based financing. In addition to supporting healthcare with more flexible funding modalities, the

proponents have claimed that the private sector should bear the potential risk, or at least there should be risk-sharing with the government (Initiative for Social and Economic Rights, 2019).

2.17.15. PPPHs increase Equity and improve health outcomes in Uganda

One of the key justifications for the PPPHs, with the PNFP in the form of financial subsidy, indicates that such engagement can significantly improve equitable access to health care by reducing or eliminating user fees for PNFP hospitals and health centres. In terms of subsidies, the Government of Uganda provides to the PNFPs, in the form of PHC grants, it offers the following reasons:

Government of Uganda subsidies to the sub-sector are supposed to reduce economic obstacles to public health users, increasing affordability and access for the low-income earners to basic health services. These can be allocated based on agreed outputs that can comply with the priority of the Health Sector Strategic and Investment Plan (HSSIP) 2010/11ð 2014/15.

That implies that the Government of Uganda subsidies will be utilised to implement any approach that can facilitate access to a health care facility. It may also result in a wide range of health care services offered by the PNFP, and at the same time reduce or eliminate user-fees for certain priority health care services.

The implementation guideline outline under the PNFP section indicates that partnership with PNFPs will significantly increase 'sustainability, access, efficiency, equity, and quality of healthcare services by allowing them to maintain their administrative autonomy. The PNFP guidelines add that PPPH can be applied to help the public-private sector engagement to achieve the wider geographical scope of population, in preference to establishing a competing service point.

As a result, the policy seems to indicate that physical access to at least one public, as well as private health facility, is essential in ensuring actual access to health care services. It, therefore, indicates that under this policy, fresh construction, reconstruction, and upgrades to the current health facility will be geared towards increasing coverage and accessibility in an underserved, especially rural area (Initiative for Social and Economic Rights, 2019).

2.17.16. PPPHs lead to Self-regulation for Better Care Quality for Ugandans

The implementation guidelines for the NPPPPH offer the justifications for a model that establishing a framework for coordination within the PNFP can bring about a system of accreditation that may significantly promote quality care services and improve the regulatory capacity of government in the subsector. As a result, one of the justifications for the PPPHs is that the private sector, a self-regulatory framework, can significantly improve upon the regulatory principles of the public sector (Initiative for Social and Economic Rights, 2019).

2.17.17. PPPHs improve community participation and oversight

These PNFP guidelines contend that PPPHs can lead to community empowerment by establishing and improving participatory approaches and community structures. It adds that the VHTs can work with the Health Unit Management Committees (HUMC), as selected and supported by the District Health Management Team (DHMT). The committee's chair should be given full power and must be a resident member of the community, and the HUMC must meet quarterly in a year. Such guidelines will apply participatory approaches, including Focus Group Discussions, a Community-Based Management Information System, and participatory Rural Appraisal.

Besides, the policy indicates that not-facility-based PNFPs will significantly develop outstanding partners in mobilising community participation, and will potentially support in sensitising the population in the community on their rights, responsibilities, and roles (Initiative for Social and Economic Rights, 2019).

2.17.18. PPPHs lead to increased coordination and harmonisation with the Private Sector

Formally, Initiative for Social and Economic Rights indicates that partnering with the private sector in the form of PPPH has been promoted as an effective means of ensuring greater harmonisation and coordination, which ultimately results in efficient resource distribution or sharing amongst people. The PNFP implementation guidelines, also use the same theory of complementarity to financial resource allocation, indicating that, to ensure resource allocation with equity, efficiency, and information-sharing about finances is important. The guidelines refer to the form of SWAp budgetary making, indicating that the PNFPs can "inform about the availability of resources" and "create and agree on a distribution approach between and within the PNFP subsector" (Initiative for Social and Economic Rights, 2019).

These guidelines also suggest that PPPHs, along with PNFPs will support the harmonisation of the structure, staffing, staff salary norms, and terms of employment, to have less discrepancy between public facilities and PNFPs. If fully adopted, they can lead to improved staffing, job securities, and low employee turnover, which can greatly enhance the quality of care and service delivery. Likewise, the policy indicates that PNFPs operate in more than 70% of Uganda's Health Training Colleges. Thus, it is important and suitable for the PPPHs to register increased participation in policy forums for the training of health workers (Initiative for Social and Economic Rights, 2019).

2.17.19. National Framework and Private Sector Players

The Government of Uganda considered National Framework and Private Actors as a good idea and promoted investments towards the private sector health industry from 1995 and over time, it has maintained that enthusiastic approach. Although, a few legal and policy documents are addressing the logistics and regulatory challenges, on particularly the reliance on the private sector for health care delivery as provided below:

Uganda's constitution of 1995, supports investing in the private health sector. More similarly, a 1997-2008, Poverty Eradication Action Plan (Government of Uganda; National Poverty Eradication Action Plan, 1997), supports the public's sector cooperation in health with the private sector (Constitution of the Republic of Uganda, 1995). Various strategies are listed within the first nation's development plan which ensures achieving a quality Uganda National Minimum Health Care Package (UNMHCP) that also emphasises more on the vulnerable populations. Every single one of the strategies listed entails collaboration with and reliance upon the private sector (Government of Uganda—National Development Plan, 2010). It is clearly stated as a goal for the 2040 vision, for a sector-wide shift to PPH arrangements.

The Government of Uganda will work jointly with the private sector to come up with insurance and greater capacity for particularly specialised services, which comprises, the foundation of international hospitals (Government of Uganda Vision 2040, 2010). The role of private actors in health care is made by a few explicit references in the NDP II, nonetheless, it goes ahead to discuss the role of PPPs in developing human resources in the health sector (Government of Uganda—Second National Development Plan, 2015). The policy portrays an acknowledgment that, Uganda's National Minimum Health Care Package (UNMHCP) does not receive enough funds and also indicates that Uganda relies on foreign aid to be able to meet its present healthcare funding needs. It discusses a strategy of the input-based costing and also

acknowledges that it offers an incomplete picture (Government of Uganda—Health Sector Strategic and Investment Plan, 2010).

The basic guidance on the formulation of PPPs, is briefly summarised in Health Sector Strategic Plan II, 2010-2014/15 (HSSP III) with great emphasis on the role of the district and lower levels in arrangements of procuring (Initiative for Social and Economic Rights, 2019). Also, the one concrete way by which the Government of Uganda encourages private-sector health investment is specified in the document. It doesn't charge duty on machinery imported from other nations as well as on raw materials that are purposely for producing pharmaceuticals. It is acknowledged by HSSP III, how the government's attempts at forming partnerships with the private sector via Health Policy Advisory Committees (HPACs) have not been effective. A need for the specific establishment of a national policy on PPPH, whose content shall be discussed is suggested by the document (Government of Uganda— Health Sector Strategic Plan III, 2010).

2.17.20. Public-Private Partnership Policy for Uganda, 2010

In 2010, this particular PPP framework was adopted to purposely guide the PPP projects and later enable the formation of the PPP act. Its goals were: efficient delivery of public infrastructure, output orientation, effective allocation and utilisation of public funds, accountability with utmost transparency (Initiative for Social and Economic Rights, 2019).

2.17.21. Public-Private Partnership Act, 2015

Uganda's PPPs Act is the principal legislation that governs the Public-Private Partnerships, which in general terms aspires to guide the relationship that exists between the government and private actors, in especially the implementation of PPPs. The structures of monitoring, procurement, and regulation of PPPs are established in this act, it also lays out the roles and responsibilities of the various players in the implementation of PPPs. It further sets out a PPP Unite, PPP Committee and entails information about the procurement rules that PPPs have to abide by (Initiative for Social and Economic Rights, 2019).

The Auditor-General is required, as provided in the PPs act, to audit every PP annually from its inception to the conclusion and also to report to parliament in a period not more than nine months from each audit. Even though the act points out various commendable provisions, it does not substantially regulate the nature of PPPHs. To start with, the PPP definition provided by the document states that, the private actor approves the use of a certain national asset, and in exchange assumes substantial risks and also receives a benefit via the government or user

fees. This language may not be fit enough for donor-funded PNFP projects in areas that the private actor does not necessarily acquire a national asset, does not necessarily assume financial risk, and might not get benefits from the government (Initiative for Social and Economic Rights, 2019).

In addition, the Act, particularly its application, significantly focuses on the infrastructure initiatives instead of the implementation of social services, and as a result, does not lend substantial guidance on the implementation of PPPs in health service delivery. This is a shortcoming which in turn renders the act's remedial mechanism redundant because this flow forms contractual obligations and yet PPPs in health are currently predominantly executed by way of MoU. Moreover, the act still places forth, that in the implementation of PPPs, ensuring value for money will be a guiding principle, thus attracting much emphasis on particularly the indicators that are mainly, quantity, quality, and substantial risk transfer. On top of that, it also discusses equity. Guidance on the information which has to be submitted is, however, not provided by the Act (Initiative for Social and Economic Rights, 2019).

Initiative for Social and Economic Rights notes that the importance of social impact indicators, which are vital and significant in-service delivery, are not recognised by the Act and are greatly considered in the AAAQ framework. The PPP committee that reports to the permanent secretary of Finance and Planning Ministry, Economic Development and Treasury's secretary, who is at the same time head of the committee, is stipulated in the Act. Consequently, this can be a conflict of interest and derail the role of oversight of the Permanent Secretary.

2.17.22. The National Policy on Public-Private Partnerships in Health, 2012

Certain sectors have a specific policy that provides greater emphasis on the framework that governs PPPs as the National Policy on Public-Private Partnerships (NPPPH) in health. The policy indicates the more important role that the private sector can play in realising that the right health is under its rationale. This goes ahead to just stratify actors in the health sector into "private not for profit health providers" (PNFP), Private Health Practitioners (PHP), and Traditional Complementary Medicine Practitioners (TCMP) but also sets out the roles of various stakeholders, such as government and the private health sector. It can be stated that, in developing countries, it has been characterised with some uncertainty, and with limited expertise, the NPPPH tries to present a progressive solution.

Despite the PPPH Policy's vision of majorly ensuring the provision of health care that is affordable to the entire population of Uganda. It furthermore focuses on streamlining the

working relationship between partners and governments, hence it pays less attention to ensuring that the interests of the health care consumers are safeguarded in similar arrangements (Initiative for Social and Economic Rights, 2019). Following the settlement of disputes, the structure brought forward is basically to handle disputes between stakeholders, an instance that necessitates addressing human rights violations of consumers that are not represented.

Besides, one of the strategic purposes of NPPPPH is for the government to encourage PFPs to become more engaged in assisting in particularly public health. These types of assistance are not clear and there are no proper financial incentives. For example, pledges are made by the document that, the government will provide support to PFPs to serve remote areas, but it doesn't provide further specifications. It is also discussed by the NPPPPH that the role of the PFP sector is especially to help Uganda to achieve its goals of human resource development. The policy appears to declare that, PFPs ought to have a role in training and credential schemes (Initiative for Social and Economic Rights, 2019).

The policy stipulates the purpose of enhancing the provision of quality services and regulation and control of service provision at the end of the section on PFPs, like for instance, via publishing of licensed health facilities yearly, and a database for every registered private provider being established (Initiative for Social and Economic Rights, 2019). Initiative for Social and Economic Rights indicates that these lead to significant regulatory questions, however, the policy does not provide much detail in these particular areas.

2.17.23. The Second National Health Policy 2010

Partnerships as one of the guiding principles are identified under the second National Health Policy. This policy stipulates that the private sector shall be looked at as complementary to the public sector with regards to the growing geographical access to health services, as well as the scope and scale of services provided. Furthermore, in its priority areas, the policy, notes the strengthening of the systems of health concerning decentralisation via technical assistance, mentoring training, and financing, together with establishing an integration that is functional to the public as well as to the private sectors, training, and research and also in healthcare delivery.

On top of that, still, this policy underlines as a means towards the realisation of quality health care together with a health service delivery system that is effective, the importance and significance of supervision, monitoring and evaluation, enacting legislation and regulatory frameworks, strengthening relevant institutions for enforcement and the establishment of

remedial mechanisms for victims of poor service provision (Initiative for Social and Economic Rights, 2019).

2.17.24. Health Sector Development Plan (HSDP) 2015-16/2019-20

Partly, a series of plans with the major goal of achieving Uganda's vision of 2040, of a mainly productive and a healthy population which can contribute to national development and socio-economic growth is, the Health Development Plan (HSDP). The plan places as a priority, investments in seven health system areas, one of which is governance and partnerships that are healthy that will direct their attention on strengthening structures of governance and partnership, such as, stewardship and management, public-private partnership and coordination, legislation, and regulations that are healthy, knowledge translation and enhancing sector competitiveness.

The health sector's development plan, more particularly objectives of PPPH, was creating a Medical Credit Fund. It indicates as one of its strategies, achieving financial substantiality, mobilising of non-public resources from the sectors that are privately owned under arrangements of PPPH, although it doesn't provide examples.

The Initiative for Social and Economic Rights document shows the role of umbrella organisations, emphasising that their role is basically to represent members within their organisations and promoting initiatives in partnerships, to coordinate the various health providers from each subsector and promoting ethics and professional development, as well as providing support services and accrediting member facilities and providers (Initiative for Social and Economic Rights, 2019).

The document does not in any way assert PFP's role in providing healthcare to vulnerable, poor, or rural populations. It goes on to describe the role of the PFP sector within the present Health Sector Development Plan, as serving to ensure the provision of free health services mainly in parts characterised with populations that have the capabilities to pay for the services.

2.17.25. Local Government Policy Documents

The conditions that have to be met for the local government to be able to receive funds from the Ministry of Health, for particularly the health care procurement, are laid down in the Document of the Ministry of Health's Sector Grant and Budget guidelines. Such guidelines entail a section devoted to the grants for PNFPs and PFPS (Ministry of health FY 2017/2018 (Ministry of Health, FY 2017/2018). The guidelines try to guarantee that private entities get

government funds when only doing so will enhance access to health care for the vulnerable and the geographically isolated populations.

Even though, these guidelines are contained in this document, more of them pertain clearly to input based on arrangements of a memorandum of understanding (Ministry of Health) and does not appear tailored for formalized PPPHs (Initiative for Social and Economic Rights, 2019). The document reflects the examples of (Ministry of Health) between PNFPs and the Government of Uganda; Government of Uganda and the Joint Medical stores and EMHS credit Line for PNFPs ND District Local Government and PNFPs.

On the other hand, the Public-Private Partnership for local governments policy, addresses specifically the PPP type arrangements, however, it doesn't offer any guidance that are specific to PPPHs (Initiative for Social and Economic Rights, 2019). Furthermore, the Initiative for Social and Economic Rights shows that the document is much more of an instructional tool kit for local government that discusses the variety of ways to structure PPP arrangements. Very little work in addressing regulatory concerns is portrayed in the document.

2.17.26. Other Legislation and Policy Documents

PPPs ought to be construed in the light of other legislations, which even though not focused on the PPPs, guided processes that are important and relevant to PPPs such as procurement. Under section 13 (1)(B), the Auditor General is empowered by the National Audit Act to conduct financial value for money and other audits for any project involving public funds. Under section 18, the auditor general is empowered to specifically examine, inquire into and report as he deems it necessary, depending on the expenditure of the public money disbursed, advanced to a private organisation which the government does not have controlling interests, which includes PPPs.

This is also in relation to article 163(3), (4) of the constitution, which requisites the Auditor General to carry out financial audits and value for money then to submit to parliament every year a report of the accounts that he audited. It is required, an application of basic principles of public procurement and disposal by the Disposal of Public Assets Act 1, of 2003 (PPDPA) consisting of accountability, transparency and fairness, non-discrimination, competition, and ensuring value for money together with emphasis for open competitive bidding and public accessibility (Initiative for Social and Economic Rights, 2019).

Under Section 55 of the Act, public procurements are required to be carried out per the rules of this particular Act. The guidelines and regulations which apply equally to public and private

institutions are provided in the Service Standards and Service Delivery Standards for the Health Sector, 2016. Whereas, a comprehensive monitoring and evaluation plan for private and public actors ensuring the delivery of the former are provided by its companion, the Monitoring and Evaluation Plan for the Implementation of the Health Sector Development Plan 2015/16-2019/20. Whereas, there are certain regulations, it provides piecemeal protection and does not sufficiently strengthen the regulation function of the state (Initiative for Social and Economic Rights, 2019).

2.17.27. Case Studies of PPPs Health Systems in Uganda

This subsection offers an overview of the salient PPPs in Uganda's health sector as described below:

2.17.28. Private-not-for-Profit (PNFP) Organisations

Formerly, the effort exerted by the Government of Uganda to implement PPPH has significantly evolved entirely around the concept of PNFP, but not PFPs and these engagements have been in form of the Ministry of Health rather than performance-based agreements. It should be remembered that as early as the 1960s, the Government of Uganda passed a national policy that stipulated the provision of financial support to the PNFP sector in the health sector.

The government established an NGO healthcare sector panel that was mandated with the role of creating practical approaches for the corporation between the NGOs and the Government of Uganda for the provision of public health services. Initiative for Social and Economic Rights reports that the NGO panel's recommendations were approved and formalised in the1999—First National Health Policy and the Health Sector Strategic Plan—2000/01-to-2004/05 (HSSP I).

In the most recent recommendations, the key role of the NGO panel was absorbed by the newly established PPPHs—Working Group, which is responsible for designing and developing policy of all forms of PPPs in the healthcare sector, and merely PNFPs and NGOs. As a result, this recent development seeks to shape the current framework for the PPPD policy in Uganda's health sector. It is also important to note that the PNFPs in PPPH working in Uganda are often faith-based organisations (Initiative for Social and Economic Rights, 2019). Most of them are currently specialised in medical bureaus that engage with the Government of Uganda, including

the Orthodox Medical Bureau, Uganda Muslim Medical Bureau, Uganda Catholic Medical Bureau, and the Uganda Protestant Medical Bureau.

It should be remembered that the Uganda Protestant Medical Bureau and the Uganda Catholic Medical Bureau started the Joint Medical Stores, which is registered as a form of PPP constructed around the supply of drugs that supplements the National Medical Stores, procuring and supplying medical products like drugs to non-government hospitals, paid quarterly by the Government of Uganda from the Private not-for-profit hospital's essential medicines and health supplies credit-line (Ministry of Health, n.d; Initiative For Social And Economic Rights, 2019).

Palliative health care is also offered through a PPP engagement between the Government of Uganda and the Palliative Care Providers with the government offering oral liquid morphine, which is in turn reconstructed by the palliative health care providers and offered through the public-private health units (Initiative for Social and Economic Rights, 2019).

2.17.29. Donor Funded Voucher Arrangements

Donor agencies have supported the Government of Uganda; however, they often provided a complicated relationship with the government and the SWAp approach. For instance, in 2017, USAID spent nearly $90 million UD dollars through its Global Health Portfolio in Uganda (GHP) (US Government, 2018). Initiative for Social and Economic Rights indicates that USAID focuses its health-related funding in Uganda through the following categories: health system strengthening, malaria prevention, HIV/AIDS, Child health, family planning, and reproductive health (USAID, 2018).

Most importantly, USAID acknowledges that the Ugandan government is often a stumbling block as a partner to its mission in Uganda (Initiative for Social and Economic Rights, 2019). However, there have been some activities conducted by the donor agencies, for instance, in piloting and implementing voucher schemes, especially with the help in HIV/AIDS prevention and the formation of maternal health care.

Another example can be acquired from the ABT Associates, which is a research and consulting firm based in the United States, that often engage with the Government of Uganda on different projects. According to their official website, the firm is leading the USAID Uganda Voucher PLUS Activity that is developed to increase affordability and access to high-quality obstetrics,

babies, and postpartum family planning (PPFP) services for women under the poverty line, through the private sector. A report by the Initiative for Social and Economic Rights maintains that the activity is currently offering facility-based deliveries with attendants, in a total of 30 districts of Eastern and Northern Uganda (USAID, 2018).

2.17.30. Private Sector-For-Profits (PFP) PPPs

The Government of Uganda has registered few PFP PPPs, but this is steadily changing. Some of the PFPs and the proposed ones are described below:

2.17.31. Cipla Quality Chemicals Ltd.

The Government of Uganda has been supporting Cipla Quality Chemicals Ltd through a PPP arrangement to produce Anti-Malarial-Artemisinin Combination Therapies (ACTs) and ARVs. The government has invested over Ugx6 billion over the period of two years, with the goal that it will also contribute at least Ugx29 billion in taxes. Nonetheless, the public concern is about the cost-effectiveness of this PPP arrangement with the Government of Uganda. For instance, the Auditor General's report revealed prices, at which National Medical Stores produced ARVs from Cipla, which were higher than prices for drugs imported into the country through the donor financed agreements (Initiative for Social and Economic Rights, 2019).

The report highlighted a total of five out of eight drugs that were supplied at relatively higher prices than the imported ones under the MoU, signed between the Ministry of Health and CIPLA quality chemicals Ltd. This might eventually lead to drug shortages due to higher prices, bring in fewer drugs purchased and yet sustain donor dependency (DAILY MONITOR, 2017). Besides, at some times, in 2009, CIPLA proposed to export drugs to neighbouring countries, but its proposal was opposed by Uganda's MPS, who claimed that to recoup the government's financing and investment in the company, it should first prioritise producing and supplying Uganda's healthcare sector (NEW VISION, 2009).

2.17.32. The Proposed Medical Credit Fund

One of the proposed sustainable solutions, as described in the Health Sector Development Plan's Specific PPPH goals, is to establish a special Medical Credit Fund. The report by Initiative for Social and Economic Rights indicates that since 2015, the World Bank Group/ International Finance Corporation (IFC) through the Health in Africa Initiatives, and

partnership with the Pharm Access Foundation, has taken an initiative in working with the Ministry of Health and Ministry of Finance, Planning and Economic Development to implement a Medical Credit Fund for private service providers, which is anticipated to be rolled out in 2019—a financial year or early 2020 (Ministry of Health, 2015; Initiative for Social and Economic Rights, 2019). In a move to improve health, the Ministry of Health endorsed the proposal.

Ministry of Finance, Planning, and Economic Development reportedly expressed willingness to financially support the Medical Credit Fund scheme under the government supervision and financing, along-side counterpart financing from the IFC and project funded by both the public sector and private funds, to be implemented under a PPP model (Initiative for Social and Economic Rights, 2019). A proposed Medical Credit Fund aims to support PFP health care providers to grow their business, while also cutting the risk that they might default on their loans.

In addition, the Ministry of Finance has promised to financially support the project with some of its funds (Ministry of Health, 2015). As a result, if the project implementation is done, some critical amount of government, like (Tax-payer) funds will be invested in the private health sector. This is credited to the fact that strengthening and allowing the private healthcare sector will significantly lead to improved health outcomes for the population living under the poverty line. However, there is a considerable concern that such financial support would be more appropriately spent to support Uganda's public healthcare sector.

It is reported that a total of 39 districts in Uganda have no referral hospitals. These include, but are not limited to Amuria, Amuru, Alebtong, Bukedea, Bukomansimbi, Bulambuli, Buvuma, Buyende, Dokolo, Gomba, lsingiro, Kalangala, Kaliro, Kamwenge, Kibuku, Koboko, Kole, Kotido, Kween, Kyankwanzi, Kyegegwa, Luuka, Lamwo, Lwengo, Manafwa, Mitoma, Nakapiripirit, Namutumba, Namayingo, Ntoroko, Otuke, Pader, Rubirizi, Serere, Sironko, Kibale, Kakumiro, Rubanda and Omoro.

According to the *District League Table,* the Ministry of Health's annual assessment report of the district health performance on the key health indicators, the absence of such facilities has significantly contributed to the worst performance in health for the last five years (Initiative for Social and Economic Rights, 2019).

2.17.33. The International Specialised Hospital of Uganda (ISHU) under PPPH

In March 2019, the Government of Uganda through the Parliament approved promissory notes for $379.71 million for a highly contested PPPs between the Government of Uganda and FINASI/ROKO Construction SPV Ltd., to design, build, finance, operate and manage a specialised national hospital in LUBOWA—Wakiso district. Uganda's Ministry of Finance, Planning and Economic Development had earlier tabled a proposal before the Committee on National Economy, on February 12, 2019. It is reported that in 2013, FINASI supposedly offered expertise in the International Medical Planning and Facility Development engagement with ROKO Construction SPV Ltd., and submitted their proposal to the President of Uganda Y.K. Museveni to build and manage specialised health facility at Uganda Cancer Institute and Entebbe Grade A. The main goal of the project was to reduce cases of disease and mortality rate due to non-communicable diseases in the country (Initiative for Social and Economic Rights, 2019).

The first phase of the ISHU project would be to construct a 264-bed JCI accredited hospital facility that consists of a national ambulance control centre and an oncology centre; and, the second phase will be to construct a 500-bed facility in Medical City. President Museveni directed the Ministry of Health and Ministry of Finance, Planning, and Economic Development to negotiating their project and the contractor funding.

On December 4, 2018, a direct agreement was signed with the Government of Uganda and FINASI/ROKO Construction SPV Ltd., and Barclays Bank of Uganda Limited, and African Export-Import Bank. On the said date, the promissory note purchase agreement was signed and entered between the following parties: FINASI/ROKO Construction SPV Limited (As Seller); and African Export-import Bank, ABSA Bank Ltd, Barclays Bank of Uganda Ltd, and Eastern and Southern African Trade and Development Bank (As Arrangers); and African Export-import Bank (As Note Purchaser, Administrative Agent and Security Agent); and Barclays Bank of Uganda Ltd (As Local Administrative Agent); and the government of Uganda, as Original Note Funders (Initiative For Social And Economic Rights, 2019).

On February 12, 2019, the Minister of State for Finance, Hon. David Bahati, tabled a proposal before Uganda's Parliament to issue promissory notes, $379.71 million to FINASI/ROKO Construction Special Vehicle Limited to finance the project (design, construct, and purchase of specialised equipment) of ISHU. The minister's proposal was approved by the Parliamentary

Committee on National Economy (PCNE). On February 25, 2019, President Museveni wrote to the Speaker of the Parliament of Uganda on his position on the proposed PPPH.

The parliamentary committee considered and voted for the promissory note to be issued, although some members of parliament (MPs) opposed, citing a minority report, that indicated that the government did not follow the procedure and failed to comply with the laws. Opposition MPs contended that the development and implementation of this PPPH and the entire process to endorse this promissory note did not comply with the laws and was irregular, citing lack of accountability, access to information, lack of participation, and infringement of the existing regulatory framework.

It is also reported that the existing policy and legal framework were intentionally circumvented (Initiative for Social and Economic Rights, 2019). Act 1, of 2003 (as amended) of the Public Procurement and Disposal of Public Assets (PPDPA), Uganda requires that an application of basic principles of public procurement and disposal, such as non-discrimination, accountability, transparency and fairness, competition, and ensuring value for money (Section 46 of the Act), with a sharp eye on open competitive bidding (Section 51 of the Act), and public accessibility (Section 53 of the Act).

Section 55 of the Act of the Constitution of Uganda requires that all public procurement be conducted in line with the guidelines of this Act. The PPDPA of Uganda does not allow negotiations between a disposing and procuring entity and contractor except a competitive approach was applied. Consequently, it is reported that there was no open competitive bidding process, contravening with the existing laws, and the minority report of the Parliamentary committee openly aired out, it was not legitimate on what motive, *(the project was not awarded to FINASI with a good heart)* FINASI/ROKO SPV LTD was simply emerged as the preferred bidder, but not the best bidder (Initiative For Social And Economic Rights, 2019).

In summary, although the promisory note was issued and awarded to the private company, the law was not followed and at the time of this study, nothing had been done. No single activities were carried out, and thus costing tax payers money. This matter is grounded on the fact that the Government of Uganda's perseverance shows that this project is under PPPH. Traditionally, with the PPP, part of their appeal is attributed to the fact that the private entity takes all the risks of a given project.

Moreover, Uganda's PPP Act makes it clear that in any arrangements, the private partner assumes substantial financial, operational, and technical risks. In this scenario, the Government of Uganda seems to bear all the risk. This is attributed to the fact that the promissory note modality issued by the government ensure the investor will receive 100% of the total funding invested and will be protected irrespective of whether or not losses are made during the agreed timeframe (eight years) a period agreed to construct and start running the hospital. Civil society organisations have come out to protest and sued the government for violating the existing laws and policy (Initiative for Social and Economic Rights, 2019).

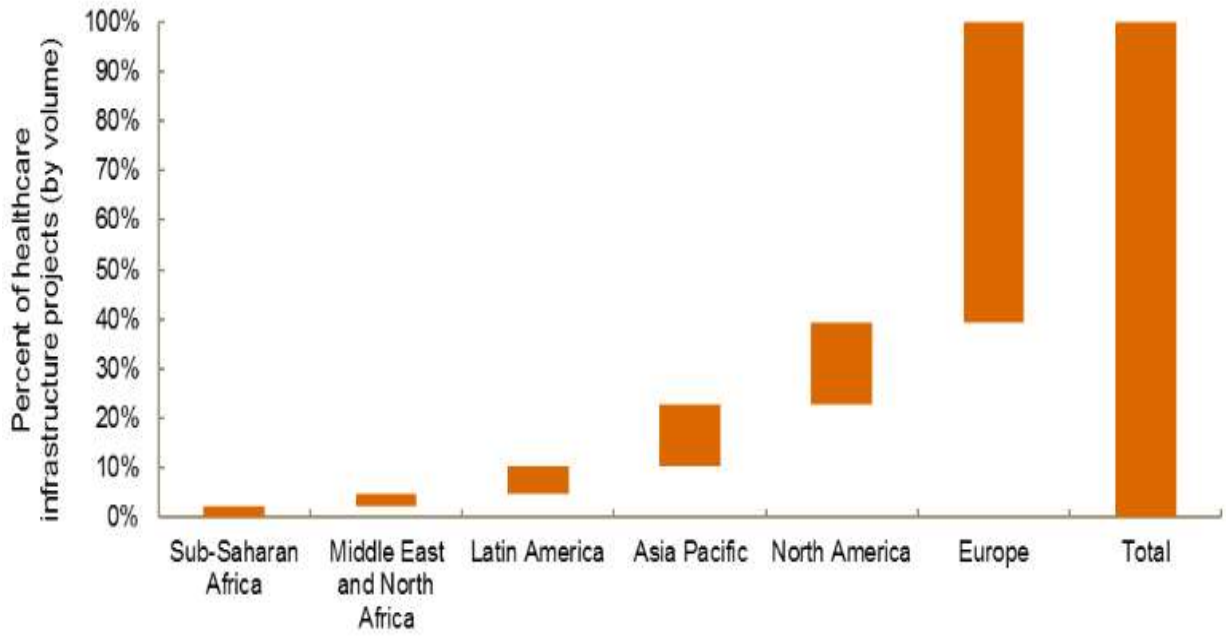
2.18. PPPs Trends in Global Healthcare

The Global Health Group indicates that in the present times, most PPP project-driven programmes globally have been adopted in non-healthcare sectors and wealthy countries, with transportation networks, making the transport subsector with a bulk of projects. Nevertheless, an increasing number of middle- and lower-income nations are embracing the health-care Public-Private Partnership projects. Regardless of these trends in healthcare, it is still difficult to give the exact scope of the healthcare PPPs market for some critical reasons, such as the different levels of PPPs development. For example, Pipeline vs. signed vs. operational; limited information available on the healthcare sector; the broad and varying range of PPP models; and the tendency for healthcare PPPs joined together with other social sectors like PPPs in the education sector (The Global Health Group, 2012).

The current data available about PPPs, both internationally and across all sectors, focus on global financial transactions and infrastructure projects. For instance, the Project Finance and Infrastructure Journal offer an estimation of 600 healthcare infrastructure assets and projects internationally, and a majority of them are PPPs (UNECE, 2016). This data offers remarkable understanding into the geographical scope and trends of PPPs in the healthcare sector, such as referral hospitals, health centres PPPs, which are operational, under development process, construction, and in pre-development stages.

More than 60% of the PPPs infrastructure identified by Project Finance and Infrastructure Journal global are in Europe; 15% from U.S.' whereas by comparison, Sub-Saharan Africa, North, and middle Africa, all joined comprises of less than 5% of PPPs projects globally (The Global Health Group, 2012).

Figure 2.8: PPP Health infrastructure by geographic region: 2017



Source: The Global Health Group. (2012). PPPs in healthcare Models, lessons and trends for the future. Healthcare public-private partnerships series, No. 4. Retrieved December 9, 2019, from globalhealthsciences.ucsf.edu:

2.19. Summary of the Chapter

Chapter Two rendered its approach in retrieving works of related literature about the role of PPPs in the Healthcare sector in Uganda. Previous studies indicate that PPPs improve care quality and healthcare service delivery through medical supplies, equipment, human resources and capacity building, and financing of the construction of hospital facility. However, the literature shows that since the introduction of PPPs in 2000, Uganda has experienced significant challenges within the different aspects of this partnership including difficulties in policy development and conceptualisation of the PPPs in healthcare, information sharing, resource mobilisation, and provision.

Chapter Two presented some literature on the role of Public-Private Partnerships in the Healthcare sector in Uganda. Moreover, the government of Uganda has received insufficient information about the importance of implementing PPPs to get relief from financial burden and low level of experts in the public sector. Thus, that presents a gap between the previous pieces of literature and the current study. Chapter Three presents critical success factors of PPPs in the health sector to attain improved quality care and healthcare services delivery.

CHAPTER 3

CRITICAL SUCCESS FACTORS OF PPPS IN THE HEALTH SECTOR

3.0. Introduction

Chapter Two discussed the Public-Private Partnerships (PPPs) concept as a strategic approach to supporting and strengthening government programmes and improving service delivery to the population. The literature includes the adoption of PPPs arrangement on a global scope and also in Uganda's health sector. PPP concept is embraced as a long-term contract between the public and private sector that establishes means for effectively delivering public goods and services, in which the private sector takes on all the risks and managerial roles. Consequently, this section has identified the critical success factors that influence the implementation and performance of PPPs projects and services.

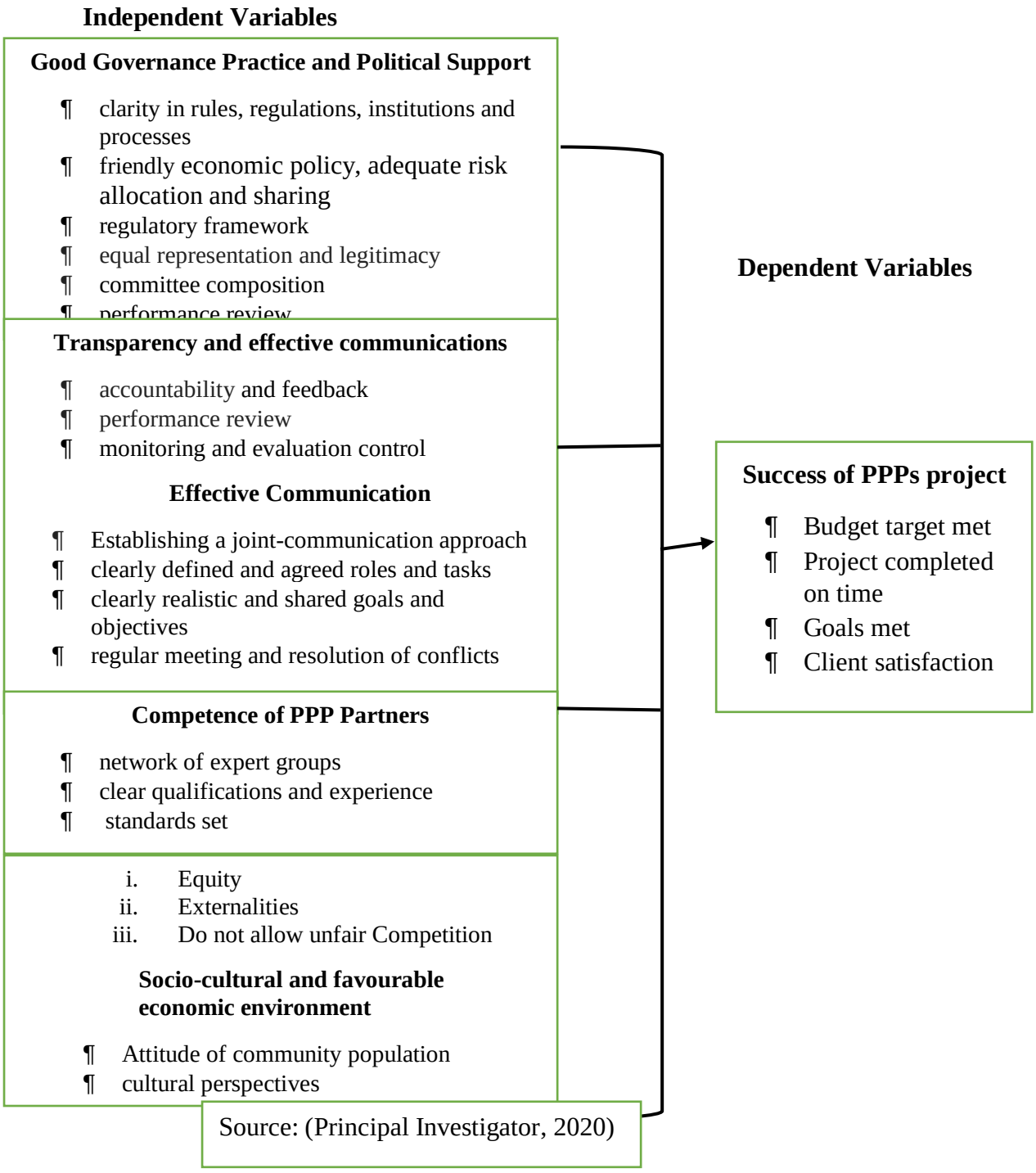
Governments across the world are increasingly embracing the concept of PPPs arrangement to deliver goods and services to the population (Cheung, Chan & Kajewski, 2012; Li *et al.*, 2005; Sanni, 2016). The term 'critical success factors' could be credited to Daniel Ronald, who invented and deployed the words in the 1960s (Chien, 2014). The term was later popularised by Rockart F. John of the MIT Sloan Scholl of Management in the 1970s, where he explained and published the term 'critical success factors' in a Harvard Business Review-Journal (Bullen and Rockart, 1981; Chien, 2014).

Since then, several authors have studied the influence of the term and implemented the concept in some fields, and most of them have assessed the idea on the PPPs to deliver works and services to the final user (Agrawal, 2010; Cheung, Chan & Kajewski, 2012; Chou *et al.*, 2012; Maosa & Muturi, 2019; Minnie, 2011; Sanni, 2016; Tang *et al.*, 2013; Wibowo and Alfen, 2014; World Bank, 2003). This chapter discussed and presents a conceptual framework of the term 'critical success factors' that influence the performance of PPPs in the health sector.

3.1. Conceptual Framework for PPPs Critical Success Factor

The conceptual framework demonstrates the relationship between the factors likely to influence the performance of PPPs, and the anticipated outcomes.

Figure 3.1: Conceptual Framework for PPPs Success Factor



The conceptual framework above demonstrates the key success factors as: - good governance practice and political support; accountability; transparency and effective communication;

competence of PPP partners; regulatory framework; equity in the process; externalities; Avoidance of unfair competition; economic policy and risk allocation; and socio-cultural and favourable economic environment as critical factors which significantly contribute to PPPs success.

This study suggests the best model that foresees these success factors, including socio-cultural environment and governance, as likely to influence the performance and success of PPPs in the healthcare sector. The independent variables of this study leverage the performance of PPPs which are operationalised by the 'critical success factors' as mentioned in the conceptual framework. In addition, the dependent variable is the performance and success of PPPs, which help both entities in determining the budget, meeting project schedule and expected goals, and measuring client satisfaction.

3.2. Why PPPs in Health Sector

In the last three decades, countries (low-income to developed-high-income), have engaged with the private sector in contracting long-term partnership projects in some areas, including energy, transport, and waste. However, healthcare PPPs have emerged more cautiously over the last two decades, starting from innovative ideas to revamp and improving hospital infrastructures; to delivery of both clinical services and non-clinical support services (Sekhri, Feachem & Ni, 2011). There is, therefore, currently no consensually-accepted definition of a PPP concept, and views regarding the engagement differ on what models are well thought out to be PPPs (Montagu & Harding, 2012).

However, the PPPs concept is widely being implemented to describe a means of long-term contact between the public and private actors, in which the two parties are involved in the delivery of public services. This long-term form of partnership generates an opportunity for both the public and private sectors to dynamically take the advantage of each partner's strengths to execute their mandates (Abuzaineh *et al.,* 2018). Although other forms of PPP project contracts are in play, such as contracting-out services and transferring public projects to private ownership, these engagements do not involve a collaborative, and long-term agreement between the entities.

