

**PUBLIC-PRIVATE PARTNERSHIPS AND  
HEALTH CARE DELIVERY:  
A CASE OF MBARARA MUNICIPALITY**

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**2014/MAs/187/PS**

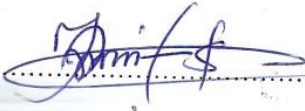
**A RESEARCH DISSERTATION SUBMITTED TO THE FACULTY OF INTERDISCIPLINARY  
STUDIES IN PARTIAL FULFILMENT FOR THE AWARD OF DEGREE OF  
MASTERS OF ARTS IN LOCAL GOVERNANCE AND  
PLANNING OF MBARARA UNIVERSITY OF  
SCIENCE AND TECHNOLOGY**

**September, 2017**

**Declaration**

I, JUSTUS ASASIRA, hereby declare that this dissertation is my original research work and has never been submitted to any higher institution of learning.

Signature.....

A handwritten signature in blue ink, appearing to be 'J. Asasira', written over a dotted line.

Date.....

20/9/2017

### Approval

This research work leading to this dissertation was conducted under my guidance and supervision.  
It is now ready for submission for external examination.

Signature.......... Date.....24/09/2017.....

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Research Supervisor

### **Dedication**

This work is dedicate to my dear father Mr. Filius J. Rugogamu, his wife Juliet Rugogamu, my grandmother Mrs Regina Kabwaijana, brothers Felix Rugagamu and Afex Rugogamu, and my dear friend Nassali Marygrace.

## **Acknowledgment**

In a special way I would like to thank the almighty God for continuing to extend many favours to me. He has blessed me with good health, courage, determination and above all wisdom which all have made me achieve all this.

I am grateful for the unlimited effort of my dear supervisor Dr. Rogers Bariyo for helping me keep focused and on right track. Without him, this work would have given me hard time to reach this success. I thank him for his valuable time he spent reading and guiding me in writing the proposal and final dissertation. I am equally grateful to FIS staff in particular Dr. Damazo Kadengye and Dr. Frank Ahimbisibwe who also helped me during proposal and dissertation writing. I cannot forget the tremendous contribution of Mrs. Wendo Olema Mlahagwa for her support during my studies. I remain thankful to Mr. Tom Ogwang, Mr. Odongo Hannington, Mrs. Specioza Twinamasiko and the entire team of DVS (Development Studies) teaching team for their continuous support. A vote of thanks to Ms. Jeniffer Philips (PhD fellow from USA) who spared time to read this manuscript and helped me on grammatical expressions to make this dissertation flow to the readers. May God bless you for the good work done.

I am indebted to those who supported me financially; Mrs Juliet Rugogamu, Ms. Atukunda Trifionia, Ms. Nassali Marygrace and Mr. Matsiko Bob, thank you all. I in a special way thank the family of Mr&Mrs Pontian Byaruhanga for all that you did to me. You all made my academic journey smooth. Without you I don't know how the journey would have been. Thank you.

To my parents Mr Rugogamu Filius and the Late Mrs Albinna A. Barigira, I am thankful for your steadfast and constant love. I am particularly touched by the many sacrifices which made a strong foundation for my Bachelors where my Masters derives inspiration from. I believe that this strong foundation will keep me inspired and motivate to achieve more. The sky is no longer the limit.

I cannot forget to my fellow postgraduate students (MA class of intake 2014) who kept me inspired even when things would get tougher; Johns Rugumya, Peter Drani, Iyaa Dominic, Bamwanga Geoffrey, Nakanjako Flavia, Muhenda Julius, Bernard Kabonekye, Johnmary Karuhanga, Asasira Andrew, Samuel Gumisiriza and Ikiriza Charity You remain a source of my hope to final completion of this academic journey. Another source of hope is the team that I sit with in FIS research office at MUST, thank you Achen Dorcus, Edmund Ahabwe, Clara Atuhairu, Philomena Apolo, Ruth K. Kaziga, Atalla Agnes and Brenda Amulo.

Last but not least I must say thank you to all my respondents in Mbarara Municipality. I remain grateful to Executive directors and health facility in-charges for supporting me in collecting data which finally culminates into this dissertation. In writing this dissertation, I had guidance and support from many others whom I have not mentioned. Your contribution is highly valued.

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## **List of Acronyms**

|        |                                                             |
|--------|-------------------------------------------------------------|
| AIDS   | Acquire Immune Deficiency Syndrome                          |
| ART    | Antiretroviral Therapy                                      |
| BBO    | Design-Build-Operate                                        |
| BOOT   | Build-Own-Operate-Transfer                                  |
| BOT    | Builds-Operates-Transfers                                   |
| CBM    | Christian Blindment Mission                                 |
| DBFO   | Design-Build-Finance-Operate                                |
| DBOM   | Design-Build-Operate-Maintain                               |
| DHO    | District Health Office                                      |
| DVS    | Development Studies                                         |
| EGPAF  | Elizabeth Glaser Pediatric AIDS Foundation                  |
| EIB    | European Investment Bank                                    |
| FIS    | Faculty of Interdisciplinary Studies                        |
| GAVI   | Global Alliance for Vaccines and Immunization               |
| GO-NGO | Governmental-Non Governmental Organizations                 |
| HENNET | Health NGOs Network                                         |
| HEPS   | Coalition for Health Promotion and Social Development       |
| HICH   | Holy Innocents Children Hospital                            |
| HIV    | Human Immune Virus                                          |
| IF     | International Federation for Spina bifida and Hydrocephalus |
| IMF    | International Monetary Fund                                 |
| IPD    | Inpatient Department                                        |
| JMS    | Joint Medical Stores                                        |
| MCH    | Mbarara Community Hospital                                  |
| MeTA   | Medicine Transparency Alliance                              |
| MJAP   | Makerere Joint AIDS Program                                 |
| MoH    | Ministry of Health                                          |
| MUST   | Mbarara University of Science and Technology                |
| NMS    | National Medical Stores                                     |
| OPD    | Out Patient Department                                      |

|        |                                                  |
|--------|--------------------------------------------------|
| OURS   | Organized Useful Rehabilitation Services         |
| PFI    | Private Finance Initiatives                      |
| PFP    | Private For Profit                               |
| PHC    | Primary Health Care                              |
| PHC CG | Primary Health Care Conditional Grant            |
| PNFP   | Private Not For Profit                           |
| PPP    | Public-Private Partnerships                      |
| PPPH   | Public-Private Partnerships in Health            |
| REC    | Research Ethics Committee                        |
| RMH    | Ruharo Mission Hospital                          |
| SPSS   | Statistical Package for Social Scientists        |
| TASO   | The AIDS Support Organization                    |
| TCMP   | Traditional Medicine Complimentary Practitioners |
| UCMB   | Uganda Catholic Medical Bureau                   |
| UMMB   | Uganda Muslim Medical Bureau                     |
| UNHCO  | Uganda National Health Consumers Organization    |
| UPMB   | Uganda Protestant Medical Bureau                 |
| WHO    | World Health Organization                        |

## **Abstract**

Public-Private Partnerships in healthcare is one of the approaches that has been embraced in Uganda's health sector to realize a change in deteriorating health services. In Mbarara municipality there are many facilities that have embraced the partnerships and the study in four private health facilities bases on some of the Public Private Partnership (PPP) facilities to document the contribution of these private partners in the health sector. The study used mixed methods; qualitative and quantitative and two designs descriptive and case study. A sample of 58 respondents was drawn from health workers, clients (patients seeking healthcare from these facilities on the day of data collection), health inspector and hospital administrators from the 4 facilities.

From the findings, 67.2% of the patients who sought services from these facilities were females and 32.8% males, majority of clients were peasants by occupation, average number of days spent inpatients (admitted) in the hospital was 3 days and for outpatient department, patients were spending an average of 81.6 minutes an equivalent of 1hour and 21minutes. The services supported under the partnership include: ART drugs and HIV/AIDS care, immunization, maternal child health, anti-malarial treatment, malaria control programs including provision of free mosquito nets to community members and outreach programs. Some of the services are free, others subsidized to make them affordable to users. The facilities get support in form of Primary Health Care (PHC) fund to support outreach programs, some hospitals had sub-seconded staff, get medical supplies from Joint Medical Stores (JMS), medical access and National Medical Stores (NMS). These facilities also get funding from charities and donors. Clients seeking ART meet a cost between Uganda shs 15,000 and 20,000/= to have them registered at the facility. Other healthcare services offered in these facilities are subsidized and clients meet a cost between Uganda shs 10,000 and 25,000 for outpatients and 25,000 to 50,000/= for inpatients depending on the number of days spent in the hospital. The clients' user fees is the main source of revenue for these facilities. Patients requiring operation services found it expensive for example at RMH found the packages for eye operate costing 230,000 and 350,000= shs for one and both eyes respectively. Beneficiaries' satisfaction was generally ranked higher than in public facilities and 97.1% of the patients would prefer to visit a Public Private Partnership facility the next visit.

The study concluded that Public Private Partnership in health are making a difference, clients appreciate the healthcare packages under the partnerships. Patients turn up in faith based facilities was found higher than in non-faith based. PPP have created external links with other countries as they offer charities and donations to subsidize the services more. The study recommended that support to these private facilities be increased from the current amount, and other forms of support be given. The Primary Health Care fund for Mbarara Community Hospital should be re-instated to make it more efficiency. Continuous monitoring of the services provided in these facilities should be ensured such that they don't deteriorate like it is a case in public facilities. A theatre at Holy Innocents Children's Hospital should be completed and handle more pediatric cases as it's a referral for these cases in western region. This will reduce referral cases at Cure hospital.

## **CHAPTER ONE: GENERAL INTRODUCTION**

### **1.1 Background to the Study**

Public-Private Partnerships in Healthcare (PPPH) refer to any formal collaboration between the public sector at any level (national and local governments, international donor agencies, bilateral government donor) and the non-public sector (commercial, nonprofit, traditional healers, midwives or herbalists) in order to jointly regulate, finance, or implement the delivery of health services, products, equipment, communication, education and research (Jeffrey, 2011). Jeffrey (2011) adds a voice and modifies Raman and Bjorkman (2009) who looked at PPPH as a collaborative relationship between public and private sector in providing health services and infrastructure. The public health sector recognizes and appreciates PPP as an important and effective model for achieving the sector goals through implementing various programs to supplement the work of the public health sector by reaching where the public health sector may not adequately address the needs of patients seeking health care support and services.

Worldwide, it is recognized that the responsibility of governments is to provide public services including healthcare for the entire population (Tanga, 2010). However, since the 1990s, ideologies have witnessed that public and private sectors need to work together for a common goal (HAI, 2000). The quest to provide and improve efficiency of the health systems in delivering services has gained attention world over and many countries have resorted to various reforms with the target of making the health care system more effective (Jamison, 2006). In response to health care delivery challenges, for instance low funding allocation manifested by low remuneration to medical staff, inadequate human resource, leaking drugs, non-functional medical equipment, corruption among others, Public-Private Partnerships (PPPs) have been highlighted as the best alternative for influencing policy innovation in this era (Matke et al, 2006). PPP is not a new phenomenon much as it is perceived as such due to its recent popularity. PPP existed before the 1990s, though it was not given due attention and even though a few studies were conducted, the role of PPPs was not clearly explained. Today, the trend is a result of changing attitudes and expectations of the society towards the government and public service (Grimsey et al., 2004).

Partnerships have the potential to achieve efficient and effective delivery of high quality health services. One of the aims of PPPs is to establish a functional integral and sustained operation pluralistic health care delivery system, through optimizing available resources and using a

comparative advantage of partners be in the public or private sector (Barakat, 2003). The government's role in such a partnership does not change, but is modified, praised, and lifted high to suit the specific meaning of the word "Governor". Therefore the government becomes the governor, funder and regulator rather than direct provider of public services in the sectors where PPPs have been incubated (European Commission, 2003).

Over the last ten years, the use of PPPs worldwide in service delivery has grown tremendously, almost five times than it was in the past, for example more than US\$4 billion of health PPP contracts were signed worldwide in the year 2010 (PWC, 2010). It should be noted that despite the global dominance of PPP in the health sector, empirical evidence of the benefits is mixed, in some countries improved healthcare has been witnessed while in other countries it has not and poor health services have been delivered by PPPs (Carty, 2012).

Generally, in Europe, private sector involvement was aimed at assisting the government in meeting its priorities, after realizing that public funds are limited, yet the government is mandated to provide many public services. For instance, in Europe, the trend of growing interest in the use of PPP rose at a high pace in the period 1990-2009 with the support of the government, and between 1990 and 2004 the United Kingdom (UK) was operating more than half of all PPP projects in Europe (Tanga et al., 2010). The UK remains the biggest producer of PPP projects, they represent 10-13% of all public infrastructure projects. Other European countries started experiencing the increased use of PPPs of recent (European Investment Bank-EIB, 2010). PPPs continue to be deemed relevant for a range of public sector infrastructure and service delivery. For instance, in 2013, UK had more than 600 PPPs in form of PFI (Private finance initiatives) worth \$100 billion for roads, bridges, prisons, hospitals, and military equipment (HM Treasury, 2013). In 2004, a list of ten countries engaging private partners in Europe, UK dominated all the PPP projects with 32.5%, followed by Korea, Australia, Spain, United States, Hungary, Japan, Italy, Portugal and Canada (EIB, 2004).

In public-private partnerships in health, Government-Non Governmental Organization (GO-NGO) partnerships have become prominent and conventional. Bangladesh is regarded a "Front-runner and an excellent case of society in government-NGO partnerships" (MOHFW, 1999). Like it is a case in other countries for instance Hong Kong, Australia among others, the creativity, innovativeness, donor funding and community approach of GO-NGO collaboration have enabled Bangladesh to deliver improved health services. The frameworks of these partnerships are the

same as in UK, through formal collaborative and contracting arrangement to informal gentlemen's agreements. The most common form of partnership is contracting and in general, governments take charge of weak partners and assigns NGOs to undertake a specific task on its behalf (World Bank, 2006; Zafarullah, 2006).

Today, there are many governments that have failed to provide adequate public services, particularly for the poor communities. Some have recognized the importance of non-state providers to fill the gaps, and the need to collaborate in order to improve services. A research conducted to examine the wide range of health service providers in six countries; Bangladesh, India, Malawi, Nigeria, Pakistan and South Africa found out that Non-state providers of basic services include for-profit firms, local entrepreneurs, individual practitioners, community and faith-based organizations and non-governmental organizations have a lot to offer (University of Birmingham, 2009). The fact that government's capacity is limited and role for community level service delivery has remained wanting, implementation of some health programs like immunization, HIV/AIDS care, nutrition among others has become the work of bigger NGOs (World Bank, 2005). In such a situation, the NGOs through bidding are contracted to implement programs. They take up roles like vaccine services, human resource, training, monitoring and supervision, quality assurance, communication, community mobilization among others. These roles or activities are coordinated with smaller partner NGOs-PPP to deliver the actual services to the community (Government of Bangladesh, 2002).

In Africa, especially in sub-Saharan Africa, incidences of diseases are many and this affects the continent's economy. Poor health affects the productivity and general economic levels. It causes pain, suffering, reduces human energy, thus making millions of Africans not able to catch up with life compared to other countries, hence destructing human capital. Developing countries are facing multiple challenge of how to provide health services (Dupas, 2011). In low-income countries, non-governmental organizations (NGOs) deliver basic services in particular areas among certain population as it is a case in The AIDS Support Organization (TASO), Makerere Joint Aids Program (MJAP), Baylor, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Mildmay among others in Uganda, where health services are provided to HIV/AIDS patients. These NGOs as private health providers refer patients to government hospitals, they also work hand-in-hand with government in the delivery of services (Muriisa, 2006). Their effectiveness in establishing sustainable Primary Health Care (PHC) systems by ensuring timely, cost effective medicine

supply, outreach programs, and flexibility is related to their engagement of community participation, having close ties with the poor, being flexible enough and having committed staff (Gelbert, 1996). The comparative advantage of NGOs and private over public health providers is assessed in terms of innovation, efficiency, quality services, ability to mobilize resources, contribution to the sustainability of the local health systems and coverage of grass-roots communities (Stefanini, 1995).

Government collaboration with the private sector has in the past involved various programs, for instance, Community Driven Development, Malaria Control Program, Global Fund, GAVI or addressed special needs within the private sector such as government subsidies to private sector (Uganda National Policy on PPP, 2012).

Public-Private Partnership in Health (PPPH) was initiated in 1997 by the Ministry of Health in Uganda with the support of a parliamentary resolution in July 2000 (Parliamentary Act, 2000). The act categorizes private sector is categorized into Private-for-Profit (PFP) and Private-not-for-Profit (PNFP) and PFP consist of both formal and informal providers; general merchandise, shops and traditional healers. The private sector understands the bureaucracies associated with the public sector that make it inefficient and unresponsive in providing good quality, cost effective, and efficient healthcare services (WHO, 2000). It argues that there should be reorientation of the public sector with the dual role of financing and provision of services because of its increasing inability on both fronts to incorporate the private health sector in provision of services (Mitchell, 2001). The public and private sectors can be innovative in providing health care services if there is room to work together. Uganda's national policy on private partnership in health (PPPH) supports sustained operation of a pluralistic health care delivery system by optimizing the equitable use of available resources and comparing the ability of partners (National Policy on PPPH, 2004).

In 2001, PNFP health sub sector in Uganda was commended as an indispensable sub system that offered comparable better and acceptable quality of health care than government (Muwanga et al, 2001). They are under three main umbrella organizations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB). It should be noted that these bureaus represented 78% of the 490 PNFP health units whereas the rest fell under humanitarian organizations and community based care organizations (MoH, 2001). Today, many more health units have been constructed in partnership with UCMB, UPMB, and UMMB. This explains why most of the PPP health units have names

relating to the three umbrella organization, others to community for instance Nyamitanga health centre II, Holly innocents Children's, Ruharo Mission hospitals.

According to the European Commission, value for money is the main object in the PPP design. The commission associated Value For Money (VFM) with reduced life-cycle costs, better allocation of risks, faster implementation, improved service quality and generation of additional revenue. However, simply concluding a contract with a private partner to deliver a service is in itself no guarantee that value for money will improve (European Commission, 2003). The health partnerships with government in Mbarara municipality supports eight (8) health facility which include four (5) hospitals and three (3) health centers. The government support is in three forms: Primary Health Care Conditional Grant (PHC CG), Essential drugs and personnel through supporting some of the medical staff (DHO, 2015). Human resource is one of the central sources to determine the impact of the reforms in the health sector (Rigoli, 2003). Some of the health units in PPPs have been beneficiaries since 2002 and new ones have emerged of recent that include one of Holy Innocents Children's Hospital and Devine Mercy hospital. The extent to which such support has impacted efficiency in delivery of health care in Mbarara municipality and surrounding communities remains undocumented. The study was conducted to assess whether Public-Private Partnerships are associated with improved healthcare delivery in Uganda using Mbarara Municipality as a case study. A completed study intends to guide the relevant ministries and agencies in the reallocation of resources in a bid to close the inequality gap in service provision. The findings from the study may guide policy makers and planners in the health sector to develop effective strategies for efficient allocation of resources and supporting health facilities under PPPs.

## **1.2 Problem Statement**

Uganda's total health expenditure per capita stands at \$51, which is below the WHO recommendation of \$60 (World Bank, 2012) and government budget allocation to the health sector is at 9%, this is below the Abuja target of 15% (Witter *et al*, 2013). This necessitates proper accountability of the limited funds, which is not ensured by the Ministry of Health as the healthcare sector is ranked among corrupt sectors in Uganda (Bouchard *et al*, 2012). This clearly explains the poor performance of health care systems in both rural and urban areas in Uganda. Working with the private sector has become relevant in responding to such a health crisis, it allows public sector organizations to access distinctive resources and capabilities in seeking to realize more innovative

response in this regard health service quality (Kivleniece and Quelin, 2012). This combined effort is what is called Public-Private Partnerships (PPPs) in healthcare, with its policy aim, to achieve higher efficiency by improving investments, infrastructure and service delivery (Engel et al., 2013).

The health sector in Uganda is facing challenges that include poorly remunerated and demotivated health workers, low motivation to enable retention of health specialists, underfunding of referral and sub-district hospitals, drug leakage, corruption, poor servicing of donated equipment, challenges of deployment and efficient supervision of decentralized human resource for health (Ministerial policy statement for the health sector, 2012). A study by Medicines Transparency Alliance (MeTA) found Mbarara among the districts where healthcare delivery in public units has deteriorated. Findings indicated that 32% of the patients do not get all prescribed drugs, after a few days, only 2% turn back to check if medicines are available in the public health facility and the rest go to private health facilities, using weighted average, satisfaction was rated at 47% but it was lower at health centre II's although medicines were available indicated by 80% (MeTA, 2014). Most of them find their way to private clinics hence high cost of healthcare, and this encroaches on their low incomes. There are public-private partners in healthcare delivery operating in Mbarara district which started in 2002, up to now other facilities are getting into the partnership a recent one is Devine mercy hospital 2016 and in Mbarara municipality there are 9 health facilities, four of these facilities were randomly sampled for this study and they include; Mbarara Community, Ruharo Mission, Holy Innocents Hospitals, and Nyamitanga Health Centre II.

The work for these PPPs projects in healthcare are known for development, sustainability of better quality health services (HENNET, 2010). However, it is not yet established whether PPPs have performed to the expectation because of continuous deterioration of healthcare in Mbarara. The study was conducted to explain whether these partnerships have impacted healthcare delivery looking at the quality of healthcare delivered by the above mentioned health units in Mbarara Municipality.

### **1.3 General Objective**

To assess whether Public-Private Partnerships have impacted healthcare delivery in Mbarara Municipality

### **1.3.1 Specific Objectives of the Study**

- To document the type of partnerships of the health units under PPPs in Mbarara Municipality.
- To establish healthcare services delivered under PPPs in Mbarara Municipality.
- To document beneficiaries' level of satisfaction with health services delivered by PPPs in healthcare compared to public health units in Mbarara Municipality.
- To find out the strategies put in place to improve beneficiaries' satisfaction levels in PPP health units in Mbarara Municipality.

### **1.3.2 Research Questions**

- What is the type of PPP of this health unit?
- What health services are delivered under PPP at the level of this unit?
- What is the beneficiaries' level of satisfaction of the health services delivered under PPPs in this health unit compared to those without PPPs?
- What are the strategies put in place to improve beneficiaries' level of satisfaction in PPP health units?

### **1.4.0 Scope of the Study**

The study covered the following under the scope: content, geographical and time scope. These explain why the study was important and clearly explains the reasons why the researcher chose to study the areas selected and the content he covered. The time scope helped the researcher to focus the analysis on the time frame of that period to derive insights and enrich his dissertation and contribution to body of knowledge.

#### **1.4.1 Content scope**

The study derived inspiration from another study that was conducted in 10 districts including Mbarara- MeTA (2014) which found out that 32% of the clients who seek healthcare in public facilities end up not getting all the prescribed drugs. Only 2% of these go back to check if drugs are available after some days. Where do the rest go after failing to get drugs from a public facility? Definitely, to private health providers. In circumstances where the client is financially stable, they resort to seeking services from public-private partnership facilities where the cost of healthcare is comparably lower to private for profit facilities. Other reasons that could be supporting their choices are not clear. The study intends to bring to light some of these reasons that influence the choice of clients visiting Public-Private Partnership facilities in Mbarara Municipality.

A few scholarly studies have been done to document the services offered by PPPH, it remains unclear whether these facilities provide services as described in the partnership. It is also imperative to document the Primary Health Care fund (PHC) in terms of how much is given to these facilities and this transcends into service delivery and client satisfaction.

Client do value spending less time at a facility seeking healthcare. This contributes to their satisfaction, otherwise dissatisfaction. An inquiry into how long they spend (outpatient and inpatient) and why they spend such a time is important to enable this research understand the reasons that support the time spent seeking healthcare at PPP facilities in Mbarara Municipality. This could help healthcare providers in streamlining the way they deliver healthcare and increase client satisfaction levels.

#### **1.4.2 Geographical scope**

The area was chosen for this study based on the findings from the study by MeTA (2014), and due to the fact that few scholarly studies have been conducted to critically analyze how PPP have impacted on healthcare system in terms of quality from the clients' perspective. The area being one of the biggest towns in western region, it was imperative to document how different population/dwellers access services and preference of a provider over other providers.

Mbarara municipality has 8 public-private partnership facilities (DHO, 2015), located in different divisions. Biharwe and Kakiika have 1 facility, Nyamitanga, Kamukuzi and Kakoba have 2 facilities each. Nyakayojo division has none. Therefore, the divisions which have such facilities benefit indirectly. The facilities bring services closer to such communities and it is important to note their contribution through this study to enable other private providers adopt such arrangement if they can with support from the government.

#### **1.4.3 Time scope**

The study considered a period of 15 years (2000-2016). This period was crucial as many partnerships were entered into during this period. The study looks at the emergency of new private healthcare providers for example Holy Innocents Children Hospital in 2009, Devine Mercy Hospital in the middle of the year 2016. Having been in existence for this period, what have they changed in healthcare system? Is it worth documenting to guide the ministry on how these partnerships could increase access and quality in services delivered to the communities that benefit from these services.

This period was chosen due to deteriorating healthcare services in public facilities prompting clients to make choice at the end of the tunnel. Where do they go? How does this new provider

fit their expectations? All these have not been documented in 15 years period and the study intends to do this. How the privates are making it is worth noting to help public facilities learn from private ones.

#### **1.4 Justification of this Study**

The justification of the study is described in a benefit that it adds to the existing body of knowledge on contribution of the private sector in healthcare provision, client satisfaction with health service, social science research and general social service research.

The study has enriched the understanding of both public and private sector reforms in healthcare delivery in urban setting by linking the relationship between the service providers in both sectors and establishing the relationship between clients receiving services from a private or public facility or both through making a comparison.

The study also explores the perception of clients and deeply explains the factors that determine their choice for a previous visit, current visit and the next visit to a private (PNFP or PFP) or a public facility. The factors in this case are either pushing or pulling factors depending on where a client seeks services from. In circumstances where clients run away from a facility, something unpleasant has happened, the same applied to when she/he comes back the next visit-something good, pleasant has compelled him to come again. Such factors are vital in measuring the efficiency of a facility; private or public.

The study recognized the contribution of the private and public providers. Their partnership have addressed the major challenge access through reducing the distance travelled. This is vividly evidenced by the spread of health facilities in the entire Mbarara Municipality and South western region. Again, the study identifies the challenges like inadequate funding, inadequate staff accommodation, higher medical costs for non-supported services under the partnership and provides remedies to health sector with emphasis on private provides. Although the challenges are more less the same, the study gives best practices that can be generalized in terms of profitability and improving health service delivery.

The Study guides public spending and contingent liabilities in healthcare PPPs, healthcare performance, and to the important components of public health services and sovereign indebtedness. Greater transparency can contribute to reducing uncertainty and increasing consensus in the current financial crisis.

## 1.5 Theoretical Framework

The Principal-Agent theory was used as the basis for this study. This theory focuses on the relationship between the principal owner of an enterprise and the agent (Awortwi, 2003). In this scenario, the principal owner delegates work of delivering services to the agent, with high expectations to perform the work (Hakenberg, 2007). Two problems may arise in this relationship: one being that it might be difficult for the principal to ascertain the actions of the agent and conflicting goals between the agent and the principal may arise as the principal tries to control the agent in order to maximize his own benefits, the latter is also driven by self-interests.

The principal and the agent have different attitudes towards risks and the consequences to both parties vary (Lane, 2004). Under the decentralized system as noted by (Lane, 2004), the central government contract-out public services to a lower level or to a private provider and the central government becomes the principal, the private provider, lower level/department becomes an agent. A private may take a form of a Community Based Organization (CBO), Non-Governmental Organization (NGO) or any other Non-Profit Organization. Local government can also be a principal depending on arrangement. For example, the district may contract a private provider to offer services on its behalf thus making it a principal and the private provider or in a partnership becoming an agent.

Through a memorandum of understanding, incentives and sanctions are spelt out and made clear to both the principal and agent. The roles of each partner is clear so that none blames the other in case things don't happen the way they anticipated. For example, who monitors, when and what are clear, most often a responsibility of the principal at his own discretion and the agent has to be prepared all the time in terms of performance, accountability and giving feedback to the principal in case the deal is flopping. This make it possible to revise the terms and continue working together where need be. The problem with Principal-Agent theory and practice is that a lot of responsibilities are shouldered on the agent and in case of low performance, the principal isolates itself from the losing team forgetting that at times a principal may be the sole cause of the inefficiency (Leonard, 2004). This may happen when the principal fails to fulfil its responsibility for instance the financing responsibility delay completion of a project in time.