3.2.1. The Core Principles and Drivers of PPPs

Table 3.1: Principles and Drivers of Public-private Partnerships

Long-term Contracting arrangements	The PPP arrangement is normally 15+ years, and or at least more than five years
Output-based Requirement	A contracting partner clearly defines all the required services
Transfer Risks	The public (contracting party) transfers the risks to the private actor
Value for Money (VFM)	¶ Costs are measured against conventional procurement ¶ The entire project budget costs and quality are combined to estimate VFM
Enter life-costing	¶ Long-term roles for creating operations and maintenance ¶ Focus on minimizing the project cost
Market Competition	The competition allows the public sector to access diverse innovations and will deliver the best outcomes

Source: (Abuzaineh *et al.,* 2018).

Table 3.1. shows the principles and key drivers of PPPs for successful performance. As a result, applying the above definition, most PPPs fall within the three key categories:

i) those PPPs that address the needs of health systems through construction and operation facilities, such as clinical services and non-clinical support services.
ii) PPPs whose focus is on establishing the provision of stand- alone clinical services.
iii) those PPPs that provide several clinical services wrapped with the construction of new and renovation of the existing infrastructure (Abuzaineh *et al.,* 2018).

Key Drivers of PPPs in the Health system

In the health sector, governments have focused on the idea of PPPs to address a wide range of health system challenges.

Table 3.2: Challenges in Healthcare System

HEALTH SYSTEM CHALLENGES	Budget investment and cash flow constraints
	The need for new and improved infrastructure
	Need for new and improved management skills to improve care quality and cost-effectiveness of healthcare delivery
	Need for robust and more effective procurement and supply chain
	Need for more skills and services, such as specialty services or expanded healthcare service capacity

Source: (Abuzaineh *et al.*, 2018).

Most hospitals and healthcare centres across the world are in poor condition, and facilities and services are poorly being managed and offered to the population. Nevertheless, many countries do not have enough budget to adequately fund new construction projects on a broader scope, and are limited by hiring and national policies that limit their capacity to effectively implement reform (World Bank Institute, 2012). By working in partnership with the private sector through PPP contracts, the government departments gain access to innovative practices, like advanced IT infrastructure and performance-based human resource management practices, which in turn allows the governments to explore capacity and efficiently improve provision of services to the population.

In addition, public and government ministries gain access to the new pool of financing sources that can share risk with the private sector. For example, under PPP engagements, the private actors usually take the risk for finances and timeframe, for the design and construction of projects, with payment pending until the facility or contract is fully complete and operational (Buse & Walt, 2000a; World Bank Institute, 2012). For the case of private sector actors, PPPs offer an opportunity to gain access to many new financial markets at a relatively lower risk margin, while contributing to the public goods and services.

Though the public healthcare markets usually provide a lower return on investment, they bring prospects to increase the scope and market share and enable the private sector actors to diversify their investment budget and service delivery portfolio (Abuzaineh *et al.*, 2018).

3.3. Critical Success Factors of PPPs in Health Sector

The available works of literature suggest and recommend several critical success factors that can effectively influence the performance of PPPs. These include implementing the strategies of good governance, accountability and effective communication, transparency, selection of competent partners, equity, open and fair competition, and process assessment of externalities (Cheung, Chan & Kajewski, 2012; Sanni, 2016).

3.3.1. Good Governance Practice and Political Support

Good governance refers to a process in which an organisation steers itself (Buse & Walt, 2000b; Rosenau, 1995). Generally, governance is comprised of the systems of standards, guidelines, institutions, and processes through which decision-making and power are executed. Good governance should have at least four sections, such as accountability, representative legitimacy, respect for due process, competence, and appropriateness (World Bank, 2003). In addition, organisational structure should have good governance which is based on rules, culture, and pillars, especially in decision-making processes to achieve accountability and transparency. Governance as demonstrated is an organisational indicator because it directs the institutional functions that improve accountability (Sanni, 2016).

The Norms and guidelines regarding governance demand that the organisational management should, therefore, execute its duties, focus on the organisation's mission, allow teamwork with the reflection to an individual input, establish control measures, be transparent and demonstrate a high level of integrity and accountability to achieve effective leadership and good governance (Maosa & Muturi, 2019; Zadek & Radovich, 2006). Besides, improved performance of PPPs needs a proper governance structure aligned to ensure that the objectives and goals of all the parties are being achieved, and there must be proper communications (Maosa & Muturi, 2019; Sanni, 2016). According to the approach of PPPs in healthcare, four partnership models of government have been recognised by the World Bank Group and they are:

The Non-governmental organisation (NGO) Model: under this model, the public actors offer resources, such as financial and organisational material to enable private players to effectively execute the public programme. A perfect example is that of the social marketing of condoms in Indonesia (World Bank, 2003). For instance, DKT Indonesia's intervention became an independent NGO social marketing in 1996. Over the years, the programme has expanded significantly, and it benefits over 5 million couples across the country. Currently, DKT

Indonesia is recognised as the largest private family planning health provider in the world, with its brand as Andalan, translated to mean a reliable product.

DKT Indonesia (Andalan) helps to reduce the maternal and infant mortality rate, and lower the rate of HIV infection through training and collaborating with midwives, and increasing the use of contraception in the world through a social marketing programme (Centre for Health Market Innovations, 2021). To increase coverage, DKT Indonesia partners with NGOs, including MTV, and other private sector players to train young people on sexual and reproductive health-related issues. Since implementation, their retail audits indicate that the Fiesta brand, for instance, has been a success, with an increased share of 10% condom market and increased overall market sales of the condoms by 22 %. Condoms are now identified as the effective method for preventing HIV/AIDS in the world. Young people recognise Fiesta as their brand (Purdy, 2006; Susanto & Rahmawati, 2016).

The Elite Committee Model: this model proposes that a committee is composed of members from partner organisations. There must be equal representation at all levels and all partners should be involved in the negotiations process and reach a decision through consensus. The model suggests that the committee does not simply implement the agreed decision, but enforces and influences their respective organisations to meet PPP objectives. For instance, Global Alliance for Vaccines and Immunization (GAVI) has established a steering committee approach that is based on this particular model, comprising all the key members and stakeholders from each partner organisation (World Bank, 2003).

The Catalyst Model: this model suggests that a catalyst organisation bridges the gap between the public and private sector, joining together the actors who would not usually work together. This catalyst, therefore, comes into play to coordinate, facilitate, conduct regular meetings, employ a local coordinator, and establishes a communication strategy (World Bank, 2003).

The Quasi-public authority Model: a well-structured organisation where both public and private actors feature designed by public sector players who should act within the interests of the public, providing goods and services, and enable the private actors to operate within the available market. For instance, the medicine for malaria venture is a perfect example of this model (Buse & Walt, 2000b). Notwithstanding the above models, to establish a suitable government model, Hayek Von suggests that the existing, and other governance models should be examined and be aligned with the objectives of all parties involved in the partnership (Hayek, 2001).

The structure of PPPs management performs the duties of the administrative function of such partnerships and is responsible for its actions (Minjire & Waiganjo, 2015). The Global Health Initiative indicates that the governance structure has to be aligned toward achieving the mission and objectives of the organisation (Global Health Initiative, 2010). Similarly, leadership combined with good governance produces a favourable atmosphere for organisation members to effectively operate (Brinkerhoff, 2002).

Therefore, to ensure the success of PPPs projects, top management must willingly get involved in the decision-making process. The best processes should be implemented during the recruitment process of new employees while considering the experiences and qualifications of these candidates. Such practices help to foster the identification of exemplary skills and talents, which leads to team retention and sustainable productivity (Maosa & Muturi, 2019).

Previous studies have found out that political support is also a critical success factor in the implementation of PPPs projects (Dulaimi *et al.,* 2010; Sanni, 2016). During the implementation of PPPs as a system of procurement, the citizens' and political leaders' support plays a vital role in the success of the partnerships. Whereas lack of citizen and political support could significantly affect the development and delivery of PPP projects.

In addition, social support should be aligned to contribute to the entire process and enable smooth management of the projects in terms of payments, and other assistance from the public. As a result, the citizen and political leaders are expected to conduct an in-depth assessment of the benefits and evaluation of project costs to determine the outcomes of the whole process (Sanni, 2016).

3.3.2. Accountability

The central role of PPPs is to harness private sector resources, including expertise and creativity for the interest of the public sector. This engagement allows the government to focus on its central role of designing and passing health policy frameworks and facilitating the delivery of high-quality care to the citizens (Quick, 2001). However, as PPPs deploy public resources and expertise, they become accountable to the public. Therefore, PPPs should indicate that public resources are being successfully utilised.

Consequently, these resources can be used to establish and implement a PPP project, when this engagement fails, the expenditure to the public, such as the opportunity expenses can be considered important. The time and other resources required can be easily underestimated, and overestimate the likelihood of success of the partnership. Effective monitoring and evaluation

of the process are central, and oversight and audit should be done by independent firms (World Bank, 2003).

The term ‘accountability’ is largely concerned with being thought responsible for your actions. With respect to a partnership, both public and private sectors should establish a proper mechanism of accountability. In the public sector, administrative structures report to the political system and heads, who in turn are accountable to the contestability of political authority. While the private sector, organisation management is held accountable to both stakeholders.

However, the issues relating to accountability within the PPPs may be less upfront, partly due to the gap between the PPP actors and the beneficiaries, and the duration needed to produce final results. In addition, partnerships whose division of labour and goals are ambiguously outlined will ultimately lack accountability. Besides, holding either public or private partners accountable brings some tough challenges. This is because the systems of sanctions that can be applied to careless partners seem not to be established and in play (Buse & Walt, 2000b).

Two mechanisms of accountability are being embraced among health global Public-Private Partnerships. In a model, the scientific groups and management report directly to the corporate sponsors. For instance, the Programme for Appropriate Technology in Health (PATH) that provides the secretariat for the Foundation of Bill and Melinda Gates Children Vaccine Programme, directly reports to Bill and Melinda Gates, who are the key sponsors. As a result, under this model, global PPPs are directly accountable and report first to their key donors, and only indirectly accountable to the public sector organisations and beneficiaries (Buse & Walt, 2000b).

In another related model, the management directly reports to the existing governing body that reports back to their respective administrations. Hereafter, the secretariat of the International Trachoma Initiative reports on a 6-monthly basis to its sponsors through the governing committee. Consequently, these reports are shared and discussed with the wider Trachoma Network, including the World Health Organisation for Global Elimination of Trachoma (Buse & Walt, 2000b).

However, there are variations in values and principles, in which the issues of governance and accountability are important, and need to be addressed at the recipient side. Limited involvement of the beneficiaries may hinder the whole idea of PPP contract. This is a limited representation of developing countries in Public-Private Partnerships could create questions of

how the international policy agenda is made, and how it is being implemented to address the development challenges to the recipient countries. Such questions can be answered by involving the beneficiaries in the issues of accountability and governance.

3.3.3. Transparency and Effective Communication

The efficiency of PPPs in the health sector is improved by ensuring transparency and effective communications (Buse & Walt, 2000a), as follows:

- clearly defined and agreed roles and tasks assigned to the responsible partner;
- realistic, achievable, specified, and shared goals and objectives;
- the perception of visible transparency in the face of the public;
- active 'maintenance' of PPPs, such as regular meetings, resolution of an existing conflict, etc. which may hinder the success of any partnerships;
- distinct benefits for all partners involved;
- equal participation; and
- honouring and carrying out defined and agreed obligations.

Both finances and protocols of PPPs are subject to certain public scrutiny. This means that if there are no transparent systems and careful attention rendered to the broader spin-offs from the PPPs, they are directly subject to the public criticism for being unethical and wasting public funds or even damaging (World Bank, 2003). Working within an industry-based system may generate new opportunities for dishonest and corrupt dealing.

According to Wheeler and Berkley (2001), public sector actors may need more effort and time in understanding their approaches to promise more resources to join than their private sector counterparts. Both public and private partners can be more willing to have everything they do to be the headline on the front page of any newspaper, and even in the media house news (World Bank, 2003). Establishing a joint-communication approach can sometimes be difficult but necessary for performance. The protocol of reporting a 'partnership' document and reaching a consensus on the final judgment of the product can relatively be difficult and slow. As a result, partners should be willing to agree to take the lowest share or public denominator in the interest of the partnership established to generate the public information (Ruchat & Dal, 2000).

3.3.4. Competence of PPP Partners

Public-Private Partnerships cause serious concerns about the competence and appropriateness of the engagement. As a public, obligation for health problems is transferred from WHO

arrangements to special global PPPs, it signals some critical concerns that the WHO programmes might fail to maintain a network of expert groups concerning these problems as it can help avoid duplicating the technical team maintained under the sponsorship of the PPP arrangement (Buse & Walt, 2000b).

For instance, the WHO Expert Committee on Biologicals, (a counsel which designed standards for vaccines) received serious criticisms in the 1980s on the practicability and standard levels set by the Organisation. The public critiques considered them unfit and irrationally rigorous because they were not benefiting the developing nation's industry, and also irresponsive to the demand of the industry (Buse & Walt, 2000b; Muraskin, 1995).

Therefore, to have an efficient and successful partnerships, the public sector should independently select its partners to cover the scope of market segments and actual coverage. This premise proposes that public and private sector organisations can join efforts to support several health programmes, such as disease prevention interventions if there is an agreed-shared benefit and a win-win situation (World Bank, 2003).

3.3.5. Regulatory Framework

The World Bank Group indicates that the regulations and guidelines that govern the implementation of PPPs need to be properly crafted and aligned to assist in delivering the projects successfully (World Bank, 2006). For instance, each country should develop a regulatory framework on PPP. That will attract and facilitate the private sector to invest easily in any sector of the economy to achieve the expected outcomes. The PPPs regulatory arrangement forms the foundation of success for organisational programmes. On the contrary, a weak national policy is a big hindrance and threat to the sector and business organisations in public procurement. There should be a proper legal structure that promotes integrity and transparency in the public procurement act.

Consequently, a good and responsive regulatory legal framework promotes healthcare delivery to the population (Maosa & Muturi, 2019). This means that the role of friendly regulations is meant to protect individuals, and allow them access to improved healthcare services with fair costs. One of the goals of these regulations could be to set standard practices as a measure of desirable quality. In addition, apart from supply chain regulations and guidelines, the legal structure in a broader perspective affects all the processes relating to the implementation of PPPs.

Favourable policies enable the resourceful and effective working of PPPs by making sure they work within the set rules and guidelines, free of interferences from the top political leaders (Maosa & Muturi, 2019). Consequently, it ensures that the PPPs are adequately and accurately financed and accompanied by integrity through effective processes in reaching final decisions (Organisation For Economic Co-Operation And Development, 2012). In an event of monopoly arrangement, private sectors seek to exploit the consumers especially if the policymakers do not establish proper control measures that can block them from manipulating the final beneficiaries.

Consequently, PPPs come into play to design, and the private sector organisations come in to play a vital role in protecting final users of the health facility, and on the other hand, consumers advocate value for money from the public sector. This requires all the partners, including stakeholders and regulators involved to ensure this role with consistent consultation, establish project design, and implement monitoring and evaluation processes to ensure compliance with the policies (Maosa & Muturi, 2019).

The 2008 International Monetary Fund (IMF) report indicates that suitable and effective legal framework assists establish the best rules and pointers for undertaking PPPs projects and requiring progress for individual actors, whose arrangement and agreement is honoured. When there is openness in the established policies, rules, and regulations, and free from any kinds of interferences, there is minimal risk that might be exposed to the private sector actors in the partnership deal (Maosa & Muturi, 2019).

Accordingly, a PPP project is a contract that needs a suitable and sound legal focus to help achieve the goals of this partnership. This is one of the key components because sometimes trade unions tend to oppose PPPs engagements since there is fear for some of their members to lose the terms of the contract. Dispute resolution approaches are equally aligned under the regulatory structure (Maosa & Muturi, 2019).

3.3.6. Equity in the Process

One of the central reasons for establishing PPPs is to address the problems related to equity and thus should not be implemented against that but through unsuitable market subsidies and interventions. Private market interventions often offer affordable goods and services to the final consumers (Widdus, 2001). For instance, the Roll Back Malaria programme supports the systems to subsidise mosquito insecticides or nets, or even both for the poor and vulnerable communities. Therefore, a PPPs project should establish a suitable strategy to ensure equity in

the process and at all levels especially when public support has been provided with the primary aim of helping the vulnerable population (World Bank, 2003).

3.3.7. Externalities

Externalities are broadly considered as the pillars of the benefits or harms beyond the anticipated objectives of the PPPs project. For instance, the positive externality in treating and managing any communicable diseases is that it affects the whole population of the community rather than the individual service consumer (Smith, Brugha & Zwi, 2001). Other externalities may include both positive and negative externalities: positive externality refers to the benefits and values generated from any economic activities which are experienced by the community (Pigou, 2017).

Notwithstanding the economic benefits and values, the externality also causes market inefficiencies. Positive externalities are categorised as production and consumption externalities, and they include infrastructure development, Research and Development, vaccination, and individual education, etc. The positive effect of activity is imposed on an unrelated third-party (Varian, 2010).

On the other hand, a negative externality imposes negative consequences due to any economic activity on an unrelated third party (Goodstein, 2014). Most externalities, including environmental and air pollution, are practically harmful to the unrelated third party due to their adverse effects, and these include water pollution, noise pollution, and air pollution. Some key examples of negative externality include passive smoking. It produces negative health effects not only on the smoker but also on the health of other people (Pigou, 2017).

The GAVI's programme to reduce the mortality rate from vaccine-treatable diseases in most developing nations will greatly help the big population with affordable healthcare services and products which lead to improved quality of life. In addition, PPPs may bring a negative impact on the employment and income of the local community particularly when the local markets are not stable. More importantly, the World Bank Group recommends that all externalities need to be cautiously assessed when designing and implementing PPP interventions (World Bank, 2003).

3.3.8. Avoidance of Unfair Competition

Some PPP projects may produce unplanned outcomes. Unfair competition, and reduced sustainability, and thus become challenging when public funds are released to subsidise goods and services that are already in the local market. The World Bank indicates that in Indonesia

for instance, high subsidised condoms dominated the condom market, and thus generated huge benefits of support from the public sector.

The subsidised condoms demotivated the commercial industry and resulted in diminishing the brands of the local condom from the market. Likewise, related impacts were registered with the NetMarks project for the marketing of subsidised mosquito bed nets. Consequently, a PPP arrangement should explore how marketing and subsidy will impact the local industry and the sustainability of the PPPs (World Bank, 2003).

3.3.9. Economic Policy and Risk allocation

The economic policy and risk allocation of PPPs success factor are comprised of three subsectors, such as appropriate economic policy, adequate risk allocation and sharing, and meeting the primary aims of the partnership (Sanni, 2016). The assessment and management of possible risks associated with the PPPs are central to the project's success (Chou *et al.,* 2012; Cheung, 2009; Li *et al.*, 2005). Consequently, the public sector must ensure that there is an appropriate risk allocation to the competent party that is well-suited to manage such risks.

Moreover, one of the most critical factors for the PPPs project success, is the availability of a strong economic policy by the political elites and policymakers. This factor guides the design and growth of the economy and offers a conducive environment towards the implementation of the PPPs projects. As a result, if there is such a favourable environment, then the aims of the PPPs can be easily achieved. These goals could be considered as successful developments for the public sector while allowing the growth of profits for the private sector actors (Sanni, 2016).

3.3.10. Socio-Cultural and Favourable Economic Environment

A 2005 World Economic Forum report indicates that PPPs are widely considered and being implemented as a contracting approach for government and private actors. The forum shows that collaborating with private partners can produce remarkable results, including improved access to healthcare services (Lopez-Claros & Zahidi, 2005) In the present times, PPPs have been implemented to address some health-related challenges, but not limited to Malaria, Ebola, Tuberculosis (TB) and the HIV/AIDS pandemic, etc. In addition, some African countries have incorporated patterns to increase the availability and accessibility of prescribed medicine that assists them in managing the occurrence of diseases (Maosa & Muturi, 2019; Lopez-Claros & Zahidi, 2005).

The review of successful implementation of PPPs projects indicated that the effective deliveries of the contracted projects in countries, such as Australia, Hong Kong, United Kingdom, Malaysia, Singapore, and South Africa (Cheung, Chan & Kajewski, 2012; Hwang, Zhao & Gay, 2013; Ismail, 2013; Li *et al.*, 2005; Wibowo and Alfen, 2014; World Bank, 2003) were attributed to the favourable economic environments. The available works of literature show that both local and international investors were directly attracted to the countries mentioned above because they knew their operation of work was going to be protected under the available legal framework and regulations and that they could easily get justice from the court of law, should there be any violations of their rights in one way or another (Sanni, 2016).

In addition, other related literatures have identified the key factors of success as follows: economic strength, reliable technical knowledge, supportive environment for investment, and sharing of information and the problem with a well-experienced entity to handle it. Also, openness, effective communication, adequate planning are all features of prosperous partnership (Maosa & Muturi, 2019; Zhang, 2005). Likewise, collective planning and operational functions, sacrifice and belief, participation, and appreciation are key success factors for PPPs projects (Lambert *et al.*, 2006).

On the other hand, Ismail and Ajija carried out a study in 2003 and identified success factors on PPPs practices in Malaysia. The study indicates that suitable practices of these parameters include sustainable economic policy, adherence to the principles of good governance, technical knowledge, supportive legal framework aligned with the PPPs programmes, socio-economic environment, and open supply chain management are significant in the project's success (Ismail & Ajija, 2003).

3.4. Chapter Summary

This chapter identifies and discusses different critical success factors that influence the performance of PPP contracts. These success factors are including, good governance practice and political support; accountability; transparency and communication; competence of Public-Private Partners; legal framework, equity, externalities, fair competition; economic policy and proper allocation of risk; and socio-cultural and favourable economic environment as critical success factors, which when addressed well could contribute to the successful implementation and performance of PPPs.

However, the successful implementation of PPPs would only be due to a favourable environment. To achieve the goals, a favourable environment should be supported with the

willingness and support from both public and private sectors' actors. However, when both parties have little or no experience working together, it will require considerable resources, including time to establish honesty, integrity, trust, and understanding.

PPPs arrangement must be based on a win-win partnership, where all parties involved have an equal opportunity and interest in executing mutually agreed upon project goals. The health sector may need to be supported with key incentives which could facilitate and speed up the partnership processes and ensure sustainability engagement without losing public support. Thus, both public and private sectors should trust each other. The proceeding chapter discusses the health PPPs business models that have been used in the healthcare sector in furthering the delivery and financing of health programmes.

CHAPTER 4

AN ANALYSIS OF HEALTHCARE PPP BUSINESS MODELS

4.0. Introduction

Chapter Three discussed the Critical Success Factors that influence the implementation process and performance of healthcare PPP projects and services. This chapter focuses on examining the healthcare PPPs business models that have been used in the healthcare sector in furthering the delivery and financing of health programmes. Some of the PPPs models operate differently in the private sector in terms of funding, risk allocation, and management, ownership control, technical collaboration, project duration, investment approach, tax arrangement, management of cash-flows, etc.

Accordingly, this chapter identifies and discusses different healthcare PPP business models being used to address the healthcare challenges and speed up the development and improvement of the health sector. Governments worldwide continue to face a broad range of multifaceted healthcare challenges fueled by ever-increasing demographics, rising healthcare costs, rapidly growing medical technologies, and an increasing burden of chronic and endemic diseases (Cheung, Chan & Kajewski, 2012; World Bank, 2003).

Healthcare systems across the world are increasingly struggling and strained with how to increase access, and high-quality healthcare products and services, while delivering affordable care. These challenges need to be addressed if the governments and international development agencies, including World Health Organisation, want to embrace the Universal Health Care Coverage (UHCC) and realise the Sustainable Development Goal three (SDG3) that is in place to promote well-being for all, at all ages by 2030 (Abuzaineh *et al.*, 2018; UNDP, 2020).

To successfully achieve the UNs SDG3, Governments should at all levels implement the concept of PPPs and identify the best models to attain a Universal Health Coverage (UHC), to deliver affordable and high-quality healthcare services to the population (Ataguba & Marie-Gloriose, 2016; World Health Organization, 2019). PPPs concept is implemented as a mutual agreement between the government and private sector actors (Naoum, 2003), who join with the primary goal of providing public infrastructure, community-based facilities, goods, and services (Levai, 2012). The Public-Private Partnership is established as a long-term collaboration characterised by sharing the responsibilities in terms of investments, risks allocation, and benefits for both actors involved (Abuzaineh *et al.*, 2018; Buse & Walt, 2000a; Great Britain Treasury Taskforce, 1998; Naoum, 2003; World Bank Institute, 2012).

The long-term partnership ensures project financing to improve the quality of services, which directly benefits the target population. PPP arrangement involves strategic planning, implementation, and maintaining of public infrastructure, with the cost-effective mechanism of delivering better and long-term public services to the citizen. Public and private sector players can agree to mobilise necessary resources, and voluntarily bring their resources such as human resources, and material, finances, among others. This enables both parties to have a bigger pool of necessary resources and share possible risks, which may not be managed by a single party. Therefore, PPP collaborations are implemented to ensure long-term and sustainable provision of goods and services.

4.1. Overview of PPP Business Models

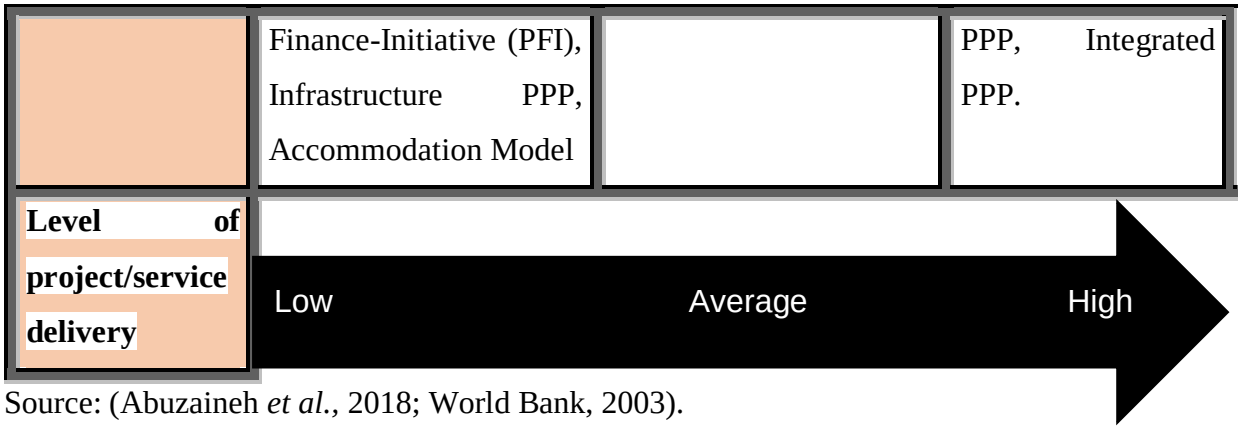
The term PPP 'Model' has been recognised as a suitable and desirable alternative for improving and delivering infrastructure projects and services (Pagoni & Patroklos, 2019; Yu *et al.,* 2018) in Australia, China, the United Kingdom, Spain, and the United States (Abuzaineh *et al.,* 2018; Hodge & Greve, 2007). PPPs model has been established on a wider scale in the field of environmental and urban governance, transportation and energy, gas, oil, and the mining sector (Liang *et al.,* 2019), the garbage and waste disposal sector (Wang *et al.,* 2019), in the reconstruction of buildings (Yang *et al.,* 2019), in electric vehicle charging infrastructure (Zhang *et al.,* 2018), and the housing delivery (Chen *et al.,* 2020). The model has proven to help governments across the world to achieve their economic goals and increase the level of the public services (Heurkens & Hobma, 2014; Raman, 2012).

4.1.1. The Three Common Health PPP Models

There are three common Healthcare Public-Private Partnership business models that have been mostly adopted across the world as demonstrated in the table below:

Table 4.1: The three common Health PPP models adopted by governments

Health PPP Models	**INFRASTRUCTURE-BASED MODEL**	**DISCRETE CLINICAL-SERVICE MODEL**	**INTEGRATED PPP MODEL**
Components of PPP Models	**Financing** + **Infrastructure** + clinical support services and non-clinical services	Clinical services	**Financing** + **Infrastructure** + clinical support services and non-clinical services
Private-partners Responsibilities	Here a private actor is given a contract to design, build, finance, and maintain (DBFM) healthcare facilities. Provision of non-clinical services can be covered here, such as cafeteria and laundry. Some advanced PPP projects include the provision of clinical support services like lab, radiotherapy, radiology, and chemotherapy.	Under this model, a private actor is contracted to provide discrete clinical services, such as specialty health care services and clinical support services	Here a private actor is contracted to design, build, finance, and operate (DBFO) healthcare facilities and provide clinical and non-clinical support services.
Common PPP Model	Design-Build-Finance-Maintain (DBFM), Design-Build-Operate-Transfer (DBOT), Design-Build-Finance-Maintain-Operate (DBFMO), Private-	Operation and management (O&M) contracts	Design-Build-Operate-Deliver (DBOD), Public-private Integrated Partnership (PPIP) Alzira model, Clinical Services



Source: (Abuzaineh *et al.,* 2018; World Bank, 2003).

Most of the infrastructure-based PPPs combine these functions into three best models:

Infrastructure-Based Model: - a contracting partner builds or renovates public healthcare facilities.

Discrete Clinical-Service Model: - the private partner expands and improves the capacity of healthcare service delivery.

Integrated PPP Model: - private sector takes on the role of providing a more comprehensive package of healthcare infrastructure and service delivery.

4.1.2. Characteristics of common Health PPP Models

Health PPPs generates several opportunities to influence private sector expertise and resources to enable budget investment in more large-scale projects that improve local public and national health goals, such as improving the quality of healthcare service delivery (Chen *et al.,* 2020), and increasing access to care and affordability of healthcare services (Pagoni & Patroklos, 2019). During the past years, governments, all over the world have engaged the private actors or investors to deliver quality services through PPPs healthcare (Abuzaineh *et al.*, 2018; Pagoni & Patroklos, 2019; Yu *et al.*, 2018), to achieve some functions as follows:

Design: this entails the design of the project, including the design of the facility and healthcare delivery model.

Build: this feature requires the private sector to take on the role of construction or renovation of healthcare facilities covered in the project.

Finance: the private sector assumes the responsibility of financing or co-financing the project.

Maintain: this entails the maintenance of a health facility and equipment as well.

Operate: the private sector takes on the role of supplying required equipment, including IT equipment, and delivery and management of non-clinical support services.

Deliver: management and delivery of required clinical services and non-clinical support services.

The decision by a government to pursue a certain PPP model is largely driven by local public needs and the environment, which includes but is not limited to social and political factors. The responsibility and level of risk which the government seeks to transfer, that the private actor is willing to take on, are also key determining factors (Pagoni & Patroklos, 2019).

4.1.3. PPP Design and Tendering Process

PPPs in healthcare brings complex tasks which require an in-depth analysis of a broad-range of factors, like national and local healthcare needs, requirements and funding sources, community and political acceptance for transferring roles and accountability to a non-public entity (Raman, 2012), investor desire for a certain sector, and government capacity to manage the contractual risks of the transfer (Abuzaineh *et al.,* 2018).For instance, the tendering process is not an event, but goes through six (6) different stages, 1) advertising the requirement, 2) selection stage/ pre-qualification, 3) evaluation of selection stage, 4) invitation to tender, 5) evaluation of the tender submissions, and 6) award contract to the best bidder. Advertising of the tender requirement can be done through the newspaper, e-portal, organisation website, trade publican, and other platforms, like social media and radio or television.

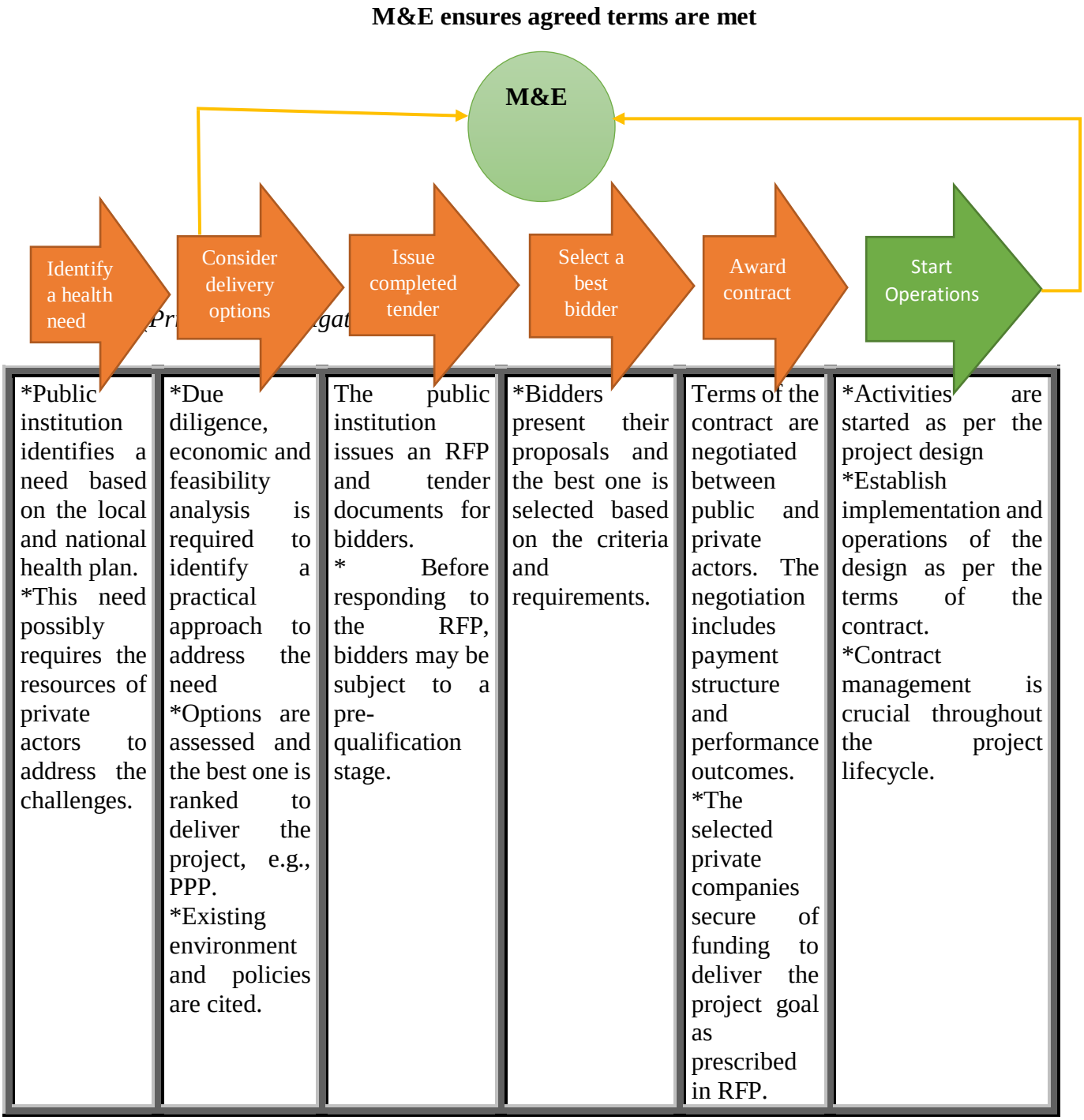
Under the selection stage, all bidders are requested to submit their documents online within a specific timeline. This is intended to collect relevant information relating to the company/ individuals bidding to ensure that they meet the minimum standards to allow the contractors or government to ensure that the bidding company is capable to meet its requirement. It also helps to advance the tender process for comprehensive and fair evaluation to shortlist the companies for the invitation to the tender stage. Selection stages help to assess the capacity, capability and experience, and qualification of the team. Evaluation of selection stage is conducted to evaluate the submissions to ensure that bidders progress for further evaluation of their tender submission or to shortlist and select the bidders who meet the project requirements to the invitation to tender, and the decision is communicated to the bidders (Abuzaineh *et al.*, 2018; Raman, 2012).

Invitation to tender may be open to all bidders (can be a single or open-stage process) where information about selection and tender are combined and communicated to only bidders who passed the selection stage. Under this stage, bidders are required to complete online

questionnaires and provide supporting information. Invitation to tender assesses the offer and the project requirements as outlined in the specifications, and these include instructions to tenderers, specifications, pricing, contract conditions (terms and conditions), tender evaluation approach, and supporting documents depending on the tender requirements. Evaluation of the tender documentation is done by a team, known as an evaluation panel (Mudjanarkoa, & Ogunlana, 2015; Odhiambo, 2019).

Finally, the award of a contract requires that all bidders that participated and submitted their tender documents are informed about the decision to award the contract via the e-tendering portal or through email. The decision letter includes the detail about a successful bidder or winner(s) and how they performed. The bidder who did not succeed may be allowed to complain or air out their concern about the decision. This is done to ensure transparency, and the award notice may be published on the public e-tendering portal (Abuzaineh *et al.*, 2018).

Figure 4.1: Illustrates a typical Health PPP Project Lifecycle



Since PPPs have complexity in terms of legal and financing requirements, private projects are usually managed and supervised by the governments at all levels depending on how a public healthcare system is structured. For instance, projects or services designed based on the Integrated Healthcare PPP model or infrastructure-based Healthcare PPP model, once the design and construction are complete, the private actor is held accountable for maintaining the

health facility and has the opportunity to bring in new clinical services and non-clinical support services. For example, typical non-clinical support services include ground maintenance, utility management, cafeteria, and housekeeping services (Raman, 2012).

Similarly, medical or clinical services include laboratory services, imaging, surgery, disinfection, rehabilitation, and sterilisation services. For public projects utilising the Discrete Clinical Services as well as Integrated Healthcare PPP models, the Private sector players may be assigned with the responsibility of providing specialty clinical support services, such as dialysis services through comprehensive, and specialty health care services. Under these models, the private sector is responsible for managing the functions of human resources, including staffing and human resource management for the services it offers.

The key characteristic of PPP models in the healthcare sector are that all PPP services and facilities are returned to government control at the end of the contract. This is done to ensure that the government continues to operate within the environment of having better services throughout a contract completion and that the constructed health facility is maintained and delivered as agreed in the terms of reference (Abuzaineh *et al.*, 2018).

4.1.4. The PPPs Tendering Process

For the best process of tendering, once a project has been realised it is expected to recognise and comply with the existing national PPP rules and regulations governing the partnership arrangement, and is assumed to be affordable and possibly lead to the anticipated results compared to other options; the line-ministry is given a green light to petition the private actors' interest over a competitive bidding process. In order to attract several responses from a pool of competent tenders, and to increase competition and unique innovation within the proposals, the government plays a central role in managing the whole tendering process to be transparent as much as possible (International Finance Corporation, 2015).

Some tenders call for separate financial and technical proposal documents. Since it is a part of the PPP bidding process, interested bidders need to state financial requirements in their response, indicating a project with fewer risks that secure a lower cost of debt. Based on the framework and services (terms of reference) stated in the tender documents, interested private entities (also known as a consortium of private entities) will probably come together to bid on the project (Abuzaineh *et al.*, 2018).

In some instances, the tender may state the inclusion criteria of competent private entities. For example, in the Integrated Healthcare PPP model adopted in Lesotho (Downs *et al.*, 2013), the

government requested interested bidders to include local organisations as a part of the private structure of the contract, and that equity funding within the private consortium moves to the local partner's overtime.

In most cases, the private sector players that respond to a bid create a new, separate contractual plan, known as Special Purpose Vehicles (SPVs) to act as the pivotal point of contact to represent the shared interests of the private entities, and collaborate with the government to deliver the project. SPVs are essential in financing the business project where money lenders are dependent on the cash-flows of a project (Downs *et al.,* 2013). Similarly, the SPVs are established specifically to execute project activities and serve as the legal entity to subcontractor work together with several private parties within the consortium, to accomplish some features of the contract (Abuzaineh *et al.,* 2018).