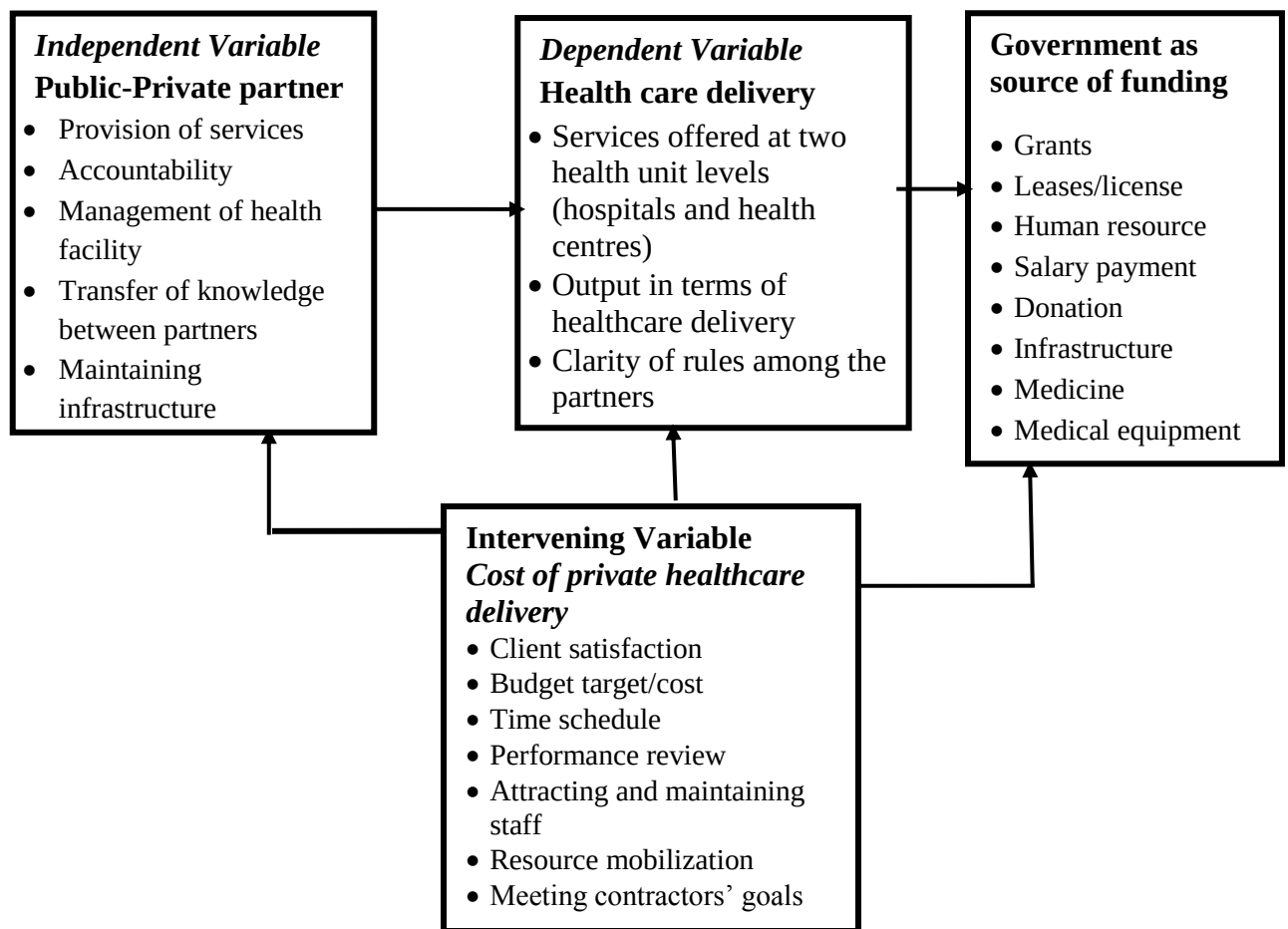
To harmonies the relationship between the principal and the agent, the following should be emphasized; the agent and the principal should be free to monitor each other, any kind of behavior

that may delay any of the partners should be left out, no conflict of interest must be declared so that one does not fear correcting another in case something is deemed going wrong. For example Bariyo (2012) noted a scenario where local politicians, councilors can award a contract to himself through a tendering process to construct health facilities, to steal government drugs in collaboration with healthcare workers. In situations where no stringent conditions are put in place, accountability challenges may be taken as an advantage on the side of the agent. For example agents have taken advantage of the principal's weakness in regulating and monitoring to cheat/overcharge patients since these patients lack adequate information to hold the agents accountable and in most cases don't know where to report and demand accountability. Such situations lead to exploitation and reduces patient satisfaction with healthcare services provided by the agent on behalf of the principal.

The agency relationship in such a partnership is a common phenomenon today for example employer-employee relationship resembles an agency relationship. Employers have various mechanisms of controlling and monitoring the activities of their employees on their performance and appropriate corrective actions are taken on the basis of the control mechanism in place. Challenges that arise in this partnership in a reflection of many partnership projects such as outsourcing services, leasing, and management contracting among others. As such, this theory was used in this study to explain relationship between the principal and agent in terms of accountability, governance, and commitment of agents to deliver health services towards health achieving goals.

This theory was used in the study to understand the relationship between agent, principles, and users. The relations was based on clients' perception, continues support from the principle (government and other donor agencies) and cooperation from the agent (partner). Understanding the working relations between the principle, agent and users is important in this study. This is why the study focused mainly on the clients on the other side understanding agents' mode of operation.

## 1.6 Conceptual framework of PPP in healthcare delivery



(Nikolic Miikisch, 2006) modified by the researcher

Provision of healthcare services in a public-private partnership setting require external financial support to enable the clients access such services at a relatively lower/subsidized cost. That is why the government/principal dedicates some funds (PHC) conditional grant to support some packages provided by the private partners. The government funds the services and facilitates delivery of these services through supporting some staff in a PPP facility. What clients benefit from such an arrangement is satisfaction which determine their repeatability of the clients to visit such a facility. In case a client is not satisfied s/he will choose another facility either Private for Profit or facility. This process involves transfer of knowledge among the partners.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.0 Introduction**

This chapter presents and reviews relevant literature that has been documented by other scholars in the same and related fields of study. The literature is reviewed in an order as predetermined by the study objective and the specific objectives in particular.

#### **2.1 Types of Partnerships**

PPPs range from short term service contracts to long term concessions, depending on how the project has improved access, affordability, and general efficiency in delivering the services. Another dimension of level of partnership is evidenced in common characteristics, for example, involving risk transfer, shared responsibilities, resources and rewards among others (Amekudzi and Morillos, 2008). Amekudzi *et al*, (2008) add that private partner involvement arrangements in PPPs depends on the level of responsibilities and risks transferred to the private partner. The responsibilities concerned may include activities for instance designing, building, financing, maintaining, operating and ownership of the facilities.

Some common form of infrastructure partnership approaches. In some cases, the private partner builds-operates-transfers (BOT), buy-build-operate (BBO). Other forms are highlighted include design-build-finance-operate (DBFO), design-operate-maintain (DBOM), build-own-operate-transfer (BOOT) and concessions (European Commission, 2005).

Concessions are a common scheme that fall under DBFO. Concession is described as a PPP scheme where exclusive rights to operate a facility and provide services are granted to a private company, which in turn has to design, build, and finance and operate the facility and provide services for the time agreed upon (IMF, 2006). What should be noted is that in Uganda, most of the PPPs in healthcare are owned by the private individuals or groups that on a request have been asked by government to integrate the PPP component to improve healthcare. Understanding if this type of partnership exists in Mbarara's healthcare system is important in ascertaining its impact on delivery of services to the patients who come for health care services at these health facilities.

PPP level is based on the input-output specified by the contracting authority. The PPP Act specifies the expected level of output depending on the level of the health facility (Mtei, 2012).

In developing countries, especially in Africa, the relationship between the public and private sector in healthcare delivery has its roots which can be traced back to the 1940s, when there was an expansion of mission hospitals, and later in 1970s, when these hospitals were nationalized, for instance, in Uganda and Tanzania. These interactions between the public and private sector were accelerated after increase in pressure demanding government to provide quality health services to the rapid increasing population (Jokezela, 2012). In Uganda, PPPH projects have been used to counter threats posed by diseases like malaria, HIV/AIDS, TB, cancer, and other health emergencies. Ugandan government has also adopted PPP as a model to increase access to pharmaceutical drugs related to HIV/AIDS and other diseases (Drunce et. al., 2004).

Mills (1997) argued that using contracts between funders and providers, even when both are public and no competition allows funders distance themselves from providers and consequently, it is argued that contract is in itself a useful tool for changing the behavior of providers. On satisfactory delivery of the provider, the contract is renewed or terminated if the target is not met by the provider. Many developing countries have started employing practical applications of cooperation between the public and private sectors. A model that merges and establishes the framework for the private providers to compete with public providers has played a big role in within the guiding framework imposed by the public health authorities (Jamali, 2004). Trust, commitment and accountability are very important aspects in helping PPP in fulfilling their obligations and make them ready to account for whatever happens (Itika et al., 2011).

In countries where PPP have been successful, like in the UK, this kind of success should not be overestimated since PPP do not constitute a panacea for all the social services delivery in terms of budgetary constraints (Larkin, 1994). Literature shows that there is a tendency of increase in the use of health services after the adoption of PPP arrangement especially in the private not for profit (PNFP) hospitals. The patients' assumption is that the profit motive drives service delivery and makes the private partners more efficient in delivering the services. In the course of PPP implementation, principal-agent problem may arise when the principal contracts an agent to perform the tasks on his behalf but cannot ensure that the agent performs them in the exact way intended by the principal. The key problem here results from the expectations of the principal especially where the expectations can't be inferred to the observable variables (Fourrie and Burger, 1999). In PPP, the government which is considered to be the principal in public service delivery which includes healthcare has no proper means of getting feedback in terms of control mechanisms and monitor

PPP projects, then the same situation may exist. There is no magic formula for the success of PPPs in all places under all conditions, but patients and careful analysis of each local situation is necessary for the effectiveness of PPP (Fourie and Burger, 1999).

In Uganda, the private health sector is varied and diverse and is categorized into two; Private-Not-For-Profit health providers (PNFP) and Private-For-Profit Health Practitioners (PFPHP). All these partners have been engaged by the government in delivering health services on its behalf (Uganda National Policy-MoH, 2012). PNFP health providers include agencies that provide health services to the population from established health units and those that work with communities and other counterparts to provide non-facility-based health services and technical assistance. The most common type of these providers are Facility-Based PNFP, with large infrastructure base comprising of hospital and health centres, and by 2012, they were operating 30% of health care facilities in Uganda with a considerable percentage of these units located in rural areas. Many of these PNFP facilities provide health services as well as training health workers and about 75% of the PNFP facilities are represented by four medical bureau, while the rest fall under other humanitarian and community based health care organization (Health Facility Inventory, MoH, 2010). The performance of health units in the three categories remains unclear, training of health workers in some of the PNFP remains unjustified and ascertaining the authenticity of training given is paramount in improving healthcare quality. The trust that patients have in the diverse categories of PPP ownership is not known and the study will identify whether a given category has an influence in healthcare delivery of any health unit under PPP.

## **2.2 Beneficiaries' Level of Satisfaction with healthcare services delivered under PPPH**

It is not impossible for consumers to be satisfied with services that are effectively and efficiently delivered and it is also not possible for them to be satisfied with services which by other measures are deemed to be poorly delivered. According to Koch and Rumrill (2008), the bottom-line is that yardsticks for measuring service delivery effectiveness and efficiency must be in synch with the tools for measuring consumer satisfaction. Measuring satisfaction should not be abstract, the questions should be well organized, such that the respondents give their true opinion of the services delivered (Capella et al, 2004).

Satisfaction to a medical care consumer may refer to one of the following theories on consumer healthcare satisfaction (Grill et al, 2009); Satisfaction is derivable when there is alignment between patients' perspective on what constitutes satisfaction in healthcare and providers view (Fox and

Storms, 1981); Linder-Pelz (1982) argued that satisfaction is a function of the patients previous expectation and personal belief and values towards health care delivery; Donabedian theory (1980) puts it clearly that interpersonal aspect of care plays very important role in determining the satisfaction patients derive from health care. For instance, for a patient to be satisfied with health care delivery he should have a positive judgement towards every aspect of the quality of care delivered especially as it concerns interpersonal side of health care; Fitzpatrick and Hopkins (1983) noted that patients' satisfaction in healthcare services is influenced by their individual social environment. Patients measure the satisfaction that they derive from health care services against the perceived comfort or discomfort they feel with respect to the services; while Ware et al, (1983) stipulated that patient healthcare satisfaction is a function of their personal preferences and expectation as health care is concerned.

Consumer health care satisfaction has many dimensions. There are unanimously agreed multi-dimensional nature of consumer satisfaction measurement, defined and generally agreed measurement criteria (Koch and Rumrill, 2008). Since the dimensions are many, it is important for the research to breakdown the medical care service into various components before going ahead to ask consumers what their satisfaction levels are for the various areas. For instance, identifying different service delivery points; reception, laboratory, medical consultation, dispensing room, medical wards, among other points. The dimension may take into consideration time spent at a given point of service delivery, whether the long hours of waiting are procedural or not, the number of medical workers at a health unit, their level of understanding in diagnosing a health related problem, warm and friendly staff, and enough parking space. An improved and customer centric service delivery will end up bringing the desired consumer satisfaction. In a real sense, consumer satisfaction research aims to basically measure consumers' perception on the quality and value of services they receive (Nelson and Steele, 2006).

Healthcare service accessibility, affordability, equity, less waiting time and availability of consultants and specialists in the clinics and drugs availability are some of the indicators of customer satisfaction (Yahya, 2012). Availability of specialists is part staff, and constitute to the ratio of patients to nurses, medical doctors to patients which the world health professionals have highlighted (WHO, 2010). Service quality (SEQUAL) is one of the approaches used to determine patients' satisfaction. The SEQUAL model has five major dimensions which include reliability, responsiveness, assurances, tangibility and empathy (Oliver, 1999). A study by Gazzola, et al to

determine the relationship between customer expectation and management perception not consumer perception revealed a very big gap. This is addition to the usual gap existing between delivery and service quality specification by the organization. Most of the time these considerations trigger dissatisfaction that is likely to affect either the customer repeat visit or the organization in general (Gazzola, et al, 2012).

The belief that medical services of clinics or hospitals, workers and consultant cure the patients makes evaluation a vital tool in understanding and measuring perceptual level, resulting in rise/constant/reduction of the patient turn up at a particular clinic. These types of evaluations about the patient's state of mind as to whether or not the service quality meet his pre-treatment expectation makes the patient have a repeat visit to the clinic or never. In a real sense, any service that falls below the patients expectations make such patients dissatisfied and disillusions his second visit to the clinic. Satisfaction encompasses the level to which the patient's expectation is met or exceeded by service provider (Cheung, 1998).

A customer values spending less time, getting genuine drugs and better treatment at a public health facility. In PPP, several variables determine the level of satisfaction of the various patients receiving health services. A study conducted in the United States on patients' satisfaction with services in the clinic revealed that patients were treated fairly, they were kept informed of the progress in case of a referral, and these aspects scored 81%. Another aspect to do with patients satisfaction is the way health workers responded the patients; they were polite and acted as professionals, took time to listen and understand the patients challenges, 93% were satisfied and 7% were neither satisfied nor dissatisfied with the services, the patients recommend and acknowledged that the staff were extremely helpful (Ventola, 2014).

Customer service received commendation from the patients that customer service providers were available whenever needed or call back when busy. The customer service centre received feedback that 14% of the patients believed that the department can confidently handle patients complaints, 79% felt that their complaints were well understood, 42% approved that the customer service kept them informed, 81% felt that customer centre can easily be reached on, and 66% believed that the staffs are polite (Ventola, 2014). Health facilities under PPP have reception points, where they first go before seeking healthcare at a given facility. How they are handled at this points may determines the level of satisfaction at the next point of service delivery. The study will investigate whether there is any relationship between customer service and actual health care delivery and if the staffs'

politeness and confidence in handling clients' complaints increases satisfaction exceeding the level of satisfaction reviewed in the above literature.

Effectively run private health facilities have improved and expanded the coverage for reproductive and child health services, which has decreased child and maternal mortality (Republic of Kenya, 2006). In Bangladesh, Non-governmental organizations programs increased contraceptive use by 78%, child immunization by 67% and antenatal care by 78% (Paxman, et al, 2005) and in terms of customer satisfaction, NGO run health facilities received higher marks than governmental run facilities. In Mexico, a study on women attending NGO health run facilities reported being more satisfied than women who attended public health facilities (Edwards, 1999). While in African rural poor, NGO run health facilities provided higher quality and more attractive despite the fees they charged (Leonard, 2004). It is on this basis that most of PPP in health care delivery in Uganda also charge fees, but in their own capacity, without consulting the clients, the partners like the government, on how and how much fees to levy in exchange of their services. In this study, focus will be made on whether charging fees affect service delivery or not and establishing whether fees levied are affordable by clients and ascertaining the responsible party in the partnership to levy and regulate fees.

Diseases of the poor- that is, communicable, maternal, prenatal and nutritional diseases accounted for 50% of the burden of disease in developing countries, that is 10 times higher than in developed countries in 2009. Improving access to essential medicines alone can save 10 million lives a year that is four million in Africa and six million in Asia (WHO, 2004). This should be accompanied with the timely delivery of the medicine. Other determinant of health that include sanitation and access to clean water, availability of highly motivated workers; auxiliary infrastructure such as housing for workers, access to roads, electricity or solar equipment to keep vaccines in rural health centres at the right temperatures (UN report, 2009). Presence of these services and facilities relate to client satisfaction and their absence results in the opposite. For this study, ascertaining if they services as mentioned by other scholars are in place is very important and to document how these underlying determinants of health contribute to client satisfaction in PPP health units.

The Universal declaration of human rights calls on governments to provide for public healthcare to its people. The constitution of Uganda also mandates the government and local governments to ensure that they promote public health, establish and rehabilitate and develop basic medical and diagnostic institutions and provide free primary health care and emergency services for all the

citizens. World over, it is known that one of the most important obligations of the government is providing public services and infrastructure including healthcare (Tanga, 2010). For this study, understanding the contribution of government in enhancing partnership is important in fulfilling part of its obligation in delivering healthcare. Establishing the kind of support given to health partners in Mbarara district will contribute to the understanding the operation of these health units in meeting the expectations of the clients.

Healthcare policies that are put in place seek to address resource wastage historically associated with health sector by shifting the bulk of funding from large urban hospitals that focus primarily on curative care, to primary healthcare facilities that focus in both curative and preventive measures (Berman, et al, 1996). Many NGO involved in providing health care quickly adopted these ideas into their operations and the NGOs are now considered key in implementation of health care policies which include PPP in healthcare delivery, because they are accustomed to working within communities, and partnering with organizations in other sectors (Akukwe, 1998). The study seeks to address the key importance of PPP health projects in accelerating health care delivery and answering questions of how much for how much of the wastage have they saved that can be channeled to providing other essential needs and infrastructure.

The Ministry of Health in Uganda, under its monitoring and evaluation plan, made client satisfaction one of the core indicators for monitoring healthcare delivery system much as there is neither baseline nor standardized monitoring instruments to date (MoH, 2010 HSSIP Core Performance Indicators). In 2010, MoH made client satisfaction a core indicator of monitoring health care delivery system, the study seek to find out if this indicator is used by health facilities in measuring their performance levels.

The “Yellow star” programs, a quality improvement strategy under the ministry of health carried out between 2000 and 2006 was the first real attempt to monitor client satisfaction with family planning services in Uganda (Centre for Health Market Innovations, 2013). In 2004, the Uganda Medical Bureau carried out a study on client satisfaction with its health facilities which was based on five patient care experiences: clinical effectiveness and outcome; access to services; organization of care; humanity of care and health environment. This study was unique and covered both in patient and outpatients (Lochoro, 2004). In 2008 MoH carried out a study in public and private health facilities on client satisfaction in six districts of Uganda and in 2012, Uganda National Health Consumers’ Organization and HEPS-Uganda conducted the same study in two districts to assess client

satisfaction with accessibility, availability, quality and accountability aspects of health (UNHCO and HEPS, 2012). These studies concentrated mostly on service delivery at health facility level and some aspects of economic access and they didn't establish the link between availability of medicine, distribution of medicine at the health facility's pharmacy, information management and exchange with client satisfaction.

A study by Medicine Transparency Alliance (MeTA) on Client satisfaction in Uganda's public health facilities in 2014 across 10 districts (Nebbi, Soroti, Iganga, Wakiso and Mbarara classified as urban district; Oyam, Nwoya, Kapchorwa, Pallisa and Kasese categorized as rural), in 202 health facilities with 3,000 patients found out that client satisfaction with health care services delivered in public health facilities was rated at 47% using a weighted average. The figure was based on; time taken to be attended to; time taken to get medicine; attitude of the prescriber (medical officer, clinician); attitude of the dispenser; attitude of other staff (nurses, midwives); complaint handling, laboratory services; and other services. The study found out that satisfaction varied across the nearer the patient were to Kampala, the higher the satisfaction with health services. The most important finding in justifying the study was that although the availability of medicine was high at 70%, the proportion of clients who didn't receive all the prescribed medicine was also high, at 32% (MeTA, 2014). The study on PPP seeks to establish the level of satisfaction of clients receiving healthcare services from these health facilities; using the satisfaction aspects in the study by MeTA 2014 which include availability of medicine, proximity to the health facility, and if the percentage of clients not getting all prescribed medicines lower than 32% to clearly indicate a positive outcome of PPP as the best alternative to improve delivery healthcare delivery in Mbarara municipality.

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.0 Introduction**

This chapter presents a description of the research design, study population, sample size determination, sampling techniques, research instruments, quality control, research procedures and techniques of data presentation and analysis.

#### **3.1 Research Design**

Descriptive and case study approaches were used in this study. The combination of the two approaches generated data that gives a complete description of the situation in the next chapter, by explaining what, why, where and how of the situation and ensured that there was minimum bias in collection of data (Kothari, 2008). The case study design is a research method for empirical inquiry that investigates a contemporary phenomenon within the real-life context: it addresses a situation in which the boundaries between the phenomena and context are not clearly evident and uses multiple sources of evidence (Conteh, 2000). A case study enabled the researcher to study in-depth particularities that shed light on the prominence of certain uncovered, complex events and processes, most of which escaped statistical manipulation (Conteh, 2000:32).

The descriptive approach was mainly used to collect data from respondents (patients, health management committees and health workers) to answer research question on the beneficiaries' level of satisfaction of the services offered under PPPs hospitals and health centres. The approach enabled the researcher to present results using simple statistics, tables, mean scores, percentages and frequencies distribution.

#### **3.2 Study Population**

Study population is a group of people with common observable characteristics. The target population for this study included health workers, administrators at health facilities, and district health office staff, and beneficiaries (community members-clients) who have benefited from PPP facilities providing healthcare in Mbarara Municipality.

#### **3.3 Sample and Sampling Techniques**

Sampling is the process by which a relatively small number of individuals, objects or event is selected for inclusion in order to find out something about the entire population from which it is

selected (Kothari, 2003). Therefore a sample is the finite of the statistical population whose properties are studied to gain information about the whole group.

Purposive and simple random sampling techniques were used to select respondents. Purposive sampling was used to select respondents from various categories and included health workers; doctors, clinicians, laboratory attendants, facility administrators, health management committees, district and municipality health officials, and local leaders based on their experience in PPPs healthcare delivery.

Cluster sampling on the other hand was used to select respondents in the beneficiaries' category that is clients. The researcher selected the clients amongst those seeking healthcare in different health facilities thus forming cluster. These were selected on the day of data collection as they visited the health units seeking for health services and a questionnaire was administered by a trained research assistant upon the client finishing all the processes of getting the services (at the point of exit). At hospital level, a high number of respondents was sampled and at health centre level, half of the population in the former was sampled as detailed in the sample size sub-section below.

### **3.4 Sample Size**

The researcher used Solvin's formula (<http://prudencexd.weebly.com>) to determine the sample size. The study considered a total population of those who sought services supported in the partnership within a period of one week when the researcher was collecting data. The population was found to be 68 patients.

$$n = N / (1 + N(e)^2)$$

n = no of samples

N = total population

e = error margin/margin of error

$$n = N / (1 + N(e)^2)$$

$$n = 68 / (1 + 68 * 0.05)^2$$

$$n = 58$$

After stratifying the total population using Solvin's formula, I got 44 clients, 18 health workers, and 6 key informants.

I used the same formula and got a sample as: 35 clients, 17 health workers and 6 key informants.

The study considered a sample size of 58 respondents from 4 PPP health units that is 1 health centres and 3 hospitals from all the categories (clients, health workers, health management committees and health officials). At the health centre and hospital level, 5 (five) and 10 (ten) clients, 2 (three) and 6 (six) health workers, 4 hospital administrators and 1 district health official and diocesan health officer. This finally led to 35 patients, 17 health workers,

The study could not be complete without key informants. The researcher chose these key informants based on the knowledge they had about the partnerships. These were found to be administrators of hospitals (4), health in-charge (1), district health office (1) and diocesan health coordinator for Ankore diocese (1) making a total of 6 informants.

At the health centre level, being at a lower level of healthcare delivery, the researcher selected half of the respondents considered at hospital level, since the turn up for clients and staff was lower comparably.

For Holy Innocents Children's Hospital where the patients were minors, the study sought ascent and the care takers of these children in the hospital shared the experience of seeking healthcare at this hospital. The same procedure was used for the case of Organized Useful Rehabilitation Services (OURS) department in Ruharo hospital where some clients were below 18 years.

### **3.5 Data Sources**

Data was gathered from two sources; primary and secondary. Primary data was gathered from respondents during field visits to PPP health facilities.

Secondary data was got from review of existing literature on health care delivery under PPP in particular. The researcher also used hospital health administrative records, books, journals, government publications, surveys, newspapers and other written documents.

#### **3.5.1 Data collection methods**

Qualitative and quantitative data was collected from respondents. The methods of data collection included administering questionnaire, interviewing and critical observation.

A questionnaire was used to collect specific data as the questions asked were in line with the objectives of this study. This reduced time spend to collect data as it was a direct method of extracting information from respondents. In-depth interviews helped the researcher in collecting data from key respondents, and this method allowed probing for more and clarification allowing the researcher to gather detailed information in regard to healthcare delivery at PPP health units.

### **3.5.2 Research Instruments**

In this study, the researcher used questionnaires, interview guide and observation checklist to collect primary data. The first two tools best determined the perception of respondents and service providers in regard with satisfaction. Touliatos and Compton (1988) noted that they are the best tools gather views, perceptions, feelings and attitudes of respondents. Observation checklist was also used to note observable events that updated and validated data collected.

#### **Questionnaire**

An open and close-ended questionnaire was used, with appropriately structured questions to answer the research questions. Some sections of the questionnaire were open ended and the close-ended questions were used to provide responses with varying degree of agreement. The questionnaire was used to collect data from clients and health management committees. The questionnaire was used because it is a reliable and dependable instrument for collecting information form respondents who are scattered in a vast area as noted by Ghosh (2000).

#### **Interview Guides**

The researcher also used an interview guide as a tool mainly used to obtain first-hand information from the respondents on their perception about the contribution of Public-Private partnerships in delivering healthcare to the communities. The method is appropriate, convenient, and allowed the researcher to explain and clarify questions asked in regard to the study. This tool was used to collect data from key informants: respondents from DHO's office, hospital administrators and health facility in-charges. This allowed interaction and social situated-ness thus motivated both the interviewer and interviewee (Amin, 2005). Data from these respondents was not recorded using a digital recorder, the researcher took detailed notes, after which the notes were analyzed based on the general experience of the key informant about services delivery in PPP health units. It was a very good tool of data collection since it gave the researcher a chance to collect more detailed data about healthcare provision at health facility and eased probing. This helped the researcher to compare the responses from the questionnaire.

### **Observation Checklist**

The checklist was developed to take note of the observable satisfaction or dissatisfaction indicators, for example, cleanliness in the facility premises, time of entry in the facility for both the clients and patients, other services like ambulance, rest room, toilets, wards, laboratory, waiting seats among others that measure the performance of PPP health units. Direct observation helped the researcher to observe situations like waiting for long resulting into fatigue of clients as they received or exit hospitals and health centres, distribution of drugs to clients and attendance of medical personnel.

### **3.6 Data collection procedure**

The researcher sought approval from Research Ethics Committee (REC) of Mbarara University of Science and Technology to allow him collect data. The researcher got approval from REC-MUST. The researcher developed a work plan which guided him to carry out all planned activities that is meeting respondents, conducting.

The researcher also politely approached the head of health facilities ask requested them for a host, to conduct his research. By the way of doing this, a letter explaining the objectives of research was written to the Executive Directors of hospital and the Health centre in-charge. The letter was attached to the ethical clearance from REC, upon which the researcher was given a go ahead. The DHO was also notified about the research and was formally written to as the health supervisor in the district again as one of the key respondents in this study.

After data collection, the researcher edited, coded, and entered data for analysis of the variables. The results from the analysis are a compilation of the proceeding chapters.