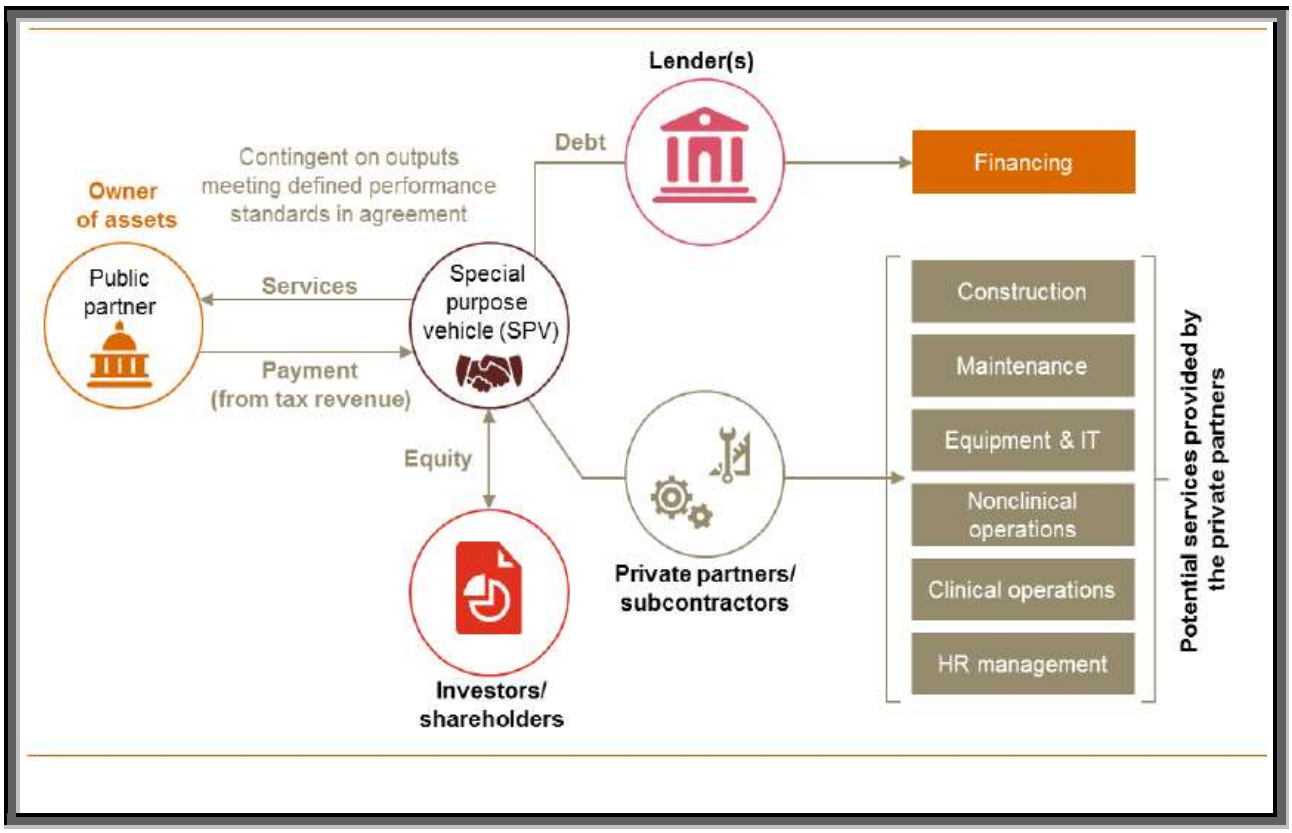
As a PPP arrangement feature, the SPVs commits to the crucial project terms and conditions, which normally include pre-determined data for completion of any design and execution of stated activities, as well as the anticipated outcomes, and quality measures for any products or services to be delivered during the PPP contract term. Under a traditional procurement arrangement that involves several entities, the government is requested to contract with each party separately.

Consequently, a PPP bidder that uses an SPVs contract offers a potentially less risky and much simpler management approach for the government, by minimising the contract numbers which the government can efficiently manage (The Canadian Council for PPPs, 2011). To be successfully persuasive, therefore, it is more crucial that the bid response clearly states how the SPVs will leverage the capacity and effectively manage the performance of its parties involved to deliver the anticipated project requirements. As a result, it places the mandate back to the government to clearly define and state project needs in the tender documents (Raman & Bjorkman, 2009).

SPVs also termed as Special Purpose Entities (SPEs) are key elements of the project finance structures and several PPPs. They are known as legal entities established to fulfil clearly stated objectives associated to a specific investment of a project. Moreover, SPVs or SPEs are formed to allow other investors to share the likelihood of project risks, craft and bring in more technical and management support, and protect both the lenders and investors' interests. They are usually barred from conducting any form of business outside the stated project. In an instance where one party can deliver all the stated goods or services for the PPP (as it is for the case with some

Discrete Clinical Service PPPs), an SPV is not necessary (The Canadian Council for PPPs, 2011).

Figure 4.2: A Typical Structure of a Health PPPð Special Purpose Vehicle (SPV)



Source: (Abuzaineh *et al.*, 2018).

Figure 4.2 shows a pictorial representation of a tendering process of a Healthcare PPP—Special Purpose Vehicle (SPV). The figure is built to help avoid project-related financial risk. The SPV is implemented particularly in limited situations, where lenders depend on the project's cash flow and security against its assets as the available means to repay the debts.

4.1.5. Sharing Risk and Reward of PPP Project

One of the key criteria and characteristics that contribute to Healthcare PPPs success includes the proper allocation of duty (balanced risk-sharing) between the public and private actors. Any form of risk transfer must be properly managed by the partner as stated in the contract (Abuzaineh *et al.*, 2018). In terms of risk, the two parties can negotiate the sharing of risk between them. The host country must have a legal framework that explains the sharing of risk between the private company and the host government. The likelihood risk to occur within the PPP project usually falls into three main categories:

- ¶ Planning-design and construction risk
- ¶ General and financial risk requirements
- ¶ Operating risk-related roles such as clinical performance

The main goal to transfer most of the risk for financing and construction to private sector players is to allow the public partner to mitigate the likelihood of project delay or failure due to financial constraints. Therefore, by transferring operational risk, the public sector has the opportunity to achieve improvements in services and cost efficiency through contract and performance control. Under a PPP project, both the public and private partners use several tools and payment mechanisms to control and manage these risks; and it also helps the public, to manage performance and cost (Raman, 2012).

Table 4.2: Typical allocation of Responsibility and Risk across three Health PPP Models

Risk Type	**Infrastructure-based PPP Model**	**Discrete Clinical Service PPP Model**	**Integrated PPP Model**
PLANNING / DESIGN RISKS			
Planning and Land acquisition	Public	Public	Public
Design	Shared	Private sector	Private sector
Changes in proposals/ planning	Varies	Varies	Varies
DESIGN CONSTRUCTION RISKS			
Construction	Private sector	Private sector	Private sector
Cost Overturns	Private sector	Private sector	Private sector
Completion Delays	Private sector	Private sector	Private sector
Latent Defects	Varies	Varies	Varies
GENERAL RISKS			
Force Majeure	Shared	Shared	Shared
Changes in guidelines/legislation	Shared	Shared	Shared
Financing	Private sector	Private sector	Private sector
OPERATING RISKS			

Operating and Maintenance Costs	Private sector	Private sector	Private sector
Equipment	Varies	Private sector	Private sector
Demand for Services	Public	Public	Varies
Clinical performance failure	Public	Private sector	Shared
Labour and staffing issues	Public institution	Shared	Private sector

Source: European Commission. (2013).

In the event of possibility high-cost of PPPs, specifically for those that incorporate construction or renovation of healthcare infrastructure, the government should assess and establish the financial implications of the projects as early as possible. This may include a clear understanding of revenue drivers, expenditures, and operating costs. Financial planning is crucial criterion needed to ensure the availability of existing revenue channels to cater to the essential payments from government associated with the designed project.

Most countries anticipate that planned PPP projects undergo sequences of reviews before offering a tender, to produce position with legal structures and deliberate plans, and to assess both the costs and anticipated benefits of the project. The motivation for these reviews is to help mitigate probability financial risks for the projects that experience delays or defaults in government payment arrangements, which can greatly impact potential banks and investors' interests.

Some countries collaborate with external consultants to support them in controlling and managing a wide range of issues associated with the project shaping, financing, procurement, and risk assessment. Several countries, Turkey, for instance, apply more mechanisms, including a liability statement, whereby the government commits itself to be responsible for the obligation of the private partner in case the contract is terminated as a means of offering guarantees to lenders or banks (UN Economic and Social Commission for Asia and the Pacific, 2011).

4.1.6. Payments and Penalties Involved in PPP Arrangements

Public-Private Partnership contracts apply a direct relationship between performance and payments. Amounts of payment, timeframe, and effectiveness are employed as project tools to

incentivise the private actors and align features with the anticipated outcomes. For instance, payments to release to private actors usually fall under four dimensions:

Payment penalties: - refers to the delay or reduction in payment if terms of the contract and projected requirements are seemingly not realised.

Service payment: - these are payment variables are based on the volume and type of services provided.

Capitation: - payment variables on an individual basis designed to control and manage the overall health of the community population.

Availability of payment: - this refers to project payments meant for maintaining and making the healthcare facility available to the service provider. This is usually a fixed payment and covers the facility cost and overall maintenance.

PPP arrangements usually state a single payment mechanism to cover all the expenses including infrastructure and services offered. Often, a mixed type payment channel is utilised to distinguish between the infrastructure portion and available costs of service delivery. Generally, the public partner may not make any amounts of payments until the key terms and conditions of the contract are satisfactorily met. This engagement encourages the private sector actors to ensure that the project activities are completed on or in time as may be stated in the contract, and meet quality and performance standards clearly stated (Abuzaineh *et al.,* 2018; Initiative For Social And Economic Rights, 2019).

PPP projects that cover clinical support service delivery involve some complex arrangements in terms of payments and amounts connected to delivering healthcare services across a large community population and realising improved clinical outcomes. For instance, the Integrated Health PPP model adopted in Valencia—Spain is grounded on a capitated imbursement contract, whereby the government pays the private actor an annual per-capita fee to provide an agreed set of healthcare services to populations of a certain geographic location, irrespective of how often the citizens utilise PPP services (Abuzaineh *et al.,* 2018).

Service payments are calculated and released based on the size of the population covered and served, and the private sector is incentivised to provide healthcare services in a manner that advances the clinical outcomes of the whole population to minimise care cost and patient visits to the hospital. Consequently, this form of PPP arrangement transfers the risk of managing service demand from the public to the private parties. Moreover, it places a more considerable

burden on both partners that forces them to become more precise in identifying and setting possible goals for performance indicators (PwC, 2008).

4.2. Focus on the Three most Common Healthcare PPP Models

The following subsections offer a deeper discussion and understanding of the three common healthcare PPP models, analysing their objectives and structure, implementation process, and lessons learned.

4.2.1. The infrastructure-based Health PPP model

Table 4.3: An infrastructure-based Healthcare PPP model

Healthcare PPP Model Components	**Infrastructure + Financing + Clinical services and non-clinical support services (so essential in a healthcare system)**
Private Sector Responsibilities	The private actor is contracted to design-build-finance and maintain healthcare infrastructures. Provision of non-clinical support services like (cafeteria and laundry, etc.) may be covered. More improved PPP projects can cover clinical support services like (laboratory services, radiology, chemotherapy, etc.)
Other Common Healthcare PPP models	Design-Build-Finance-Maintain-Operate (DBFMO), Design-Build-Finance-Maintain (DBFM), Design-Build-Operate-Transfer (DBOT), Initiative-Private Finance (PFI), Accommodation Model, Infrastructure PPP Model (Adhikari, 2019; Kurniawana, Mudjanarkoa, & Ogunlana, 2015; Odhiambo, 2019).
Implementation and Examples	The most common healthcare PPP models are globally implemented. The British Initiative Private Finance PFI healthcare model is a highly-cited example of all

Source: (Adhikari, 2019; Kurniawana,, Mudjanarkoa, & Ogunlana, 2015; Odhiambo, 2019).

Table 4.3 illustrates an infrastructure-based healthcare PPP business model implemented between the government hospitals and private contractors to deliver quality and timely health services to the population.

4.2.2. Objectives of Infrastructure-based Health PPP Model

The infrastructure-based Healthcare PPP model aims to improve the care quality and efficiency of the delivery of both clinical and non-clinical support services. This is achieved through either building new or renovation, and or expansion of the public healthcare facility, such as hospitals, primary health care clinics, and outpatient health centres, possibly in a short timeframe. In addition, the infrastructure-based Healthcare PPP model participates in increasing the capacity and quality of public healthcare infrastructure to provide better and affordable care services. The model also helps the governments to increase access to the required capital to finance their cited-out infrastructure projects.

4.2.3. How the Infrastructure-based Healthcare PPP Model Works

Under this PPP model, the private sector or private company is given a contract to design, build, renovate or replace a public infrastructure, and is responsible for maintaining the facility throughout the lifecycle of the project contract. In more revised and improved ways of an infrastructure-based model, the private actor is also contracted to manage, and provide some clinical services and non-clinical support services. The contracts of this model are typically long-term, at least 15+years, (Abuzaineh *et al.*, 2018; Savas & Savas, 2000), and the private actors are responsible for the following:

Design: the requirements and deliverables are set by the government

Build: the private partner is contracted to construct a new facility or renovate the existing one.

Finance: the private sector is accountable for funding or co-funding the project.

Maintain: maintenance of health infrastructure and existing equipment.

Operate: this involves supplying required equipment and management of non-clinical support services.

The infrastructure-based healthcare PPP model is broadly adopted across the world, and it has many variations, such as management support services, maintenance of facility and equipment, IT services, and delivery of clinical services. In most cases, if not all, the government is responsible for managing and delivering clinical support services. The government usually shifts management roles for facilities and land to the private sector actor throughout the contract lifecycle. However, all infrastructures are handed over to the government at the end of the contract or after fulfilling the contract (Adhikari, 2019; Mudjanarkoa, & Ogunlana, 2015).

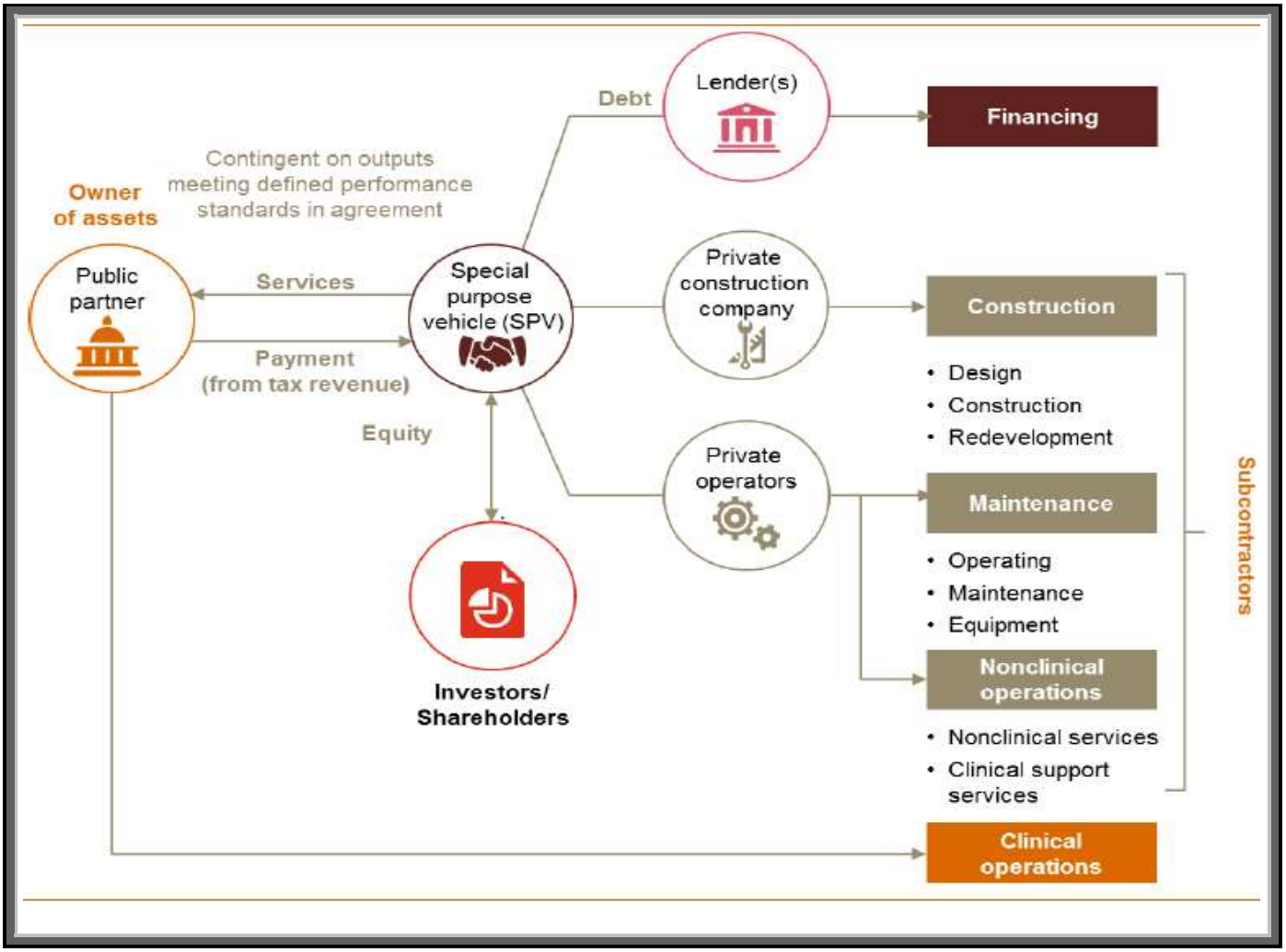
Under normal circumstances, the private company partner is responsible for the design risks and construction of the new facility, cost overruns, delay in anticipated project completion, and costs of maintenance. Since several payments are done under this model upon project completion (usually between a 18-to-24 month period after the contract is initiated), the private company is incentivised to complete the construction of a new facility or renovation of the existing one on time and within the allocated budget. Furthermore, since its capital finance is at risk, the private sector actor has reliable incentives to continue supporting the project contract up to its completion (Abuzaineh *et al.,* 2018).

The government repays the private investors for the construction or renovation of the health facility through an amortized annual payment throughout the contract lifecycle, coupled with an annual contract payment for maintenance. This enables the private sector partner to wisely use the advantage of long-term debt funding opportunities and thus making the project more cost-friendly for all parties involved in the contract (European Commission, 2013). Most PPP projects that provide non-clinical support services into the contract, directly shift additional risks and roles to the private sector players for these operation services and cost maintenance ((Abuzaineh *et al.,* 2018).

On the other hand, non-clinical support services sometimes include utilities, housekeeping, services, reception, ground maintenance, catering, laundry, parking and waste management services (Sekhri, Feachem & Ni, 2011). Since most of these expenses can be measured, and thus quantified, they are typically covered through a single annual payment. These projects and service budget costs are usually re-examined against the value obtained at regular intervals during the contract lifecycle, normally every five years (Mudjanarkoa, & Ogunlana, 2015).

Lastly, most governments collaborate with the private sector for staffing and providing clinical support services, including laboratory services, radiology, chemotherapy, etc. as part of the contract. These differences represent the most improved type of Infrastructure-based healthcare PPP models, and offer the public the best experience in monitoring and managing the most complex project services delivery to the population (Abuzaineh *et al.,* 2018).

Figure 4.3: A Typical structure of Infrastructure-based Health PPP Model



Source: (Abuzaineh *et al.*, 2018).

Figure 4.3 is a conceptual structure of how the infrastructure-based healthcare PPP model is implemented for efficient and effective delivery of a public project. The public partner, which is the project owner, through the SPV, collaborates with the private company to finance, construct, maintain and operate public infrastructure.

4.2.4. Adoption of Infrastructure-based Healthcare PPP Business Model

The infrastructure-based healthcare PPP model has been adopted widely across several sectors as a key approach of financing large-scale project investments, such as energy, education, transport, and the health sector, etc. This model became predominant in the 1990s in the healthcare when the United Kingdom implemented a large-scale project to upgrade and improve aging infrastructure and increase capability within its National Health Service (NHS). Since then, at least 100 new NHS healthcare facilities were financed and built through the 'Private Finance Initiative (PFI) model' within a period of twelve years (PwC, 2011).

Due to extensive capital investments required in the UK structure, and the government's poor track of the previous record in delivering similar projects within the allocated budget investment and on time, it is, therefore, hard to claim that the NHS could have executed the projects on a large-scale in such a short time without involving additional development partners. In most cases, collaborating with private sector partners and implementing incentive arrangements facilitated a process for better management which resulted in the project being built and completed within the set budget and on time (Sekhri, Feachem & Ni, 2011).

The infrastructure-based healthcare PPP model has been widely used since the 1990s, and has become a common arrangement of healthcare PPP and has been embraced on a global scale, such as Australia, Canada, Egypt, Japan, Italy, Latin America, and South Africa. For instance, since 2003, Canada alone has already implemented more than 50 PPP hospitals using the infrastructure-based model, valued at CAD 18 billion, roughly $14 billion (Montagu & Harding, 2012).

The PwC/UCSF PPP reports deeply look at projects in Asia, Australia, and Latin America that joined the Private Finance Initiative PPP model with the operation of clinical and non-clinical support services. In Australia, for instance, most regions have conducted healthcare PPP projects. By March 2014, there were at least 22 healthcare facility PPPs in construction, and most of them covered some features of non-clinical support service provision in addition to infrastructure capital investment.

In 2005, Mexico tendered its first PPP pilot project and implemented at least 10 Infrastructure-based PPP healthcare projects. This was started by implementing projects that covered non-clinical support services, such as security, laundry, housekeeping, cafeteria, and parking services. Later on, the implementation of projects incorporated clinical services, such as hemodialysis, laboratory, and medical gages, which had previously been outsourced (Abuzaineh *et al.*, 2018; International Finance Corporation, 2010).

4.2.5. Lessons Learned from the Infrastructure-based health PPP model

The infrastructure-based healthcare PPP model has been adopted and there is successful evidence in delivering the much-needed capital required to finance the public sector for a large-scale infrastructure project. However, shifting risk and transferring the capital cost of the project construction based on a long-term fixed payment to the private sector actor, implies that governments may experience less budgetary flexibility in the events of financial consolidation.

4.3. The Discrete Clinical Services Health PPP Business Model

Table 4.4: The Discrete Clinical Services Health PPP Business Model

Healthcare PPP Model Components	Clinical Support Services
Private-partner Roles	Private-partner is given a contract to deliver discrete clinical services, such as specialty care services, clinical support services.
Other Forms of Healthcare PPP modes	Operation and Management (O&M) project contracts
Examples and Implementation	¶ An asset-light model based on increasing support capacity for certain clinical support services. ¶ The Clinical Support Services PPP model has increasingly been implemented across Asia and India.

Source: (Abuzaineh *et al.,* 2018).

Table 4.4 shows the Discrete Clinical Support Services PPP business model. Under this model, a private model is given a contract to deliver discrete clinical services, such as specialty care services, and clinical support services, including drugs and medical supplies.

4.3.1. Objectives of Discrete Clinical Support Services Health PPP Model

The Clinical Support Services healthcare PPP model helps to:

- ¶ Improve care quality and access to clinical support services.
- ¶ improve control and management of clinical support service provision for high-demand-driven services.
- ¶ Mobile and solicit for the involvement of the private sector in the provision of healthcare services to the beneficiaries.

4.3.2. Operations of the Discrete Clinical Support Services Health PPP Model

The roles of Private sector partners include:

- ¶ **Finance: -** the sector is responsible for financing or co-financing the capital investment cost
- ¶ **Operate and Deliver: -** all operations involving management roles and delivery of certain clinical support services, often include the supply of equipment.

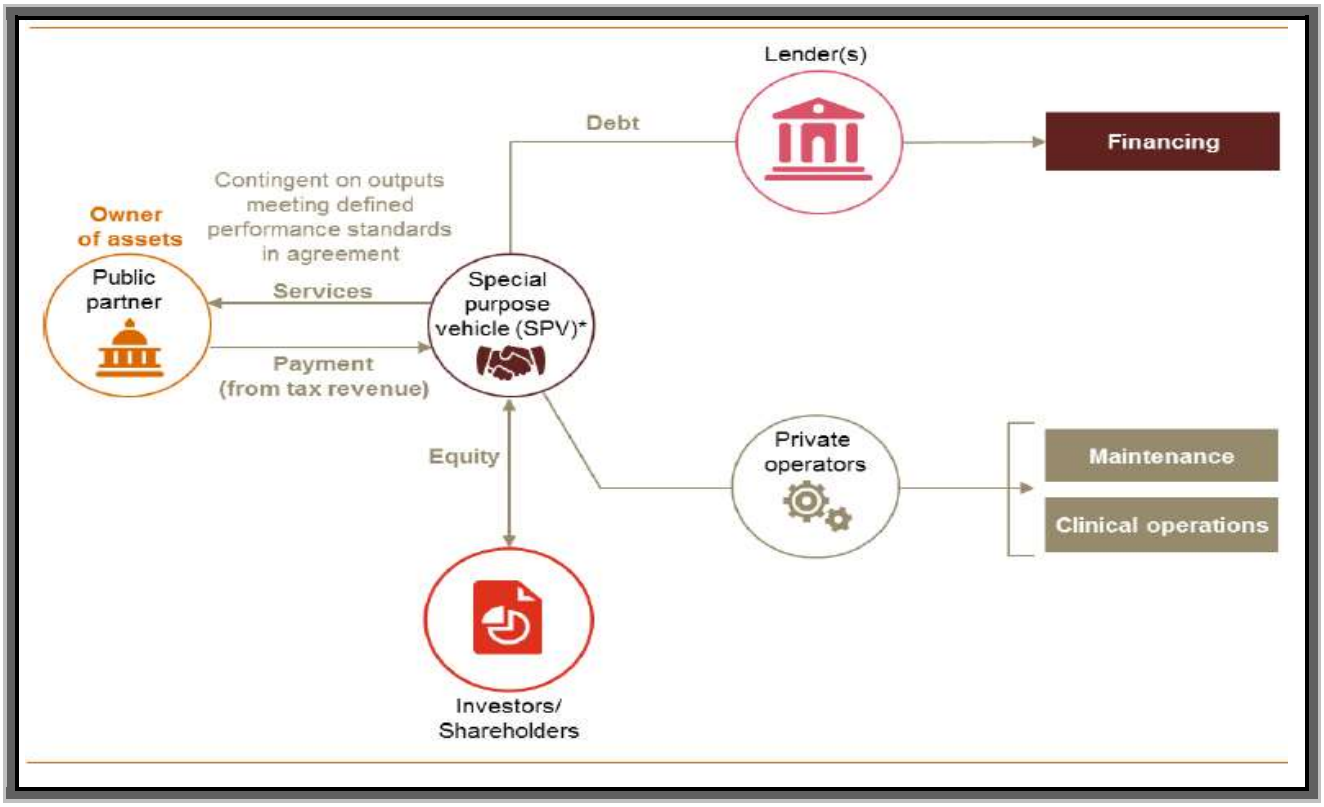
- **Maintain: -** private sector is responsible for maintenance of the healthcare infrastructure including equipment, and the provision of certain clinical support services.

The Discrete clinical services healthcare PPP model entails a government arrangement with a private sector actor to operate and provide specific clinical support services, which are generally conducted on the principle of public hospitals. These systems of arrangement are made in different forms and have the capacity to include a wide range of health services, including diagnostic, laboratory, dialysis, and other related support services. The PPP arrangements, and their management performance, mainly focus on the series of services offered to patients (Abuzaineh *et al.*, 2018; Mudjanarkoa, & Ogunlana, 2015). The Discrete clinical services healthcare PPP contract offers remarkable benefits as compared to projects delivered by the Integrated Healthcare PPP model that provide targeted clinical support services in the form of assets, and thus minimising the costs and complexity.

Although they are generally higher risk ventures as compared to Infrastructure-based healthcare PPP models, they are significantly lower-risk businesses than Integrated healthcare PPP models (Abuzaineh *et al.*, 2018). Moreover, the project contracted under Discrete clinical Services healthcare PPP are typically short-to-medium-term, generally, less than 10 years to align with the clinical equipment lifecycle, but it can be made longer-term as arrangements are amended and extended (European Commission, 2013). Projects which with longer-term contracts normally have greater potential for improved private sector capital investment, as the private sector has a period of time to recover or gain a return on its capital investment costs. In most cases, manufacturers of medical equipment will partner with clinical support service providers to bid on the available projects.

There is a contentious debate whether these forms of PPP arrangements fall under the definition of the concept of PPP, especially if a contract is said to be a short-term time, and requires minimal private sector investment capital. Although, most Discrete Clinical Services healthcare PPP projects are typically performance-based ones and incorporate other forms of requirements that are common in larger-scale PPP contracts, including repair, or replacement, or maintenance of clinical equipment. These features transfer more likelihood risk to the private sector partner, promoting for consideration of PPP contracts (Abuzaineh *et al.*, 2018).

Figure 4.4: A typical structure of Discrete Clinical Services Health PPP Models



Source: (Abuzaineh *et al.,* 2018).

Figure 4.4 shows a typical structure of Discrete Clinical Services Healthcare PPP Models implemented to provide clinical services support. The government through the SPV collaborates with the private company to either maintain the public facility or provide clinical service support.

4.3.3. Adoption of Discrete Clinical Services Healthcare PPP Business Models

Discrete Clinical services healthcare PPP models have been widely adopted on a global scale, especially in countries with inadequate capacity for certain clinical support services. For instance, in some developing countries, where there is limited availability of advanced diagnostic clinical services particularly for high-end devices like MRI and CT, the government's capacity to control and manage more huge and complex projects is limited. Consequently, many projects have been registered successfully under the Discrete Clinical Services healthcare PPP model, and they are good indicators for the asset-high model approach, which typically require lower capital investment and the length of operation results in projects contracts which is most likely to have less risk to accomplish and deliver to increase access to care (Abuzaineh *et al.,* 2018).

More important, radiology diagnostic PPPs are traced back to 2004 in teaching hospitals, partnering with the Sawai Man Singh (SMS) Medical College Hospital in Jaipur, India.

Teaching hospital's high-volume patient offers significant opportunities for private sector actors to balance patient demand risk. Since then, there have been nearly seven projects, of which they all operate teaching hospitals with others being designed (PwC, 2011). In 2003, healthcare facilities across Romania were registered to be among the hospitals under-served in terms of access, quality of dialysis services for new and existing patients, including the outpatients, with only 36 hemodialysis machines installed to serve per million population as compared to 93 and 102 medical machines per population in the Czech Republic and Hungary respectively (International Finance Corporation, 2008).

In addition, following International Finance Corporation (IFC) regulations and guidance released in 2004, the government of Romania awarded PPP contracts to 4 private actors to run and manage dialysis facilities across 8 healthcare facilities to increase access and improve quality of care, and make it simpler for the funding sources for dialysis support services (International Finance Corporation, 2010). The government of Romania paid an annual payment per peritoneal dialysis patient, and private players received a uniform amount per hemodialysis treatment; during this contract, the private actors were responsible for renovating the dialysis healthcare facilities, procuring essential supplies, providing and maintaining equipment, and controlling care service delivery, such as managing the human resources (International Finance Corporation, 2010). International Finance Corporation reports that the government of Romania saved nearly 3 million Euros between 2005 and 2008 through these PPP contracts (International Finance Corporation, 2008).

4.3.4. Lessons Learned from Discrete Clinical Services Health PPPs model

Based on the project goals, if Discrete Clinical Services Healthcare PPPs are well-structured and aligned with clear performance indicators, can offer lower-risk options for the public sector to involve in PPP projects, and for the private sector, players to participate in delivering public services to the population, and thus pave ways for more complex Integrated Healthcare PPP models in the future.

4.4. An Integrated Clinical Services PPP Model

Table 4.5: The Integrated Clinical Services PPP Model

Healthcare PPP Model Components	Infrastructure + Financing + Non-clinical Services + Clinical support services + Clinical Services
Private-partner Roles	Private-partner is given a contract to Design-Build-Finance-Operate facilities-and deliver clinical and non-clinical services.
Names of Common PPPs	Public-private Integrated Partnership (PPIP), Design-Build-Operate-Deliver (DBOD), Integrated PPP, Clinical Services PPP, and Alzira Model.
Examples and Implementation	This is the most complex of all healthcare PPP models. It has been widely cited across many countries, including Australia, Peru, Lesotho, and Spain

Source: (Abuzaineh *et al.,* 2018)

Table 4.5 shows the features of the Integrated Clinical Services Health PPP Model, including its roles, and how it is implemented. This partnership allows a private company to design a project, construct, finance, operate, and provide clinical support and non-clinical services.

4.4.1. Objectives of the Integrated Health PPP Model

The Integrated Clinical Services health PPP Model is implemented to improve the management of clinical services delivery to the population; improve management of primary health care referrals to enhance community-level clinical outcomes and effectively manage costs; increase access to comprehensive healthcare services, and improve care quality, and mobilise long-term private sector capital investment contract in the provision of healthcare services. In addition, the Integrated Clinical Services health PPP model builds, refurbishes, and expands a public healthcare facility, which includes primary care clinics, hospitals, out-patients, etc. arranged usually in a shorter timeframe.

The government can increase the capacity of public healthcare infrastructure to provide services to the people. Finally, the Infrastructure-based healthcare PPP model enables the public company to increase access to required capital investment, to finance the construction of healthcare infrastructure projects.

4.4.2. How does the Integrated Clinical Services Health PPP model work?

Under this model, the private company is implemented to:

Design: - the private sector players take on the role to design facilities based on the requirements stated by the government.

Build: - the private sector is responsible for the construction of new healthcare facilities, and renovate or maintain the existing ones.

Finance: - the responsibility for financing or co-financing of the project capital investment lies in the hands of private sector actors.

Maintain: - the private sector is responsible for maintaining the building infrastructure and equipment as required.

Operate: - delivery and management of non-clinical services, such as the supply of equipment as required.

Deliver: - responsible for delivering and management of clinical support services.

The Integrated Healthcare PPP model is the most complex one of all PPP models. In addition to expanding and improving the healthcare infrastructure, this model influences private sector management expertise to manage inpatient and outpatient clinical services, deliver quality care services, including existing and new services. Adopting this model, governments across the world have aligned the effort to improve the management of medical service delivery, and improve quality and access to care (Abuzaineh *et al.,* 2018).

Furthermore, by mobilising and encouraging the private sector actors to have financial effectiveness through enhanced management practices and systems, Integrated Clinical Services PPP model aims to improve healthcare services, at the same time balancing the operating cost to both to the government and patients, who have limited financial capacity payment for improved services (Sekhri, Feachem & Ni, 2011). Under this PPP model, the private sector investor is responsible for all aspects of providing patient care services as may be stated in the project contract. This usually covers providing all health care within the hospital, renovate, and manage a small number of referral hospitals, providing them with the ability to manage referrals and coordinate care.

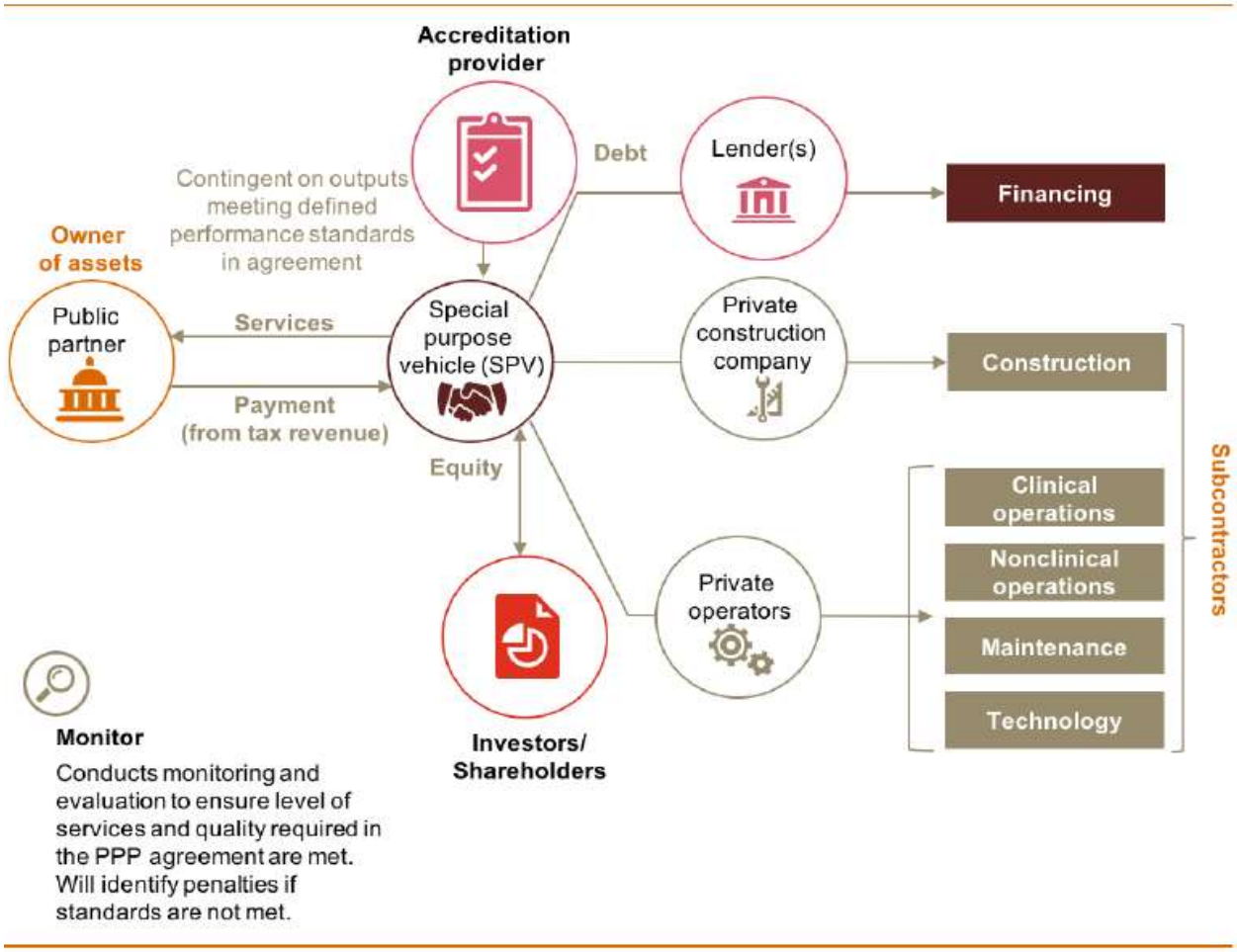
Based on the definition, the Integrated Clinical Services PPP model requires a complex set of contracts with the private consortium or partner to manage the elements of design, financing,

construction, and improved services delivery. In addition, the model is so critical that the arrangement can be flexible to address major changes, including changes in services delivery and the needs of demographic characteristics over a long-term contract (Abuzaineh *et al.*, 2018).

The private sector partner, under the Integrated Clinical Services PPP model, is not only responsible for taking the risk for cost overturns and project delays in the construction process as with other types of PPP arrangements, but also for service delivery risks, such as controlling and managing changes in-demand services to have improved service quality ethics and managing human resources. Given several competencies involved in building and running a healthcare facility, the private sectors involved in the infrastructure-based healthcare PPP models usually include one set of partners to design and finance or construct the facility in a short-run contract, and another partner take on the management and delivery of care services over a long-term project arrangement.

The majority of Integrated Clinical Services PPP model financing contracts assume that the private actor has the duty to manage overall cost through the accomplishment of service delivery effectiveness (The Global Health Group, 2010). Transferring the roles for providing clinical services to their party signifies a considerable change for governments because they must effectively transform from just being a service provider, to a more long-term relationship, as the manager of the quality and contractor of services, through performance and contract management (Abuzaineh *et al.*, 2018).

Figure 4.5: A Typical Structure of Integrated Clinical Services PPPs Model



Source: (Abuzaineh *et al.*, 2018)

Figure 4.5 illustrates a typical Structure of the Integrated Clinical Services PPPs Model. The figure shows that the government contracts with the private construction company to construct a healthcare facility. An Integrated Healthcare PPPs Model can maintain, provide additional support, such as clinical operations, non-clinical operations, and technological services.

4.4.3. Adoption of Integrated Healthcare PPP Business Model

As governments across the globe continue to embrace healthcare PPPs, more are steadily experimenting with the Integrated Healthcare PPP model. There are notable examples across some countries and income differences. The 1st and 3rd Reports of the PwC/UCSF PPP project series provide a comprehensive analysis of highly conducted and published contracts in Maseru, Lesotho, in the construction of the Queen Mamohato Memorial National Referral Hospital, which is the first healthcare PPP project of its kind on the African continent, and the first to be accomplished in a low-income nation; and in Valencia-Spain, (commonly known as

the Alzira PPP model), which was reproduced across the five health districts in the country (PwC, 2008).

4.4.4. Lessons Learned from the Integrated Health PPP model

An Integrated healthcare PPP business model is essential because it helps the public sector cut the cost of medical supplies procurement, healthcare service delivery, vaccine, and drugs, associated with public health. The integrated PPP business model can bridge the financial and technical gap and thus may improve the quality of health outcomes due to sufficient funds and superior scientific and technical skills. The public sector has a wider pool of financial and human resources to ensure the completion of the project.