### **3.7 Data Quality Control**

Data was collected by the researcher bearing in mind that measuring client satisfaction of services provided by PPP health units can be best ascertained by visiting health units and interacting with the beneficiaries and providers of these services. Since the researcher is well versed with the study and data collection tools, it is highly expected that data was reliable. The research tools were well designed to collect relevant data necessary to answer all the objectives. At the end of each day of data collection, questionnaires and notes from the interviews were checked for errors, editing of notes and missing data in order to rectify this while still at the study site.

### **3.8 Data Processing, Presentation and Analysis**

After collecting data necessary, filled questionnaires and interview data were checked for completeness and consistence then sorted for analysis. Qualitative data was analyzed using verbatim analysis and researcher's experience from the field. All data from in-depth interviews was validated by visiting other sources. Observed data was noted using an observation checklist and the data was analyzed using narratives, to describe how significant the observed data contributed to patients' satisfaction or dissatisfaction.

Quantitative data was edited, coded, checked, and entered in analysis software Statistical Package for Social Scientists (SPSS) program and then analysis was carried out. It is presented using simple statistics using tables, graphs, and pie-charts accompanied by explanation to exhaustively assess the phenomena.

### **3.9 Ethical Considerations**

The study ensured that it did not harm respondents and other sources of data. It did not jeopardize the process of service delivery since data was collected after getting services for the case of out-patient respondents. The in patients respondents were found in the wards at the time when there were less activities of health workers. The respondents views were respected by presenting them in a way that elicit their feeling, perception and general situation of healthcare delivery under PPPs. Certain information like names of respondents were not required, those who said their names were kept confidential. Written consent was sought from respondents expressing their voluntary participation before interviewing them.

The respondents like children were not recruited in the study, instead the caretakers responded on behalf of their children. Most of these children were very young, others could not speak especially in the children's hospital and in other hospitals where young patients come to the health facility seeking healthcare.

Quotations and archive data is acknowledged including all data sources of the literature used in the study. This was done as the researcher re-phrased the views and ensured that he keeps in the bounds to explain the phenomena in this study. The researcher allowed any respondent who wishes to withdraw from the study or abstain answering questions amidst the interview. Although none of the respondents opted to withdraw from the study.

### **3.10 Limitations of the Study**

The researcher faced financial challenges for instance meeting all the costs for a successful study. These costs involved printing of questionnaires, drafts and final dissertations, transport to health units to collect data, and general welfare during data collection. In case a respondent withdraws from the research because of suspicious or ill motives by the researcher, it would be difficult to convince others to participate in the study. The researcher explained very well the intention of the study and none of the respondents that were recruited withdrew from the study. The objectives of the research study were also explained to respondents before they verbally consent to participate voluntarily in the study. Fortunately, no respondent withdrew from the study.

The health centre and hospitals being busy all the time to attend to patients, it was difficult to collect data from the health workers, given their busy schedule. The researcher had to wait for long hours until a health worker felt a bit free to collect the necessary data. This was time consuming on the side of the researcher.

## CHAPTER FOUR

### PRESENTATION, ANALYSIS AND DISCUSSION OF FINDINGS

#### 4.0 Introduction

This chapter presents and discusses the findings of this research. The discussion is derived from the analysis quantitative and qualitative data from statistics and narrations respectively.

#### 4.1 Study Sample

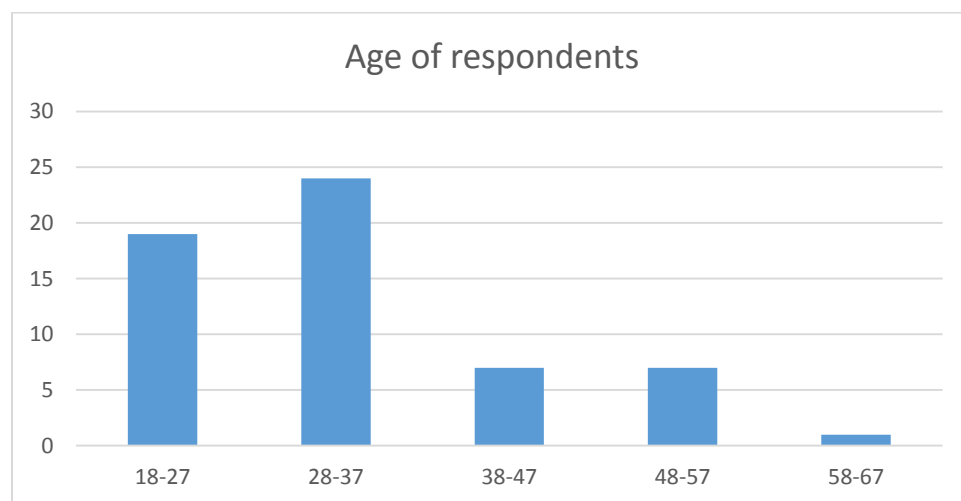
The sample for the study consisted of 35 patients, 17 health workers, 4 hospital administrators, 1 district health inspector, 1 diocesan health officer Ankore diocese a total of 58 respondents. The health facilities visited were 4 and included 3 hospitals-Holy Innocents Children's hospital, Mbarara community hospital, Ruharo Mission hospital, and 1 health centre-Nyamitanga Health Centre II. The study achieved response rate of 100% for all categories of respondents. The health workers despite their busy schedule expressed their willingness share their experience in providing healthcare and clients seeking health services in private health facilities.

#### 4.2 Characteristics of Respondents

The study had two categories of respondent that is clients/patients and health workers. Analysis was done by combining data templates and at some point analyzed separately. Depending on the variable under analysis.

##### 4.2.1 Age

The mean age of all respondent categories was 33.36 years. The highest age was 65 and lowest 18 years of age.



Source: Field data, 2017

Most of the respondents were between 28 and 37 years. These respondents included all the categories of respondents as highlighted in the sample study section. There were no respondents below 18 years although the part of study was conducted in a children's hospital, assent was sought from the caretakers and they are the ones who responded instead of their children. The study found out that all the age categories were represented and therefore clients seeking healthcare in these facilities are from all the age groups as described in this study. Since data was collected from facilities including children's hospital even the children were represented although they are not reflected in the age groups.

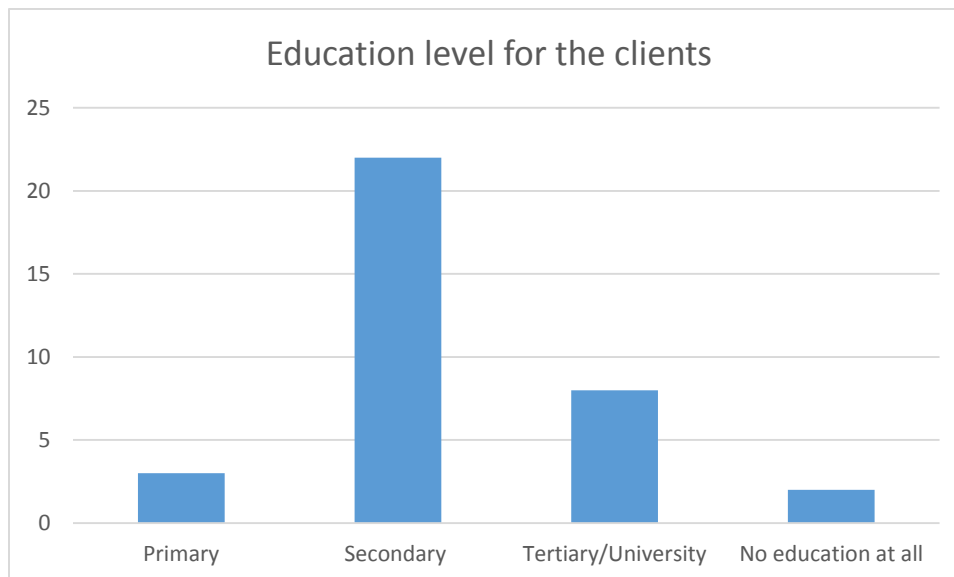
#### 4.2.2 Gender

| Sex     | Frequency | Percentage |
|---------|-----------|------------|
| Male    | 19        | 32.8       |
| Females | 39        | 67.2       |
| Total   | 58        | 100        |

#### Source: Field data, 2017

From the study, 39 respondents (67.2%) were females and only 19 (32.8%) were males. These results depicted that women seek healthcare services than men. The study found out that women accompanied patients more than men as this was a case at Holy Innocents children's hospital and Organized Useful Rehabilitation Services (OURS) department because of the extra care that women have to give their children during the period of admission.

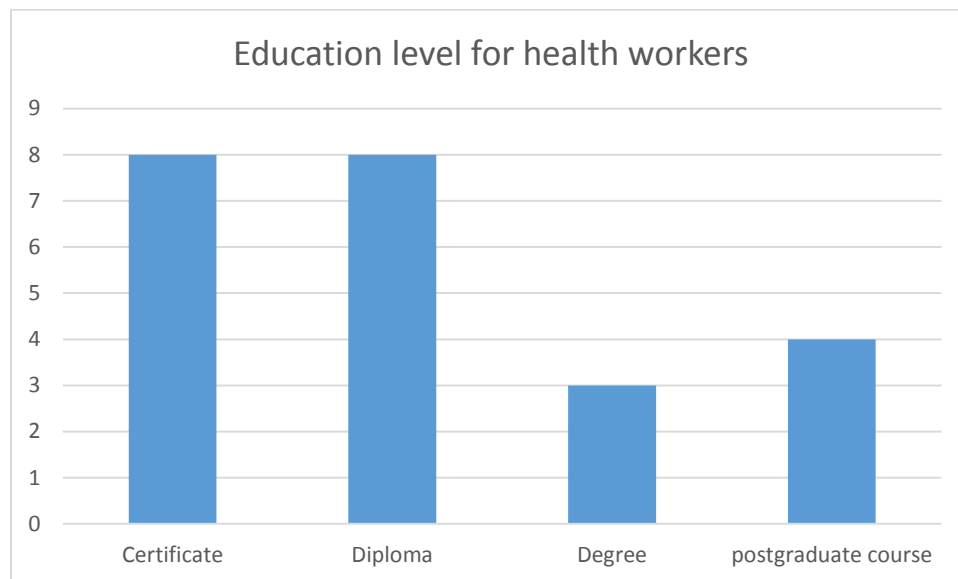
#### 4.2.3 Education level



**Source: Field data, 2017**

The study involved 35 clients. Clients seeking health services in these health facilities had attained level education while others had not, from the graph above, 22 (62.8%) of the respondents had attained secondary education, 8 (22.9%) of the respondents had attained tertiary or university education, 3 (8.5%) had attained primary while 2 (5.7%) had no education at all. There were few clients of primary and those who had not attained education at all. This explains why the clients seeking healthcare services in these facilities are categorized as educated. The element of private in these facilities attract different categories of clients both educated and non-educated.

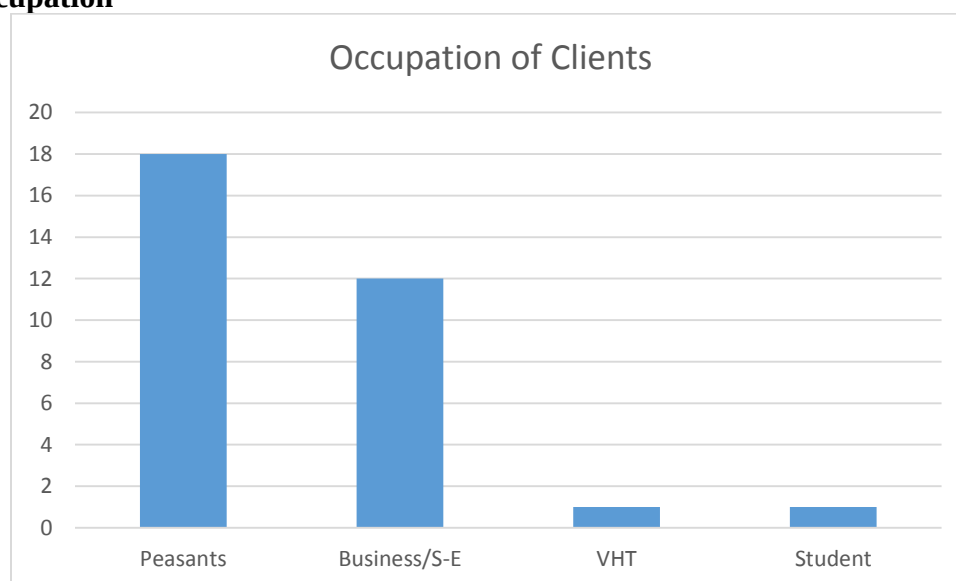
**Health workers**



**Source: Field data, 2017**

According to the bar graph above, majority of the respondents 8 (67.6%) in health workers' category had attained certificates and diplomas, only 4 (17.4%) had attained graduate course and 3 (13%) had attained bachelor's degree. The reason for majority of respondents holding certificates and diplomas was that highly qualified staff (specialists) leave for better opportunities. To respond to this situation, these health facilities recruit many low cadres, whose rate of return is low. The highly qualified staff were in executive positions like hospital directors, administrators and medical officers. These highly qualified personnel were to ensure a tight supervision on the low rank staff to ensure high quality service provision at PPP health facilities.