Though the Integrated healthcare PPP business model is the least common of the three healthcare PPP models implemented today, it provides considerable opportunities for governments seeking to make health reform with more emphasis on the quality of care, management, and cost of clinical service delivered to the population. Although they are complex, this model offers the highest potential to enhance clinical outcomes, and governments will have the capacity to manage resources, and their political and leadership support will be required to sustain such project arrangements before embarking on them.

4.5. Summary of the Chapter

The Healthcare sector is an increasingly changing environment from increasing demographic characteristics, to rapidly emerging medical technology, treatments, and therapeutics to seemingly evolving conditions, diseases, and service demands amidst ever-increasing mobile populations. PPPs design has emerged to address these evolving needs. By influencing private sector capacity, including expertise, financing, and management of public health systems and discipline, have taken advantage of the emerging technologies and clinical support practices from PPPs for their population.

The effort to implement PPPs has also encouraged governments to acquire relevant experience in transitioning from providing quality care to overseeing it through policy framework, regulations, and management of crucial experience, that over time enables governments and healthcare organisations to expand their support and services beyond a traditional public capacity and be able to manage healthcare over the spectrum of public-private and informally delivered medical services.

When identifying and determining whether a PPP project arrangement is a suitable option, some of the key factors for the public sector to consider is that PPPs are not necessarily a 'one-size-fits-all' approach to address all the pending healthcare challenges.

Consequently, Healthcare PPPs must be designed and conducted within the local context, needs, and aligned with the government's national healthcare delivery strategy and policies.

In addition, health care needs to be considered to ensure that the decision-making about PPP strategy is inclusive and transparent, purposely to involve the community and public healthcare providers, engage with stakeholders across the political spectrum, and leverage private sector players.

Clearly stated and measurable output-based performance guidelines should be identified that specify the final goal which the public sector wants to gain through the PPP arrangements, rather than the definitions of how PPP services will be provided. The roadmap can provide the private sector actor mobility to combine new methods of acquiring the anticipated financial and patient outcomes, as health conditions emerge.

Chapter Five presents the research methodology, where research design, study population, sampling, data collection methods, data analysis, and ethical considerations have been discussed, based on the study problem under investigation.

CHAPTER 5

RESEARCH METHODOLOGY

5.0. Introduction

Chapter Four discussed different healthcare PPP business models that have been implemented to address the challenges of healthcare and improve healthcare service delivery in Uganda. This chapter describes the research methodology of the study and presents how both primary and secondary data were collected. The study examined the roles of Public-Private Partnerships (PPPs) in the health sector in Uganda.

A mixed research method was deployed to concurrently collect data and compare the results of both quantitative and qualitative approaches. According to (Kroll & Neri, 2009), in a concurrent study, quantitative and qualitative data are collected at the same time (p.37). Data collection tools were used, such as literature reviews, questionnaires, and interview guides. The secondary data was obtained from libraries where textbooks, journal articles, and internet searchers were selected and analysed accordingly. The descriptive analysis was performed for quantitative data and thematic analysis for qualitative data.

Research Methodology defines the means of finding out the facts of a given problem on a specific matter. According to Goddard & Melville (2004), answering unanswered questions, or exploring what currently does not exist, is known as research. On one hand, research is a careful investigation, as well as inquiry, especially through searches for new facts in any branch of knowledge, aimed at gaining new knowledge (Redmen & Mory, 2009). The research methodology allows researchers to organise, plan, design, and conduct a systematic study (Mohajan, 2017).

5.1. Research Design

This study employed a mixed-method research design. Accordingly, qualitative and quantitative were used to collect relevant data, analyse, interpret information based on the problem statement, integrate the results, and draw inferences, using both quantitative and qualitative methods. The justification for mixing methods in this study was:- this study sought that using a single method of research would be insufficient to address the most complex issues associated with the target population. A mixed research method, therefore, provided a better understanding of the study participants, the problem and generated critical information from the respondents, because both approaches complemented each other. (Tashakkori & Creswell, 2007).

For instance, survey questions were administered to collect primary data about quantities, while interview guides were more helpful in collecting information about the lived experience of the participants, their feeling and knowledge about the problem under investigation, and thematic information about the phenomenon, or previous and current events, which were observed, such as the ongoing construction projects that were observed in Fort Portal RRH, Lira RRH, and Soroti RRH, and services like immunisations, Safe Male Circumcisions (SMC) in Soroti RRH, HIV screening and counseling services, in Fort Portal RRH and Mubende RRH.

Since the study interview questions were designed in an open-ended format, it rendered an opportunity for the participants to discuss in-depth the most critical issues, affecting the successful implementation and performance of PPPs, which had not been mentioned in questionnaires. The critical issues that the qualitative approach captured include political interference, corruption, bureaucracy on the government side, the poor working relationship amongst the hospital workers (public and privately employed), conflict of interest, poor priority, a discrepancy in compensation structure, insufficient funding, poor communication, and collaboration. Therefore, what the quantitative method missed to capture during the survey process was captured in the qualitative approach.

5.2.Research Strategy

This study used the strategy of case study, quantitative survey, and qualitative interviews. A research strategy defined plans of action that gave a direction and enabled the process of conducting a systematic research to generate quality findings and detailed reporting.

5.2.1. Case study

This study identified four case studies, including Fort Portal RRH, Mubende RRH, Lira RRH, and Soroti RRH because these have the unique features to represent the other government RRHs to inform this research about the contribution of PPPs in the health sector in Uganda. Therefore, these four government hospitals were chosen as representatives of the four administrative regions, serving as regional referral hospitals in Uganda. A case study enabled an in-depth investigation and analysis of the importance and role of the PPPs, the challenges affecting the successful implementation and performance of PPPs, and the best type of PPPs model for the healthcare sector in Uganda.

According to (Schoch, 2016), a case study offers a better understanding of a more complex subject, and knowledge of what is already known by the study, and the participants based on the previous related studies (p.245-47). To achieve this, the current study implemented a case

study strategy through survey questions and interview guides as methods for collecting primary data from the four case studies. This study identified four key questions to answer about the role of PPPs in Uganda's health sector. This view was supported by Miles, Huberman & Saldana, (2014), indicating that a case study strategy seeks to answer a question like, what and where is the case study? (p.28). Accordingly, this strategy enabled the current study to answer the following research questions:

RQ.1. Why have PPPs become such an important concept for governments?

RQ.2. What roles have PPPs played in improving the quality and delivery of healthcare services in Uganda?

RQ.3. What are the challenges affecting the successful implementation and performance of PPPs in the healthcare sector in Uganda?

RQ.4. What type of health PPPs model should exist for healthcare in Uganda?

5.2.2. Research approach

With regards to this study, a research approach helped to define the procedures and plan of action to establish the comprehensive methods of data collection, analysis, and interpretation of findings. As a result, quantitative and qualitative research approaches were employed to collect data from the selected case studies as identified in the previous sections.

5.2.2.1. Quantitative research approach

In this case, questionnaires were administered to all the selected participants. This approach enabled the study to collect and present quantitative data in forms of figures, graphs and numbers. The approach was used to test and qualify the assumptions that PPPs play an important role in improving health outcomes and healthcare services in Uganda. This approach used questionnaires as a data collection tool that employed survey questions to collect the required information from the field.

Previous studies indicate that the quantitative research approach involves the use of questionnaires designed in the form of logical questions to collect a large-scale data set (Creswell & John, 2014; Sekaran, 2003). This approach has been recognised and interpreted as important to be carried out methodically and rigorously to produce useful and meaningful results (Braun & Clarke, 2012; Nowell *et al.,* 2017). The approach is more concerned with trying to quantify things (Bryman & Cramer, 2012). It takes several questions, such as to what

extent, or to what degree a respondent agrees or disagrees with the questions. A quantitative approach is more interested in the amount of data and makes a sweeping statement based on study findings from the sample of a large population (MacDonald & Headlam, 2008).

5.2.2.2. Data collection tool

Questionnaires: to collect relevant data, questionnaires were designed as a quantitative data collection tool and administered to the selected and eligible study participants to gather data based on the questions for generalisation, trustworthiness, and reliability of the study findings. The study designed survey questions in a more logical order to allow consistency in the data. The survey questions were then delivered to the participants, and the research team explained to them before making any responses to the questions. The sampled respondents completed the questionnaires in a written form using both open-ended and closed questions.

5.2.3. Qualitative research approach

For the purpose of collecting and presenting data, qualitative research was presented in terms of words. This approach was used to understand the views, knowledge and lived experience of the sampled study participants about the role of PPPs in Uganda's health sector. Qualitative approach enabled the study to collect in-depth insights on the importance, roles, challenges and the best PPPs model for Uganda's health sector. This approach employed interview guides with both open-ended and closed-ended questions, and deployed a document review that critically explored theories and concepts in a more detailed manner.

Previous studies indicate that a qualitative research method is a type of social activity undertaken to investigate the way people make sense of their knowledge, lived experience, and how they interpret events to better understand the why, or how the problem occurred, and their views on the issues at hand (Gopaldas, 2016). It generally depends on people's experience, and insights from participants' perceptions (Mohajan, 2018). Qualitative research focuses on obtaining data through open-ended format, and one-on-one conversation and it establishes a systematic way for communicating with the participant about the study. This method was inductive in nature, and the study typically examined insights and meanings into the problem.

On one hand, a qualitative method is a quality-focused type of approach that attempts to attain a deeper understanding of the underlying motivation and explanations for a certain action, and find out people's opinions about the situation, lived experience, and surrounding environment. The method offers meanings of the problem and generates diverse views about the issues (Mohajan, 2018; MacDonald & Headlam, 2008).

In this study, a qualitative method gathered both primary and secondary data through interviews and a literature review approach. Interview refers to the use of face-to-face interactions between the interviewer and interviewees to collect in-depth data about the problem (Hammarberg, Kirkman, & Lacey, 2016; Silverman, 2020). This approach was more concerned about the target population's experience, what they think, and why they think so, about the PPPs in Uganda's health sector. In other words, the study sought to understand the problem from the perspective of the stakeholders, and private project implementers involved.

5.2.3.1. Data collection tool

Interview guides: interview guides were designed to collect qualitative data through interactive conversations with the sampled study participants. Interview guides were used, facilitated oral, face-to-face interactions with the selected participants purposely identified, and it enabled the interviewers to ask questions orally, and received answers orally in a real-time mode. The technique made the whole data collection process easy. As a result, this approach was used to examine the knowledge and lived experience of the participants as supported by (Creswell, 2014; Hammarberg, Kirkman & Lacey, 2016; Silverman, 2020).

Carrying out an in-depth interview is one of the most common qualitative research approaches used today. An interview research method is a personal, or individual interview session conducted with one study participant at a time (Hollway & Jefferson, 2008). The method is typically conversational, and it allows opportunities to capture lengthy, and detailed information from the respondents (Creswell & John, 2014).

Interviews are important for generating stimulate facts, and knowledge concerning the topic under investigation, using a series of questions. Besides, Polit and Beck (2010), explain that either face-to-face or telephone calls can also be used to conduct interviews. Whereas these options exist, this study employed face-to-face interviews with the informants, to collect primary data.

5.2.3.2. Document Reviews

The study also collected data through a document review. In light of secondary data sources, the study reviewed related documents about the study of PPPs in the health sector. In addition, the researcher furthered the study in University libraries by reviewing and analysing published textbooks, journal articles, and internet-related data sources. Document review is a data collection technique used in collecting, particularly secondary data, though desktop research.

This study, therefore, found that the process to establish the strategic PPPs policy for Health began way back in 2000, with the PPPH Working Group tasked to draft the policy. The process led to the development of the policy and elements on PNFPs. The PPP concept is a contract established between the public (government) and private (profit-making or not-for-profit) sector (World Bank, 2015), for delivery of health facilities, equipment, and healthcare services. The justification for the PPP arrangement in Uganda's health sector is to achieve Universal Healthcare Coverage, improve quality care and delivery of health services to the people (Awor *et al.,* 2018). Besides, PPPs ensure resource management in terms of medical supplies, finances, and human resources.

According to Onwuegbuzie, Leech and Collins (2012), documents are published works [secondary sources of data] that present facts about the topic of study (p.2). This study reviewed several secondary sources of data on Public-Private Partnerships in the health sector, including published textbooks, journal articles, and internet searches. To collect secondary data, the study employed google searches by entering the keywords, including 'Public-Private Partnerships', 'health sector', 'healthcare service delivery', 'government regional referral hospitals', and 'healthcare in Uganda'.

This method may comprise of a summary of key data sources, however, in social sciences and humanities, the approach typically takes a design of both synthesis and summary of categories (Paré & Kitsiou, 2017). Document reviews are deployed to offer an overview of the key sources analysed during the study to demonstrate to the readers and beneficiaries of the study how the results fit within a particular field (Fink, 2019).

On one hand, a document review represents a step of actions of the entire research design in a mixed research method. Besides, a document review became the inspiration and foundation of this study. This is because, rigorous facts and knowledge in any academic discipline are increasingly becoming essential in maintaining the growing studies, assisting researchers in finding, analysing, and synthesising the contents of both conceptual and empirical studies (Onwuegbuzie, Leech & Collins, 2012).

Previous studies indicate that the government of Uganda has embraced the concept of PPPs in the service sectors, including the health sector through different projects, and services (Asasira & Ahimbisibwe, 2019). The studies show that the first form of PPPs in the health sector in Uganda created a relationship between the private partners and the Ministry of Health. This form of PPP is tracked back to the early 1960s, under the 245 Notice of 1961, which became a

tool to offer support to government sectors as the Profit-making organisation, for both facility and non-facility entities (referred to then as PNFPs) in Uganda (Tashobya, Musoba & Lochoro, 2007). However, this support was not successful and eventually stopped during the 1970s crises (Bataringaya & Lochoro, 2002).

The government of Uganda instituted a 1987 document, known as the Health Policy Review Commission Report, and they recommended, integrating the private sector into the national healthcare system (Health Policy Review Commission, & Owor, 1987). The commission established a basis for the 1993 Government White Paper directed for Health Policy that emphasised the need for implementing the private sector in the health system in Uganda. Tashobya, Musoba and Lochoro (2007), show that it took the government until 1996 until the matter was recognised directly on the health policy agenda.

The process established the Public-Private Partnership for Health (PPPH) with the motion of nominating the non-government organisation health sector panel, which later identified the role for forming the means for partnership between the public and private sectors. The recommendations made by the panel were incorporated into the national health policy and health sector strategic Plan 2000/01-to-2004/05 HSSP-1 (Tashobya, Musoba & Lochoro, 2007). This partnership and collaboration between the government and the private sector in the health system became key in guiding the principle of the National Health Policy, and an important component in strengthening the healthcare service delivery system as stipulated in the HSSP. This demonstrated the need to move away from working the "gentleman's agreement" to outline the policy for PPPH (Health Policy Review Commission, & Owor, 1987).

5.3. Methods of Data Analysis

This study analysed both quantitative and qualitative primary data obtained from the case study. Two main types of data analysis, namely quantitative and qualitative were used.

5.3.1. A Quantitative Data Analysis

A quantitative analysis was measured in terms of numbers of study findings. Quantitative analysis used measurement scales, scores and percentage frequency were presented in a statistical interpretation. The quantitative data was collected using survey questions. The data was sorted, categorised, and entered into Statistical Packages for Social Sciences (SPSS), which is computer software for analysing social science research. SPSS is a statistical computer application that is largely used to analyse data collected, based on the study objectives.

The study deployed descriptive statistics to analyse quantitative data. After SPSS, data was transferred into a Microsoft spreadsheet (excel-sheet) to generate clear graphs, pie-charts, percentage and frequency tables, and finally presented in a Microsoft word document. In addition, the study used frequency and percentage distribution to demonstrate the demographic characteristics of the participants. This technique allowed the study to meaningfully describe the distribution of scores. Quantitative data analysis was based on the investigation of research questions and objectives that served to determine the scope and topics to be examined.

5.3.2. A Qualitative Data Analysis

A qualitative analysis answered the four main study questions: 1) Why have PPPs become such an important concept for governments? 2) What roles have PPPs played in improving the quality and delivery of healthcare services in Uganda? 3) What are the challenges affecting the successful implementation and performance of PPPs in the healthcare sector in Uganda? and 4) What type of healthcare PPPs model should exist for healthcare in Uganda? Each of these study questions was answered using interview guides designed in an open-ended format as supported by (Saunders, Lewis & Thorn hill, 1997).

Consequently, the current research used thematic analysis to organise data into themes by identifying the repeated keywords. To achieve this, the study made summaries about the statements, and read the notes repeatedly to make summaries of the information. This was performed to extract common statements, and get into the depth of the data collected. Thematic analysis helped the study to understand the roles and importance of PPPs in the health sector in Uganda.

For instance, the analysis found out that PPPs are an important arrangement because they improve healthcare service delivery and hospital infrastructural development; improve on the health standards; provide the necessary funding to run different activities at the Government regional referral hospitals and projects; and improve on human resources through skills, through recruitment, training, capacity building, and salary/compensation of health workers, and improve on medical supplies and equipment. Thematic analysis is a systematic approach used to analyse qualitative data, to understand the patterns that form common themes during the inquiry (Braun & Clarke, 2006).

Thematic analysis has been supported, and largely defined as a systematic research approach where the researchers attempt to find out people's knowledge, opinions, views, ideas, values,

and lived experience from a data set (Braun & Clarke, 2019; Kiger & Varpio, 2020), such as survey responses, interview transcripts, and or social medial networks (Joffe, 2012). It is a research approach for analysing qualitative data set, where the researcher closely examines the data to identify common ideas, patterns, and themes of the meaning that are found to be repeatedly captured (Cooper *et al.*, 2012).

Thematic analysis is systematically used to identify, sort, and provide understanding into the patterns of meaningful themes across data-set (Braun & Clarke, 2006; Castleberry & Nolen, 2018). While focusing on the data-set, thematic analysis allows the study to identify, and generate ideas from the lived experience and knowledge of participants (Alhojailan, 2012; Braun & Clarke, 2019). The approach has been widely used for qualitative data, for instance, previous studies, including (Ahmed, Mrsonda & Pretorius, 2019; Biygautane, Neesham &Yahya, 2019:192-219; Braun & Clarke, 2012; Hossain, Guest & Smith, 2019:46-68; Nduhura, 2019; Opara & Rouse, 2019; Solheim-Kile, Lædre & Lohne, 2019), deployed thematic analysis to analyse data collected about PPPs.

5.4. Type of Study

The study employed a descriptive study.

5.4.1. Descriptive Study

Using this type of research, the study was able to describe the demographic characteristics of the sampled population and the problem under investigation. For example, the features of the population included gender characteristics, age, marital status, education level, occupation, duration of service at a given hospital, and location of the study participants. On one hand, the phenomenon covered issues relating how the PPPs have evolved and improved the health outcomes and healthcare services to the population.

The descriptive study did not answer issues and questions concerning when/why/how the characteristics occurred, but it addressed the ‘What’ questions as shown under research question subheading. Accordingly, the analysis indicates that the health sector is growing due to the ever-increasing population, to rapidly developing medical treatment, therapeutics, and equipment to seemingly emerging health conditions, complex diseases and high demands amidst the rapidly increasing demographics. As a result, the idea of PPPs has come into play to respond to these emerging health needs. The study findings show that the government of Uganda has influenced the PPPs to improve on its financing, expertise, and management capabilities of health systems.

5.4.1.1. Transferability

To determine transferability, this study invited readers and offered them an indication that the results obtained apply to other sectors and populations. The idea here was not to make claims and judgments to the findings but to involve readers to make the relationship between the components of the current study and their experience of dealing with the PPPs in improving quality and service delivery to the population. To achieve this, the readers were given sufficient information about the background, the problem under investigation, and the population of the original study, purposely to determine whether the study is similar to their views and experience.

As a result, the readers, therefore, provided an in-depth description of their research methods and the context of the study. For instance, the study invited some of the readers that have conducted studies about PPPs in the transport and hydro-electricity sector in Uganda. And they conclude that the findings and recommendations of this study are applicable not only to the health sector but also to other government ministries, including education, transport, agriculture, and others.

Transferability refers to the extent to which the findings of the qualitative study can be transferred to the setting and population with other readers or participants (Wenger & Olden, 2012). It is, therefore, established by offering the other participants the necessary evidence that the results of the study could be applied to other events, settings, and populations. Therefore, the detailed elements of the study findings make them serve as a model for transferability (Nguyen *et al.,* 2020).

5.4.1.2. Dependability

This study conducted an inquiry audit to establish dependability. This involved inviting external persons to review and evaluate the entire study process and data analysis to find out whether the results were consistent and, or could be repeated. The key role of external persons was to establish whether the study was conducted in a misguided manner or made some faults in conceptualising the research design, data collection, analysis, interpreting the data, and reporting the results.

The external persons, therefore, offered a clear explanation of the original research proposal, and what was executed during the study process. They reviewed and edited the thesis and they offered their expertise in addressing some of the supervisors' comments and thus reduced multiple revisions. The decision to involve the external persons was to ensure that if at any

given time other researchers were invited to look over the findings of this study, they would eventually arrive at the same results, analysis, interpretations, and recommendations about the findings of this study.

According to Guest, MacQueen and Namey (2012), a qualitative study can conduct an inquiry audit to determine the level of dependability. The author adds that this process requires an external reviewer to look at and assess the study process, data collection, and analysis to make sure that the results are dependable and can be repeated (p.106).

5.4.1.3. Confirmability

This study sought to determine the extent to which its findings may be reviewed and confirmed by other researchers. This section was more concerned with knowing that data and interpretations are not just the imagination of the research data analyst but directly drawn from the primary data collected from the field based on the study questions and objectives. The answers and interesting features were recorded during data collection and interpretations were offered based on data analysis that facilitated the conclusion. The entire research process was recorded and helped the study to reflect on each step, concerning the study aims.

Confirmability is one of the criteria of trustworthiness that a qualitative study must determine (Ghafouri & Ofoghi, 2016). This deals with the degree of confidence that the study results are not the researcher's illusions and biases, but are based on the participants' words and experience. Therefore, confirmability was applied to confirm that the study results are informed by the participants, not a qualitative investigator (Lietz & Zayas, 2010).

5.4.1.4. Credibility

To achieve credibility of the findings, the current study scrutinised, checked the publisher and date, summarised the secondary sources, the objectives of the sources, and its content. The idea was to produce quality information. This study determined the data credibility as follows:

Accuracy: the already known information was verified against the data found in the secondary sources of information. This was done by looking for the disclaimers section to determine the level of accuracy of the published content.

Authority: the secondary sources of data were scrutinised and checked to establish whether the content was written by a trustworthy institution or authors. For the case of internet sources, such as webpages, the publishers and authors were identified by the URL and a copyright

section at the bottom of the page. This was done to find out whether the authors had proper credentials and knowledge on the concept of PPPs.

Coverage of the sources: this was checked to determine whether the content fits and addresses the subject scope of this study. This was done to determine the relevance to this study and whether it addresses the matters raised.

Data credibility is the degree to which sources of data or informants of the study can be trusted to make sure that the data represents exactly what the data is supposed to represent, and that there are no plans to misrepresent the original purpose of the data. Besides, the representation of data should have no biases (Elo *et al.,* 2014; Statisticssolutions, 2021).

5.4.2. Validity and Reliability of Data

This study used reliability and validity techniques to decrease the study's chance to insert or encounter bias in the data. In a study, data collection instruments, such as questionnaires, are widely used to collect data mostly in social science research. According to Taherdoost (2016), the main goal of questionnaires and interview guides in a particular study is to collect meaningful information more reliable and valid (p.2). Consequently, the consistency and accuracy of the data collection instruments create an important concept in research methodology, which is commonly known as reliability and validity of research instruments.

5.4.2.1.*Content Validity (CV)*

To obtain a CV of data collection instruments used, an in-depth document review was undertaken to generate the related issues and items. Instruments were sent to the project supervisor to identify the essential items. In this study, to establish validity, the content validity index (CVI) was measured from the number of survey questions returned as valid, and divided by the total number of the questions administered to the respondents. This is demonstrated as CVI= (items declared valid). The CVI of 0.5 (Polit & Beck, 2006), and an average of CVI-0.8 is good to undertake a study (Shi, Mo & Sun, 2012). This is considered as the central part of any type of analysis that is accurate, and reliable (Cohen, Manion & Morrison, 2013: p.49).

The CV was calculated for each instrument, using Lawshe's (1975) 's formula (Lawshe, 1975). CV refers to the extent to which research instruments (questionnaire and interview guides) reflect the actual content to which the items will be generalised. Usually, CV involves an assessment of the survey instruments to ensure that all the tools can eliminate undesirable issues to a subject (Taherdoost, 2016: p.4). Polit and Beck defines validity as the extent to

which certain data collection instruments can accurately measure, and provide what is meant to be measured, and thus produce accurate data (Polit & Beck, 2006).

On the one hand, it is the extent to which the research instruments have adequate sample items for the hypothesis being measured (Taherdoost, 2016). Validity entails assessing each item of the interview guides, questionnaires administered to the participants to establish whether or not the items used will produce what was expected of them. This study used content validity to establish the accuracy of research instruments.

5.4.2.2.*Reliability*

To achieve this, the study examined the reliability of the research instruments, using the test-retest technique. This technique was used by administering a test of data collection instruments on two different occasions at two separate points in time. This approach ensured that there was no change in the quality and questions being examined. The test-retest was used to assess the repeated use of research instruments to a person with relevant experience on more than two separate occasions.

Consequently, study questionnaires were sent to the research supervisors for the first time to make an assessment, and returned to the researcher for corrections, and after making the corrections to the comments, the instruments were sent back to the supervisor for the final administration and approval. This approach is supported by Taherdoost (2016), who notes that reliability is more concerned with repeatability. Measuring reliability is important because it helps to ensure consistency across the instrument (Christodoulou *et al.,* 2015; Huck, 2007).

Reliability refers to the ratio of consistency among items used and the extent to which research instruments will generate consistent results over a wide range of areas (Kimberlin & Winterstein, 2008). According to (Mohajan, 2017), reliability refers to the trustworthiness of study findings.

5.4.2.3.*Management* of Bias

Bias was also controlled by selecting and training the entire research team about the concept of PPP in the health sector in Uganda. The training included areas on the context of PPPs and their role in the health sector in Uganda, research protocols, data collection instruments, and ethical issues. In addition, upon accessing some areas of study, like Lira Regional Referral Hospital, it was required to obtain a fresh ethical clearance from Lira RRH Ethics Committee.

The study subjects were recruited through telephone calls, email, face-to-face interaction, and referrals. The study aims, objectives, significance, and benefits were clearly explained to the participants. Participation in this study was purely voluntary. Besides, the sampled study participants were oriented and the research instruments were explained to the respondents. The study distributed some additional resources for personal reading particularly on different types of PPP business models being used in the health sector.

5.5. Sampling

The study used sampling as a tool to identify and select a portion of the entire target group to represent the whole population. Purposive and snowball sampling were deployed to identify the key study participants. Sampling refers to a research technique used to select a single portion of the whole population or location to collect empirical data that helps in drawing the final judgment based on the entire population (Zikmund, 2000:338). In other words, it defines a process of selecting a small size of the population that can represent the whole target group.

5.5.1. Study Population

It was important for this study to identity the target group. Therefore, the population for this study included government officials from the Ministry of Health, and health workers, including doctors, medical social workers, Allied health professionals, clinical officers, pharmacists, physiotherapists, and housekeepers. The study did not sample the vulnerable groups, such as children, psychiatric patients, individuals with impaired decision-making capacity, persons with independent relationships (e.g., lecturers researching with students), persons with a mental disability, and persons in prison.

According to Sekaran (2003), the study population is the total number of subjects in a particular group being investigated, and from which a certain study sample size can be drawn (p.265). The study population is the feature that meets the requirements for inclusion in the study. In other words, the study population is the number of units through which data can be gathered (Parahoo, 1995:218). It refers to the summation of eligible subjects that form a study (Mason, 2010: 21).

5.5.1.1. Eligibility of Study Participants

To ensure participants' eligibility, the study followed both inclusion and exclusion criteria as was recommended by (Lunny *et al.,* 2018). The target participants included the government officials from the Ministry of Health officials, hospital directors, hospital administrators, health workers, and hospital staff.

5.5.1.2. Inclusion criteria

The inclusion criteria of this study were as follows: 18 years and above, both male and female participants, of all races were eligible, and had obtained the Uganda Certificate of Education (UCE) at the time this study, and were working in the health sector for a period of one year and above.

5.5.1.3. Exclusion Criteria

The study excluded vulnerable groups, such as children, psychiatric patients, individuals with impaired decision-making capacity, persons with independent relationships with the researcher (e.g., lecturers conducting research with students, or family), persons with a mental disability, and persons in prison.

5.5.1.4. Recruitment of Study Participants

The study used an introductory letter obtained from the Gatekeeper (Ministry of Health headquarters in Kampala), requesting all the four Regional Referral Hospital Director Generals to provide necessary assistance to the study in terms of participation, and providing relevant information and recruiting of eligible participants to take part in the study. For instance, the study participants for quantitative data were contacted and recruited by direct referral from the Hospital Director Generals, and Hospital Administrators, which allowed the research team to conduct face-to-face, and telephone recruitment techniques. The answers were limited to questions relating to the roles of PPPs in the health sector in Uganda. Each eligible participant stood an equal opportunity of being selected from the population.

5.5.2. Sample Size

To determine the sample size for a quantitative method, the study sampled 160 participants with relevant knowledge in providing the necessary information about the concept of PPPs in Uganda's health sector; and the sample size for qualitative research determined the size of 32 participants. This figure was used as representative of the target population.

According to Nieuwenhuis (2007), a sample is defined as a subset of the entire target population (p.5). The sample size is a necessary component of an empirical study, in which the main aim is to conclude the entire population from a sample. In empirical findings, relevant data is collected based on the whole population, and thus, the sample size becomes equal to the population size. Determining the suitable sample size in both qualitative and quantitative research is a significant way of drawing judgments in evaluating the type and quality of information gathered from the study area (Sandelowski, 1995).

5.5.3. Sampling Techniques

This study employed both purposive and snowball sampling techniques to collect both quantitative and qualitative data from the selected participants.

5.5.3.1. Case study Sampling

With regards to this study, Fort Portal RRH, Mubende RRH, Lira RRH, and Soroti RRH were selected as case studies, unique to represent the other government regional referral hospitals to inform this research about the role of PPPs in the health sector in Uganda. These four hospitals were selected as representatives of the four administrative regions, i.e., Eastern, Central, Northern, and Western regions, serving as case studies of the regional referral hospitals in Uganda.

For example, Fort Portal RRH was chosen to represent the western region; Mubende RRH represented the central region; Lira RRH represented the northern Uganda regions, and Soroti RRH served as a representative of the eastern region. To achieve this, the study used survey questions, and interview guides as methods for collecting primary data. The case study helped to narrow down the study to subjects within a case that helped to concentrate on a single area and offered rich-data.

A case study refers to an in-depth inquiry of a given event within its real-life setting (Schoch, 2016). Schoch indicates that a case study entails a comprehensive analysis of a specific situation, event, location, social unit, or organisation. This means that a case study sampling refers to time events and space. Therefore, a case study sampling focuses on a specific event, location, person, community, and, or organisation that informs research about the problem under investigation. Schoch adds that the technique offers a better understanding of a more complex subject, and knowledge of what is already known by the study, and the participants based on the previous related studies (Schoch, 2016, p.245-47).

According to Miles, Huberman and Saldana, (2014), a case study sampling technique seeks to answer a question like, what and where is the case study? (p.28). This type of sampling can be qualitative, or quantitative, or both. (Yin, 2017, p.2). The aim of using this type of sampling is to identify the case to conduct the study in a selected area or field. According to Nduhura (2019), narrowing the research to a case study, and subjects within a case, can generate enriching information rather than sampling a big sample of a large population. This technique helps the study to conduct an in-depth data analysis of a specific problem. Nduhura maintains

that for a case study to be chosen as representative of a large group or community, it should have some unique features in them to create an outstanding study (p.99-100).

5.5.3.2. Sampling within the selected case study

Once the case studies were determined, the study employed a sampling technique to identify and select the eligible participants that took part in informing the data collection process. The study used both snowball and purposive sampling techniques as discussed below:

5.5.3.3. Snowball Sampling

Snowball sampling technique was deployed to collect quantitative data from the eligible study participants. Referrals were made by participants who were purposively recruited, including Hospital Director Generals and Hospital Administrators. These referred the study to their co-workers, assistants, and juniors, including doctors, government officials, nurses, medical social workers, allied health professionals, clinical officers, pharmacists, physiotherapists, and housekeepers, who were then recruited and took part in the study. This category was included to answer the study questionnaires.

Table 5.1: Category and sample size of study participants for Survey Questions

Country of Study Participants	**Sample Size**	**Sampling Method**
Government Official-MoH	3	Snowball Sampling
Doctors	48	Snowball Sampling
Medical Social Workers	2	Snowball Sampling
Allied health professionals	2	Snowball Sampling
Clinical Officers	2	Snowball Sampling
Pharmacists	6	Snowball Sampling
Physiotherapists	1	Snowball Sampling
Paramedical-Orthopedic Officer	1	Snowball Sampling
Nurse/Midwife	56	Snowball Sampling
House Keepers	2	Snowball Sampling
Total	**125**	Snowball Sampling

Table 5.1 shows a description of the study participants that were recruited through referrals from the hospital directors, and hospital administrators to participate in answering the questionnaires. While using the snowball sampling technique, the study was referred to recruit

additional participants that were not initially included as table 5.1 demonstrates. This technique is supported by (Harrison *et al.*, 2017; Sharma, 2018) as an approach where contact that has already been made, uses their social network to refer the study to their colleagues, co-workers, and juniors.

A snowballing approach is another type of commonly used sampling technique, also known as chain referral sampling. In this technique, study informants or participants with whom contact has already been made, use their social network to refer the study to their peers, co-workers, assistants, juniors, friends, and communities (Harrison *et al.,* 2017). In simple terms, it is known as a non-probability sampling technique, where existing-selected participants identify and recruit respondents from amongst themselves (Sharma, 2018). By implementing this method, the researcher referred to involve other participants that were not initially targeted by the study.

5.5.3.4. Purposive Sampling

Qualitative research employed purposive sampling to identify and select data-rich cases about the entire population. In the selection process, the study participants were recruited based on their experience and knowledge of PPPs in the health sector, and the position at a government regional referral hospital. Consequently, to collect qualitative data, the study recruited Hospital Director Generals and Hospital Administrators to provide information on their technical expertise in PPPs arrangements. The process of identifying and recruiting the eligible participant was central in minimizing bias and unsatisfying data.

Table 5.2: Category and sample size of study participants interviewed

Category of Study Participants	**Sample Size**	**Sampling Method**
Hospital Director Generals	3	Purposive Sampling
Hospital Administrators	1	Purposive Sampling
Total	**4**	Purposive Sampling

Table 5.2 shows a description of study participants that were purposively recruited to take part in interview sessions and they also referred their juniors, and co-workers who were deemed eligible for the study. This approach has been used and recommended by (Abdelhakim *et al.,* 2019: 151-157)

A purposive sample is referred to as a non-probability sampling technique that is chosen based on the behavior and characteristics of the target population, and the objectives of the study (Etikan, Musa & Alkassim, 2016). The technique is also known as judgmental-selective sampling, in which the study decides to rely on their judgments while selecting a sample group of the whole population to participate in the study.

Sharma (2017), defines purposive sampling as a research strategy that follows the grouping of the target population into strata. Sharma adds that strata are a part of the target population that has the same characteristics. The sampling technique is credited to the fact that it protects missed data and variance of data from study informants. This is justified on the basis that participants possess similar features and experience about the topic under investigation, Begley *et al.,* (2018) indicates that missed data can easily be collected and verified by other participants in the strata set for responses.

5.6. Ethical Considerations

Since this study involved human subjects; it was anticipated to encounter some ethical issues. Ethical considerations that were projected in conducting this study include informed consent, potential damage to subjects, privacy and confidentiality issues, compensation to participants, scientific instruments used, and how the study could benefit the participants, and the country at large. These ethical issues were identified far back by Nigel, Amanda and Amanda (1998:1) as a serious concern in the study.

The current study went through ethical checks and clearance as follows:

These include: the principal investigator undertook an online ethical training with Macquarie University, and obtained a certificate in Human Research Ethics for the Social Sciences and Humanities, project supervisor approval, permission from the Ministry of Health (MoH), clearance from Gulu University Research Ethics Committee (GUREC), clearance from Uganda National Council for Science and Technology (UNCST) clearance in Uganda, and finally a clearance from North-West University Ethics Committee.

Consequently, these clearances helped the research team to collect primary data without fear or favour. Privacy and confidentiality of the study participants were crucial during the fieldwork, and reporting of the final findings. This covered the issues related to participants' privacy, and secrets they freely provided to this study during data collection and were highly observed.

5.6.1. Confidentiality of Participants

Confidentiality refers to the degree to which the research team protects the private details of the participants involved in the study. Participants' detail will be treated not only as study data but also as a researcher's asset. This study acknowledges that confidentiality entails, ensuring the privacy of data or information gathered, such as authorisation to view, read, edit, share, and use it. In this case, measures were put in to manage confidentiality such as:

i. Only primary investigators have access to the identifiable information.
ii. All research tools, including documents were stored in a locked place and assigned passwords to all computerised records or data.
iii. Physically secured digital devices and documents containing data
iv. Managing data acquisition by ensuring privacy and confidentiality. No sensitive data, such as Bank account/ pin numbers, social security numbers, and passwords were collected.
v. Ensured proper management of data utilisation to protect the privacy and confidentiality of individual data to which the data represents.
vi. Managing devices well is another central measure used to protect data confidentiality. This has been achieved by following the basic cybersecurity protocols, including using powerful antivirus software, regularly patching software, enabling firewalls, suspending inactive sessions or programmes, and using device passwords.
vii. No video or photo of the study subjects were recorded.
viii. Data will be stored and deleted after a period of 5 years as per NWU guidelines.

Confidentiality refers to the process of protecting the privacy of a study participant (Machanavajjhala & Reiter, 2012). Privacy, on one hand, refers to a person's interest to protect their private information from others (Sieber, 2001). Participants' privacy was kept by protecting the personal details including names, addresses, and respondents' titles. These particulars were not included in data analysis, and in compiling, and writing of the final report. Anonymity was kept secret. Connelly (2014) demonstrates that ethical considerations cover informed consent of the study participants, privacy, and possible threat to participants.

5.6.2. Anonymity

Anonymity was observed to protect participants' privacy. For instance, ensuring confidentiality of data collected from participants ensured that only the principal investigator or individuals of the research team have the power to identify the responses of the participants or individual

subjects. Similarly, the study ensured anonymity of data collected from participants by avoiding collecting identifying information of individual subjects, such as names, address, account number, fingerprints, images/full face photo, date of birth, employer's name, relatives' name, voiceprints, telephone number, email address and password.

5.6.3. Informed Consent

An informed consent form was used as a means to recruit the target study participants. The study participants were contacted and recruited through letter/email messages, verbal/telephone calls, and face-to-face interaction. Prior to taking part in this study, the study obtained the informed consent of participants by reading the consent form, and afterwards appended their signature against the study instruments.

5.6.4. Accessibility

To gain access to study areas, an introduction letter was obtained from the NWU to the gatekeeper (Ministry of Health, Uganda), seeking permission to carry out a study in four selected government regional referral hospitals of Fortportal, Mubende, Lira, and Soroti RRH. Permission was granted from the Ministry of Health to the principal researcher to undertake the study based on the protocols, and guidelines stated in the letter, which also helped the researcher to obtain ethical clearance from NWU.

A copy of the letter, allowing the study was also copied to Fort portal, Mubende, Lira, Soroti government regional referral hospitals as the selected areas of study. The letter was sent via email to the four directors of the hospitals mentioned above for coordinating, and easy accessibility to the selected participants. An email message stressing the need for this study was accompanied by a telephone call which offered further detail and facilitated real-time feedback, and proper arrangements were made with the designated gatekeepers.

Upon arriving at the areas of study, it was required that the principal investigator along with the research team introduce themselves and explain the purpose of their visit to the individual hospital director, who, afterwards introduced the entire team to the hospital staff and eligible selected participants. All participants were accessed at their workplace. Therefore, there was no movement in a way that could expose the participants to environmental hazards or risks associated with Uganda's terrain transport network. It was such an opportunity that the whole research team introduced themselves and interacted with the study participants to collect primary data. Data was collected using questionnaires that offered closed-ended questions and qualitative interview guides were used.