#### 4.2.4 Occupation

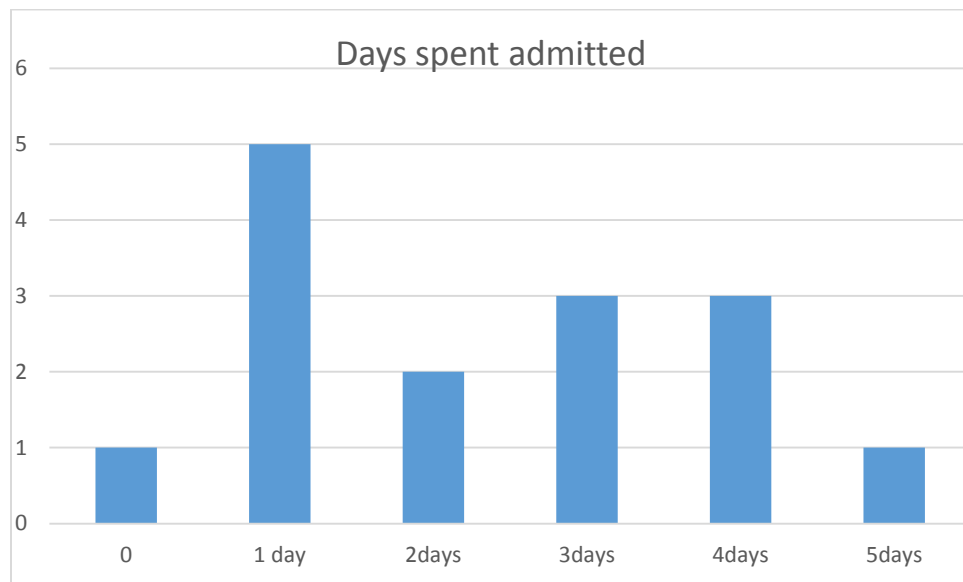


**Source: Field data, 2017**

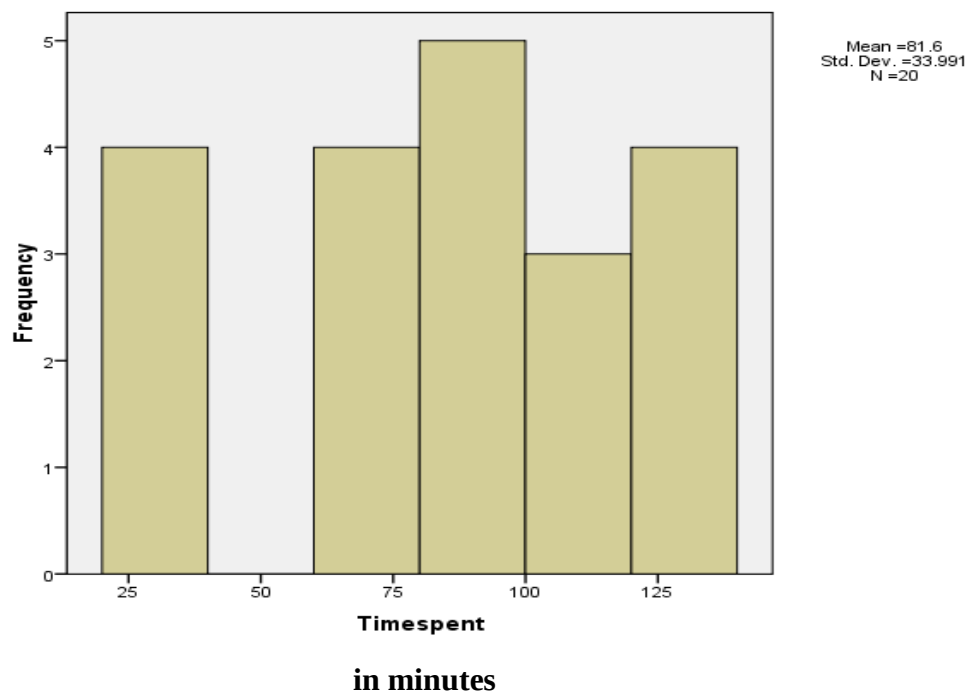
Clients' occupation was dominated by peasants (18) representing 51.4%, followed by business/self-employed (12) representing 34.3%, civil servants (3) representing 8.6%, Village Health Team (1) representing 2.9% and student (1) representing 2.9%. At Ruharo Mission hospital, services that involved operation of eyes were found at cost of 230,000 for one eye and 350,000 for both eyes. This partly explains why some of the clients at times complained of high medical fees charged by the PPP health facilities. At Holy Innocents Children's hospital, the cost of medical care was at 12,000 for out patients and 30,000 (for the first day) then the cost reduces to 25,000 the subsequent days for in patient which according to the study the cost was rated to be relatively low compared to private for profit health facilities of which the cost of medical care is higher above 150,000 per day for in patients.

Business men and women revealed that they seek health services from these facilities because they offer high quality health services compared to public health facilities.

#### 4.2.5 Clients duration on admission and OPD



#### Time spent at a health facility: Clients



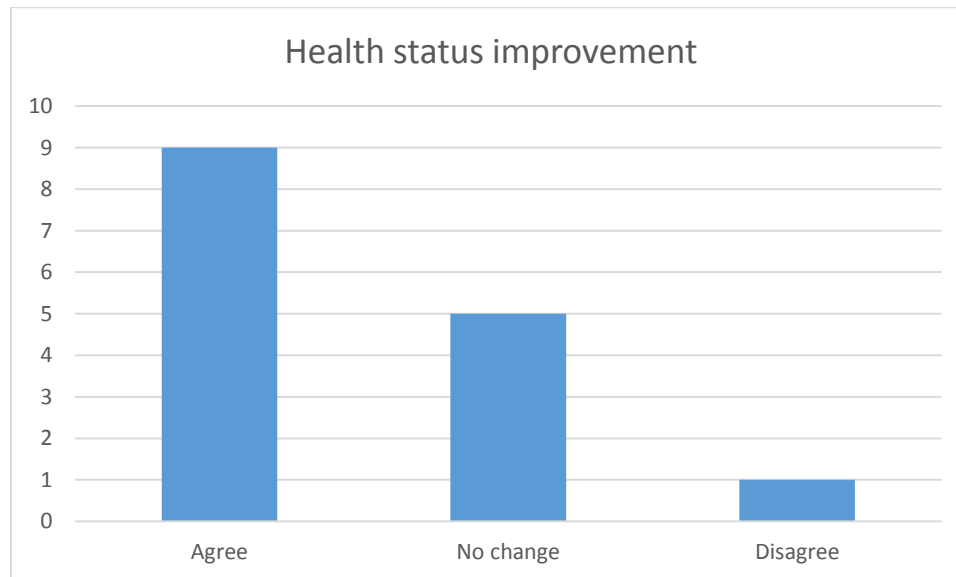
Source: Field data, 2017

From the graphs above, out of 35 patients interviewed during the study, only 20 (57.1%) were outpatients, and 15 (42.9%) were inpatients. The study found out that the inpatient spent an average of 3 days admitted in a PPP hospital before being discharged. The average time spent by outpatients at a PPP health facility was 81.6 minutes. The findings are in agreement with a study by MeTA (2014) that found out that 58% of the respondents indicated that long waiting hours were the most cause of dissatisfaction although the study did not indicate how long patients were waiting. The findings are not different from a study by Tateke (2012) which found out that the mean waiting time at a private hospital was 80.1 minutes compared to 134.1 minutes spent in public hospitals. The minutes spent at the facility was enough for patients to interact with medical staff for consultation which according to Sajid (2007) supports that spending long time during physical examination and contribution is associated with higher satisfaction level.

The few days (3 days) spent on admission motivated the clients to come back to PPP facility seeking healthcare services since they were spending few days compared to minimum of 5 days public health facility. This explains why most patients would visit a PPP hospitals the next time they get a health issue. The clients in OPD revealed that whenever there was a delay it was procedural and therefore complained less about time spent since they found the staff. The overall satisfaction of clients was found to be higher in PPP than in public health facilities. The patients were critical on the waiting hours, although the waiting time was lower compared to time waiting to receive services in public facilities, the study findings indicated that the low levels of staffing had an impact in terms of health care quality (Bowling, 2012). The patients being many posed a question on whether there was adequate attention amidst low staffing levels. The clients expressed taking long hours waiting for results from the laboratory due to few lab attendants. However, at Nyamitanga health centre II the patients inflow was low an average of 5 to 8 clients. The number of patients at this facility was manageable. This was found to be the same with Mbarara community hospital where patients walking in the facility was low an average of 15-20 patients compared to other hospitals where the study was conducted for example at Holy Innocents hospital the patients were at an average of 70 per day.

#### 4.2.6 Health status improvement of patients after admission

##### Health status improvement of admitted patients



**Source: Field data, 2017**

Out of 15 patients who were admitted at hospitals visited, 9 (60%) of the admitted patients agreed that their health status had improved, 5 (33.3%) had no change in their health status and only 1 (6.7%) disagreed. The inpatients that had realized an improvement had spent more than one day, others waiting to be discharged. The ones who had no change had spent a few hours on admission and the one whose health status had not improved after 1 day of admission was waiting for an operation.

#### 4.3 The type of partnerships of the health facilities under PPPs in Mbarara Municipality

The type of partnership under health care system in health facilities under PPP in Mbarara municipality was Design-Build-Finance-Operate (DBFO) across all the facilities visited in this study. The facilities under the partnership were built by individuals, others faith based. The individuals and faiths operate these facilities with minimal support from the government.

The health facilities are supported by government to deliver specific packages of healthcare as stipulated in the partnership. These packages include ART drugs and HIV/AIDS care, immunization, maternal child health, anti-malarial treatment, malaria control programs including

provision of free mosquito nets to community members and outreach programs. These health facilities get PHC fund enables them to deliver these packages to the patients.

These facilities also get support in terms of supervision from the health officials at the district and ministerial level. The supervision is to strengthen the healthcare system and identify other areas of partnership. Supervisions also aims at identifying the partners and their role at a given facility so that the government does not duplicate what is already being done. Since these facilities are given support, supplied with medicines, medical equipment, and health records materials, the supervision also ascertains whether these are put in proper use to improve healthcare. The medicines and other medical equipment are given to these facilities through medical access and Joint Medical Stores.

Health inspectors visit these facilities whenever they need to make comprehensive report about health status in the district as it is a requirement by the Ministry of Health. The report is merged with that from public facilities to enable proper budgeting the health sector.

The services are offered under the partnership in these health facilities were ART drugs and HIV/AIDS care, immunization, maternal-child health, anti-malarial treatment, malaria control-free mosquito nets and outreach programs.

#### **4.3.1 Mbarara Community Hospital (MCH)**

At Mbarara community hospital no cost is involved in accessing the health packages mentioned above since they were accessible under the partnership arrangement, except paying consultation fee of 20,000/= for patients for ART enrolment. The consultation fees was paid by the patient to cater for paper work, enrollment and opening a file, making baseline investigations for example complete blood count, liver function tests and renal function tests. Patients who have done these tests from a different health facility also pay this money, since their files are opened and kept at this facility. This fee is paid once and the visits after paying this fee are free of charge.

At this hospital, when a patient has another ailment apart from the free services supported by the government through PHC fund, the patient is treated as outpatient or admitted and treated as a private patient and meets some cost of accessing the health services. Although the services at this hospital are subsidized, including some others not supported by the government, the number of patients was low at this hospital compared to others. It was revealed to the study that the hospital receives an average of 20 patients per day compared to Holy Innocents which receives an average of 80 patients per day.

The other health care services are public supported and the government supplies health facilities with the drugs, and supporting them with PHC fund. Unfortunately, at this hospital, the PHC was withdrawn based on unclear circumstances. The medical superintendent explained that he was not in the know of the reasons for withdraw of PHC. An officer (Health Inspector) under DHO's office revealed that he was also not aware of the cause for the withdrawal of PHC fund at this health facility. He added that private sector involvement has made the health sector competitive, making it easy for the citizens to access high quality healthcare easily and conveniently. The inspector revealed that DHO's office was in touch with the ministry to re-instate PHC fund for this hospital, promising that next financial year this hospital we be back on board.

With the withdrawal of PHC fund, the hospital still receives supply of medicines from Joint Medical Stores and Medical Access to supplement its operation. These supplies include immunization doses to keep the hospital in a functional mode and a recognized partner in health care delivery.

*“We have not been excluded from the partnership, we still deliver the services as stipulated in the partnership despite withdraw of PHC fund. We deliver these services using internally generated funds from the user fees and free supplies from JMS and Medical Access”* (Medical Superintendent, Mbarara Community Hospital, 2017)

At Mbarara community hospital, anti-malarial drugs are also given to mothers admitted in maternity wards, depending on how the client walks in. for example, those who walk in and are assumed to be in a category of rich are charged for these services and those who look needy, underprivileged and with less financial ability are given the drugs free.

#### **4.3.2 Ruharo Mission Hospital (RMH)**

At Ruharo mission hospital, the support given to the hospital by the government is used to give services that include HIV/AIDS care and offering free or subsidizing the General Medical Services (GMS) in the GMS department. The other departments in this hospital include Eye and Organized Useful Rehabilitation Services (OURS) departments.

The hospital benefits from the government through the PHC fund of Uganda shillings 62M annually, presidential anti-malarial drugs supplied by Joint Medical Stores (JMS) supplied once a year, Medical Access supplying free ART clinic drugs and these drugs are distributed free of charge to HIV/AIDS patients, supporting the hospital with equipment for example beds and

mattresses (from the central government), and CD4 count machine (from local government). PHC fund is tied to drugs/medicines, administration expenses for example meetings, utilities, outreaches and at times supplements staff salaries.

**Joint Medical Store delivering drugs at Ruharo mission hospital**



**Source: Field data, 2017**

## JMS staff offloading drugs from JMS cabin



**Source: Field data, 2017**

The hospital appreciates government effort to support it as a private health provider. The hospital runs a budget of 5 billion annually, when compared to the PHC fund it receives (62Million) this is little support again comparing the number of people it supports in terms of coverage. For non-supported services for example treatment of eyes; if it to be operated a client pays 230,000 Uganda shillings, services offered in the department where a patient pays 7,000 per day for accommodation, food and medicine. The hospital generally charges less user fees and this explains why they have kept good relations with the government and have kept receiving the funds and other form of support to keep the hospital operate efficiently. An officer in charge of finance explained the PHC accounting procedures to keep in good books of government as a trusted partner in health. He elaborated that a separate file is opened every year to fully account for the PHC fund. The accountability report for this fund is submitted annually to the district for auditing.

Ruharo Mission hospital is among the hospitals the study found exceptional, having other partners apart from the government. These partners included; Christian Blindment Mission (CBM) a fund that supports eye and Organized Useful Rehabilitation Services (OURS) departments, International Federation (IF) supporting OURS, Seeing Is Believing supporting eye department, Light for the World, Uganda Protestant Medical Bureau (UPCMB), Lillian Fund (LF) supporting OURS and GMS gets funding mostly from user fees and PHC.

It is from these different sources that the hospital has a vote of 46Million on its annual budget to supplement clients who are unable to meet their cost of medication at this hospital. In most cases, patients helped under this initiative are those seeking operation services especially in the eye department. The study found out that eye patients require 230,000 shillings for operation of one eye and 350,000 shillings for both eyes. Some patients find it difficult to raise this amount, although some come when they are prepared to meet the cost, others expressed their inability to afford this cost arguing that it was high.

*“230,000 Uganda shilling is a lot of money, I did not know that this is the much charged, I would have come prepared to meet the cost, however it is too much that I can’t afford it. If this cost can be reduced then I would be able to get the services I have come for at this hospital”* (A Patient elaborated during an interview, 2017).

The 46 Million on the annual budget according to the officer in charge of finance is allocated to help such patients who are assessed on their inability to afford the cost for seeking medical services at this hospital.

In addition to free services, the hospital participates in outreach programs to offer more free service. In 2016 December, the hospital had outreaches in Ibanda district and Mugarusya Kashari County in Mbarara district where the health workers treated people with eye cases, and gave out free eye glasses. The hospital organizes a free surgery week every year to freely treat patients with eye problems. Outreach programs have not only worked for eye patients in Ibanda and Mbarara, in Omoro county, Rotarians have worked with hospitals in of Nagulu, Bukoto and Gulu to freely treat over 2,000 patients. The services offered included general clinic, malaria treatment, laboratory services, ear, nose, throat, eye and dental clinic and blood donation (The New Vision, May 1, 2017).