5.7. Summary of the Chapter

This chapter has discussed in detail the research methods and ethical considerations of the study. The study protocol was approved by Gulu University Research Ethics Committee, Uganda National Council for Science and Technology, and North-West University Ethics Committee. Permission to conduct this study in government Regional Referral Hospitals was granted by the permanent secretary, Ministry of Health, Kampala as the main gatekeeper for this study.

The current study widely used a mixed research method of data collection. Both qualitative and quantitative approaches were deployed to collect primary data from the selected eligible participants, using questionnaires and interview techniques. To achieve this, purposive and snowball sampling techniques were employed to identify potential participants and collect data. After data collection, the study undertook descriptive and thematic data analysis.

Chapter Six presents the study results as brought forward through survey questions, and interview guides.

CHAPTER 6

PRESENTATION OF STUDY FINDINGS

6.0 Introduction

The previous chapter discussed the research methodology and ethical considerations of the study. This chapter presents the statistical findings of the study. The main objective of the current study was to assess the roles of PPPs in the health sector in Uganda. The chapter consists of a detailed interpretation of the data, the information presented here is based on the research topic, objectives, and study questions. The study undertakes a descriptive analysis of data for the quantitative method, using Statistical Packages for Social Science (SPSS) based on the variables. Descriptive data was presented using graphs, pie charts, and percentage and frequency tables. On the other hand, thematic analysis was used to analyse qualitative data to find out people's knowledge, opinions, views, ideas, and lived experiences of PPPs in the health sector in Uganda.

Quantitative data was collected by using questionnaires. The participants for the quantitative method were recruited through referrals from the subjects purposely selected because they were of high-ranking positions in the government RRHs, possess relevant knowledge, and lived experience of PPPs. Whereas qualitative data was collected, using an interview approach, and this was achieved through face-to-face interactions with the participants that were purposely included in this study. The reason for using an interview approach was to allow free interactions, and capture the knowledge and lived experience of the sampled participants, about the role of PPPs in the health sector in Uganda. Before data analysis, all the surveys were merged into a single data set. Consequently, the participants' knowledge and opinions were recorded and analysed using thematic analysis.

This chapter is divided into two sections, i.e., ***Section A and Section B:*** whereby *Section A* presents an analysis of the demographic characteristics and background information of the study participants. While *Section B* presents an analysis of study objectives and variables based on the statement of the problem. The data extracted from the analysis is presented here by the use of graphs, pie charts, and percentage and frequency tables to ease interpretation of data and concluding the study findings.

Table 6.1: Response Rate of Questionnaires

Response Rate	
Category	**Frequency (n)**
Valid	126
Invalid	34
Total Sample Size	**160**

Table 6.1 shows the response rate of the survey questionnaires administered to the study participants and returned as either valid or invalid. The current study determined a sample size of 160 subjects to represent the target population. The survey questionnaires were administered under the supervision of the principal investigator, with assistance and directions from the Ministry of Health; and majority n=126 (79%) copies of questionnaires were answered correctly, and returned valid, giving n=34 (21%) as invalid questionnaires.

Figure 6.1: Percentage Response Rate

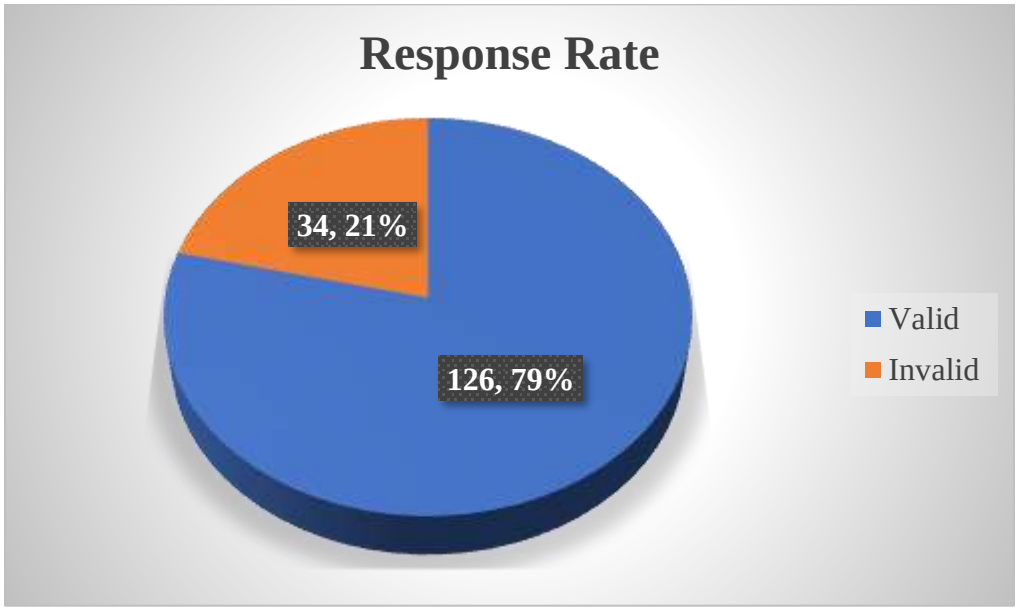


Figure 6.1 shows the percentage response rate of survey questions that were administered to 160 participants and returned 126 valid and 34 copies were invalid as Adnan (2019), demonstrates. Consequently, a response rate of 50% is average or good; a response rate of 60% is adequate and acceptable for data analysis, and a response rate of 70% and above is deemed, and considered extremely good and acceptable for data analysis and reporting. The

response rate has been supported by Morton *et al.* (2012), and with regards to this study, a 79% response rate supported data analysis and interpretations of results.

This rate was adequate and supported the data analysis process and reporting of results as demonstrated in the proceeding sections. The response rate was determined based on the number of valid and invalid questionnaires returned from the field. This view was supported by Cole et al. (2014), where post questionnaires were used to determine the valid response.

DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

6.1 Demographic characteristics of study participants

Demographics refers to the specific characteristics of a target population, and these include gender, marital status, sexual orientation, age, race, ethnicity, education, religion, occupation, income status, homeownership, family size, and health status. Demographic information is an independent variable because it can never be duplicated. This data generates information about the study participants, and it helps to determine whether or not the subjects are a representative sample of the entire populace for generalisation purposes (Salkind, 2010).

Consequently, this study determined the demographic characteristics of the participants as gender, age, marital status, education level, occupation, duration of service, and location. As indicated in the sample size section, the study purposively selected 4 hospital directors of RRH as key informants and sampled n=160 participants on a referral basis for quantitative research, and 32 respondents to generate qualitative data. Table 6.2 shows the demographic characteristics of study participants.

Table 6.2: Gender, Marital status, Age, and Education of Study Participants

Variables		***Frequency (n)***	***Percentage (%)***
Gender of Study Participants	M	71	56.3
	F	55	43.7
	Total	**126**	**100.0**
Marital Status of Study Participants	Single	61	48.4
	Married	63	50.0
	None of the above	2	1.6
	Total	**126**	**100.0**
Age of Study Participants	21-35	71	56.3
	36.45	31	24.6
	46-55	19	15.1
	Above 56	5	4.0
	Total	**126**	**100.0**
Education of Study Participants	Secondary	2	1.6
	Tertiary	38	30.2
	University	86	68.3
	Total	**126**	**100.0**

Table 6.2. shows the demographic characteristics of the study participants as gender, marital status, age, and level of education, which were deemed important for data analysis and reporting.

6.1.1 Gender of Study Participants

Specifically, it was important for this study to establish the gender distribution of the participants that voluntarily took part in providing the required information concerning the role of PPPs in the health sector in Uganda. There is a notion that female health workers, including nurses and doctors, offer better care than their male peers. Most people agree on a large-scale statistic that female doctors offer better patients' outcomes, and female nurses and doctors have a better communication interface with their clients than male doctors.

For data analysis and reporting, the study findings on gender distribution show that the majority n=71 (56%) male, and followed by n=55 (44%) female participants who responded to this particular question. The study findings show that health systems in Uganda employ more male than female physicians. Gender inequality creates limitations to the health sector in delivering quality care to patients. For instance, the public perceives that if a certain government hospital recruits more males than females, it creates a gap in the healthcare services. Consequently, improving gender role equality can minimise rates of poor healthcare services offered to patients.

6.1.2 Marital Status of Study Participants

Table 6.2 shows the marital status of participants that took part in this study. It was important for this study to find out the marital distribution of the staff on the pretext that this variable has a bearing on the care offered to the patients. The findings as demonstrated in table 6.2 shows that the majority of n=63 (50%) staff were married, slightly followed by n=61 (48%) singles, and lastly, n=2 (2%) of those who responded to this question are either married or single, meaning they follow under the category of the widow, or widowed, or separated.

6.1.3 Age of Study Participants

Table 6.2 shows the age distribution of participants that took part in this study. The findings show that the majority n=71 (56%) of those who responded to this particular question were in the age bracket of 21-35, followed by n=31 (25%) staff were in the 36-45 age group, n=19 (15%) participants were in the age bracket of 46-55, and lastly n=5 (4%) health workers were in the age group of 56 and above. This variable indicates that a substantial number of staff are still young, and energetic to improve care to the population.

6.1.4 Education of Study Participants

The level of education is a key and prerequisite to be enrolled in both the private and public service system in Uganda. The study sought it important to find out whether Uganda's health systems employ educated and trained personnel or not. After data analysis, the study findings in Table 6.2 show that majority of n=86 (68%) staff employed in government hospitals hold a bachelor's degree, followed by n=38 (30%) health workers who had qualifications from tertiary institutions, and lastly only n=2 (2%) participants indicated that they hold a secondary school certification of either O-level Uganda Certificate of Education or Uganda Advanced Certificate of Education.

The findings show that Uganda's health systems employ educated and qualified workers to provide healthcare services to the patients. This creates confidence in the minds of the population that the care providers have been tested and possess the required skills to work in the health sector, and also to manage the patients.

Table 6.3: Title/occupation, Duration, and Location of Study Participants

Variables		**Frequency**	**Percentage**
Title/Occupation of Study Participants	Allied Health Professional	2	1.6
	Clinical Officer	2	1.6
	Doctor	48	38.1
	Government Official-MoH	3	2.4
	Hospital Administrator	1	0.8
	Housekeeper	2	1.6
	Medical Social Worker	2	1.6
	Nurse/Midwife	58	46
	Paramedical-Orthopaedic Officer	1	0.8
	Pharmacist	6	4.8
	Physiotherapist	1	0.8
	Total	**126**	**100**
For how long have you been serving?	1year and above	60	47.6
	1-5	16	12.7
	1-10	11	8.7
	1-15	9	7.1
	15 and above	30	23.8
	Total	**126**	**100.0**
Which Government Regional Referral Hospital?	Fort Portal RRH	36	28.6
	Mubende RRH	24	19.0
	Soroti RRH	34	27.0
	Lira RRH	32	25.4
	Total	**126**	**100.0**

Table 6.3 shows some demographic characteristics as title/occupation, duration of participant's work, and location of study respondents.

6.1.5 Title/Occupation of Study Participants

The current study sought to establish the occupation of the participants that were sampled. The reason for recruiting participants based on their role, or positions in the daily operations of the government hospitals was to collect vast data and diver opinions about the topic under investigation.

Table 6.3 presents the title/ position of each participant that took part in this study. The table shows that the majority n=58 (46%) staff were nurses, and n=48 (38%) participants were doctors, n=6 (5%) respondents were pharmacists, and this was followed by n=3 (2%) of whom were government officials from the ministry of health, n=2 (2%) Allied Health Professionals, n=2 (2%) were clinical officers, n=2 (2%) were medical social workers, n=2 (2%) were house-keepers, and the rest, such as hospital administrator, paramedical-orthopedic officer, and physiotherapist each scored n=2 (1%) of the participants who took part in this study.

In total, eleven categories of participants were sampled and provided information to this study as Table 6.3 demonstrates. The findings, therefore, imply that government hospitals employ a huge number of nurses to provide care to the patients compared to any other categories of health workers, as shown in Table 6.3. However, there is a slight margin of 8% between the number of nurses and doctors employed by the government hospitals.

6.1.6 Duration of service by the Study Participants

This section represents information about the number of years each respondent had served in their position as public servants in the government regional referral hospital at the time of this study. Duration of service is important because it helps the employees acquire skills and experience in their careers. Table 6.3 shows that the majority n=60 (48%) of the participants had served in the government hospitals for 1-year and above, n=30 (24%) staff at the time of this study had served 15-years and above, and this was followed by n=16 (13%) respondents who had worked in the health sector between 1-5 years, n=11 (9%) staff had served in the government hospital between 1 and 10 years; and lastly n=9 (7%) of sampled participants reporting to this study, having served between 1 and 15 years in the government regional referral hospitals in Uganda.

The study findings, therefore, indicate that the majority of health workers in Uganda had served in the health sector, in a particular government regional referral hospital for less than 5 years,

with a second category that revealed having worked for 15 years and above at the time of this survey. Consequently, these two categories revealed relevant information to this study regarding the role of PPPs in the health sector in Uganda. For instance, most of the participants sampled noted that partners in the private sector have offered funds to the regional referral hospital, especially where the government was not in a position to finance several projects, and services urgently needed to deliver quality care to the patients, and save lives.

The projects and services reported to this study through the interview approach include the provision of clinical equipment, infrastructure, capacity building, employment opportunities, medical supplies, drugs, monetary and human resources that have significantly improved on staffing and quality of care offered to patients. There was no way sampled groups could possess such rich data without having worked a reasonable period, for more than one year of service. Consequently, this study discovered that duration of service helps workers get familiar with the workplace, and has a bearing on the person's experience.

6.1.7 Distribution of Participants in Government Regional Referral Hospital

The current study sought to establish the number of health workers, and PPP projects and services based on the location of the government regional referral hospitals. The government regional referral hospitals that were selected and sampled included Fort Portal, Mubende, Soroti, and Lira RRH. Consequently, Table 6.3 shows that the majority n=36 (29%) sampled participants were from Fort Portal RRH, this was followed by n=34 (27%) staff came from Soroti RRH, with a slight margin of n=32 (25%) participants were from Lira RRH, and lastly n=24 (19%) informants were from Mubende RRH. The difference in the number of staff could be attributed to the scope and population, a government hospital serves.

SECTION B

KEY STUDY VARIABLES

Section B presents the key information collected and analysed based on the study objectives to assess the roles of PPPs in the health sector in Uganda. Study respondents provided their knowledge and lived experience regarding PPPs, their role in the health sector, the importance for government hospitals, and communities in Uganda. The purpose was achieved through survey questions and interview guides.

6.2 OBJECTIVE ONE: The PPPs in Uganda's Health Sector

Table 6.4: The PPPs Health Sector in Uganda

Study Variables		Frequency (n)	Percentage (%)
Have you ever heard or know about health PPPs in Uganda?	YES	124	98.4
	NO	2	1.6
	Total	**126**	**100.0**
Do you know of any healthcare projects/ services implemented under the health PPPs contract in Uganda?	YES	109	87.2
	NO	10	8.0
	NOT SURE	6	4.8
	Total	**125**	**100.0**
Did not answer this question	**System**	**1**	**.8**
Total		**126**	**100.0**
If yes, do you agree with the views that the health PPP models can improve the healthcare sector in terms of quality and service delivery in Uganda?	YES	114	94.2
	NO	3	2.5
	NOT SURE	4	3.3
	Total	**121**	**100.0**
Did not answer this question	**System**	**5**	**4.0**
Total		**126**	**100.0**

Objective one of this study was to examine the importance of PPPs in the health sector in Uganda. Table 6.4 shows participants' knowledge, the health projects, and healthcare services implemented and delivered under the PPPs arrangement. The table also shows the respondents' agreement with the view that PPPs have improved care and healthcare service delivery in Uganda.

The study variable on question one inquired to establish the participants' knowledge about PPPs in the health sector in Uganda. Table 6.4 shows that the majority of n=124 (98%) sampled participants have knowledge of the health PPPs, and only n=2 (2%) staff have never heard about health PPPs arrangement. However, this gap was bridged by the interview approach, where the term PPPs was explained to the participants in detail.

It was, therefore, important to find out whether there are healthcare projects or services implemented by private partners in the government regional referral hospitals. To achieve this, the study asked the respondents about any health projects, and, or healthcare services delivered or ongoing in Uganda. Table 6.4 demonstrates that n=109 (87%) out of n=124 who demonstrated their knowledge about PPPs, reported that there are several PPP projects and services implemented in almost all government RRH, and only n=10 (8%) participants do not know any health projects, or services, and n=6 (5%) respondents were not sure about this particular study variable.

More importantly, the third question inquired to find out whether PPPs have improved the quality of care and healthcare service delivery in Uganda. Table 6.4 shows that n=114 (94%) participants agreed to the study variables, and this was followed by n=3 (3%) respondents who agreed with the notion, and n=4 (3%) participants were not sure whether the PPPs can improve the quality care and healthcare service delivery.

Table 6.5: Mean and Standard Deviation of the importance of PPPs for government RRH in Uganda

Descriptive Statistics

Study Variables	**N**	**Mean**	**Std. Deviation**
Have you ever heard or know about health PPPs in Uganda?	126	1.02	.125
Do you know of any healthcare projects/ services implemented under the health PPPs contract in Uganda?	125	1.18	.493
If yes, do you agree with the views that the health PPP models can improve the health sector in terms of quality and service delivery in Uganda?	121	1.09	.387
Average	**120**	**1.09**	**0.34**

Table 6.5, therefore shows that the majority of study participants agreed that PPPs are important arrangements for Government Regional Referral Hospitals in Uganda (mean=1.09; SD=0.34). The level of agreement from the questionnaire approaches is in harmony with the data obtained using the interview method. For instance, the interviewees noted that PPPs have been recognised to be agents of improved healthcare service delivery to the patients. The quantitative data is in agreement with qualitative data obtained from using the interview approach. The interviewees contend that PPPs are agents of *improved* care and healthcare service delivery to the patients.

The interviewees indicated that PPPs are key drivers for improved healthcare service delivery to the patients. The informants maintain that the involvement of the private sector helps the government RRHs to improve human resource capacity through training and capacity building of staff. *ñ Private sectors improves, strengthen capacity capacity building, provide health services and equipment on time, and are efficient in terms of service delivery, medical supplies like ARVs, drugs, and non-clinical support like counseling services. ò*

6.3 OBJECTIVE TWO: The Roles Played by PPPs in the health sector in Uganda

Table 6.6: The Roles Played by PPPs in the health sector in Uganda

Study Variables		**Frequency (n)**	**Percentage (%)**
What roles that health PPPs have played in the	The private partners designed, built, maintained, and or renovated the public healthcare facilities	11	8.8
	The private partners expanded and improved the capacity of health facilities and improved healthcare service delivery	9	7.2
	The private partners financed the construction of a health facility, and provision of health services to the population	5	4.0

healthcare systems in Uganda?	The private partners have provided financial, advisory, clinical, and non-clinical support services	5	4.0
	All the Above	95	76.0
	Total	**125**	**100.0**
Did not answer this question	**System**	**1**	
TOTAL		**126**	
To what extent do you agree or disagree that the implementation of health PPPs has played a vital role and achieved its objectives in improving the care quality and delivery of healthcare services in Uganda?	Strongly Agree	47	39.5
	Agree	64	53.8
	Strongly Disagree	1	.8
	Disagree	1	.8
	Neutral	6	5.0
	Total	119	100.0
Did not answer this question	**System**	**7**	**5.6**
TOTAL		**126**	**100.0**
To what extent do you agree or disagree that PPPs have performed well in the healthcare sector in Uganda since implementation?	Strongly Agree	37	30.1
	Agree	67	54.5
	Strongly Disagree	1	.8
	Disagree	5	4.1
	Neutral	13	10.6
	Total	123	100.0
Did not answer this question	**System**	**3**	**2.4**
Total		**126**	**100.0**

Objective two assessed what PPPs have done in the health sector in Uganda. Table 6.6 presents the primary data collected about the key roles of Public-Private Partnerships in Uganda's health

sector. For instance, the PPP policy allows private sectors to deliver the following projects, or services: design, build, maintain, and, or renovate the public health facilities; expand, and improve the capacity of hospitals; finance the construction of a health facility, and provision of healthcare services; provide financial services, advisory services, clinical and non-clinical support services to the public hospitals.

The study findings show that the majority of n=95 (76%) participants agreed with the variables that the private sector has played its mandate towards improving the care and healthcare service delivery through projects and healthcare services provision. For instance, private partners have greatly played a vital role through designing, construction, provision of equipment, provided healthcare services; and also helped in offering financial services, advisory services, clinical and non-clinical support services to the public hospitals. Only n=1 participants of those who responded to this particular question did not answer.

Besides this, the qualitative data obtained through the interview approach, complements the findings of the quantitative method. For instance, the *Japan International Cooperation Agency (JICA*) project offers grants to government regional referral hospitals through the construction of hospital buildings like an OPD facility, and the provision of medical equipment. The study participants reported to this study that *ñ t h i s p a r t n e r s h i p h a s i m infrastructure at Fort Portal RHH, Mubende RRH, and LRRH through the construction of buildings, and has supported in quality improvement of the health services offered to the patients. JICA has constructed several emergency facilities, such as outpatient department (OPD), theatre in Mubende RHH, and equipped it, and they compensate the workers they e m p l* At the time of this study, it also found that JICA is also funding the ongoing health big facilities in Lira and Fort Portal RHH.

More importantly, Table 6.6. also shows the level of the participants' agreement to whether the PPPs have played a vital role, and achieved their mandate and objectives of improving the care quality and delivery of healthcare services in Uganda. Table 6.4 shows that the majority n=64 (54%) participants agreed that the private sectors have fulfilled their role and achieved their objectives in the health sector, and this was followed by n=47 (40%) respondents who strongly agreed with the study variable, with only n=6 (5%) participants who are neutral about this study question.

Besides, the majority n=67 (55%) participants agreed, and this was followed by n=37 (30%) respondents who strongly agreed with the study variable that PPPs have performed well in the

health sector in Uganda since the private sector policy implementation way back in 2000, and only n=13 (11%) of those who took part in this study were neutral to this particular question. In addition, the data obtained through survey questions are in harmony with the interview approach, where the interviewees revealed to this study the following achievements as:

ñPPPs have improved the quality of care through clinical diagnosis; improved in the availability and accessibility of healthcare services; there is now a reduction in Anti-microbial drug resistance; improved on accountability, monitoring, and evaluation of health projects and services offered; eliminated HIV stigmatisation; reduced the rate of infection and HIV related diseases like TB; there is a reduction in HIV cases, reduced financial burden on the government side; and reduced congestion at the government RRH facilities due to the improvement in many infrastructures and capacity, improved on manpower through recruitment and training, increased medical supplies, and ca p a c i t y o f t h e e q u i p m e n t . ò

6.4 OBJECTIVE THREE: challenges affecting the successful implementation and performance of PPPs in the health sector in Uganda

Table 6.7: Challenges affecting the successful implementation and performance of PPPs in the healthcare sector in Uganda

Study Variables		**Frequency (n)**	**Percentage (%)**
Do you agree with the view that PPPs face challenges during implementation processes and times of performing their roles?	YES	107	86.3
	NO	7	5.6
	NOT SURE	10	8.1
	Total	124	100.0
Did not answer this question	**System**	**2**	**1.6**
Total		**126**	**100.0**
Do you agree that Policy development and conceptualisation of the partnership, resource mobilisation and allocation, information sharing, monitoring, and accountability are major challenges affecting the successful implementation and performance of PPPs in the health sector?	YES	104	83.9
	NO	2	1.6
	NOT SURE	18	14.5
	Total	124	100.0

Did not answer this question	**System**	**2**	**1.6**
Total		**126**	**100.0**
Do you agree with the view that health PPPs in Uganda need policy reforms or large rethinking based on the implementation processes and performance?	YES	114	90.5
	NO	2	1.6
	NOT SURE	10	7.9
	Total	**126**	**100.0**

Objective three of this study examined the challenges affecting the successful implementation and performance of PPPs in the health sector in Uganda. Table 6.7 presents the participants' agreement that PPPs face serious challenges, and their views on whether PPPs need policy reform, were captured. The table shows that the majority n=107 (86%) participants agreed with the study variable that PPPs face critical challenges during the implementation, and at the execution process, with n=10 (8%) who were not sure, and however, n=7 (6%) participants reported to this study, indicating that private partners do not face any challenges at the time of implementation.

Another survey question examined to find out whether policy development and conceptualisation of the partnership, resource mobilisation, and allocation, information sharing, monitoring, and accountability are some of the major challenges affecting the successful implementation and performance of PPPs in the health sector. Table 6.7 shows that the majority of n=104 (84%) participants agreed with these variables, n=18 (15%) respondents are not sure about which exact challenge affects the PPPs in the health sector, and lastly, only n=2 (2%) of those who took part in this study reported no to the study variables. This implies that there are more critical challenges that significantly affect the successful implementation, and execution of the PPP mandate in Uganda's health sector.

Table 6.8: Mean and Standard Deviation of the Challenges affecting health PPPs in Uganda

Descriptive Statistics

	N	Mean	Std. Deviation
Do you agree with the view that PPPs face challenges during implementation processes and times of performing their roles?	124	1.22	.578
Do you agree that Policy development and conceptualisation of the partnership, resource mobilisation and allocation, information sharing, monitoring, and accountability are major challenges affecting the successful implementation and performance of PPPs in the health sector?	124	1.31	.712
Do you agree with the view that health PPPs in Uganda need policy reforms or large rethinking based on the implementation processes and performance?	126	1.17	.553
AVERAGE	124	1.23	0.61

Table 6.8 shows that the biggest number of participants agreed to the view that health PPPs face critical challenges during the implementation process and performance (mean=1.23; SD=0.61).

More importantly, the quantitative findings were complemented by the qualitative data obtained through the interview approach, where interviewees revealed to this study some critical challenges, and their lived experience dealing with the private sector while implementing the PPP projects and services. For instance, the interviewees revealed the following critical challenges as the stumbling block towards the successful implementation and delivery of PPPs projects and services in the government regional referral hospitals in Uganda. The informants;

ñ T h e p r i v a t e s e c t o r s a r e c o n f r o n t e d b y p o l conflict of interest, parallel working relationships among the health workers from the private and government side, poor communication, the discrepancy in compensation structure, poor priority, insufficient funding, and sustainability plan, collision on the same project among private partners, poor follow-u p a n d m a n y o t h e r s . ò

Due to the critical challenges affecting the successful implementation, and delivery of PPP mandate, the study inquired to find out whether the health PPP policy needs reforms. Table 6.7 also presents the participants' agreement based on the challenges, and what has been achieved. The table shows that the majority n=114 %) participants agree that health PPPs need policy reform, this was followed by n=10 (8%) respondents who were not sure of the study variable, and lastly n=2 (2%) participants reported that there is no need to make policy reforms.

6.5 OBJECTIVE FOUR: The best type of PPPs Business Model for the Health Sector in Uganda

Table 6.9: The best type of PPPs Business Model for the Health Sector in Uganda

Study Variables		**Frequency (n)**	**Percentage (%)**
Do you agree Uganda's health sector has followed any of these PPP modes, infrastructure-based Model, Discrete Clinical-Service Model, Integrated Clinical-Services Model?	YES	96	78.7
	NO	9	7.4
	NOT SURE	17	13.9
	Total	**122**	**100.0**
Did not answer this question	**System**	**4**	**3.2**
Total		**126**	**100.0**
If yes, which one of the following health PPPs is the best business model to be implemented in Uganda's health systems?	Infrastructure-Based Model	29	27.9
	Discrete Clinical-Service Model	33	31.7
	Integrated Clinical-Service Model	42	40.4
	Total	**104**	**100.0**
Did not answer this question	**System**	**22**	**17.5**
Total		**126**	**100.0**

Objective four of this study assessed to identify the best health PPP model for Uganda's health sector. Two closed-ended questions were designed to achieve this particular objective. Question one of objective four sought to find out whether Uganda's health sector has followed

any of the PPP models; and Table 6.9 shows that the majority n=96 (78%) participants agreed that the government has implemented the health PPP models, this was followed by n=17 (14%) respondents who were not sure, n=9 (7%) of those that responded to this question, and lastly only n=4 (3%) of those that were sampled did not respond to this particular question. However, since the majority 78% answered in affirmative, this means that Uganda has embraced the support, and importance of Public-Private Partnerships, and this justifies the significance of this study.

The second question of objective four sought to identify the best health PPP business model in Uganda's health sector. The health PPP models were identified as infrastructure-based Model, Discrete Clinical Support-Service Model, Integrated Clinical-Services Model. Consequently, Table 6.9 also shows that the majority n=42 (40%) participants reported to this study that Integrated Clinical-Service Model is the best, this was followed by n=33 (32%) respondents who selected the Discrete Clinical-Service Model as the best, and lastly n=29 (28%) of those who responded to this particular question voted for an Infrastructure-Based Model, though with a slight margin.

The quantitative data obtained through questionnaires is in agreement with the findings of the qualitative method collected through the interview approach. For instance, the interviewees identified an Integrated Clinical Services business model as the best PPP model for the health sector in Uganda, followed by the Discrete Clinical Services PPP model, and lastly Infrastructure-Based Model for Uganda's health sector. However, the interviewees call for a strategic, and effective way when it comes to implementing these PPP models. *ñ I ntegrated Clinical Services PPP business model is the best, but there should be an approach to implement the best PPP model. For instance, the best model should be based on the priority and needs of t h e p o p u l a t i o n . ò*

6.6 Summary of the Chapter

This study result presents the primary data obtained from the field through a questionnaire and interview approach. The purpose of using both survey questions, and interview guides was to bridge the statistical gap that may exist as a result of using a single method. For instance, questionnaires captured closed-ended responses, and an interview allowed free interactions and obtained knowledge and lived experience regarding the role of PPPs in Uganda's health sector. The study employed descriptive analysis of data, and SPSS was used. Descriptive data was

presented using graphs, pie charts, and percentage and frequency tables. Consequently, this chapter presents the knowledge, lived experience, and opinions of the sampled participants.

The study administered 160 questionnaires and obtained a 79% response rate that supported data analysis and interpretations of the final findings. It was found that government hospitals in Uganda recruit more male physicians than female health workers. The study findings indicate that PPPs are an important tool implemented towards improved care quality, and healthcare service delivery through financing, construction of hospital infrastructure, medical supplies, equipment, and non-clinical support services, such as cleaning, recruitment, training, and capacity building of staff.

The study found the following as key challenges affecting the implementation and performance of health PPPs: political interferences, corruption, bureaucracy, conflict of interest, parallel working relationship among the health workers from private and government sides, poor communication, the discrepancy in compensation structure, poor priority, insufficient funding, and sustainability plan, collision on the same project among private partners, poor follow-up and many others. More importantly, the Integrated Clinical Services health PPP business model is the best for Uganda's health sector. Chapter Seven presents research and a detailed discussion of the study findings.

CHAPTER 7

DISCUSSION OF STUDY FINDINGS

7.0 Introduction

Chapter Six analysed and presented the empirical findings of the study. It comprised of a detailed interpretation of data analysed based on the research topic and objectives. The chapter undertook both thematic and descriptive analysis. The discussion chapter is divided into two sections, i.e., Section A and Section B: whereby *Section A* discusses the demographic characteristics of the respondents. Whereas *Section B* discusses the findings of the key study variables. Descriptive data were presented using pie-charts, descriptive and frequency tables to form quantitative analysis as supported by (Nick, 2007).

On one hand, thematic analysis is used to understand the patterns that form common themes of qualitative data (Ahmed, Mrsonda & Pretorius, 2019; Biygautane, Neesham & Yahya, 2019:192-201; Hossain, Guest & Smith, 2019:46-68; Nduhura, 2019; Opara & Rouse, 2019). The current study used the approach to find out people's knowledge, opinions, views, ideas, values, and lived experience of the PPPs in the health sector of Uganda (Solheim-Kile, Lædre & Lohne, 2019).

7.1 Demographic Characteristics of the Study Participants

Demographics analysis refers to the study of quantifiable statistics of a target population based on their gender, marital status, sexual orientation, age, race, ethnicity, education, religion, occupation, income status, homeownership, family size, and health status. Researchers use demographic data to understand the sample of the study participants (Connelly, 2013). Demographic data is crucial to social science studies (Sifers *et al.,* 2002). The information helps to make specific generalisations about the population to identify eligible study participants.

Demographic data is an independent variable because it cannot be changed or duplicated by anyone. This data generates information about the study participants, and it helps to determine whether the subjects are a representative sample of the entire populace for generalization purposes (Hammer, 2011; Salkind, 2010). The current study determined the demographic data, such as gender, age, marital status, education level, occupation, duration of service at a given hospital, and location of RRH. However, the discussion section has focused on the gender and position of the respondents at the government regional referral hospitals. The decision to discuss these features is that they hold a bearing on the health outcomes. For example, previous

studies show that female doctors, comparing male and female doctors, offer better care to patients than their male colleagues (Jerant *et al.,* 2013; Tsugawa *et al*., 2017).

7.1.1 Gender of Study Participants

Gender role distribution in public service plays an important role in delivering quality care to patients. For instance, in the health sector, doctors handle their patients differently according to gender because sex has a significant impact on the practice of medicine (Barres, 2006; Hølge-Hazelton & Malterud, 2009). This study found out the gender distribution of health workers in the government hospitals in Uganda. The study results show that the health systems in Uganda employ more male than female peers *(see Table 6.2 on page 163).* This is attributed to the high number of male students that enroll for nursing and medical courses compared to the female category that receive relatively less numbers. This creates a big gap in the provision of healthcare services to the population, and the goal to achieve primary Health Care Coverage (HCC) becomes a challenge to the health sector.

The variation in gender shows that female health workers offer better patient outcomes and they have a better communication interface with their clients than male doctors. The differences in average mortality rate between patients treated by male and female health workers are low but statistically significant to the health sector. It also implies that gender inequality may create dangers in medical practice if not well-managed.

However, there is a growing body of literature, suggesting that female doctors offer better care to patients and improved communication with their patients than male doctors do (Tsugawa *et al*., 2017). Despite the increasing challenges that female health workers face, previous studies maintain that female health workers achieve better patient outcomes than those of their male colleagues (Healthline Media, 2021). The Journal of the American Board of Family Medicine conducted a study to find out the relationship of the gender of a patient's source of quality care, with healthcare consumption and death. Their finding shows that patients under the care of female doctors shown, having less mortality rate compared to patients under the care of male doctors (Jerant *et al.,* 2013).

The most recent studies have shown that on average, female health workers may have a small edge in some cases. For instance, Tsugawa *et al*., conducted a study in 2017, using a cross-sectional approach on hospitalised care among 65-year-olds and above beneficiaries of healthcare. Their study indicates that patients treated by female health workers, such as nurses,

doctors, and physicians had lower readmission and mortality rates than patients treated by male peers (Tsugawa *et al*., 2017).

Besides, Wallis *et al.* in 2017 compared post-operative clinical outcomes among patients aged 18-years old and above, they also found similar outcomes. The study shows that patients under female surgeons had lower rates of one-month death than those patients under the care of male surgeons (Wallis *et al.,* 2017). Male and female health workers differ in their practice of medicine in ways that may significantly impact patient outcomes. Previous studies also indicate that female health workers are more likely to make follow-up recommendations of counseling and to make preventive clinical tests, such as mammograms and smears (Frank & Harvey, 1996). This means that female doctors offer counseling services to patients more than their male peers do. The studies indicate that patients under the care of female doctors are less-likely to die or be readmitted to the hospital after discharge than patients cared for by male peers.

7.1.2 Occupation of Study Participants

The current study found that Uganda's health sector employs more nurses to provide care than other categories of health workers *(see Table 6.3 on page 165).* There is a slight margin between the number of nurses and doctors employed by the government hospitals. Besides, studies show that when in the hospital, the patients put their lives in the hands of other people, who are trained, trustworthy, and have committed themselves to care for their clients. It has been suggested that nurses are the most committed and trusted health workers, compared to doctors, because they spend 24/7 caring for their patients and advocating for their rights (Krislov, 2020).

For instance, studies show that the number of nurses in the United States has more than doubled in the past seven years (Finnegan, 2020). The increasing growth of nurses is attributed to the rapid expansion of health education programmes that have significantly attracted millennial nurses. As a result, they now graduate as many as possible each year. For instance, Fierce healthcare reported in February 2020 that the number of nurses in the U.S. grew from nearly 91,000 to 190, 000 staff from 2017 to 2020 (Auerbach, Buerhaus & Staiger, 2020).

KEY STUDY FINDINGS

7.2 Discussion of the Key Study Findings

This section discusses the key study variables based on the objectives. The findings of this study are discussed in relation to the previous works of literature. As a result, each fact obtained and presented here has been compared with the previous studies to help make an informed conclusion and recommendations.

7.2.1 OBJECTIVE ONE: The PPPs in Health Sector in Uganda

The aim of objective one was to establish the importance of PPPs in Uganda's health sector. The sampled participants showed a deeper understanding of the existence and importance of PPPs arrangements in Government Regional Referral Hospitals, as Table 6.4 on page 168 shows. For instance, the study found several healthcare projects and services implemented by private partners in RRHs. The quantitative data, for instance, indicates that the majority of the participants agreed with the study variable that PPPs are important arrangements for government hospitals because they improve the quality of care and healthcare service delivery in Uganda.

For instance, the interviewees noted that PPPs are an important arrangement for government because: "*1) they improve healthcare service delivery and hospital infrastructure; 2) improve on the health standards; 3) provide the necessary funding to run different activities and projects; 4) improve on human resources through recruitment, training, capacity building, compensation of health workers, and the 5) impr*
respondents noted. The current study is in harmony with some of the previous studies regarding the importance of PPPs. For instance, the National Academies of Sciences, Engineering, and Medicine show that PPPs is not a new concept to improve service delivery, for instance, a 1993 World Health Assembly Resolution urged the WHO to mobilise and solicit remarkable support from partners in the health sector, including government institutions and NGOs (Buse & Waxman, 2001; National Academies of Sciences, Engineering, and Medicine, 2016). PPPs are key components in strengthening the entire health system through pooling relevant resources and technical skills to ensure quality care and service delivery to patients (Ferreira & Marques, 2021).

Also, a study by Tshombe, Molokwane, Nduhura, & Nuwagaba (2020) shows that most African countries have recognised the need to have PPPs as apparatus to finance infrastructural development in the region. The authors identify some development partners, including the

African Development Bank, the International Monetary Fund, and the World Bank as key funders of the infrastructure development for the emerging economies (p. 152). Besides, this study adds that Korea International Cooperation Agency (KOICA) *and Japan International Cooperation Agency (JICA) partnerships also provide* grants through construction and equipping of hospital facilities with equipment and medical supplies in almost all government RRH. Consequently, PPPs have been embraced as a means for procuring public goods and services to improve the lives of people and governments have put their hope in the private sector partners.

The current study found many NGOs providing remarkable equipment and services to the population. The qualitative data, for example, shows that the Infectious Disease Institute (IDI) has improved human resources. *ñ I D I p a r t n e r s t r a i n h e a l t h w o r community to educate the patients in their own homes about the dangers and prevention mechanism of infectious diseases, such as Ebola, COVID-19, among others. Also, IDI partnership has improved on microbiology, and infrastructural development like laboratory facility*", the interviewees noted. In addition, RHITES, known as a regional health integration to enhance services in Lango-Acholi Sub region. The participants revealed to this study that RHITES offers capacity building, provide funds to purchase medical supplies and reagents, and sample collection tools. The project also delivers TB and HIV services to patients in Soroti RRH.

The interviewees in Soroti RRH revealed that different partners have improved the quality of care and service delivery, compared to before. For instance, they noted that Baylor has been instrumental in Soroti RRH. In their own words, they indicate that— *ñ B A Y L O R U G A N D A offers free treatment and management of HIV, and support people living with HIV/AIDS. They provide services like safe male circumcision (SMC) and have greatly improved on staffing through recruiting, and compensation arrangements. BAYLOR has also constructed a blood collection service centre, and offers family planning services to the community in a bid to improve the q u a l i t y* All these projects and services have been implemented to offer a quality of care and improved service delivery to the population.

***7.2.1.1** PPPs improve quality of care and service delivery to the patients*

The current study examined the importance of PPPs in the health sector on the pretext that they play an important role in improving care and healthcare service delivery to the patients through human resources, infrastructure, funding, and medical supplies and equipment. The study

results indicate that private sector involvement improves human resource capacity through recruitment, training, and capacity building of staff. They also provide healthcare services and equipment on time and in an efficient manner in terms of service delivery, medical supplies like ARVs, and non-clinical support like counseling services.

The informants noted that in their own words— *ñ p r i v a t e p a r t n e r s p r o v i d e to Lira Regional Referral Hospital (LRRH) to support the eye department, and finance the eye camps, offer transport funds to the patients, free drugs, which the Ministry of Health cannot provide to the patients. They also provide eye patients with free meals during the surgical period, and this has reduced the congestion at the hospital unit. Private partners offer subsidised healthcare services, drugs, sometimes even free medicine, provide non-clinical support like training, capacity building, and cleaning the hospital, which in the end leads to improved quality care and efficient services. PPPs bring in crucial skills, expertise in heath s e c t o r , a n d i m p r o v e t h e p r o f e s s i o n a l i s m o f h*

Some of the previous work of literature indicate that notwithstanding substantial supports and success, the provision of primary health care services by the government has its challenges, including limited funding, shortage of human resources, and poor infrastructure (Bergkvist & Pernefeldt, 2011; Joudyian *et al.,* 2021). To address this challenge, PPP arrangements are key to help improve healthcare service delivery to the population (Baig *et al.,* 2014; Engel & van-Lente, 2014; Oluoha, Umeh, & Ahaneku, 2014). For instance, Brad Schwartz and Bhushan (2004) show that PPPs have improved immunisation equity in Cambodia (p.661-667).

Besides, comparing the governments, the interviewees noted that the government of Uganda lacks intensive monitoring. In their words— *ñ t h e m o n i t o r i n g on the end sup government side are little, whereas private sector has strict monitoring and a supervisory role, i m p r o v e d r e p o r t i n g , a n d a c c o u n t a b i l i t y , w h i c* the interviewees added. PPPs are important because the budget of the Ministry of Health is limited to the current needs of Uganda's population.

The study findings reaffirm the studies carried out by Ferreira and Marques that compared the quality and support of both public and private sectors in providing health services to the population. Their study shows that PPPs are implemented to carry financial and human resource burdens, and the government transfers risks to private partners. For instance, the authors maintain that in Portugal, health PPPs are implemented to build hospitals and provide clinical services (Ferreira & Marques, 2021). Their study adds that the PPP arrangements

ensure efficient and sustainable use of healthcare services, and ensures that the patients receive high-quality care and timely services in an equitable way (Woodson, 2016).

7.2.1.2 *PPPs support in infrastructural development*

Private sector players are involved in design-build-finance and maintain a health facility (Abuzaineh *et al.,* 2018). The current study found that health PPPs have done a tremendous job in improving the status of government hospitals' infrastructure, including clinics, theatre, OPD, and emergency departments. For instance, *Japan International Cooperation Agency (JICA)* offers grants through construction and equipping of hospital facilities with equipment and medical supplies in almost all government RRH. Through this partnership, an emergency facility and theatre were constructed, for instance, at Mubende RRH, which was equipped, and facilitates the health workers they employ. The interviewees maintain that— *ñ J I C A partnership has improved the status of the hospital infrastructure like OPD facility in Mubende RRH, Lira RRH, Soroti RRH, and Mubende RRH,* ART clinics in Fort Portal RRH, *and offers supports in quality improvement of t h e h e a l t h s e r v i c e s o f f e r e d*

The study found that most of the modern facilities have increased in number and the capacity of operations, such as medical laboratories, hospital wards, and ART clinics have been constructed in most of the government RRH to offer support to children with sickle cell conditions, heart disease, and liver problems, through designing, financing, construction, medical supplies, and necessary materials and equipment like eye equipment, Slit Lamp, scan machine, and protective gear.

Most of the projects have been through health PPPs models adopted, such as build-operate-transfer (BOT), build-lease-transfer (BLT), and design-build-operate (DBFOT) among others (Adhikari, 2019). Most of these PPPs models operate through funding, ownership control and management, risk sharing and transfer, technical collaboration, investment approach, tax arrangement, and management of cash-flows (Indian Economy, 2016). This partnership has been possible through a long-term contract. The World Bank Institute indicates that PPPs is a long-term agreement between the government and a private company, which identifies a means of delivering public projects and services and, or assets, in which the private actors have the mandate to bear all risks and management roles (World Bank Institute, 2012).

7.2.1.3 PPPs bridge finance gaps

The United Nations Economic Commission for Africa indicates that health sector funding is still a problem to most of the developing countries (Aliko-Dangote, GBC Health, & United Nations Economic Commission for Africa, 2019). In addition, the study interviewees noted that the government of Uganda cannot meet its financial obligations of providing equitable and efficient services to the population. The government spends a lot on salaries, which in the end leads to poor health outcomes. The findings of this study are in agreement with the previous work by Sundewall and Brady, the study found that the government of Nigeria spends more on salaries and tertiary healthcare, vertical expenditure on government directorates at different units of the health sector. Moreover, the available limited funds are not well-managed, and thus lead to stock-out, inadequate medical supplies, and poor healthcare services delivered to the patients (Sundewall & Brady, 2019).

Consequently, the current study shows that PPPs are crucial for health sector funding and development in Uganda. The study informants maintain in their own words that— *ñ p r i v a t e p a r t n e r s p r o v i d e f u n d s t o g o v e r n m e n t h o s p i t a l s w h e r e t h e g o v e r n m e n t i s n o t i n a p o s i t i o n t o f i n a n c e s o m e p r o j e c t s a n d s e r v i c e s n e e d e d t o d e l i v e r q u a l i t y c a r e t o t h e p a t i e n t s , a n d a n y a s s i s t a n c e s r e n d e r e d t o t h e g o v e r n m e n t h o s p i t a l s e i t h e r d i r e c t l y o r t h r o u g h t h e M i n i s t r y o f H e a l t h a r e i m p o r t a n t t o i m p r o v e t h e h e a l t h c a r e s e r v i c e d e l i v e r y a n d t h e q u a l i t y o f c a r e o f f e r e d t o t h e p a t i e n t s ò .*

For example, private partners lobby for the government hospitals like MILDMAY in Mubende RRH helps the government to fund raise for funds outside the country, which in turn supports the operation of the entire hospital. The interviewees noted— *ñ M I L D M A Y h a s g r e a t l* *in service delivery and medical supplies, which the government may not manage, such as* *Result-base d F u n d i n g o f m e d i c a l e* The government of Uganda *d s t a f* lacks enough funding to meet its constitutional mandate of ensuring that quality care, efficient and timely healthcare services are delivered to its citizen. The private sector bridges these gaps, where the government is incapacitated to provide. Health PPPs offer great benefits for funding and implementing projects and services, and in the case of Uganda, it has become too expensive and resource-intensive for the government to finance using its own resources.

The findings of the current study are in agreement with some of the previous projects conducted on healthcare and funding initiatives. The studies show that there are funding gaps in the health

sector in Africa, estimated at $66 billion per year. The authors add that private sector financing holds great potential for growth and development. It is important to note that PPP synergies are important to the development of health systems on the African continent. (Wang *et al.*, 2012). The government of Ethiopia has largely depended on President's Emergency Programme for AIDS Relief (PEPFAR) partnership to provide almost everything from medical supplies to strengthening human resources to HIV, TB, and prevention of infectious diseases among its population. Therefore, the PPPs arrangement has registered tremendous success and impact on the community (Aliko-Dangote, H., GBC Health, & United Nations Economic Commission for Africa, 2019).

7.2.1.4 *PPPs strengthen the capacity of human resources*

As international development agencies and donors continue to increase global funding in response to the world's pressing health issues, including HIV/AIDS, and in support of the United Nations 17 Sustainable Development Goals (SDGs), the concern of organisation and human resource capacity is also steadily becoming important in the health sector (Wyss, 2004). The capacity of human resources is less visible, and yet important in the operational productivity, efficiency, supply chain improvement, and sustainability of the healthcare services. For instance, in Indonesia, PPPs have been established and offer unique services and support for the health sector to address system inefficiencies, health quality, and gaps in achieving primary health coverage (Health Policy Plus, 2020).

The open-ended interview questions enabled the informant to provide in-depth information that complimented quantitative data. In Uganda, PPPs have been recognised to improve on organisation and human capacity of government hospitals. The interviewees showed that PPPs are key drivers for improved healthcare service delivery to patients. The informants explain that the involvement of the private sector helps the government RRHs to improve human resource capacity through recruitment, training, retention, and capacity building of staff. *ñ P r i v a t e s e c t o r i m p r o v e s t h e c a p a c i t y o f h u provide health services and equipment in time, and are efficient in terms of service delivery, medical supplies like ARV drugs, and non-c l i n i c a l s u p p o r t l* the *k e c o u* interviewees added. PPPs offer training to health workers, improve the human resource management system and build organisation networks (Nkabane-Nkholongo *et al.,* 2015; Vian *et al.,* 2007).

The current study is in harmony with some of the previous studies conducted about the role of human resource capacity. Previous studies indicate that continuous mechanisms to address new issues and increase access to quality healthcare service, do not only necessitate medical supplies and financial support, but also a huge investment in human resource development, and management is needed to improve service delivery (Dwyer *et al.*, 2006; Sekhri, 2009). Since human resources play a significant role in improving healthcare service delivery to the population; it implies that the absence of a strong and competent health workers team would result in poor quality of care (Wyss, 2004). According to Vian *et al.* (2007), the ability of health organisations to improve access to quality care and healthcare services, largely depends on the capacity of the human resource (p.1).

7.2.1.5 *Essential areas are not given priority by the Government*

In Uganda, it has been reported that many health needs and the most urgent priorities of both men and women are not identified and attended to by the health systems (Ministry of Health, 1999). The interviewees also indicate that in many cases the government does not give priority to some of the most essential areas in the hospital, and lacks interest in some areas. Consequently, when the private partners come in, they bridge that gap, especially where the government has not taken a keen interest.

The study interviewees responded in their own words— *ñ P P P s a r e i m p o r t a n t i the government has no interest, but vital to the patients, so if there are any private donors that are willing to bring in such services and resources, it can help the common person and save millions of lives. Private partners venture and explore areas where the government has never e n t e r e d d u e t o f i n a n c i a l c h a l l e n g* Therefore, the *a d e q u a* current study is in harmony with the Ministry of Health report published in 1999. The report shows that the government of Uganda does not give priority to essential healthcare areas, and the development and implementation of healthcare policies and programmes that do not address gender issues, and thus shows little effort to how inequality impacts the wellbeing of the population (Ministry of Health, 1999). More importantly, Watkins *et al.*, show that priorities should be given to eliminating mortality and disease control, especially in times of a pandemic (Watkins *et al.*, 2018). Previous studies continue to assert that healthcare priorities should be based on ethical considerations, public values, and scientific evidence (Sundewall, & Brady, 2019).

Universal Health Coverage (UHC) involves the solidarity principle and should be based on human rights perspectives. As a result, it helps to direct health budgeting with the prioritised packages. National Development Plan II (NDP II) states Uganda's health financial year 2015/16—2019/20 priorities include universal access to family planning services, malaria management, minimising maternal death, development and improving the status of health infrastructure, reducing neonatal and child mortality and morbidity rate, the establishment of the National Health Insurance Scheme, and scaling up prevention of HIV/AIDS (Initiative for Social and Economic Rights, 2018).

7.2.1.6 *PPPs supplement on Government efforts in delivering healthcare service*

The study participants note that the health sector is too wide for the government of Uganda to effectively provide healthcare services to its citizens. The interviewees stressed that— *ñ t h e s c o p e o f h e a l t h c a r e s e r v i c e d e l i v e r y i s t o o* *aspects of issues, such as limited and poor facilities, poor care, shortage of equipment and medical supplies, social support for the sick, including counseling services to the people living with HIV. Yes, it is true the private sector work hand in hand with the government RRH to support a lot of activities, such as providing antenatal care services to pregnant mothers, clinical equipment and reagents for the equipment, carry out community outreach where the government may not have the financial muscles and enough human resource to reach the local p e r s o* the respondents noted.

PPPs are also important because the government hospitals cannot offer services that everyone requires. So, when private partners come in, they support the regional referral hospitals to provide healthcare services that match everyone's needs, efficiently and on time. During the interview, the interviewees noted— *ñ P P P s s u p p o r t i n d e l i v e r i n g h* *radio and television talk shows, which has really helped in sensitising and empowering the c o m m u n i t y a b o u t t h* Previous studies show that the private sector, such as NGOs, for-profit providers, and international donors play an important role in the health financing and provision of care to the population (Whyle & Olivier, 2016).

7.3 OBJECTIVE TWO: The Roles Played by PPPs in the Health Sector in Uganda.

Objective two of this study examined the roles and impact of PPPs on the health sector of Uganda. Previous studies have shown that PPPs are important in supporting the governments

through financing, and construction of public projects, and provision of services to the population (Abuzaineh *et al.*, 2018; Ahmed, Mrsonda & Pretorius, 2019; Montagu & Harding, 2012; Mudjanarkoa, & Ogunlana, 2015; Sekhri, Feachem & Ni, 2011). Moreover, The World Bank Group shows that most governments lack sufficient resources to provide services that meet the needs of the population, and thus the involvement of PPPs is critical to the well-being of the citizens, development, and growth of the emerging economies (World Bank Institute, 2012). Therefore, this study found that PPPs come in to give necessary support to governments, including financial, human resources, and advisory services.

The current study established the role of PPPs in the health sector of Uganda, and quantitative data shows that the private sector has supported the government of Uganda through financing, construction, maintenance, and renovation of health infrastructure. Consequently, PPPs have expanded and improved the capacity of health facilities and improved the performance of human resources through recruitment, training, capacity building, retention, and compensation of health workers. The findings of this study show that the private sector takes on the role of providing a more comprehensive package of ensuring health care coverage. The majority of the respondents revealed that private partners have designed, built, maintained, and or renovated most of the health facilities at regional referral hospitals in Uganda (see Table 6.5 on page 169 and Table 6.6 on page 170).

The quantitative data add, with the majority of study participants *(see* Table 6.5 *and Table 6.6),* showing that the implementation of health PPPs has played a vital role, performed well, and achieved its objectives in improving the quality of care and provision of healthcare services in Uganda. In addition, during the interview sessions, qualitative data maintain that the presence of PPPs has delivered the following healthcare services to the population:

The informants revealed in their own words—*ñ P P P s h a v e i m p r o v e d t h e accessibility of healthcare services to Ugandan population; improved service delivery to the final consumers; bridged the financial gap through services and provision of equipment, medical supplies, and materials like mattresses; improved on human resource capacity; improved the status of government hospital infrastructure; improved the quality of lives for patients; improved healthcare indicators of ART clinic, Tuberculosis (TB), HIV; supported and empowered people living with HIV/AIDS, control and prevention of infectious diseases, like Ebola, TB, and COVID-19; trained health workers; and maternal health; offered counseling services to people living with HIV; improved on monitoring and evaluation (M&E) and*

supervision of hospital operations; improved accountability and monitoring of hospital activities; improved the inventory management of medical equipment, drugs, and medical supplies. PPPs have also helped to mobilise and sensitise the community about their health, including the most devastating diseases like malaria, HIV, COVID-19, and TB; supported in the study of Anti-microbial resistance, supported in immunisation and vaccination of patients against the killer dis the interviewers noted during the *ve rnme* interviews.

To gain a deeper understanding of the roles played by PPPs, the study sought to identify some of the health projects and services delivered or ongoing under PPPs arrangement. It was reported during the interviews that different private players, including Infectious Disease Institute (IDI), Japan International Cooperation Agency (JICA), John Snow Inc., (JSI), Makerere University Joint AIDS Program (MJAP), regional health integration to enhance services (RHITES), Rotary Club of Lira, Centres for Disease Control and Prevention (CDC), Bank of Baroda and Bank of Africa, BAYLOR UGANDA, President's Emergency Plan For AIDS Relief (PEPFAR), The AIDS Support Organisation (TASO), and among others have implemented many projects and services in almost all the government RRH in Uganda as presented below:

Infectious Disease Institute (IDI): IDI has been instrumental in terms of human resources. For instance, IDI recruits, trains health workers, and sends them to the community to educate the people in their own homes about the dangers and prevention mechanisms of infectious diseases, such as malaria, Ebola, HIV, COVID-19, among others.

The study findings are in consonant with information obtained from the organisation's official website. According to the official website, Uganda's Ministry of Health has partnered with IDI to carry out countrywide emergency care training to improve the quality of care and outcomes of patients with cases of emergencies, including COVID-19, maternal and child mortality rate, and among other diseases. More importantly, the main goal of IDI is to strengthen health systems on the African Continent, with much attention given to preventing infectious diseases through research and development programmes (Infectious Diseases Institute, 2020).

This partnership was also implemented to improve microbiology and infrastructural development like laboratory facilities Lira RRH. IDI supports the management and prevention of Anti-microbial drug resistance and bio-terrorism in Mubende RRH. Therefore, IDI plays a

critical role in preventing most infectious diseases. *The interviewees noted hereð ñ I D I h a s helped the government regional referral hospitals in improving the human resources capacity, educate the community about the dangers of infectious disease, when malaria, Ebola and COVID-19 arrived in Uganda, they came in to offer support in prevention mechanism. For instance, IDI has really supported us in managing and prevention of anti-microbial drug resistance and bio-t e r r o r i s m ò* as their informants noted.

***Japan International Cooperation Agency (JICA)*:** JICA partnership offers grants to the government through the construction of hospital buildings like the out-patient department (OPD) facility in Mubende RRH, Lira RRH, and Soroti RRH, and have provided medical equipment in almost all government RRH. The interviewees maintain that this partnership has improved the status of the hospital infrastructure, especially at Mubende RRH where the emergency facility and theatre were constructed, equipped, and facilitates the health workers they employ. *The interviewees noted in their own wordsð ñ J I C A g i v e s g r a n t government through the construction of health facilities and helps in improving the quality of care and services offered to the population. JICA also supports in quality improvement of the health services offered to th e p a t i e n t s ò .*

The government of Uganda entered into a partnership with JICA after the past internal conflict in northern Uganda with the rebel groups, including Allied Democratic Forces (ADF) and the Lord's Resistance Army (LRA) that lasted for over two decades that affected the provision of social services and deteriorated the infrastructure development in the country, northern Uganda in particular. As a result, JICA's partnership with Uganda is mainly tailored to: 1) raising incomes in rural communities, 2) improving the environment for economic growth, 3) improving the living environment through the water supply, 4) provision of healthcare services to the population and 5) offering support in the most affected areas of northern Uganda (Japan International Cooperation Agency, 2021).

Rotary Club of Lira: the interviewees noted that the Rotary club of Lira entered into a partnership with Lira RRH, to provide equipment, finance some of the orthopedic workshop activities, and training in JAIPUREFTLT SIZE-9 technology. During the interview, it was revealed that the club has also supplied consumable equipment and materials, like High-Density Polyethene (HDP), and non-consumable equipment, such as drilling machines to make limbs for amputees who lost their legs to the Lord's Resistance Army (LRA) in Lango Sub-region. Rotary Club of Lira also offers wheelchairs for amputees.

During the interviews, the respondents noted ñ Rotary Club of Lira is doing well in LRRH on a contract basis. The club has helped the hospital with money to facilitate some orthopedic workshop activities, it provides necessary equipment and machines, like non-consumable equipment such as wheel chairs to the amputees, drilling machines to make limbs for amputees who lost their legs during the war. They also help the staff and beneficiaries with training in JAIPUREFTLT SIZE-9 t e c h n i c a l i n f o r m a t i o n reported.

According to the official webpage of Rotary Tanzania and Uganda, the club is dedicated to servicing the community. It has a network of world volunteer leaders who join resources, including time and skills to curb the world's most demanding humanitarian challenges. The rotary works to impact people's lives through financial and human resources support across the world (Rotary Club of Lira, 2021).

United States Agency for International Development (USAID)-John Snow Inc (JSI)/ Regional Health Integration to Enhance Services in North, Acholi Activity (RHITES-North, Acholi). RHITES offers capacity building, provides funds to purchase medical supplies and reagents for clinical equipment, and sample collection tools. The project also delivers TB and HIV services, such as counseling and ARVS to patients with Lira RRH. The interviewees maintained in their words— *ñ R H I T E S - N o r t h, Acholi project has improved the effectiveness of sustainable health services in Lango Sub-region. It is a five-year activity that targets eight districts (Agago, Amuru, Gulu, Kitgum, Nwoya, Omoro, Pader, and Lamwo) in Northern Uganda, and serves an estimated 1.2 million people. Since commencement in 2017, USAID-RHITES has supp o r t e d a b o u t 3 3 1 h e a l t h f a c i l i t i e s i n*

USAID works towards international development and ensures that humanitarian resources are aligned with the need to reduce poverty, save lives, strengthen democratic governance, support people and communities to thrive beyond assistance. In addition, USAID implements a United States foreign policy through promoting wide-scale human growth, increase free societies, and establish trade partners and markets for the U.S, and enforces goodwill across its borders (USAID, 2019).

It was reported during the interviews that RHITES-North, Acholi is a consortium where private partners join efforts to ensure measurable improvement in HIV, TB, Malaria, family planning, nutrition, water, and sanitation. The project also supports the promotion and adoption of health behaviour in individuals at the community levels in Acholi, Lango-Subregion. The

interviewees added— *"USAID has funded base projects, including the construction of laboratories, equipment, medical supplies, drugs, and manpower to Lira RRH. The presence of USAID in Lira also provides non-clinical support services to TB patients with a nutritional food supplement, e.g.,* the *food*, respondents added.

The main goal of RHITES-N, Acholi project is to strengthen the efficiency and effective use of integrated health services in the Acholi Sub-Region of Northern Uganda and build strong health systems that respond to the health needs and results. This has been aligned to be realised through three areas: 1) increased availability and accessibility of healthcare services, 2) increased implementation of healthy behaviours, and 3) improved health systems for quality services offered to the population in northern Uganda (Govtribe, 2017).

The AIDS Support Organisation (TASO) and Care Uganda: the TASO, Care Uganda partnership was implemented in Lira RRH and Port Portal RRH to provide TB and HIV treatment and management of the conditions. During the interviews, the respondents reported to this study that— "*TASO offers TB and HIV care, and management, counseling services and empowers people living with HIV to be managers of their own lives, recruit nursing officers, health workers and train them in infectious disease controls.* The interviewees added that— *"TASO and Care Uganda offers food items for the TB patients. The partnership has also improved on human resource capacity and hospital facility; mobilises and sensitises the community about the HIV and TB, offer free health education through community outreach, radio and tele*The study found that the presence of TASO and Care Uganda and other partners has significantly impacted the lives of people living with HIV and TB through screening, treatment, and counseling of the patients.

TASO is a Ugandan-based non-government organisation founded in 1987 by Dr. Alex G. Countinho. It began as a small meeting of volunteers who had no prior experience in handling HIV-related cases but offered support to people that tested HIV/AIDS positive. By 2006, TASO had expanded to become an official not-for-profit making entity with over 25, 000 HIV patients, and nearly 300 employees. In 2004, the organisation began to provide antiretroviral therapy (ART), free social support, including counseling, community engagement, medical care to its beneficiaries, networking, and advocacy in Uganda's history (Kleinman *et al.,* 2011). The study results are in line with the information obtained from the secondary sources, which show that TASO has continued its partnership with the government of Uganda to support HIV

patients, facilitate and train medical workers in HIV/AIDS counseling services (Kleinman *et al.*, 2011; TASO, 2020).

Baylor College of Medicine Children's Foundation Uganda, known as BAYLOR UGANDA: the partnership offers treatment and management of HIV, and supports people living with HIV/AIDS. During the interviews, the respondents reported that—*"the goal of Baylor government hospitals is to support people living with HIV and TB patients, with drugs, and counseling services. The interviewees added that Baylor Uganda also offers safe circumcision (SMC) services, constructed ART clinics for HIV and TB patients, and helps in blood collection."* Baylor Uganda offers safe male circumcision (SMC) services to the community and has greatly improved on staffing through recruiting, conduct training, and capacity building of staff, and remits monthly salaries to the health workers. BAYLOR has also constructed a blood collection service centre and offers family planning services in Soroti and Port Portal RRH. The partnership has improved the hospital infrastructure through the construction of an ART clinic and laboratories at the facility.

According to its official webpage, Baylor College of Medicine Children's Foundation Uganda is a not-for-profit organisation established in 2006. Baylor Uganda leads a high-quality treatment service, adolescent HIV/AIDS prevention and family-based pediatric, and capacity building and clinical research. In addition, Baylor College of Medicine Children's Foundation Uganda provides other services, such as infrastructure improvement, food and nutrition, mentorship, training, and capacity building, monitoring and supervision, equipment and medical supplies, social support to vulnerable children and orphans.

These services and projects are carried out in government referral regional hospitals, including Mulago National referral hospital, Fort Portal and Mubende RRH, and Lira RRH where access to family-centred HIV and pediatric health services is mostly constrained. The support of Baylor Foundation Uganda is complimented by the funding from CDC and PEPFAR. The Foundation collaborates with Local governments and the Ministry of Health to decentralise HIV and pediatric services to increase availability, accessibility, and use of quality healthcare services to the population through the health systems strengthening model (Texas children's Hospital, 2006).

Strengthening Uganda's Systems for Treating AIDS Nationally (SUSTAIN): during the interviews, the respondents noted—"*the Ministry of Health entered into a partnership*

agreement with SUSTAIN Uganda to improve the capacity of human resources, offer medical supplies, improve hospital facility, and support people living with HIV with testing kits, and ARV drugs. The respondents maintained that SUSTAIN Uganda partnership has improved on staffing through recruiting and training of health workers and offered many medical supplies to the hospitals like in Soroti RRH. This partnership delivers infrastructure-based projects like a laboratory facility in Mubende RRH. For instance, this partnership built an ART Clinic, offered free HIV testing kits and ARVs to people living with HIV/AIDS in Lira RRH and Mubende RRH.

SUSTAIN Uganda has also played a great role in improving and reverting the effects of microbiology on patients. The project was implemented to improve microbiology, for instance, the interviewees noted that "one of the most important things that SUSTAIN Uganda has done is to improve the status of hospital buildings, hence creating enough space for medical workers. The goal of SUSTAIN is to strengthen Uganda's public health systems and improve the quality of healthcare services to meet the patients' needs (University Research Co., 2020).

Mildmay Uganda (Mug): Mildmay Uganda offers free HIV-related medical products and services to people living with HIV. During the interviews, the respondents maintained—*ñ Mildmay Uganda has been instrumental in co provides care, counseling services, and treatment to HIV patients in Mubende RRH. They carry out community outreaches, mobilise and sensitise the population about HIV/AIDS and TB, provide medical supplies, offer free services to the community, train staff, and facilitate them; they perform free Safe Male Circumcision (SMC), and cervical cancer screening. They also offer non-clinical support services like renovation of laboratories, engage in preventing child and mother mortality rates in RRH. Mildmay Uganda also provides direct funding to the hospital projects in Mubende RRH. For instance, it purchased a powerful generator that generates powe* the respondents added. *hospitalò ,*

The official home page of Mug shows that the organisation has taken the lead in empowering people and communities for sustainable livelihoods and health by offering quality care, strengthening human resources capacity for health, and research to influence the healthcare policy. For the past years, Mug has grown and diversified its operations and services in providing holistic healthcare, such as health systems strengthening, treatment services, and other additional social services, like health education and training, research, and development (Mildmay Uganda, 2019). The interviewees stressed that Mug's operations cover about 16

local government districts of Uganda, with financial support from CDC and PEPFAR. The respondents show—*ñ Mildmay Uganda has helped over 16 services, like clinical and non-clinical support interventions.ò*

Korea International Cooperation Agency (KOICA): this partnership has improved hospital infrastructure through the construction of facilities, equipment, medical supplies, and training of health workers. The study interviewees noted*ð ñKOICA has funded the many hospital facilities, offered necessary equipment, medical supplies and capacity building of workersò.*

KOICA is a South Korean organisation, with a focus on international development collaboration that offers physical and material aid to curb poverty and achieve the Sustainable Development Goals (SDGs) of the United Nations. The Agency reports to the Department of Development Cooperation of the Ministry of Foreign Affairs and Trade of the South Korean government. KOICA operates as an agency of South Korea to increase the effectiveness of the government's grant aid programs aimed at benefiting developing nations through technical cooperation programs and grant aid (Korea International Cooperation Agency, 2021).

Mbale Clinical Research Institute (MCRI): the partnership was implemented to improve the facility. For instance, MCRI has constructed an ART Clinic in Soroti Regional Referral Hospital. The study informants noted— *ñSoroti RRH has been blessed services, such as quality evidence-based clinical studies, training and capacity building of staff to help in providing beyond the respondents showed that this has to the* been a remarkable gesture by MCRI to the people of Uganda.

The interviewees provide information similar to that on the webpage of the MCRI. The official website indicates that MCRI was founded as a research Bureau in Mbale RRH that gradually developed by conducting many biomedical and clinical studies. For the past years, MCRI's portfolio has progressively expanded to offer high-quality research, including Malaria, Hydroxyurea with SCA, Severe Anaemia, Severe Hypoxia, Severe Pneumonia, and many other studies (Mbale Clinical Research Institute, 2020).

President's Emergency Plan For AIDS Relief (PEPFAR): it is reported that PEPFAR provides women with reproductive system services through screening of Human Papillomavirus (HPV), which causes cervical cancer in women. The officer website of Centres for Disease Control and Prevention shows that HPV is a sexually transmitted infection,

commonly known as STI, which can affect the skin, the anus, cervix, mouth, and throats (Centres for Disease Control and Prevention, 2021). During the interviews, respondents reported— "*PEPFAR has helped us in managing and preventing cervical cancer through HPV vaccination in women a* and these were recorded as Soroti RRH and Fort Portal RRH. PEPFAR has offered HPV vaccines to prevent the effects that may be caused by HPV infections.

United Nations International Children's Emergency Fund (UNICEF): the vision of UNICEF is to ensure that every child lives and thrives, and one of organisation's goal is to reduce the child mortality rate across the world (United Nations International Children's Emergency Fund, 2021). The interviewees noted in their own words— *"UNICEF partners presence in Mubende and Lira RRH offers equipment, maternal health services, and nutrition support t* The study findings are in consonant with the goals of the organisation. For instance, the official website of UNICEF shows that the organisation was founded to save the lives of children, defend their human rights, and help them realise their potential.

WaterAid: this partnership has engaged in research and construction of isolation centres for Ebola cases. During the interviews, the respondents reported that WaterAid was instrumental in the fight against the spread of Ebola and COVID-19 through sanitation equipment and water supply. *"WaterAid helped us to fight Ebola disease even our sanitation was in a* the interviewees noted *ate, t* The official website of WaterAid also maintains that the organisation helps the government to improve essential services and products, including providing clean water, good hygiene, and decent toilets (WaterAid, 2020).

Faith-Based Organisation: the faith-based organisation works in government hospitals under youth mission in Soroti city to support vulnerable children affected by HIV in Soroti RRH. The informants noted in their words— *"Faith-Based Organisation offers basic health needs, including clothes and food to boost their immune system,* the interviewees noted.

United States Centre for Disease Control and Prevention (CDC): CDC provides clinical support services to Soroti Regional Referral Hospital. The study participants noted in their words— *"CDC has played a role in improving the clinical outcomes, through clinical and medical supplies,* The study finding is in agreement with the CDC goals, where it works to stop the transmission of infectious and

vector-borne diseases, curbing bioterrorism threats, and revitalise the public health infrastructure (CDC, 2021).

In addition, the current study found that the private sector has done well and achieved some of its goals. For instance, the interviewees noted the following as the achievements of the PPPs and stakeholders in strengthening the capacity of health systems and services delivery:

i. Improved the availability and accessibility of healthcare services
ii. Improved the quality of care through clinical diagnosis, treatment, and management of infectious diseases such as TB, Malaria, COVID-19, and Ebola.
iii. Reduced Anti-microbial drug resistance
iv. Improved on accountability, monitoring, and evaluation of health projects and services
v. Offered free services to the patients. For instance, HIV care services and drugs are now free. As a result, PPPs improved the lives of people living with HIV and eliminated stigma and improved maternal healthcare.
vi. Reduced the rate of infection and HIV related diseases like TB
vii. Compliment the government efforts and reduced financial burden on the government side
viii. Congestion has been reduced due to increased infrastructure, manpower, medical supplies, and equipment.
ix. improved human resources, staffing, and empowered health workers to manage different diseases, including Malaria, Ebola, and COVID-19.
x. The implementation of PPP projects and services came with many employment opportunities.
xi. There is now an improvement in patient follow-up and community engagement through outreaches, radio, and television talk shows.
xii. There is a reduction in mother-to-child HIV transmissions
xiii. Improved on hospital infrastructures and equipment, e.g., emergency wards, theatres, ART and ENT clinics, water supply, tents, generator house in Mubende RRH. Many health facilities have been constructed under the PPP arrangement in most of RRH.
xiv. PPPs have reduced workload through recruiting, capacity building, and training of health workers.
xv. There is an improvement in monitoring of adverse events, and treatment of any side-effects among patients.

xvi. Workshops and laboratories have been established and equipped, for instance, there is a functioning workshop for Amputees in LRRH. PPP offered machines to fabricate artificial limbs.

The findings of this study, therefore, are in agreement with some of the previous studies carried out about the role of PPPs in Uganda and other parts of the world. For instance, a study by Asasira & Ahimbisibwe (2019) indicates that the government of Uganda has embraced PPPs to provide public services including health care. Also, Nduhura (2019) study shows PPPs have improved the construction of dams, generation, transmission, and distribution of hydropower across the country. The study maintains that Uganda has broadly embraced PPPs to improve electricity effectiveness, efficiency, availability, accessibility, and affordability across the energy industry. Private sector engagement is an indicator that the government resources and infrastructure are not enough to meet the ever-increasing demand of the public (Torchia, Calabrò & Morner, 2015). PPPs have attained broad adoption and are progressively becoming popular in public sector management (Nsasira, Basheka & Oluka, 2013: p.48).

The Astana Declaration on Primary Health Care calls for the governments' commitment to giving priority to PHC in partnership with private sector players (Joudyian *et al.,* 2021: p.1). The declaration takes a bold political will for the health agenda across all sectors. It continues to encourage a multi-sectoral effort through health in all aspects, including policies, and strategic plans aligned with the WHO agenda. Astana Declaration stated that governments should enable a health favourable environment, where individuals and communities are empowered and involved in improving their well-being and health (World Health Organisation, 2019d).

Since the early 1990s, Uganda's partnership with the private sector has progressively evolved, and the private actors are gradually playing a key role in the health sector. More importantly, the government of Uganda has focused on harnessing the potential of PPPs to improve the provision of public projects and services to the population. For instance, the NDP II envisages the effectiveness of PPPs to achieve the National Sustainable Development Goals (Initiative For Social And Economic Rights, 2019). This shows that Uganda has embraced and recognises the role of PPPs in the government's development programmes in terms of funding and implementation of the NDP II goals.

Notably, the country's National Health Policy II (NHPP II) indicates the government's commitments to fully implement PPPs in improving the rights and access to healthcare services. These entail areas, such as ensuring full participation of PPPs in policy formulation and implementation, quality assurance, and services provided to the population (National Health Policy II, 2010); as this is reflected in the Health Sector Development Plan 2015—19 (HSDP 2015—19), that echoes the government's commitment to promoting a viable and strong health PPPs. Also, the HSDP focuses on strengthening the PPPs as a means to improve the health labour force and recognises PPPs in healthcare governance and collaboration (Initiative For Social And Economic Rights, 2019).

Moreover, it is also important to note that Uganda's Ministry of Health acknowledges that PPPs play an important role in the provision of health services and products to the population. For instance, Uganda's health PPP policy re-joins to the 1995 constitution's goal of encouraging private involvement and self-dependence, which necessitates the collaboration between the government and the private sector. The PPP bills were endorsed by the cabinet in 2012 and enacted into law by the parliament of Uganda (Ministry of Health, 2017: p.10). According to the 2017 Ministry of Health publication, the report shows that PPPs describe the range of relationships between the private and public sector, whereby different public and private players collaborate in formulating the objectives, defining the approach, and the implementation of a contract relating the cooperation initiative (p.8). It is, therefore, a government's role to ensure equity, availability, accessibility, and affordability of health care services to the population.

7.4 OBJECTIVE THREE: Challenges affecting the successful implementation and performance of health PPPs in Uganda

The third objective of this study examined the challenges affecting the successful implementation and performance of health PPP in Uganda. The majority of respondents noted that health PPPs face critical challenges during implementation processes and times of executing their roles (see Table 6.7 on page 173 and Table 6.8Table 6.8 on page 175). More importantly, the quantitative data shows that health PPPs in Uganda need policy reforms and large rethinking based on the challenges affecting the implementation processes and performance. Besides, quantitative data shows that policy development and conceptualisation of the partnership, resource mobilisation and allocation, information sharing, accountability,

monitoring, and evaluation among others are some of the challenges hindering the performance of PPPs in Uganda, as Table 6.7 displays.

In addition to quantitative findings, the qualitative data complements the results obtained through survey questions. During the interviews, the respondents noted the following as some of the challenges affecting the implementation processes and performance of health PPPs: political interference, bureaucracy, conflict of interest, the parallel working relationship amongst PPPs workers, poor communication and coordination, a discrepancy in compensation structure, advanced equipment by PPPs outmatches the users' knowledge, poor priorities, insufficient funding and poor sustainable plan, strict timeframe by the private sector, collision on the same projects, poor follow-up, poor approach, negative attitude about PPPs among the public servants, limited space at the hospital and the support provided is less compared to the population.

7.4.1 Political interference

Politics plays a key role in shaping the social and economic development of a country (Gourevitch, 2008; Olson, 1965: p.525-554). Regarding the issues of political interference, the interviewees noted in their own words— *ñ i n pat,hprivate donors used to bring medical equipment, drugs, and funds directly to the hospitals, but some politicians and technocrats from the ministry came in and interfered with the process, they blocked it completely. When we askedð they told us that the assistance needed to pass through their offices for clearance. But besides, the political will for implementing the PPP projects and health services is very low. Yet, these assistances were directly benefiting the targeted patients, like people living with HIV/AIDSò* ,the interviewees noted.

During the interviews, the informants added— "*political interference also creates significant threats to the donor projects. For instance, the suspension of the Democratic Governance Facility (DGF) affected most of the projects funded through a consortium and other partners t h a t g e t f u n d s d i* DGF is a multi-donor facility funded by eight private *t y ò .* actors under a mutual agreement with the Government of Uganda. These private donors include Austria, European Union, Denmark, Ireland, Netherlands, Norway, Sweden, and the United Kingdom. As a consortium of donor partners, DGF shares its goal with the government of Uganda; and the citizens of Uganda of having a corrupt-free country (Democratic Governance Facility, 2021). Consequently, the goal of the facility is to contribute towards ending corruption

by Supporting Civil Society Organisations (CSOs) and many government institutions whose constitutional mandate is to curb all forms of corruption in Uganda. DGF harmonises donor partner support to identify government institutions and CSOs to engage in promoting good government and democracy in Uganda (UN Caccoalition, 2021).

More importantly, the respondents contend that political interference has caused high pricing and corruption in the process, especially where equipment and, or medical supplies of low prices are procured at a very high price. To qualify this, the interviewee in LIRA RRH shown an ordinary sewing machine that is claimed to have been bought at 200 million Uganda shillings, which is equivalent to $555,556 US dollars, and yet it can cost 500,000 Uganda shillings or $139 US dollars on a local market. *ñ P o l i t i c s a r e s o m e o f t h e f a c t o r s p t i o n affecting the quality and performance of health PPPs, and also the hospital productivity. For example, we have a sewing machine that they told us was bought at 200 million Uganda s h i l l i n g s , i t ô s f a k e , a n d t o m a k e i t w o r s e , Something you can get at 500, 000 Uganda shillings on the local market, it cost a lot of money, v e r y c o r r u p t , i t i s t h e i n f o r m a n t s n o t e d . o h e a r s u c h s t o r*

The findings of this study are in harmony with some of the previous studies conducted about the challenges facing the performance of PPPs. In terms of political interference, according to Baithili, Mburugu & Njeru (2019), politics plays an important role in the performance of PPPs (p.285). However, Daniel, Germà and Albert (2019) indicate that politics causes negative impacts on PPP arrangement due to cost overruns, and in many cases, politics turn the effort of private donors into white elephant projects. This perception requires the effort to overcome political interference by ensuring operational risks are addressed before they manifest and that requires strong governance systems and policies.

The study examined the possible solutions that can address each challenge affecting the performance of the PPP projects and healthcare service delivery. Some of the related works of the literature suggest the most efficient and effective way of dealing with politics, such as creating consensus through consultative engagement, public education, and ensuring oversight and transparency mechanism are in place to facilitate the management of PPPs (Baithili, Mburugu & Njeru, 2019: p.285). For instance, Mzikayise (2009) created a Participatory Development Systems Model (PDSM) that focuses on the need to involve the local people and communities in the planning, implementation, and management of PPP projects as a means of good governance systems.