The government as a public partner in the PPP arrangement is an important player in a way that it provides general framework and guidelines to enable the hospital delivery healthcare services efficiently and effectively. Through the ministry of health, the private partner interacts with the government in meetings to lay strategies for better service delivery.

The government has equipped Ruharo Mission hospital with relevant medical equipment; a number of theatre machines, oxygen, beads and reagents for laboratory have found their way in Ruharo mission hospital as a private partner. The government also gives support to the maternity ward and supplies Maama kits, anti-malarial, HIV, TB drugs, family planning methods, different preventive mechanisms; in this regard supply immunization vaccines, fridges (to keep the drugs) and mosquito nets. The hospital also receives salary support from the government to sub seconded staffs and the hospital gives top up since the government pays them less to match their salary to the staffs in the hospital. In addition, the government gives training for example on nutrition and gives support supervisions through the office of DHO. The principal-agent theory applicability here is that the government has in a partnership arrangement has helped the PPP facilities to through training, support supervision through the DHO, provision of equipment and drugs all of which are its mandate in the PPP agreement (Lane, 2003).

Patients seeking services like immunization, family planning and HIV/AIDS care don't pay as these services are funded through PHC. The anti-malaria programs like supply of mosquito nets are also channeled through this partnership.

The hospital being a church-based facility, the diocesan health board supervises its operation through the office of the diocesan health officer, the church also participates in strategies to raise funds for example donors and linking the hospital with the outside world. This office supervises other health institutions under the church in Ankole diocese. The hospital also has hospital management team which responsible for policy making and overall supervision of the hospital.

The hospital is among the projects that the church runs, with many other health centres under its supervision and control under the office the diocesan health coordinator. With the mission "*Continuing Christ's Mission*" it contributes directly to the running of church activities and subscribes 30Million Uganda shillings annually. The *Mission of Christ* is promoting life both physical and spiritual, the hospital's mission in terms of providing quality healthcare to God's people. The hospital pays this money in affordable installments or at times as a whole, although at

times when the hospital is unable to pay this money, they discuss with the church to waive off to enable the hospital run efficiently. This was a different case with Holy Innocents Children's hospital which does not contribute anything to run church activities.

Ruharo mission hospital engages so much in corporate social responsibility through giving to communities they serve. The hospital's scope of operation is all over the western region. The researcher's interaction during data collection found out that patients come from as far as Kibale, Masaka, Sembabule among other districts. The free services that they offer have widened their level of operation and made the hospital known beyond western region borders. For example, last year during the free surgery week, 500 patients received free hearing gargets. This event is in the hospital's annual budget, and covers a lot of things beyond surgery (Office of Finance department RHM, 2017).

The hospital capitalized on the outreach as a form of advertisement and to let the public know about the services it delivers in terms of quality and coverage. The services offered through outreaches and special days like surgery week makes patients feel the touching bit of the hospital in service delivery. In other private facilities including Holy innocents Hospital, advertising has taken a form of marathon and mobilizing funding by selling the coupons/tickets to runners. For example, a catholic-church aided hospital; Nkozi that started in 1942 has been on a campaign to mobilize money to construct a 2.8 billion emergency ward to be able to handle the overwhelming accident cases that are common on Masak- Kampala high way (The New Vision, Monday, June 19, 2017). The marathon that took place to fundraise for this cause attracted the speaker of the 10<sup>th</sup> Parliament Rt Hon Rebecca Kaaaga who contributed 10 million, leader of Opposition Hon Winne Kiiza among other legislators (Ibid). In a way of advertising the hospital, the Bishop of Masaka diocese Bishop John Baptist Kaggwa requested the government to continue supporting development projects of faith-based hospitals.

#### **4.3.3 Holy Innocents Children's Hospital (HICH)**

Holy Innocents Children's Hospital started in 2009 as a result of a need to offer specialized services to children. This was a vision of Archbishop of Mbarara Paul K Bakyenga who is known for fighting for the rights of children. The Archdiocese has other hospitals and health centres in Ibanda, Comboni, Kyabirikwa-Isingiro, Nyamitanga health centre II among others.

The aim of starting the children's hospital was to speak for the children by advocating for improved, easy access and relatively affordable to health services. The Archbishop in collaboration with his other friends abroad in San Diego, USA offered to walk the talk. The late Thomson Tom volunteered to get funds from abroad to start the hospital in Mbarara Archdiocese. Donations from charitable group especially American people put up infrastructure (buildings) where the hospital is operating from.

The initial proposed name of the hospital was Malaria hospital, but later, Holy Innocent was thought as an ideal name that related it with the church. It was called Holy Innocents in commemoration of the Children killed by King Herode.

The hospital runs and is accredited by UCMB which gives technical support in running the hospital. Holy Innocents is a referral centre for pediatric cases. The interesting bit of it is that it is at a lower level of operation compared to Mbarara Regional Referral Hospital, but MRRH refers some cases to Holy Innocents. Since its inception in 2009, the hospital has treated 165,000 children (Hospital Administrator's records, January 2017).

Holy Innocents has partnerships with the government through the Ministry of Health and gets PHC of 37Million annually. This fund mainly facilitates community outreaches, immunization, pediatric HIV treatment services and diabetes clinic. Other form of support from the government was a 4 years presidential, pledge intended to support 12 staffs (sub-seconded staff). Although this expired after 4 years of hospital's operation, it was not covering the entire staff of the hospital, it was even paying less compared to the rate of other health workers who were paid by the hospital requiring the hospital to make a top up (Hospital Administrator HICH, 2017). The Ministry of Health donated an ambulance to the hospital, much as the hospital has many other ambulances donated by Archbishop Bakyenga's friends from Germany.

Diabetes clinic operates on Friday every week and for the last 2 years the hospital has turned to be a focal point for diabetes treatment in western Uganda.

The hospital offers other services that include pastoral care services (a mass is said to the clients) every Tuesday at 5pm to give the sick and caretakers belief and social support. Recreational services that entertainment on TVs, different types of wheels for playing especially for relatively old children those above 3 years, ambulance services and internship for healthcare trainees. Pastoral related work was found in Ruharo mission hospital where youth come to the hospital

every Wednesday to interact with patients, especially those admitted. Ruharo hospital has a Chaplain who coordinates religious activities at this hospital. Such services are not common in public health facilities thus making the private facilities more attractive where interaction with God and entertainment make patients feel at home much they are at a health facility where they enjoy almost the same services as they do at home.

Other services offered at Holy Innocents Children's hospital ambulance services to patients who need them. The hospital has 3 ambulances; one donated by the ministry of health and other three donated by Archbishop's friends from Germany. Hiring an ambulance at this hospital costs 30,000/= for town catchment and beyond the town the cost depends on the distance (fuel) costs, allowances for a driver and nurse. The hospital also offers internships for healthcare trainees.

The hospital through UCMB and the Archbishop is lobbying government to increase its funds. Out of 1.044Billion annual expenditure, the hospital only gets 37Million (PHC) from the government. The money government gives the hospital cannot even the hospital for a month, as the hospital runs a budget of 87Million per month.

Its monthly expenditure is on staff salaries, medicines and utilities. Most of the funds are raised from user fees and the hospital raises between 50Million to 60Million monthly from user fees. The user fees according to the hospital administrator are not expensive. A survey was made before arriving at the cost for healthcare packages for outpatient and inpatient departments. For outpatient department, a patient requires Uganda shillings 12,000/= to access healthcare at Holy Innocents hospital and for inpatient department, a patient requires 30,000/= (for the first day) and 25,000 for subsequent days. The cost of each package caters for only essential drugs and an extra cost is met by a patient to access premium drugs and other drugs. Comparably, the health services at Holy Innocent Children's hospital are affordable based on the private setting and without a partnership with the government, the cost would be higher than 12,000, 30,000 and 25,000 as elaborated above. The role of the church partly is ensuring the wellbeing of its followers, which the Catholic Church is doing by providing high quality health services at an affordable cost through its established health facilities in South Western Uganda. The finding concur with Ministry of Health (2008) which documented that 82% of clients seeking services from a private pharmacy or health unit found more medication cost more expensive than at government facility. Golooba-Mutebi (2005) found out in Mukono district that seeking healthcare in private facilities was very expensive. Some patients who are very poor and cannot afford high cost of private healthcare facilities and resort to

overcrowded poorly functioning government facilities or remain at home without any treatment or service (Hulme, 2003 cited in Bariyo, 2012).

Holy Innocents Children's hospital treats an average of 80 patients per day. The big numbers of patients seeking healthcare services at this facility would flock the public facilities congesting them and compromising the quality of health care provided in these public facilities. The existence of the various faith based facilities have relieved the public facilities with overwhelming numbers. The public facilities would be constrained without engagement of the private sector in health care system. The principal in this case the government is relieved because the agent (private health facilities) has accepted to take on some responsibilities thus decongesting the public health facilities. As of March 2017, 1.4 million people are living with HIV/AIDS in Uganda and only 1.04 million are enrolled in care while 0.98 million are on antiretroviral treatment (ART). New HIV infections reduced from 135,000 in 2010 to approximately 60,000 in 2016, representing 60% among women and 40% among men. New infections among children reduced from 26,000 in 2010 to 4,000 by the end of 2016 (The New Vision, June 7, 2017, pg.8). The private partners had a significant contribution towards this reduction and handling the HIV/AIDS cases through providing support care and ART. For instance Mildmay a private healthcare provider today (2017) offers support care to over 100,000 HIV/AIDS patients which is 13% of the total number of clients on ART 7,000 of whom are children (The New Vision, Tuesday, June 27, 2017, pg.11). It should be noted that since 2014, all children born to HIV-positive mothers at Mildmay have remained negative and Mildmay has promoted a campaign for HIV-positive mothers to know that they can have HIV free generation after them (The New Vision, Tuesday, June 27, 2017). The engagement of private sector has led to a reduction in HIV death related cases annually from 100,000 in 2004 to 28,000 in 2016 (The New Vision, June 7, 2017, pg.8) The private sector has greatly contributed to national goal of universal access to healthcare and has been significant in reducing congestion in public health facilities which the principal would not have managed operating without an agent.

The hospital gets support from donations (from partners although this kind of funding is not regular, it comes when there is need). The donations come from international community especially from Ireland, Germany, and United States of America (USA). The hospital has built links beyond Uganda through the friends of Archbishop Paul K Bakyenga. These friends have continuously supported the hospital and have donated 2 ambulances and contributed to the construction of the theatre (under construction). Internally generated funds and support through

user fees, free medicines (anti-malarial drugs from Joint Medical Stores), immunization packages from Ministry of Health and medical access supplies free medicines for HIV clients. HIV/AIDS patients at this hospital also get free drugs for other diseases. The existence of the private facilities has attracted international partners on their own which adds on the list of partners in the country. This directly implies that the government is able to meet its obligations through the private engagement in delivering services on its behalf. Above all, private facilities are believed to be more efficient than public facilities as Raman and Bjorkman (2009) noted that the management of most primary health centres, community health centres and super-specialty hospital has been outsourced to the private in most states in India because they were found more efficient. The partnership in the health sector is advantageous to the government in that the government realizes reduced expenditure on salary head, high end treatment, availability of professional expertise and effective budget utilization (Shantaram *et al*, 2016). This makes the private more advantageous compared to public facility making the private more efficient than a public facility.

The supplies from medical access are quarterly, while JMS supplies drugs according to the demands of clients, depending on the use of drugs. JMS supplies drugs to the hospital when need for specific drugs arises. Due to the high number of patients that seek healthcare services at this hospital, the hospital buys other drugs on its own from its treasury to ensure continued care. The hospital's monthly budget of 87million part of the money is allocated to purchase of drugs that are not supplied by Joint Medical Stores and Medical Access. The patients who would flock public facilities and exit with no drugs after waiting for long hours end up in a private facility and can easily access without waiting for long hours as it is a norm with public facilities.

#### **4.4 Healthcare services delivered under PPPs**

The services offered at Mbarara community and Ruharo hospitals as PPP facilities were found the same. The services included HIV/AIDS care provided under ART clinic, outreach programs including health education to communities, maternal and child health including immunization, hepatitis B vaccination, free mosquito nets (malaria control), and anti-malaria drugs provided to patients through the maternity wards.

At the Holy Innocents Children's hospital, the patients received anti malaria drugs, immunization, pediatric HIV treatment and services, Diabetes care and community outreaches where the hospital gives health education to communities where they go for outreaches.

At Nyamitanga health centre II, patients received services like malaria treatment, immunization HIV/AIDS care. This health centre refers patients especially children to the children's hospital for further treatment, especially those found to be tested HIV positive since it does not distribute HIV/AIDS drugs to them if they are proved to be HIV positive.

These services were offered depending on the arrangement of the health facility. For example, at Mbarara community hospital, it requires a client to pay 20,000/= for Hepatitis B vaccination. Normally, in absence of a partnership a client would require more than 40,000/= to get the vaccine for Hepatitis B when compared with PFP facilities. Although the study findings indicated that Mbarara Community hospital's PHC fund was withheld this financial year, they continued providing services as the hospital continuously received supplies from JMS and Medical access, including packages to keep supporting immunization program and fighting against malaria.

The cost of malaria treatment was 12,000 for example at Holy Innocents Children Hospital (HICH) and at Ruharo Mission Hospital, the cost was at 15,000 maximum. The partnership has lowered the costs for clients in these facilities.

Services offered under the partnership are few, as seen in the previous paragraphs. The packages include malaria treatment, HIV/AIDS care, and community outreach for health education, Diabetes treatment, Hepatitis B vaccination and immunization.

The study found out that patients received more than three services generally, including those that were not catered for under the partnership arrangement. It should be noted that some services are almost free, while others are subsidized and others expensive. For example HIV/AIDS care services and drugs were free, although at Mbarara community hospital a patient had to pay consultation fee of 20,000. Rehabilitation services at OURS department were subsidized and the patient only pays 7,000 per day for upkeep (this includes meals, accommodation and using hospital facilities) and medical costs are donor supported.

The partnership lowered costs of services accessed by clients, and provided them with a better option that made the patients like the organization of the private facilities as providers of healthcare. It's the reason why most private facilities under the partnership have been able to attract international and national agencies other than the government to pattern with them since they are believed to be providing quality healthcare in an organized, less costly manner.