Baithili, Mburugu & Njeru (2019), maintain that engaging local communities help in managing political interferences and improving project ownership and creativity in the overall projects. Therefore, engaging with project beneficiaries is a crucial approach in managing diverse interests that normally happen in the process. Consequently, it remains difficult to separate politics from PPPs arrangement, and yet it requires consultations with the stakeholders (p.285). The respondents also noted the government has a constitutional mandate to address all challenges surrounding PPPs. *ñ I f t h e g o v e r n m e n t w a n t , t h e y i n c l u d i n g c o r r u p t i o n* the interviewees noted. *t i c a l i n t e r f e r e*

The results of the current study are in agreement with some of the previous studies. For instance, United Nations Transport and communications bulletin for Asia and the Pacific (ESCAP) in 2016 acknowledges that there are economic, social, legal, administrative, and political challenges surrounding PPPs. However, the United Nations ESCAP shows that governments have a constitutional mandate to address several challenges affecting PPPs to ensure the efficiency and performance of the projects and services. For example, private partner involvement requires the government to engage them in planning, regulatory matters, and policy formulation.

Moreover, to promote private sector involvement, governments should enact strategic financial and legal reforms that they can manage effectively. Consequently, United Nations ESCAP maintains that the mandates of the government include: formulation and implementation of PPP policies, creation of a favourable environment, proper administrative mechanisms, promotion of good government systems, capacity building of government servants, and addressing political and social concerns of PPPs projects and services (United Nations ESCAP, 2016).

Solutions to address political interference

The respondents noted that the government should fulfil its responsibility to address some of the challenges because if not resolved, they can hinder service provision to the beneficiaries. For example, the interviewees suggested the following in their own words: — "*all activities and matters of the health sector should be separated from politics, and the government should introduce policies that do not restrict and interfere with the programmes of the private p a r t n* To deal with corrupt officials, the respondents recommended— "*the government should arrest and persecute any corrupt officials found in deals of fraud, and there should be*

proper auditing and improve on monitoring and evaluation (M&E) of PPP projects and services offered to the population, the respondents reported.

According to Charles (2006), PPPs must explicitly be designed and implemented to be accountable for projects and service delivery. Everyone involved should be accountable for what they do. This is possible through regulatory oversight, pre-identified monitoring and evaluation process, and the use of incentives to promote specific goals in the provision of services (p.696).

Besides, Mutyaba maintains that the presence of a functioning regulatory and legal framework reduces probability tendencies and aligns the interest of partners, and offers confidence to the private actors because it acts as a shield against political interference from government players (Mutyaba, 2017). Therefore, the government must enact a financial, legal, and regulatory framework to address the challenges affecting the implementation process and ensure the effective provision of health projects and services to the population. This would address the issues of political interferences and corruption in the processes.

7.4.2 Conflict of Interest

The study found that conflict of interest is one of the major challenges affecting the implementation process and performance of health PPP. During the interview sessions, the respondents noted that private partners come with goals that conflict with the hospital work plan. They narrated in their own words— "*private donors have their own goals, and conflicting objectives, which are not even tailored to the hospital goals and objectives. They only come in to use the hospital facility and enforce what they want to achieve, but not to benefit the population, and this greatly affects the performance of the general health activity. This is because, at a time when a hospital has laid its work plan and goals, the donors come in to claim for the facility space, sometimes to achieve their own goals at a large scale, with minimal benefits to the population. In most cases, private partners dictate what services or projects to implement, they think because they have money and other resources, they can undermine the hospital administration policy. They also come with strict guidelines that interfere with the hospital rules*," the interviewees noted.

Previous studies define conflict of interest as a relationship or a series of conditions that create the risk when actions or professional decisions regarding a primary interest will be unjustifiably influenced by a secondary interest induced by a secondary party (Gupta, Holla & Suri, 2015;

McComas, 2008; Bordonada, & García, 2018; Warnasuriya, 2017). According to Warnasuriya (2017), such circumstances present potential barriers and undermine the impartiality of a particular party due to the clashes between the party's interest and the public interest (p.53). In the health sector, conflict of interest occurs in clinical trials relating to the health effects of pharmaceutical products, including food, chemicals, alcohol, and tobacco (Bordonada, & García, 2018).

Conflict of interest circumstances may be personal or organisational, and it mainly occurs due to financial or post-employment opportunities, or benefits, or during PPPs arrangement. The conflicting interests, for instance, in the formation of public policy, specifically health-related policy, including vaccines, clinical trials, and tobacco control policy can harm the population. While the United Nations fight against corruption cites conflict of interest as a service vehicle to corruption (Gupta, Holla & Suri, 2015). Studies show that if a conflict of interest is not addressed early, it can cause a serious impact on the lives of people, undermine rule of law and legitimate decision making, compromise the application of policy, and affect the allocation of public services (Organisation for Economic Co-Operation and Development, 2005: p.94).

Solutions to address conflict of interest

Some studies suggest that the health sector should implement common policies and standards to detect, avoid, minimise or eliminate the impact of conflict of interest, and ensure that these are properly enforced. The government should formulate clear policies regarding what comprises a conflict of interest, and how these should be communicated (Bordonada, & García, 2018). The interviewees suggested the following as means to overcome the conflict of interest:

1) the general goals, objectives, and mission of the hospital should be well-documented, and made known to the private partners, 2) involve all stakeholders at both low and top management levels, while planning and implementation, as this would address the issues of conflict of interest, 3) all parties should declare a conflict of interest before implementing a PPP project or services, 4) well-documented memorandum of understanding (MoUs) with clear resolution clauses, and 5) align the PPP goals with that of the government hospital. Identifying and addressing conflict of interest circumstances is important to good governance and ensuring transparency and trust in the public sector (Organisation for Economic Co-Operation and Development, 2005: p.3).

7.4.3 Parallel workplace relationship and discrepancy in the compensation structure

The current study found poor coordination at the ground, whereby the workers deployed by private partners do not consult with their colleagues employed by the Ministry of Health at the hospital. This creates a parallel working relationship. During the interview sessions, the interviewees noted in their own words—*ñ t h e r e i s a p a r a l l e l w o r k i n g health workers from the private sector and those employed directly by the government. For instance, you find that there are no interactions at all, and yet we are supposed to consult with one another to deliver quality care services for the benefit of our patients. Poor relationships greatly contribute to low teamwork and performance. There is no proper coordination at the hospital. You find that because someone is employed by private partners, he or she is not answerable to the hospital director or top management, but their bosses. Even the supervision g i v e n t o a p r i v a t e h e a l t h* the respondents reported. *A r y m i n* positive workplace relationship makes the workers enjoy what they do and increases organisational productivity. It is important for the well-being of workers (Haar *et al.,* 2019: p.14).

In addition, the salary structure of the government is not aligned with that of the private donors, whereby private workers receive higher pay than the government does. The interviewees noted—*ñ T h e p a y m e n t s t* partners does not reflect that of the government, *t e a c t u a l l y t h e y d o n ô t h a v e a f o r m a l s t r u c t u r e . government pays, and this demotivates some of the health workers on the government side. It also weakens the private workers, especially when the project or healthcare service ends because government hospitals find it hard to retain the private health workers on the government salary structure because they may expect to be paid the same amount as remitted by their for m e r b o s s e s , a n d t h i s g* the interviewees reported. *r e c t s t h* to this study.

Besides the poor relationships, the study found the issue of poor approach by the private partners. *ñ P r i v a t e p a* poor implementation approach, which becomes difficult to *harmonise with that of the Ministry of Health. The manner of planning and implementation is n o t c l e a r o n t h e s* the interviewees reported. *p r i v a t e s e c t o r ò*

A negative attitude among the government health workers was also pointed out as one of the challenges affecting the performance of PPPs. The respondents noted— *ñ i n m o s t c a s e s the private partners bring in a new project to the hospital, the hospital staff becomes money-centred, and this greatly affects the implementation process and performance of these projects because those who may be willing to join their effort eventually pull back after realising that t h e i r m o n e t a r y e x p e* the informants revealed to this study. *c t b e m e t ò ,*

Solutions to address the challenge

The current study found that private projects are implemented in government hospitals, and that means sharing the workplace environment and facility. During the current study, the government health workers reported bad working relationships with the employees deployed by the private donors. The respondents suggested some possible solutions that can address the said challenge. The suggested solutions include the following:

- The government through the public services should take on the role of recruiting employees on behalf of the private partners as this would treat them as government health workers deployed to serve the same purpose. The informants added that even the salary should be a government structure and uniform. The respondents reported that private partners pay their employees higher than the government. They noted that— *it should be the role of the ministry of health to recruit all health workers deployed at the hospital, and there must be a uniform salary structure. The Ministry of Health should be the recruitment agency for the private sector such that when donors come in to implement a certain project, it should be the role of the government to advertise and hire workers on behalf of their partners. Also, the same should be done when it comes t o r e m i t t i n g t h e s* the respondents stressed. *p r i v a t e w o r k*
- The government should integrate the staff deployed by private partners into the administration of government hospitals, and work under the supervision of the hospital administration and director-general of the RHH. This will directly create a working relationship between the health workers employed by the government and those deployed by the private partners at the same hospital. They maintain that all personnel at the hospital will be reporting to the hospital director as their boss. "*The government through the ministry of health should merge the private health workers with that of the hospital. The implementation process of a private project should be aligned with that of the go v e r n m e n t* the interviewees reported in their own words.

- In addition, the respondents suggested having a mindset change to address the issue of negative attitude. *ñ Negative attitude requires mind building ò .*

7.4.4 Poor communication

The study findings show poor communication between the private donors and the management of the hospital and its workers. It was reported that in most cases, the private partners undermine the administration and hierarchy of the hospital, and that alone makes it very hard to deliver the intended services to the beneficiaries. For instance, the hospital staff is not oriented about the project or healthcare services being implemented by the private partners. *ñ Because the donor workers, they are told what to do without our health knowledge, sometimes we just see them on the ground. We are not included in the implementation stages, and yet we are supposed to participate in the delivery of these services. So, that alone makes it hard for us to know what is being implemented, its intended purposes, and the targeted beneficiaries ò ,* the interviewees noted.

The respondents added that because there is no clear communication framework, private partners can bring equipment and drugs which are of poor quality, and others do not meet the hospital standards. More importantly, some projects and services are underfunded by some private donors. The interviewees noted— *ñ sometimes private donors bring equipment of poor quality, and some projects and services implemented are not well funded. For instance, some equipment was brought by some NGOs to the hospital, but they did not train the users, no one knows how to operate it, no reagents were provided, and that alone results in wastage of resources. In addition, stakeholders are not involved at the planning stages. Private donors just set their own objectives without involving the top management of the hospital and the beneficiaries* stressed their concern. *projects ò ,*

Solutions to address poor communication

The respondents suggested the following solutions to address the issues of poor workplace communication among health workers:

- The private donors should inform the management of the hospital about the goals and objectives of their project or healthcare services.

- ¶ There should be a timely reporting of the ongoing project or services because it gives a chance for the intended beneficiaries to receive support from the private partners.
- ¶ There should be proper communication and informing of the implementers on the ground, especially those who are part of the hospital management.
- ¶ Private partners should be aware of the presence and mandate of the administration of the hospital and respect its hierarchy.
- ¶ The roles of the private partners and that of the hospital should be made clear and be well-documented.
- ¶ Stakeholders should be involved in the planning stages of the projects and services if good results are to be attained.
- ¶ Both the government and private partners should enforce teamwork among the health workers providing health services to the community and patients.

Enforcing workplace communication requires a defined process of conveying the work ethics, projects requirements, information and ideas, either verbally or nonverbally between one person and group within the organisation structure. Such information can be exchanged through conference meeting, email messages, video-conferencing, call, and note (Whittaker, Frohlich & Daly-Jones, 1994). Previous studies have found that effective workplace communication is important in getting a job done, and increases employee productivity and organisation performance (Stevens, 2005; Picardi, 2001). To improve employee relationships and avoid missed deadlines, or issues that may hinder the organisation's productivity, effective communication is critical (Borkowski & Meese, 2020; DeIuliis & Flinko, 2016).

7.4.5 PPPs offer equipment and systems that are not user-friendly

The issue of substandard products is rampant in Uganda. Substandard, also known as "out of specification", are authorised medical supplies that do not or fail to meet either the specifications and quality standards, or even both (International Council of Nurses, 2009; World Health Organization, 2018a). The sampled participants noted that— "s*ometimes PPPs bring in equipment without a user manual and training materials to assist the final user, and even do not take time to follow up on the equipment given to the hospital. In most cases, they offer highly advanced equipment which is beyond the capacity of the hospital staff, who do not have the required skills to use or even repair in case of any malfunction. Also, the reagents are too expensive and not even available on the local market, the technicians are not there to*

service this equipment. It stops delivery, the interviewees noted.

The interviewees suggested the following as possible solutions to address the problem of offering equipment and systems which are not user-friendly:

- Private partners should supply equipment and make proper documentation, and provide a user manual to help the users understand the technicality of the supplies.
- Private donors should give adequate training to the final users of the equipment supplied, to identify the possible challenges that may occur during operations.

7.4.6 Limited space

The current study found out that some government regional referral hospitals lack space to effectively accommodate a number of daily activities. The workspace is limited, whereby both female and male wards are not enough to accommodate the population. In their words— ñ *we donôt have enough room, clinics, and wards are relatively small compared to the increasing population. Limited space is due to limited land space that does not allow the government to increase its hospital infrastructure. Consequently, this creates congestion at the hospital facility, for example, you find that the OPD space is limited compared to the population that reports every day*; For instance, LIRA RRH lacks space, which in turn creates congestion at the hospital facility, such as laboratories, clinics, wards, administration blocks, and staff housing”, the interviewees reported to the current study.

The informants suggested the following solutions address the challenge of limited space:

- There should be affirmative action to address the issues of limited space at the hospitals. To achieve this, the government needs to identify new locations, perhaps free land to expand and improve on the infrastructure.
- The government can partner with the local government authorities, like the local councils, municipal councils, the public or private universities, and among others to identify free land that can be utilised by the government to expand hospital infrastructure. This would help to reduce congestions at the hospital premises because the new buildings could create enough space.

7.4.7 PPPs come with their own priorities and strict timeframe

In a normal working environment, priorities are set based on the needs of the project or services, and the urgency of the deadlines. Setting priorities helps to considerably improve the art of the workplace and put resources to best use. Therefore, the organization needs to make a list of what is needed based on the urgency and relevancy of the project (Hoover, 2010). The interviewees noted—*ñ PPPs do not engage with the administration on the priority or what is lacking or what is needed at a given time. They have a tendency of setting their own priority. This affects the operations and impacts the health outcomes. They do not communicate their goals to the stakeholders. For instance, when RHITES came to Lira RRH, they were not open on what they had come to do*, the interviewees noted.

The interviewees also reported to this study that in most cases private donors come with a strict timeframe and impose on the administration of the government hospitals. *ñ Private partners sometimes set their own goals and strict timeframe for the hospital to execute. This happens when the private partners introduce a new project or service to the hospital and expect the management to implement it immediately based on their goals and timeline. It greatly jeopardises the general operations of the hospital*, the informants reported.

In addition, PPPs come with donations that are not urgently needed. This was reported during the study—*ñ it holds no meaning, for example, providing contraceptives during the pandemic period. Besides, sometimes private partners provide maternal health that does not treat the conditions we need*, the informants noted. In the respondents' view, RRHs lacked COVID-19 related medical supplies than reproductive measures and family planning services. Uganda only registered high rates of domestic violence especially in the first Lockdown of COVID-19. Therefore, contraceptive supplies were not most needed at the time of a pandemic.

Solutions to the challenge

The informants suggest that the private sector should always involve the management of the hospital and other stakeholders to identify and discuss what may be lacking and create the best means of providing the projects or healthcare services to the people. The following were suggested by the study respondents:

- ¶ Private partners, especially non-government organisations should involve the stakeholders at the grassroots levels when planning before implementing any projects or services to identify the areas that need to be prioritised, and identify the most urgent services rather than implementing the projects, which are not needed at the moment.
- ¶ The gaps or urgent needs should be identified by the top management of the hospital, and then engage with the private partners to solicit support. This can be done through proper M&E. It should not be that the private donors come with a predetermined project or services to implement, and there should be flexibility based on the needs of the hospital.
- ¶ There should be early engagement with the stakeholder to help both parties to reach a middle ground, and thus makes it easy to implement and achieve the set common goals.
- ¶ To address the strict timeline imposed on the hospital, it should be resolved that all ongoing projects at the hospital remain government property, and should be implemented according to the hospital work plan, and not what the donors want to achieve.

7.4.8 Collision on the same project

Since identifying the most urgent and critical projects and services, the government regional referral hospitals remain a challenge, the current study found that more than one private donor implements the same project. Consequently, this creates a collision and wastage of resources. The respondents reported— *ñ s o m e t i m e s w e f i n d t h a t o m o r e t h a n o n e o r t w o p r i v a t e p a r t n e r s a r e i m p l e m e n t i n g t h e s a m e p r o j e c t . F o r e x a m p l e , J M E D I C C , R H I T E S , M I L D M A Y , T A S O , P E P F A R , B a y l o r , S u s t a i n U g a n d a , a n d I D I a l l c o m e t o o f f e r H I V c a r e a n d t r e a t m e n t t o t h e p e o p l e l i v i n g w i t h H I V / A I D S ò ,* the informants noted.

There must be stakeholder involvement to identify the gaps in healthcare services. This will help to address the challenge of more than one private partner delivering the same project or services. The participants noted in their own words—"*e a r l y s t a k e h o l d e r e n g a g e m e n t s h o u l d b e p e r f o r m e d t o a d d r e s s t h e c h a l l e n g e o f h a v i n g m o r e t h a n o n e p r i v a t e p a r t n e r , i m p l e m e n t i n g t h e s a m e p r o j e c t , o r p r o v i n g t h e s a m e h e a l t h c a r e s e r v i c e s i n t h e s a m e h o s p i t a l . T h i s h e l p s t o a d d r e s s r e s o u* interviewees noted. *a g e ò , t h e*

7.4.9 Insufficient funding and poor sustainability plan

The private partners can implement a project or healthcare services, without a sustainability plan, and they lack an exit plan. It becomes hard for beneficiaries, for instance, if the project ends, they suffer a lot because they are used to accessing free services offered by the private donors, due to the financial disparities. The respondents reported—*ñ s o m e t i m e s P P P p r are underfunded, and there is no continuity plan of the projects offered by private partners due to uncertainty of donor funding. When the project or service contract ends, the services also e n d a n d t h i s g r e a t l y a f f e c t s t h e b e n e f i c i a r i*

The interviewees reported to this study that the following solution has the potential to address the issue of insufficient funding and poor sustainability plan:

- "Government should come in to financially support some of the projects and services implemented by private partners to ensure continuity, in case they experience monetary challenges. For example, in case the private partners are incapacitated to pay their health workers, the government should consider the health benefits against money, and set aside the budget to compensate these workers employed directly by donor partners. This is because private partners play an important role in delivering healthcare services to the general population, which is even a government mandate. So, the government needs to treat private health workers as partners supporting to fulfill its constitutional role.
- The government should introduce investment policies that allow the Private sector, especially NGOs to invest in some income-generating projects, which are tax-free to allow continuity and adequate funding of the projects or services without experiencing any issues due to insufficient funding.
- There should be proper budgeting. Private donors should also make a feasibility study of the project goals, scope, timeframe, and introduce more sources of funding, and budget according to the scope of the project. This would help them in proper budgeting and finance adequately, and address the issues of insufficient funding.
- The government through the ministry of health should conduct capacity building and train more health workers that could take on the roles especially when the contract of the private partners ends. In addition, there should be a policy that allows the transfer of the project or services implemented by the private partner to the government.

7.4.10 Bureaucracy in the process

The informants pointed out the issue of bureaucracy as one of the factors limiting the performance of health PPPs in Uganda. During the interviews, the respondents reported in their own words— ñ *bureaucracy in the process is also a implementation process and the current policy framework has caused delays in the delivery process, which in the end affects the clinical outcomes and impacts the lives of peo p l* the ò , interviewees reported. A bureaucratic system allows public servants and administrators who are not elected officials to be charged with performing roles associated with some government programmes and policies. The system makes delays in service delivery because it goes through different levels of public administration to reach the beneficiaries (Krutz & Waskiewicz, 2019).

The private partners face challenges in approving the projects and medical supplies. As a result, the informants noted— ñ *t h* o*vernm*e*nt can take long to approve a private project. This happens when there is a donor who is seeking approval of a particular project or service from the Ministry of Health headquarters. It takes a long period. This leads to wasting of valuable resources , i n c l u d i n g* the interviewees noted. *d t i m e* ò ,

Solutions to address bureaucracy in the health sector

According to Amir *et al.* (2014), the health sectors in developing countries require rigorous bureaucratic reforms to improve the process of healthcare service delivery to the patients (p.70) Previous studies show that these policy reforms need to be professional tools that work more efficiently and responsively to the population (Pollitt & Bouckaert, 2011). In public administration, a bureaucracy is defined as a system, in which the majority of key decisions are made by government officials rather than the beneficiaries and the representatives of the citizen (Waters & Waters, 2015: p.114). The bureaucratic reforms are crucial for developing nations because they serve as a professional tool in directing the government in terms of service delivery to the population (Amir *et al.*, 2014: p.70-71; Reinert, 1999).

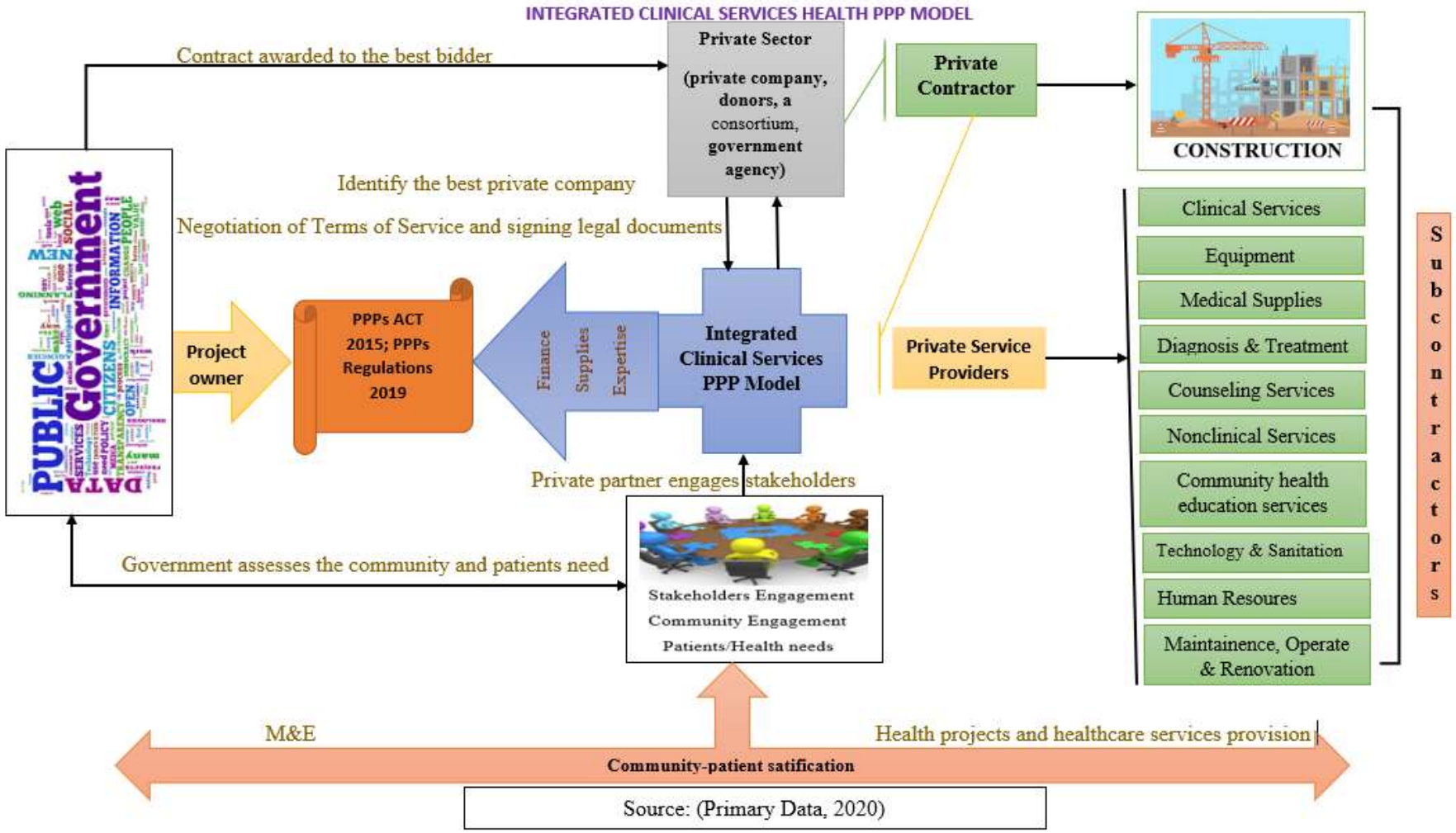
The interviewees suggested in their own words— "*the government should allow private partners to directly implement their project, and the government should only come in to perform a supervisory role and should give a timely accountability for all the services offered b y i t s* The respondents contend that if the private sector is given a straight path, they can offer more improved services to the beneficiaries. This is attributed to the fact that the approach creates private sector engagement with the population rather than the public

administrators and government officials who sometimes do not directly interact with the local persons. Therefore, it is upon that information that the government should consider bureaucratic reforms that allow the beneficiaries and representatives of the people to engage with private donors.

7.5 OBJECTIVE FOUR: The best PPPs model for the health sector in Uganda

Objective four examined the best type of health PPP models for Uganda's health sector. Remarkably, the study found that Uganda's health sector has followed PPP models while implementing projects and delivering healthcare services to the community. For example, the findings show that the government through the Ministry of Health has embraced health models as: 1) Infrastructure-based Model, 2) Discrete Clinical Services Model, and 3) Integrated Clinical Services Model in engaging with private partners to offer projects and healthcare services. Consequently, the respondents identified Integrated Clinical Services as the best PPPs model for the health sector in Uganda. The majority of participants reported to this study that Integrated Clinical-Service Model is the best, this was followed by Discrete Clinical-Service Model, and lastly, an Infrastructure-Based Model (*see* Table 6.9 *on page 176).*

Figure 7.1: Integrated Clinical Services Health PPP model



Source: (Primary Data, 2020)

Figure 7.1. is a pictorial representation of an Integrated Clinical Service PPP model, showing how the health projects and services are procured; how the government and private sector engages with the community, stakeholders, and patients to identify the priority and needs of the population. The model leverages private sector resources and expertise to deliver quality care services, medical supplies, human resources, community health education, and infrastructural development. Therefore, adopting this model helps to align the effort to improve the management of medical service, improve quality and access to care.

The goals of an Integrated Clinical Services PPP model are to improve healthcare services as well as balancing the operating cost to both the government and patients with limited access to healthcare and financial capacity payment for better health services. Under this PPP model, the private sector takes the responsibility to design, build, finance, maintain, operate, and deliver health projects and services to the community. In doing so, the government procures private companies and transfers potential risk to the private companies.

Moreover, Table 4.5 on page 132 shows the features and benefits of the Integrated Clinical Services Health PPP Model, including its roles, and how it is implemented. The model allows private partners to offer multiple projects and healthcare services, including infrastructure, medical supplies, clinical equipment, and non-clinical services, such as human resources, capacity building, cleaning of the facility, and others. However, the interviewees call for a strategic, and effective way of implementing these PPPs models. The respondents reported—

ñ Integrated Clinical Services PPP model should be an effective approach to implement this model. For instance, the best model should be based on the priority and needs of the interviewees population.ò,

In Valencia, Spain, for example, an Integrated Clinical Services PPP model was adopted to expand and included all referral clinics and primary care in the health district, and in most cases covered long-term health care goals. Though this arrangement requires more levels of community involvement and political support, it plays a key role for a private actor to gain control over the full spectrum of referrals and services for the selected population, and thus enables them to have further efficiencies and include more comprehensive care promotion strategies that contribute to the overall improvement of healthcare services delivery (Abuzaineh *et al.,* 2018).

In addition, the 2nd PwC/UCSF PPPs report in the series, includes Lessons learned from Latin America, which provides an overview of the three Integrated Clinical Services PPP contracts—

awarded in Peru to construct (Hospital Guillermo Kaelin de la Fuente and Torre Trecca, Hospital Alberto Leopoldo Barton Thompson). The report shows that Peru was among the first nations in Latin America to implement this type of PPP model and to incorporate non-accurate hospitals within the scope of the projects and services provided to the community (Abuzaineh *et al.*, 2018).

Therefore, an Integrated Clinical Services PPP model allows a private company to design a project, construct, finance, operate, and provide clinical support and non-clinical services to the facility. Integrated Clinical-Service Model puts the private sector in a role of managing all ancillary support services, such as the delivery of non-clinical support services (radiology, laboratory, cafeteria, housekeeping, and clinical support services), and identify and manage clinical equipment and patient systems, which are essential for delivering quality care to the patients (Raman, 2012). Generally, the private sector designs and manages all the human resources for healthcare services and support services. The transition of service delivery from public management is a key change agent, which requires key considerations and pre-planning management change (World Bank, 2003a).

7.6 Summary of the Chapter

This chapter discussed the findings of the current study. The chapter reviewed some of the related literature to find out whether there is consistency in the finding. The importance and roles of PPPs in Uganda's health sector were reported as 1*)* they improve healthcare service delivery and hospital infrastructural development; 2) improve on the health standards; 3) provide the necessary funding to run different activities and projects at the government RRH; 4) improve on human resources through recruitment, training, capacity building, and compensation of health workers; and 8) improve on medical supplies and equipment. More importantly, the Integrated Clinical Services PPP model was identified as the best model for Uganda's health sector.

Besides, the study also discussed critical success factors of PPPs in the health sector and found that political interferences, bureaucracy, conflict of interest, parallel working relationship, poor communication, the discrepancy in salary structure, poor priority, insufficient funding, and sustainability plan, and collision on the same project among private partners, as challenges affecting the performance of the private sector. Suggestions were made by the sampled participants of government regional referral hospitals, such as involving the stakeholders at the planning levels before implementing a specific project or providing healthcare services as this

helps to identify the most urgent needs; the government should arrest and prosecute any corrupt officials, proper auditing, improve on monitoring and evaluation (M&E) of these projects and services, and the government should allow private partners to directly implement their project, and only come in to perform a supervisory role, and give timely accountability for all the services.

CHAPTER 8

CONCLUSION AND RECOMMENDATIONS

8.0 Introduction

Chapter Seven discussed the key study results obtained from the field through survey questions and interviews. The chapter compared some of the previous works of literature with the current study findings to find out whether there is consistency or gaps in the available information. Consequently, Chapter Eight offers conclusions and recommendations on the study results obtained about the role of PPPs in the healthcare sector in Uganda.

8.1 Conclusion on the literatures

Over the years, governments across the world have embraced the importance of PPPs for improved service delivery and efficiency. Moreover, the available literature indicates that the financial crises that hit the world's developed and emerging economies has re-emphasised the importance of PPPs for resources mobilisation, utilisation, and improved public service delivery to individuals and communities. Faced with limitations on government resources, while embracing the need for investment in infrastructure and human resources to revamp their economies grow, many countries are progressively appreciating the roles of the private sector as an alternative means of an additional source of public funding to bridge the financial and human resource gaps.

PPPs have been recognised globally as a means of introducing private-sector innovations and expertise, and technology in offering improved public services through enhancing the operational efficiency of delivering projects and services within the budget and on time. Besides, PPPs are important because they supplement the government's capacities and resources to meet the ever-increasing demand for infrastructure development and improved services delivery to the community. More importantly, they help the governments enjoy long-term value-for-money through adequate risk transfer to the private companies, right from design-build-finance-maintain, and operate the public infrastructure. These are increasingly attracting the government-owned enterprises to increasing the presence of private sector involvement and reorganising PPPs in a manner that ensures risk transfer.

The current study reviewed several studies to establish a definition of the concept of Public-Private Partnership. The study found that there is no single internationally recognised definition of PPPs. However, based on the nature of operations, this study concludes that PPP is a long-term business contract between a government entity and a private partner that enables a

favourable environment for offering public goods and services, whereby the private player accepts the potential risk and management role, and payment is associated to performance and productivity. The current study, therefore, maintains that PPPs should be a legally binding agreement between the public and private sectors. This means that PPPs are implemented when the public and private sectors establish a sustainable contract based on relationships grounded on the organisational structure and policies.

In other words, PPPs enable a levelled ground to bring together resources of the two sectors to offer public infrastructure and services at an improved value for money. The current study found that PPPs became popular at the international programme as a development strategy after agenda 21 was globally adopted in Rio-Brazil that brought in new ideas, in which the UN conference on Environment and Sustainable Development unanimously agreed on some pressing issues, such as the end poverty, zero hunger, good health and wellbeing, life on earth, sustainable cities and communities (sustainable environment), clean water and sanitation, and economy and the social setting.

More importantly, the current study found that during the World Economic Forum in 1998 in Davos, Switzerland, the United Nations Secretary-general at the time, Kofi Annan, emphasised the role of PPPs, and encouraged both public and private sectors to mobilise resources for efficient delivery of goods and services to the community. In Africa, this study found that a 2002 Johannesburg World Summit was convened to discuss issues on Sustainable Development and the importance of PPPs was stressed, as a means of achieving sustainable social, economic, and environmental development goals on the continent. Over the years, it is evident that PPPs have been recognised to be more effective in supplementing public resources and delivering improved services to the community.

Based on the previous works studies that were reviewed, this study concludes that PPPs are an important mechanism for mobilising resources and putting them to the best use to improve public infrastructure and service delivery to the intended population. Uganda adopted the concept of PPPs in early 2000. However, the body of literature shows that the country has been facing some critical challenges, such as difficulties in PPPs policy development and conceptualisation, bureaucracy in the process, information sharing, resource mobilisation, and service provision to the community. To address these challenges, previous works show that PPPs requires political will, good governance practice, transparency and accountability, regulatory framework, effective communication, the competence of PPP partners, equity in the

process, externalities, fair competition, economic policy and risk allocation, and a favourable socio-cultural and economic environment, as key critical factors that contribute to PPPs success.

8.2 Conclusion of the Study Results

The current study examined the role of PPPs in the health sector in Uganda: a case study of government regional referral hospitals. A mixed research method was deployed concurrently to collect and compare both quantitative and qualitative primary data. As a result, this section presents the conclusion of the study results as per the study objective. The study determined an acceptable response rate based on the survey questions sampled. A total of 160 copies of the questionnaire were administered, and 126 copies were returned valid and 34 copies invalid. Accordingly, a response rate of 50% is an average, 60% is adequate and acceptable, and a response rate of 70% and above is considered good and acceptable for data analysis and reporting, see *Table 6.1 on page 161 and Figure 6.1 on page 161* for **Error! Reference source not found.**. Therefore, a 79% response rate supported data analysis, discussion, and report writing.

8.2.1 The need for PPPs in the health sector

This section summarises the importance of PPPs in Uganda's health sector. With the effort to improve health infrastructure and service delivery, the current study found some health projects and services implemented by the private sector in government regional referral hospitals. The current study maintains that PPPs have been recognised as an important approach for infrastructure development and improved healthcare service delivery in Uganda.

Consequently, the current study shows that PPPs are an important mechanism for government because they improve health facilities through design, construction, and financing, and human resource capacity through recruitment, training, and capacity building of staff. They also provide equipment on time and in an efficient manner, medical supplies like ARVs, medical beds, mosquito nets, and non-clinical support, like counseling services. PPPs are crucial because they bridge the financial gaps through funding of many health programmes and infrastructural development, and medical supplies, and equipment. For example, the partnership of *Japan International Cooperation Agency (JICA) has provided* grants through construction and provision of necessary equipment and medical supplies to the government RRHs. Through partnerships, the status of government health facilities such as OPD, clinics, theatre, emergency units, and ICU departments have been built and some revamped in RRHs.

In addition, PPPs have benefited the communities in Northern Uganda through the provision of funds every quarter to the eye department, for instance, in Lira RRH donors have funded the eye camps and provided transport funds to the patients and this has reduced the congestion at the hospital unit. They also offer free drugs and meals during the surgical period, which the government of Uganda would not have managed to meet the ever-increasing demand for these products and services. Besides, private partners offer subsidised treatment (sometimes free medicine), provide non-clinical support like training, capacity building, and cleaning the hospital, which in the end leads to improved quality care and efficient services. Human capital brings in crucial skills and expertise in the heath sector and improves the professionalism of health workers.

In terms of funding, the health sector of Uganda is too big and demanding for the government to fully finance its programmes and ensure primary healthcare coverage. It was found that the biggest percentage of the government expenditure goes on salaries rather than public services. The funding gap does not only face the government of Uganda, but the literature shows that other African countries like Nigeria also spends more on salaries and vertical expenditure, and on government ministries, and sometimes the budget does not do its intended purpose, this means that the public funds are poorly managed by the governments. Since the government of Uganda cannot meet its budgetary responsibility, PPPs remain crucial and come into necessary support in the form of funds, where the government is incapacitated to finance some of the health programmes. Accordingly, the current study concludes that PPPs are crucial for health sector funding and development in Uganda.

The study results show that the government of Uganda cannot offer products and services that meet everyone's needs, and the involvement of PPPs supplements the government's efforts. Consequently, when private sector players collaborate with the government, they offer support to the government through funding, projects, and clinical services, and non-clinical support services to the regional referral hospitals. Such support is not only limited to funds but also support in delivering health education, through radio and television talk shows, for example, IDI and Mildmay Uganda have helped in sensitising and empowering the community about primary health care. This is evident that the private sector partners, such as non-government organisations, for-profit providers, and international donors play an important role in the health financing and provision of improved healthcare to the community.

The current study shows that Uganda has implemented several PPP models, but in general terms, such as design, build, finance and maintain (DBFM), design, build, finance, and operate (DBFO), Design-Build-Finance-Maintain (DBFM), Design-Build-Operate-Transfer (DBOT), Design-Build-Operate-Deliver (DBOD), Design-Build-Finance-Maintain-Operate (DBFMO), Operation and Management (O&M), and among other forms of contracts to deliver projects and services across all sectors, including the health sector. The government of Uganda has not defined a health PPP model, but partnerships have been made broadly to deliver health projects and services. This was established during this study, for instance, the respondents didn't know or could not identify the type of PPPs models being applied to deliver a specific health project or service. Despite the study respondent's lack of knowledge about the nature of the PPP models being implemented, the current study found that the government through the Ministry of Health has implemented health PPP models namely: - 1) Infrastructure-based Model, 2) Discrete Clinical Services Model, and 3) Integrated Clinical Services Model in engaging with the private sector to deliver projects and healthcare services, see **Error! Reference source not found. Error! Bookmark not defined.** for the features of these models. Accordingly, the informants identified Integrated Clinical Services as the best health PPPs model for Uganda's health sector.

The study concludes that PPPs are crucial because they have played an important role in the health sector in Uganda. For instance, before the adoption of PPPs in 2000, it was hard to access healthcare services. Accordingly, the study found that the following has been registered:

- ¶ the adoption of PPP arrangements in the health sector has improved the availability and accessibility of quality care to the Ugandan population.
- ¶ improved healthcare service delivery to the final consumers bridged the financial gap through construction and provision of equipment, medical supplies, and material like mattresses.
- ¶ PPPs improved on hospital infrastructures and equipment, e.g., emergency wards, theatres, OPD, ART and ENT clinics, water supply, tents, and generator house in Mubende RRH. Many health facilities have been constructed under the PPP arrangements in most of the RRH. Subsequently, congestion has been reduced due to increased infrastructure, manpower, medical supplies, and equipment.
- ¶ improved human resource capacity through recruitment, training, capacity building, and remunerations of health workers.

- ¶ improved the quality of life for patients, offered maternal health services to pregnant mothers, healthcare indicators of ART clinic, Tuberculosis (TB), HIV, provided counseling services and empowered people living with HIV/AIDS, control and prevention of infectious diseases, like Ebola, TB, and COVID-19 pandemic.
- ¶ improved monitoring and evaluation (M&E) and supervision of hospital programmes and operations.
- ¶ improved accountability and monitoring of hospital activity.
- ¶ improved the inventory management of medical equipment, drugs, and medical supplies.
- ¶ PPPs have also helped to mobilise and sensitise the community about their health, including the most devastating diseases, such as TB, HIV, COVID-19, and Malaria.
- ¶ PPPs have significantly supported the study of Anti-microbial resistance, supported in immunisation and vaccination of patients against the killer diseases in all governments.

However, the current study found some of the challenges affecting the performance of PPPs in the health sector in Uganda. The following critical challenges were reported as - political interference, bureaucratic process, conflict of interest, the parallel working relationship amongst PPPs workers, poor communication and coordination, a discrepancy in compensation structure, advanced equipment provided by private partners—outmatches the users' knowledge, poor priorities, insufficient funding and poor sustainability plan, strict timeline by the private sector, collision on the same projects, poor follow-up, poor approach, negative attitude about private partners among the public servants, limited space on the hospital, and support offered by private partners is limited compared to the population.

In conclusion, for the government of Uganda to expand and improve on its infrastructure and healthcare services delivery to the community, the PPPs should be fully implemented as an important alternative that lies between the public procurement framework and the private sector. This is important for the government because it brings private-sector efficiencies, innovation, resources, such as competencies of human resources, and necessary funding to improve public infrastructure and services, especially when the government has limited funds to meet its budget requirement. The government enters into a contract with the private sector, including for-profit-making and not-for-profit making to transfer risks and management roles and expect improved public service delivery.

8.3 Recommendations

This section makes some recommendations for further studies and gives critical recommendations to the governments and private sector.

8.3.1 Recommendations for further studies

Further studies should be conducted to:

i. To conduct an in-depth investigation of the challenges facing the performance of Public-Private Partnerships and possible policy reforms. This is because the current study found some varied opinions about the challenges that hinder the performance of PPPs.

There is a growing body of literature, showing that female health workers provide better patient outcomes and they have a better communication interface with their patients than the male doctors do. Demographic data of this study also show that female doctors offer better care than males do. For example, a study by the Journal of the American Board of Family Medicine shows that patients handled by female health workers shown having less mortality rate compared to patients handled by male doctors.

ii. Consequently, further studies should examine the mortality and readmission rate of patients treated by male doctor versus female health workers in health systems in Uganda.

8.3.2 Recommendations to the government

i. The current study found many nurses compared to the specialised health workers like doctors, physicians, and surgeons who offer critical and extensive medical services to the patient. This means that the number of doctors does not match the increasing number of patients. Therefore, the government should employ more specialised doctors, and physicians to handle the most complex health conditions.

ii. This study found that the government of Uganda cannot meet its financial obligations of providing equitable and efficient healthcare services to the population, and yet they spend a lot on salaries and vertical expenditure on ministries, hence leaving out the health needs of the population. Moreover, the available funds are poorly managed, with no proper accountability, which leads to stock-out and inadequate medical supplies. To address this challenge, the government should enforce proper budgeting and accountability, and transparent mechanisms that ensure value for money.

iii. Both the government and private partner should take careful diligence to clearly understand the PPPs terms of reference (ToF) contract before approving the contract and signing against it. This can help to overcome the issue of irregularities and violation of the Public Procurement and Disposal of Public Assets (PPDPA) 2003 (as amended) Act and ensure project deliverables as intended in the original procurement documents.

iv. The current study also recommends continuous documentation and appraisal of the contributions and roles of different players to Public-Private Partnerships, including how private sector actors work with the government. This is because some participants have shown limited knowledge about the type of PPP models, their features, and how they are implemented.

v. The government has a constitutional mandate to formulate and implement policies, create a favourable environment, ensure proper administrative mechanisms, promotion of good government systems, capacity building of government servants, and addressing the political and social concerns of PPPs. Therefore, the current study recommends that the government of Uganda must enact a financial, legal, and regulatory framework to address the challenges affecting the implementation process of PPPs and ensure the effective provision of health projects and services. This would address the issues of political interferences, irregularities, bureaucracy, and corruption in the procurement process.

vi. Conflict of interest was reported to be one of the factors hindering the performance of PPPs. For instance, a conflict of interest is dangerous and possesses a potential risk to the ongoing projects when actions about a primary interest are unreasonably influenced by a secondary interest made by a secondary party. Therefore, this study recommends that the government should implement common policies and standards to detect, avoid, minimise or eliminate the impact of conflict of interest, and ensure that these are properly enforced. More importantly, the government should formulate standards of what comprises a conflict of interest and how these should be communicated and dealt with.

vii. This study found poor communication and coordination on the ground. For instance, health workers deployed by private partners do not consult with their colleagues employed by the Ministry of Health at the hospital, and this has created a parallel working relationship. As a result, this study recommends that the government of Uganda through the public services should take on the role of recruiting employees on behalf of the private sector and categorise them as the government health workers

recruited to serve the same purpose. Alternatively, the government of Uganda should integrate the staff deployed by private partners into the government structure (employment and salary structure), and they should also work under the supervision of the hospital administration and director-general of the RHH. This will directly create a working relationship and improve the quality of care and service delivery.

viii. There should be a health policy to address the issues of limited space at the hospital facility. To achieve this, the government should identify vacant spaces for infrastructure expansion, perhaps, this can be any free land, like local governments land, local councils, municipal councils, public or private universities, and among other areas.

ix. Insufficient funding is still a challenge on the side of the private sector and this leads to sudden withdrawal. Therefore, the current study recommends that the government of Uganda should come in to financially support these projects and services implemented by private partners to ensure continuity.

x. In addition, the current study recommends that the government of Uganda should introduce investment policies that allow the Private sector, especially NGOs to invest in some income-generating projects, which are tax-free to allow continuity and adequate funding of the projects or services.

xi. The government of Uganda should carry out capacity building and train more health workers that can take on the roles especially when the private partner contract ends.

xii. More importantly, the government of Uganda should introduce a policy that allows knowledge transfer and transfer of health projects or services implemented by the private partner to the government.

A scenario of failed Public-Private Partnerships for Health (PPPH)L International Specialised Hospital of Uganda (ISHU).

In March 2019, the Government of Uganda through the Parliament approved promissory notes for $379.71 million for highly contested PPPs between the Government of Uganda and FINASI/ROKO Construction SPV Ltd., to design, build, finance, operate, and manage an International Specialised Hospital of Uganda. Both the Ministry of Health and Ministry of Finance negotiated the project terms on behalf of the government. Accordingly, on December 4, 2018, a contract was signed. On February 12, 2019, the Minister of State for Finance, Hon. David Bahati, tabled a proposal before the Parliament of Uganda to issue the promissory notes of $379.71 million to FINASI/ROKO.

The minister's proposal was approved by the Parliamentary Committee on National Economy (PCNE). On February 25, 2019, H.E. YK. Museveni wrote to the Speaker of the Parliament of Uganda about his position on the proposed PPPH. However, some members of parliament (MPs), opposition MPs in particular, contested claiming that the development and implementation of this PPPH did not comply with the laws and was irregular, citing lack of accountability, access to information, lack of participation, and infringement of the existing regulatory framework. They added that the existing policy and legal framework were intentionally circumvented.

Act 1, of 2003 (as amended) of the Public Procurement and Disposal of Public Assets (PPDPA) of Uganda does not allow negotiations between a disposing and procuring entity and contractor except a competitive approach (bid) was applied. Consequently, it is reported that there was no open competitive bidding process, contravening with the existing laws, and the minority report of the Parliamentary committee openly aired out, it was not legitimate on what motive and FINASI/ROKO SPV LTD was simply emerged as the preferred bidder, but not the best bidder. To make matters worse, it was the Government of Uganda providing the funds to the private partners, and the government released money to the private company. Three (3) years now, nothing has been done, not even a single stone has been laid to kick off the construction of the said hospital. No value for money.

Moreover, Uganda's PPP Act states "that in any circumstances, the private partner assumes substantial financial obligations, operational, and technical risks. In this case, the Government of Uganda instead bears all the risk. This is because the promissory note protects the private company from any losses and ensures that the investor will receive 100% of the total funding invested and will be protected irrespective of whether or not losses are made. The opposition MPs protested against the contract, and some civil society organisations have come out to protest and even sued the government for violating the existing PPDPA laws and policy.

xiii. Therefore, the current study recommends that the government of Uganda should introduce PPP bills that protect Act 1, of 2003 (as amended) of the Public Procurement and Disposal of Public Assets (PPDPA) and infringement of the existing regulatory framework.

xiv. There should be policy development and conceptualisation of the partnership that allows for resource mobilisation and allocation, information sharing, accountability, monitoring and evaluation, fair competition, competitive bidding, and full participation.

8.3.3 Recommendations to the Private Sector

i. The current study found that some projects and services implemented by private partners are underfunded and some end before completion. Therefore, the study recommends that private donors should always make proper feasibility studies about the project goals, timeframe, and introduce more sources of funding, and budget according to the scope of the project. As a result, this will help to address the issue of insufficient funding and poor sustainability plan.
ii. This study found that private partners provide equipment and systems that are not user-friendly. Some are even out of specification. The current study recommends that private companies should supply equipment and systems that are user-friendly, with proper documentation, and provide a user manual to help the final users understand the technicality of the supplies. Also, private actors should give adequate training to the final users of the equipment and systems supplied, to identify the possible challenges that may occur during operations.
iii. It was established that private donors sometimes come with their priorities and strict work-plan that directly interferes with the normal operations of the hospital. Therefore, this study recommends that private partners, especially the NGOs, should involve the stakeholders at the grassroots levels during the planning and implementation of any projects or services. This will help to identify the areas that need to be prioritised, and identify the most urgent services rather than implementing the projects that are not needed at a given time. For instance, some private donors provided contraceptives during the COVID-19 pandemic. The informants noted that this was not necessary at the time of a pandemic. In addition, these projects or healthcare services should be implemented according to the hospital work plan, and not what the donors want to achieve.
iv. More importantly, there should be early stakeholder engagement to identify the gaps and address them accordingly. This helps to ensure value for money and addresses resource wastage in both the short and long term.

PPPs have supported governments to improve health care for individuals and communities. They provide health services ranging from infrastructure, clinics, equipment, medical supplies, and laboratories to medical medicine, diagnostics, and vaccines to ancillary services such as ambulance and emergencies, and expertise and training to capacity building of medical

workers. Therefore, this study maintains that if private sector providers are properly engaged, and the laws and regulations governing PPPs and PPPDA are complied with, they have the potential to significantly improve the health outcomes and service delivery in Uganda.

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Appendix 1: NOTICE OF SUBMISSION

PO Box 1174, Vanderbijlpark
South Africa 1900
Tel: 016-910-3182
Web: http://www.nwu.ac.za
For Registrar
Tel: 016-910-3033
Email: Jenna.Wilson@nwu.ac.za

2 September 2021

Dear Mr JP Settumba

NOTICE OF SUBMISSION

Note has been taken that you wish to submit your mini-dissertation/dissertation/**thesis** for examination. The registered title as it must appear on the examining copies and on the title page of the final copies is indicated below. An example of your title page will be sent together with this letter.

An assessment of public private partnerships in the Healthcare sector in Uganda: A case of government referral hospital

Your attention is drawn to the following matters regarding the above.

- You may submit your examination copies from **20 September to 25 November 2021 to possibly qualify for the Autumn (May) graduation ceremony in 2022.**
- **Submissions received after 25 November 2021 will be considered in time for examination towards possible graduation during the Winter graduation series of 2022.**

You are required to submit your examination copy in the following format:

- **One electronic copy in Word format and one electronic copy in PDF format to be submitted via email to a HDA official. You may also submit in person, over the counter to a HDA official. Please submit one hard copy in person, over the counter to a HDA official.**

The following forms must be submitted with your examination copies:

- **The signed Solemn Declaration form**
- **Personal particulars form (only applicable for PhD students)**
- **Acknowledgement of Receipt**
- **Copy of your ID**
- **Please visit the DIY Student 360° to ensure that your personal details are correct on the system and on your degree certificate please**

I trust you find the above in order. Please do not hesitate to contact the undersigned for any more related information

Yours sincerely

Ms J Wilson
FOR REGISTRAR

Original details: (\\Nt\HDA Toolbox\Phase 3\2. Notice of Submi\Letter to student\July 2018\NOS July 2018 letter .docm
6 March 2018
File reference: 7.1.11.2.1

Appendix 2: ETHICAL CLEARANCE

PO Box 1174, Vanderbijlpark
South Africa 1900

Tel: 016 910-3111
Fax: 016 910-3116
Web: http://www.nwu.ac.za

Faculty of Humanities
Tel: 016-91003441
Email: Chrizanne.vaneeden@nwu.ac.za

31 March 2020

Dear Prof Lukamba and Mr JP Settumba,

ETHIC APPLICATION APPROVED

This letter serves to inform you that your ethics application was approved by the Ethics Committee for Basic and Social Sciences (BaSSREC) of the NWU.

ETHICS APPLICATION NUMBER:	NWU-HS-2019-0068
STUDY PROMOTOR:	Prof MT Lukamba
APPLICANT:	Mr JP Settumba
PROJECT TITLE:	Assessment of public-private partnerships in the health care sector in Uganda: A case of government referral Hospitals.
DURATION:	1 April 2020 to 30 April 2021. An annual monitoring report is required.
ETHICS APPROVAL DATE:	24 March 2020

Your acceptance of the reviewers' recommendations is appreciated and your research will be conducted in line with such recommendations. Your application for ethics approval was approved by BaSSREC on the 24th March 2020. Please note that you have approval for one year and should reapply by means of a progress report by 30th April 2021. The REC wishes you well with your study.

Yours sincerely

C. van Eeden

Prof C Van Eeden
Chair: BaSSREC

Original details: (10057013) P:\Daleen\BaSSREC\Prof C van Eeden-letter.docm
10 September 2019

File reference: 9.1.5

Appendix 3: UNCST STUDY APPROVAL

Uganda National Council for Science and Technology

(Established by Act of Parliament of the Republic of Uganda)

Our Ref: SS 5140

23rd December 2019

Mr. John Paul Settumba
Principal Investigator
Uganda Management Institute
Kampala

Dear Mr. Settumba,

Re: Research Approval: An Assessment of Public – Private Partnerships in the Health Care Sector in Uganda: A Case of Government Referral Hospitals

I am pleased to inform you that on **10/12/2019**, the Uganda National Council for Science and Technology (UNCST) approved the above referenced research project. The Approval of the research project is for the period of **10/12/2019** to **10/12/2021**.

Your research registration number with the UNCST is **SS 5140**. Please, cite this number in all your future correspondences with UNCST in respect of the above research project. As the Principal Investigator of the research project, you are responsible for fulfilling the following requirements of approval:

1. Keeping all co-investigators informed of the status of the research.
2. Submitting all changes, amendments, and addenda to the research protocol or the consent form (where applicable) to the designated Research Ethics Committee (REC) or Lead Agency for re-review and approval prior to the activation of the changes. UNCST must be notified of the approved changes within five working days.
3. For clinical trials, all serious adverse events must be reported promptly to the designated local REC for review with copies to the National Drug Authority and a notification to the UNCST.
4. Unanticipated problems involving risks to research participants or other must be reported promptly to the UNCST. New information that becomes available which could change the risk/benefit ratio must be submitted promptly for UNCST notification after review by the REC.

LOCATION/CORRESPONDENCE
Plot 6 Kimera Road, Ntinda
P. O. Box 6884
KAMPALA, UGANDA

COMMUNICATION
TEL: (256) 414 705500
FAX: (256) 414-234579
EMAIL: info@uncst.go.ug
WEBSITE: http://www.uncst.go.ug

5. Only approved study procedures are to be implemented. The UNCST may conduct impromptu audits of all study records.
6. An annual progress report and approval letter of continuation from the REC must be submitted electronically to UNCST. Failure to do so may result in termination of the research project.

Please note that this approval includes all study related tools submitted as part of the application as shown below:

No.	Document Title	Language	Version Number	Version Date
1.	Research proposal	English	2.0	November 2019
2.	Informed consent forms	English	N/A	N/A
3.	Interview guides	English	1.0	October 2019
4.	General Questionnaire	English	2.0	November 2019

UGANDA NATIONAL COUNCIL FOR SCIENCE & TECHNOLOGY
P. O. BOX 6884
KAMPALA - UGANDA

BETH MUYOMBA
For: Executive Secretary
UGANDA NATIONAL COUNCIL FOR SCIENCE AND TECHNOLOGY

Copied: Chair, Gulu University, Research Ethics Committee

Appendix 4: PROOF OF GATEKEEPER PERMISSIONS_ MOH

Telephone: General Lines: 256 - 417-712260
Permanent Secretary's Office: 256 -417- 712221
Toll Free 0800100066

E-mail : ps@health.go.ug
Website: www.health.go.ug

IN ANY CORRESPONDENCE ON
THIS SUBJECT PLEASE QUOTE NO. ADM. 145/01

THE REPUBLIC OF UGANDA

Ministry of Health
P. O. Box 7272
Plot 6, Lourdel Road
KAMPALA
UGANDA

14th October, 2019

Director General
Uganda Management Institute
KAMPALA

ADMISTRATION CLEARANCE FOR MR JOHN PAUL SETTUMBA TO CONDUCT A PHD RESEARCH IN THE MINISTRY OF HEALTH REFERRAL HOSPITALS IN UGANDA

Reference is made to your letter dated 4th October, 2019, Ref: CG/49 requesting for Administrative clearance to conduct a PHD research in the Ministry of health 4 Regional Referral Hospitals of Uganda.

We acknowledge that the objective of the Research is mainly for Academic purposes. Furthermore, we note that the study:

- Seeks to investigate the role of public-private partnerships in addressing the challenges and delivering of social entrepreneurships in health sector of Uganda.
- Will contribute towards the understanding of Uganda's experience of the public-private partnerships in health care sector.
- will include conducting some key informant interviews at 4 Regional Referral Hospitals ie, Lira, Fort portal, Soroti and Mubende.

The Ministry of Health further notes that the Research proposal has received the necessary approvals from the Institute and permission has been granted for him to proceed with the data collection. The Ministry of Health therefore grants permission to Mr. John Paul Settumba to collect data from the 4 regional Referral Hospitals above.

By copy of this letter, the Hospital Directors of the above mentioned Hospitals are accordingly informed and requested to accord Mr. John Paul Settumba the necessary information that he requires.

Thank you.

Dr. Henry G. Mwebesa
Ag. DIRECTOR GENERAL HEALTH SERVICES

cc. The Permanent Secretary
cc. Hospital Director Lira Regional Referral Hospital
cc. Hospital Director- Fortportal Regional Referral Hospital
cc. Hospital Director - Mubende Regional Referral Hospital
cc. Hospital Director- Soroti Regional Referral Hospital

Appendix 5: RESEARCH PROPOSAL APPROVAL LETTER

NWU®
NORTH-WEST UNIVERSITY
NOORDWES-UNIVERSITEIT
YUNIBESITI YA BOKONE-BOPHIRIMA

PO Box 1174, Vanderbijlpark
South Africa, 1900

Faculty of Humanities
Vaal Campus Humanities Research
Management Committee
Tel: (016) 910-3662
23991437@nwu.ac.za
Date: 10 September 2019

Mr JP Settumba

Student no: 29417937

Research title as approved by the VCHRM committee:

AN ASSESSEMENT OF PUBLIC PRIVATE PARTNERSHIPS IN THE HEALTH SECTOR IN UGANDA: A CASE OF GOVERNMENT REFERRAL HOSPITALS

Dear Mr Settumba

This letter serves to confirm that your PhD research proposal has been approved by the Vaal Campus Humanities Research Management Committee.

The ethics application is referred to the:

* Research Ethics Committee- BaSSREC:_X___.

* Research Ethics Committee-HHREC:_____.

You will find the details on the procedure that you will have to follow to submit to the Ethics Committee on the NWU-website. For the VCHRM-records, please inform Ms Precious Nale as responsible person to folder the ethical submission when your submission has been successfully completed and approved (Precious.Nale@nwu.ac.za).

Yours sincerely

Prof C Hofisi
Chairperson: Vaal Campus Humanities Research Management Committee

1

Appendix 6: INFORMED CONSENT FORM

PO Box 1174, Vanderbijlpark South Africa, 1900

Web: http://www.nwu.ac.za

DATE

BaSSREC Authorization

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: AN ASSESSMENT OF PUBLIC-PRIVATE PARTNERSHIPS IN THE HEALTHCARE SECTOR IN UGANDA: A CASE OF GOVERNMENT REFERRAL HOSPITALS.

REFERENCE NUMBERS: 29417937

PRINCIPAL INVESTIGATOR: Mr. Settumba John Paul

ADDRESS: Kampala, Uganda

CONTACT NUMBER: +256702700578/ +256776700578/ or j.settumba@gmail.com

You are being invited to take part in a research project that forms part of my academic requirements. Please take some time to read the information presented here, which will explain the details of this project. Please ask the researcher any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not

affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part. Prior to publication of the study's results (or the point that publication is in process), you may also withdraw the data you generate.

This study has been approved by the **Basic Social Sciences Research Ethics Committee (BaSSREC) of the Faculty of Humanities of the North-West University (NWU, Vaal Campus South Africa)** and will be conducted according to the ethical guidelines and principles of the international Singapore Statement on Research Integrity (2010) and the ethical guidelines of the National Health Research Ethics Council. It might be necessary for the research ethics committee members or relevant authorities to inspect the research records to make sure that we (the researchers) are conducting research in an ethical manner.

What is this research study all about?

- *This study will be conducted* ***purposely to assess and find out what roles have Public-Private Partnerships (PPPs) played in improving the care quality and delivery of healthcare services in Uganda*** *and will involve respondents answering questionnaires and interview sessions with the participants to obtain data relevant to the study problems. The researchers have been trained to use the methods mentioned in the previous sentence.*
- *The study has determined a sample size of 100. Approximately 80 participants for quantitative and 20 participants for qualitative research will be included in this study.*

The objectives of this research are:

i. To establish the importance of PPPs concept for governments and societies.
ii. To examine the roles played by PPPs in improving the care quality and delivery of healthcare services in Uganda.
iii. To assess the performance of PPPs in Uganda from the time they were established.
iv. To assess the challenges affecting the successful implementation and the performance of PPPs in the healthcare sector in Uganda
v. To identify possible PPPs reforms in the healthcare sector of Uganda based on the performance.
vi. To identify the best type of PPPs model for the healthcare sector in Uganda.

Why have you been invited to participate?

- *You have been invited to participate because you are* eligible to be included in this study and you're one of the officials from the ministry of health, health practitioners, NGO implementers or contractors and private sectors in the health, Authorities Associations, policymakers, and implementers. Lastly, this study was referred to you by the Permanent Secretary Ministry of Health,
- *You have also complied with the following inclusion criteria:*
  i. Age: 18 and above
  ii. Gender: male and female
  iii. Ethnicity: no discrimination of the participants
  iv. Education level: Hold an O-level certificate of education (UCE)
  v. Socio-economic level: working-class (public and private sector)
  vi. Duration of serving in the ministry/organisation: More than one year
  vii. Line ministry/organisation: Ministry of Health

- *You will be excluded if:*
  i. Persons below 18 years-old will not be included
  ii. Participants below A-level certificate (High School Level)
  iii. Duration of stay: less than one year
  iv. Patients or unsound participants: shall not be included
  v. Participants identified as faced charges of corruption: shall not be included
  vi. People with cognitive disability: shall not be included
  vii. NWU staff and students: shall not be included
  viii. People living in vulnerable life circumstances: shall not be included

What will your responsibilities be?

- *You will be expected to have read, understood and sign the participant informed consent form, thereafter, you will be* expected to answer the questionnaires and take part in the interview sessions about the questions raised on the study problem as well as the topic.

Will you benefit from taking part in this research?

The direct benefits for you as a participant will probably be: this is a completely voluntary project. However, If you decide to participate in this study, you will have an opportunity to receive feedback about the study findings before publishing them.

i. *The indirect benefit will probably be: this study will indirectly* inform the public and private sectors including all stakeholders about the importance and challenges of PPPs and the urgent steps toward improving the healthcare sector in Uganda, where you're among the beneficiaries. This means that improved healthcare services you will get are deemed as the indirect benefits of this study.

Are there risks involved in your taking part in this research and how will these be managed?

- *The risks in this study, and how these will be managed, are summarised in the table below:*

Probable/possible risks/discomforts	***Strategies to minimize risk/discomfort***
Because you will spend about 1 hour completing the questionnaires, it is possible that you will become tired.	The researchers facilitating your completion of the questionnaire will give you a 15-minute break, with some refreshment (a juice or bottle of water) about halfway through.
Because during the interaction, you may mention something about your bad experience with the healthcare in Uganda, this could invoke anxiety and stress, and eventually make you feel uncomfortable.	The researcher has a list of local mental health practitioners I can contact them for one counseling session of 30 minutes.

- *However, we do believe that the benefits to you and to science (as noted in the previous section) outweigh the risks we have listed. If you disagree, then please feel free not to participate in this study. We will respect your decision.*

- *Should we learn, in the course of the research, that someone is harming you, or that you are intending to harm someone, then we must tell someone who can help you/warn the person you are intending to harm.*

Who will have access to the data?

- *Anonymity (that is, in no way will your results be linked to your identity) will be followed to protect participantsô privacy*
- *Confidentiality (that is, I/we assure you that we will protect the information we have about you) will be ensured by the principal investigators, researchers, and individuals of the research team. Reporting of findings will be anonymous by not asking or avoiding collecting identifying details of individual subjects, such as names, address, account number, fingerprints, images/full face photo, date of birth, employerôss, voiceprints,, telephone number, email addô name address, and password.*
- *Only the researchers and individuals of the research team shall have the privilege to identify the responses of the participants or individual subjects. Data will be kept safe and secure by locking hard copies in lock for electronic data, it will be password protected.*
- *Data will be stored for a period of 5 year*

What will happen to the data?

The data from this study will be reported in the following ways:

This will be reported in a summary report and presentation formats.

Summary reports provide the study methods, the purpose of the study, and an abstract and a brief conclusion of the whole topic being presented. Whereas presentation formats will be typically verbal and face-to-face interaction with the audience. In all of this reporting, you will not be personally identified. This means that the reporting will not include your *names, address, account number, fingerprints, image relatives, voiceprints, telephone number, email address and password* that will help others to know that you participated.

This is a once-off study, so the data will not be re-used.

Will, you be paid/compensated to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study, but refreshments will be provided during all sessions. If participating in the research means that you have to travel especially for the purpose of participating, then your travel costs will be paid. This means that you will not incur any cost.

How will you know about the findings?

- The general findings of the research will be shared with you by a summary report and presentation formats.
- If you would like feedback on your personal results, then you will give us a notification so that share a meeting.

Is there anything else that you should know or do?

You can contact Mr. Settumba John Paul at **+256702700578/ +256776700578/ or j.settumba@gmail.com** if you have any further queries or encounter any problems.

- You can contact the chair of the Basic Social Sciences Research Ethics Committee (Prof C van Eeden) at 016 910 3441 or chrizanne.vaneeden@nwu.ac.za if you have any concerns or complaints that have not been adequately addressed by the researcher.
- You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ……..……. agree to take part in a research study entitled:

I declare that:

- ¶ I have read and understood this information and consent form and it is written in a language with which I am fluent and comfortable.
- ¶ I have had a chance to ask questions to both the person obtaining consent, as well as the researcher (if this is a different person), and all my questions have been adequately answered.
- ¶ I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- ¶ I understand that what I contribute (what I report/say/write/draw/produce visually) could be reproduced publically and/or quoted, but without reference to my personal identity.
- ¶ I may choose to leave the study at any time and will not be penalised or prejudiced in any way.
- ¶ I may be asked to leave the study before it has finished, if the researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) .....…..……. on (*date*) ……...…….. 20....

....

Signature of participant **Signature of witness**

- ¶ You may contact me again ☐ **Yes** ☐ **No**
- ¶ I would like a summary of the findings of this research ☐ **Yes** ☐ **No**
- ¶ I would like feedback on my functioning/wellbeing as reflected in the questionnaires I completed ☐ **Yes** ☐ **No**

The best way to reach me is:

Name & Surname: _____

Postal Address: _____

Email: _____

Phone Number: _____

Cell Phone Number: _____

In case the above details change, please contact the following person who knows me well and who does not live with me and who will help you to contact me:

Name & Surname:

_____

Phone/ Cell Phone Number /Email:

_____

Declaration by person obtaining consent

I *(name)* ……..…… declare that:

- ¶ I explained the information in this document to ……..
- ¶ I encouraged him/her to ask questions and took adequate time to answer them.
- ¶ I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- ¶ I did/did not use an interpreter.

Signed at (*place*) .....…..…….. on (*date*) ……...…….. 20....

....

Signature of person obtaining consent **Signature of witness**

Declaration by researcher

I *(name)* ……..…… declare that:

- ¶ I explained the information in this document to ……..
- ¶ I encouraged him/her to ask questions and took adequate time to answer them.

- ¶ I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- ¶ I did/did not use an interpreter.

Signed at (*place*) .....…..……. on (*date*) ……...…….. 20....

..... **Signature of researcher .....**

..... **Signature of witness**

Appendix 7: QUESTIONNAIRES

SERIAL NO:

APPENDIX A

GENERAL QUESTIONNAIRE

AN ASSESSMENT OF PUBLIC PRIVATE PARTNERSHIPS IN THE HEALTHCARE SECTOR IN UGANDA: A CASE STUDY OF GOVERNMENT REGIONAL REFERRAL HOSPITALS

JOHN PAUL SETTUMBA MCIPS, MSC. PSCM

STUDENT NUMBER: 29417937

Introduction:

Dear respondent,

My name is JOHN PAUL SETTUMBA, a student at North-West University pursuing Doctor of Philosophy in Public Management and Governance. I am currently conducting a research study as a requirement for completing my PhD programme, which is the main reason I have involved you in this ***study—purposely to assess and find out what roles have Public Private Partnerships (PPPs) played in improving the car-quality and delivery of healthcare services in Uganda.*** The information you will give here is purely academic and shall be treated with utmost confidentiality. This questionnaire is divided into two sections: *section* **A** seeks for capturing the demographic characteristics of the respondents, while *section* **B** solicits for data on the study variables. It will take less than 15 minutes of your time.

Consent:

I hereby give my consent to participate in this study understanding that my participation is purely voluntary, and that I do not take liability for any inappropriate use of the information I provide to this survey.

Name(***optional***):…….Ministry/Organization(***optional)***……..
…. Signature: ……..Date……....

SECTION A: DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Let us begin by knowing a little bit about you.

Guide for completing this questionnaire: *Tick, Circle (or write) the correct option*

1. Indicate your Gender.

a) Male [ ]

b) Female [ ]

2**. Indicate your age bracket.**

a) 21-35 [ ]
b) 36-45 [ ]
c) 46-55 [ ]
d) Above 56 [ ]

3. State your marital status

a) Married [ ]

b) Single [ ]

c) Widowed [ ]

e) None of the above

4. Indicate your level of education

a) University [ ]
b) Tertiary [ ]
c) Secondary [ ]
d) Other (*please specify*) [……..…..]

5. Title/Position

a) Government Official [ ]
b) Minister [ ]
c) Doctor [ ]
d) Nurse
e) Other ***(please specify)*** *[é é é é é é é é é é é é é é .]*

6. For how long have you been serving?

a) 1 year and below [ ]
b) 1-5 [ ]
c) 1-10 [ ]
d) 1-15 [ ]
e) 15 and Above [ ]

7. Location (Regional Referral Hospital)

a) *FORT-PORTAL [ ]*
b) *LIRA [ ]*
c) *MUBEMDE [ ]*
d) *SOROTI [ ]*

SECTION B: THE KEY STUDY VARIABLES

Now that we know you, provide us with the information about what you think as well as your knowledge about Public-private Partnerships (PPPs), its role in health sector, the importance of PPPs for governments, developing partners, and communities, *in particular Uganda. (**Please use a tick or write in the box**).*

8. Have you ever heard or know about health PPPs in Uganda?

a) Yes [ ]
b) No [ ]
c) Not sure [ ]

9. Do you know of any healthcare projects/ services implemented under health PPPs contract in Uganda?

d) Yes [ ]
e) No [ ]
f) Not sure [ ]

10. If yes, do you agree with the views that the health PPP models can improve healthcare sector in terms of quality and service delivery in Uganda?

a) Yes [ ]
b) No [ ]
c) Not sure [ ]

11. **What roles have health PPPs played in the Healthcare systems in Uganda?** ***(please select all that apply)***
    a) the private partners designed, built, maintained, and or renovated the public healthcare facilities [ ]
    b) the private partners expanded and improved the capacity of health facilities and improved healthcare service delivery [ ]
    c) the private partners financed the construction of a health facility, and provision of health services to the population [ ]
    d) the private partners have provided financial, advisory, clinical and non-clinical support services [ ]
    e) All the above [ ]
12. **Based on** question 11 above, **to what extent do you agree or disagree that implementation of health PPPs have played a vital role and achieved its objectives in improving the care quality and delivery of healthcare services in Uganda?**
    (**SA**=Strongly Agree, **A**=Agree, **N**=Neutral, **D**=Disagree, **SD**=Strongly Disagree). (***Please use a tick only*****)**

Level of agreement (variables)	**Use a tick below**
Strongly Agree	
Agree	
Neutral	
Disagree	
Strongly disagree	

13. **To what extent do you agree or disagree that PPPs have performed well in the healthcare sector in Uganda since implementation?** (**SA**=Strongly Agree, **A**=Agree, **N**=Neutral, **D**=Disagree, **SD**=Strongly Disagree). (***Please use a tick only*****)**

Level of agreement (variables)	**Use a tick below**
Strongly Agree	

Agree	
Neutral	
Disagree	
Strongly disagree	

14. Do you agree to the views that PPPs face challenging during implementation processes, and times of performing it roles?

a) Yes [ ]
b) No [ ]
c) Not Sure [ ]

15. Do you agree that *Policy development and conceptualisation of the partnership, resource mobilisation and allocation, information sharing, monitoring and accountability* ***are major challenges affecting successful implementation and performance*** **of PPPs in the healthcare sector in Uganda?**

a) Yes [ ]
b) No [ ]
c) Not sure [ ]

16. Do you agree to the view that health PPPs in Uganda need policy reforms or large rethinking based on the implementation processes and performance?

a) Yes [ ]
b) No [ ]
c) Not sure [ ]

17. Public-private Partnerships are implemented as business model. Do you agree that Uganda's health sector has followed any of the following health PPP models?

¶ **Infrastructure-Based Model: -** a contracting partner build or renovate the public healthcare facilities.

¶ **Discrete Clinical-Service Model: -** the private partner expands and improve the capacity of healthcare service delivery, and provided clinical support, and non-clinical support services.

¶ **Integrated PPP Model: -** private sector takes on the role of providing a more comprehensive package of healthcare infrastructure and service delivery.

a) Yes [ ]
b) No [ ]
c) Not Sure [ ]

18. If yes, which one of the following health PPP models used **(mention above in question 17)** before is the best business model to be implemented in Uganda's health systems?

a) Infrastructure-Based Model [ ]
b) Discrete Clinical-Service Model [ ]
c) Integrated Clinical-Serviced Model [ ]

.....THE END……

*****Thank You So Much for Taking Part in This Study*****

Appendix 8: INTERVIEW GUIDES

SERIAL NO:

APPENDIX B

INTERVIEW GUIDE

AN ASSESSMENT OF PUBLIC PRIVATE PARTNERSHIPS IN THE HEALTHCARE SECTOR IN UGANDA: A CASE OF GOVERNMENT REGIONAL REFERRAL HOSPITALS

Principal Researcher: JOHN PAUL SETTUMBA MCIPS, Msc. PSCM

STUDENT NUMBER: 29417937

Introduction:

Dear respondent,

My name is JOHN PAUL SETTUMBA, a student at North-West University pursuing Doctor of Philosophy in Public Management and Governance. I am currently conducting a research study as a requirement for completing my PhD program, which is the main reason I have involved you in this ***study purposely to assess and find out what roles has Public Private Partnerships (PPPs) played in improving the care quality and delivery of healthcare services in Uganda.*** The information you will give here is purely academic and shall be treated with utmost confidentiality. This interview guide consists of only one *section: Section* **A** solicits for data on the study variables, and it will take less than 30 minutes of your time.

Consent:

I hereby give my consent to participate in this study understanding that my participation is purely voluntary, and that I do not take liability for any inappropriate use of the information I provide.

Name(***optional***):…….Ministry/Organisation(***optional***……..
…. Signature: ……..Date……....

THE KEY STUDY VARIABLES

This section seeks respondentôs knowledge a
its importance for governments, developing partners, and communities *in Uganda.*

16. Why is it important to implement health PPP business model in Uganda's health sector?

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17. What roles have Health PPPs played in the Health sector in Uganda?

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18. Mention some of the health projects and or services delivered under PPPs contract

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19. What was the goals of this project/ service?

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20. What did this project/ service achieve that you think would not have been achieved without partnership arrangement?

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21. What are the current health PPPs business models being used in Uganda's health sector? *(please list below)*

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22. Based on your experience, and knowledge of PPPs, what is the best type of health PPP business model that can be implement across the sector?

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23. What have been the critical challenges affecting the successful implementation and performance of health PPPs in health systems in Uganda?

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24. What should be done to improve the performance of health PPPs in Uganda's health systems?

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.....THE END……

Thank You So much for Taking Part in This Study*

Appendix 9: STUDY PARTICIPANTS RECRUITMENT SCRIPT

EMAIL RECRUITMENT SCRIPT

Dear Study Project Participant,

My name is Settumba John Paul I am currently conducting a research study about Public-Private Partnerships (PPPs), which is the main reason why I have involved you in this study ***purposely to assess and find out what roles have PPPs played in improving the care quality and delivery of healthcare services in Uganda***.

I / We are requesting your assistance with relevant information on the study topic. You must be at least 18 years of age and above to participate, and you must be directly or indirectly working with the Ministry of Health, Uganda.

The questionnaire will take you roughly **30** minutes. If you choose not to respond upon the receipt of the questionnaires, we will send you a reminder in one week.

This study is anonymous, so please do not enter your personal details into the research instrument. All the data you give shall be kept confidential and only for the purposes of data analysis and reporting and or publication in any published journals.

Participation in this study is solely voluntary and you may withdraw from participation at any time. If you have any questions, you may contact the student/ researcher and/or research assistant:

Student/Researcher: Mr. Settumba John Paul
Address: Kampla
Mobile: +256702700578/ +256776700578
Email: j.settumba@gmail.com
Research Assistant: Isaac Nambula
Mobile: +256773390207/ +256759239020
Email: nambulaizacc@gmail.com
Principal Supervisor: MT. Lukamba at MT.Lukamba@nwu.ac.za / +169103374

VERBAL / TELEPHONE CALL SCRIPT

Hello study Participants,

My name is Settumba John Paul I am currently conducting a research study about Public-Private Partnerships (PPPs), which is the main reason why I have involved you in this study ***purposely to assess and find out what roles have PPPs played in improving the care quality and delivery of healthcare services in Uganda***. You're eligible to be included in this study and you're one of the participants selected by the researcher.

If you decide to participate in this study, you will have an opportunity to find out more about the study before making any decision. This is a completely voluntary project. You freely decide to take part in the study or not.

May I know if you would like to participate in this study so that we can go ahead and schedule a time for me to meet with you at your most convenient time to give you more information. You may also call me or email me for your decision if you need more time to decide

Feel free to contact me if you have any questions concerning this process or need to know more about your participation. Reach me at **Mobile:** +256702700578/ +256776700578/ j.settumba@gmail.com or North-West University at +016910311 or Principal Supervisor at MT.Lukamba@nwu.ac.za / +169103374

Thank you so much.

FACE-TO-FACE INTERACTION

Hello Study Participant:

My name is Settumba John Paul I am currently conducting a research study about Public-Private Partnerships (PPPs), which is the main reason why I have involved you in this study ***purposely to assess and find out what roles have PPPs played in improving the care quality and delivery of healthcare services in Uganda***. The information you will give here is purely academic and shall be treated with the utmost confidentiality.

You qualify to be included in this study because you are one of the eligible participants working directly or indirectly with the Ministry of Health, Uganda. This is a completely voluntary project. You freely decide to take part in the study or not.

Feel free to contact me if you have any questions concerning this process or need to know more about your participation. Reach me via **Mobile:** +256702700578/ +256776700578/ j.settumba@gmail.com or or North-West University at +016910311 or Principal Supervisor at MT.Lukamba@nwu.ac.za / +169103374

Thank you so much.

Appendix 10: PROOF READING CERTIFICATE

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Proofreading Certificate

It is hereby certified that this proposal/dissertation/thesis/article has been proofread and edited for spelling, grammar and punctuation by a professional English language editor
from www.OneStopSolution.co.za

Client

JP Settumba

An assessment of public private partnerships in the Healthcare sector in Uganda: A case of government referral hospitals

Submitted in fulfilment of the requirements for the degree of
Doctor of Philosophy in Public Management and Governance
at the North-West University

Editor

Lesley Venter ....

Name Signature

02 December 2021
.....

Date

I cannot guarantee that the changes that I have suggested have been implemented
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