In some departments where there is no support from the government or any partnership the cost of healthcare was found to be high. For example in the eye department, the cost of treatment was very high. To operate one eye the patient requires 230,000/= and for two eyes it costs 350,000/=. To lay patients, this money is a lot. Other services not supported under the partnership their costs were also found high in addition to consultation fee which ranged from 15,000 to 20,000 at hospital level and at health centre level patients were not paying consultation fees.

Other services including child development and rehabilitation are provided in these health facilities. In Ruharo mission hospital, OURS department offers services that enable child growth and development. These are special services offered at this hospital and in the whole of western Uganda. The department admits clients from many districts of western Uganda and offers them an opportunity to explore exercises that they have missed during their infant stages. On admission of these clients, the caretakers are expected to spend recommended days at the hospital and respond to regular reviews after exiting the facility.

Due to the unique services that OURS department offers, it has been able to attract different partners like International Fund (IF), Christian Blindness Mission (CBM), and Lilian fund. This department has been successful in establishing good relations through community outreaches. These outreaches shape its existence, the health education and various compliments like nutritional education the departmental staff provide to caretakers has expanded its opportunities.

Through the PPP arrangement, other services have been subsidized especially those not included in the partnership with an intention of attracting patients to these facilities. These facilities mainly operate as private and government funding supplements specific programs that are described in the Memorandum of Understanding with the public partners. The health facilities using the strategy of subsidizing other services provided in order to attract more funding and also to target donors as these facilities exist as PNFP.

#### **4.5 Beneficiaries' level of satisfaction with health services delivered by PPPs in healthcare compared to public health facilities**

In this study, the researcher used various indicators to ascertain satisfaction levels of clients at private health facilities under the partnership. The different indicators are detailed in the following tables.

#### 4.5.1 Clients visit to facilities; Private under the partnership or Public

To understand satisfaction, the study used the previous visit of the clients when they had a health issue as one of the indicators. The health divided the facilities visited into three categories; public, PPP and PFP. Clients were asked the reasons for visiting a facility they did the previous visit to support their choice.

**Previous health facility visited by the client**

| Health facility category | Frequency | Percentage |
|--------------------------|-----------|------------|
| Public                   | 8         | 22.9       |
| PPP                      | 24        | 68.6       |
| PFP                      | 3         | 8.6        |
| Total                    | 35        | 100        |

**Source: Field data, 2017**

24 (68.6%) expressed having visited a PPP facility during their previous visit, 8 (22.9%) had visited a public facility and only 3 (8.6%) had visited a private for profit facility during their previous visit. The majority of the clients having visited a PPP facility indicated that they were satisfied with the services offered. The clients were asked why they did not go back to the private for profit facility and explained that they were required to pay a lot of money ranging from 100,000 shillings after getting inadequate attention from a medical worker. For the clients who visited a public facility, they expressed having been neglected for long hours, waiting for a health worker in vain, delay in receiving the services, not getting all prescribed drugs, and above all being asked to pay a bribe to be attended to.

#### **Repeatability against trust PPP health facility**

The explored clients' repeated visits to PPP health units. The study find out that majority of the clients were not visiting the facility for the first times the client has visited the facility. This indicator aimed at establishing whether the client was visiting the facility for the first time or making a repeated visit which explained trust or mistrust of the client with facility services which directly measured satisfaction.

### Visiting the facility for the first time

| Visiting facility for the first time | Frequency | Percentage |
|--------------------------------------|-----------|------------|
| Yes                                  | 11        | 31.4       |
| No                                   | 24        | 68.6       |
| Total                                | 35        | 100        |

**Source: Field data, 2017**

24 (68.6%) of the clients have visited a PPP facility more than 2 times. Only 11 (31.4%) were visiting the facility for the first time. This implied that trust of these facilities was higher compared to public facilities.

#### Number of times client has visited the facility

| Times      | Frequency | Percent |
|------------|-----------|---------|
| 2          | 12        | 50      |
| 3          | 6         | 25      |
| 4          | 3         | 12.5    |
| 10 or more | 3         | 12.5    |
| Total      | 24        | 100     |

**Source: Field data, 2017**

24 out of 35 clients had visited PPP health facility more than once. Only 11 clients were visiting the facility for the first time. The study found out that 12 (50%) of those visiting the first more than once has visited the facility 2 times, 6 (25%) had visited the facility 3 times, 4 (12.5%) had visited the facility 4 times and 3 (12.5%) had visited the facility 10 times or more. This was an indicator of client satisfaction as they visited the facility more than once.

#### Clients visit to public facility

| Visiting a public facility | Frequency | Percentage |
|----------------------------|-----------|------------|
| Yes                        | 32        | 91.4       |
| No                         | 3         | 8.6        |
| Total                      | 35        | 100        |

**Source: Field data, 2017**

32 (91.4%) respondents revealed that they had ever visited a public health facility and only 3 (8.6%) had never. The services received in public health facility was found to be an indicator of dissatisfaction with long hours of waiting, uncaring staff, some drugs not available in such facilities which explains the explain the repeatability of clients in PPP facility. This has compelled such patients to run away from public facilities due to dissatisfaction.

| <b>Clients' rating services received at public facility</b> | <b>Frequency</b> | <b>Percentage</b> |
|-------------------------------------------------------------|------------------|-------------------|
| Very good                                                   | 1                | 3.1               |
| Good                                                        | 6                | 18.8              |
| Fair                                                        | 15               | 46.9              |
| Poor                                                        | 9                | 28.1              |
| Very poor                                                   | 1                | 3.1               |
| Total                                                       | 32               | 100               |

**Source: Field data, 2017**

32 (91.4%) of the clients had ever visited public health facilities. These clients rated the services offered at public facilities as thus; only 1 (3.1%) was very good, 6 (18.8%) ranked as good, majority 15 (46.9%) revealed that the services were fair, 9 (28.1%) rated the services as poor and 1 (3.1%) said that the services were very poor.

#### **4.5.2 Receiving healthcare services at PPP facility**

The study documented the number of services received by the client, character of the service provider, time taken, expectation of the clients, access to drugs, and rating satisfaction of every service received by the client at a PPP facility.

#### **Services received at PPP health units**

Clients who received not more than 2 services accounted for 6 (17.14%). 29 (82.86%) of the clients received more than 2 services at a PPP health facility. The clients who received not more than 2 services were those seeking immunization services and HIV/AIDS care. These services are supported in the partnership and are free of charge at PPP facilities.

#### **Character of staff at PPP health units**

| <b>Rating</b>  | <b>Frequency</b> | <b>Percentage</b> |
|----------------|------------------|-------------------|
| Strongly agree | 27               | 77.1              |
| Agree          | 8                | 22.9              |
| Total          | 35               | 100               |

**Source: Field data, 2017**

The clients agreed that health workers at PPP facilities are approachable, cared about them than in public units. 27 (77.1%) strongly agreed with the study that the staff took extra care to attend to clients and 8 (22.9%) agreed that the staff were approachable and behaved well while attending to clients. In addition, all the clients who sought healthcare services at a PPP facility were able to see a medical personnel to attend to them. . The clients added that the health workers were approachable,

calm, and always available even at night and humane. No client negatively commented on the behavior of the health workers. This study compared the behavior of the health workers in public facilities who were found to be very rude, frequently absent especially on weekends and night shifts, demanded for money (bribes) before being treated (MeTA, 2014).

#### **Time taken by a client to see a medical personnel**

| <b>Time spent</b> | <b>Frequency</b> | <b>Percentage</b> |
|-------------------|------------------|-------------------|
| 1-20 minutes      | 29               | 82.9              |
| 21-40 minutes     | 3                | 8.6               |
| 41-60 minutes     | 2                | 5.7               |
| More than 1 hour  | 1                | 2.9               |
| Total             | 35               | 100               |

#### **Source: Field data, 2017**

The response of medical personnel at PPP facilities was rated as quick. 29 (82.9%) of the clients who were interviewed in this study revealed that they took less than 20 minutes to see a medical personnel. 3 (8.6%) took between 21-40 minutes, 2 (5.7%) took between 41-60 minutes and only 1 (2.9%) took more than 60 minutes to see the medical personnel. This was an efficiency indicator as medical personnel try their level best to see the clients in time without waiting for long hours. This partly explains why patients preferred coming to PPP facility knowing that they would spend few minutes to be attended to.

#### **Clients' expectations in terms of attention from the medical personnel**

| <b>Attended to client's expectation</b> | <b>Frequency</b> | <b>Percentage</b> |
|-----------------------------------------|------------------|-------------------|
| Agree                                   | 27               | 77.1              |
| Disagree                                | 8                | 22.9              |
| Total                                   | 35               | 100               |

#### **Source: Field data, 2017**

Clients were in position to express their expectation from medical personnel's attention. 27 (77.1%) agreed having been attended to according to their expectations while only 8 (22.9%) disagree having been attended to by a medical personnel. The clients who agree having been attended to according to their expectation give area of expectation like taking a few minutes to see the first medical attendee, being given more time to be listened to, attended to with privacy, and accessing all the prescribed drugs.

### **Clients access to prescribed drugs at PPP health unit**

Clients were able to access drugs from the pharmacy of the PPP health facility, although at cost. The cost was differing depending on the type, amount of prescribed drugs and whether the health issue of the client was under the services supported in the partnership. Clients revealed that drugs were always available but the cost at times deters them from getting all prescribed drugs. All the clients revealed that the pharmacist at a PPP health facility explained to them how to use the drugs. All these factors contributed to their satisfaction level in accessing health services at a PPP facility.

#### **Access to drugs at PPP facility**

| <b>Client's access to drugs</b> | <b>Frequency</b> | <b>Percentage</b> |
|---------------------------------|------------------|-------------------|
| Yes                             | 32               | 91.4              |
| No                              | 3                | 8.6               |
| Total                           | 35               | 100               |

#### **Source: Field data, 2017**

32 (91.4%) of the clients revealed that drugs were accessible at PPP health facilities. Only 3 (8.6%) revealed not accessing all drugs they were prescribed. The reasons for not getting the drugs was that some drugs were expensive and were not under those drugs supplied under the partnership. Service quality dimensions that contributed to patients' satisfaction included availability of drugs, cost of treatment, physical structure, clean environment and adequacy of staff at some of the hospitals visited. The finding agree that satisfaction is more related to cleanliness of the facility, availability of drugs and equipment (Wondon, 2013).

#### **Clients accessing Laboratory services**

| <b>Clients receiving Lab service</b> | <b>Frequency</b> | <b>Percentage</b> |
|--------------------------------------|------------------|-------------------|
| Yes                                  | 27               | 77.1              |
| No                                   | 8                | 22.9              |
| Total                                | 35               | 100               |

#### **Source: Field data, 2017**

Majority of clients 27 (77.1%) have ever received laboratory services and expressed their satisfaction with laboratory services and only 8 (22.9%) have never been to the laboratory at a PP facility. The clients that had never received laboratory services included those who had come seeking services like immunization, hepatitis vaccination or came with results from another hospital/health facility.

| <b>Rating satisfaction with lab services</b> | <b>Frequency</b> | <b>Percentage</b> |
|----------------------------------------------|------------------|-------------------|
| Very satisfied                               | 18               | 66.7              |
| Satisfied                                    | 8                | 29.6              |
| Not satisfied                                | 1                | 3.7               |
| Total                                        | 35               | 100               |

**Source: Field data, 2017**

18 (66.7%) clients revealed that they were very satisfied, 8 (29.6%) were satisfied and 1 (3.7%) were not satisfied with laboratory services. Satisfaction of the clients with laboratory services depended on the attitude of the laboratory attendant, and the expectation of the clients. One client was not satisfied with laboratory services because of the delay of laboratory results.

**Clients' awareness of ambulance services**

| <b>Aware of Ambulance at PPP facility</b> | <b>Frequency</b> | <b>Percentage</b> |
|-------------------------------------------|------------------|-------------------|
| Yes                                       | 19               | 54.3              |
| No                                        | 16               | 45.7              |
| Total                                     | 35               | 100               |

**Source: Field data, 2017**

Clients' knowledge about the presence of ambulatory services was also explored. The aim was to ascertain if clients would be in the know using such services in case of an emergency. 19 (54.3%) were aware of the ambulance services while 16 (45.7%) were not aware of the ambulance services at a PPP facility.

In some of the health facilities, there were no ambulance services. Ambulances were only found at Holy Innocents Children's hospital and Mbarara Community hospital. At Ruharo mission, the Executive director lamented having no Ambulance. He added that the van they were using does not have the services like those of an ambulance.

Holy Innocents Children's hospital was found to have 3 ambulances, some of the ambulances were donated by the German friends of the Archbishop and another ambulance was donated by the ministry of health. Mbarara Community had one ambulance.

Nyamitanga health centre II has no ambulance and being at a lower level of healthcare provision, it realized no use of an ambulance. At this level of the facility, the ambulance is not a concern

since most of the services here involve less emergencies and clients in bad conditions are not accepted here as they are referred immediately.

Out of the 35 clients interviewed, only 1 had used an ambulance. The client was not charged any fee to use the ambulance. The study explored the reasons for not using the ambulance and found out that the clients would come to the health facility when they are still stronger and could easily use boda-bodas (motorcycles) or come in hired or owned cars to seek services.

However, there was a cost attached to use of ambulances, for instance at Holy Innocents Hospital a client who wished to use an ambulance met a cost of 30,000=USh. This cost applied to the town catchment and those beyond Mbarara town catchment incurred an extra cost depending on the distance and allowances for the driver and the nurse.

#### **Clients' awareness of a theatre at PPP facility**

| Clients' awareness and Existence of a theatre | Frequency | Percentage |
|-----------------------------------------------|-----------|------------|
| Yes                                           | 18        | 51.4       |
| No                                            | 17        | 48.6       |
| Total                                         | 35        | 100        |

#### **Source: Field data, 2017**

18 (51.4%) were aware of existence of a theatre its services while 17 (48.6%) were not aware of the theatre at all at PPP health facility. At Ruharo mission hospital where a functional theatre was recognized, clients were aware of it. All the clients interviewed knew about the existence of the theatre at this hospital. At Holy Innocents Children's' hospital, the theatre was under construction and had reached the completion stages. Some clients knew about it and others were not aware. Those who knew about its existence were those who have ever been admitted and in need of theatre services and were referred to other hospitals. In an interview with the hospital administrator, the theatre is likely start functioning in August 2017. Mbarara community hospital had a theatre, although patients knew little about its existence.

#### **Clients' use of theatre**

| Clients' use of the theatre | Frequency | Percentage |
|-----------------------------|-----------|------------|
| Yes                         | 6         | 17.1       |
| No                          | 29        | 82.9       |
| Total                       | 35        | 100        |

**Source: Field data, 2017**

The use of these theatres was explored by the research, it was rated low and only 6 (17.1%) had used the theatre services and the clients who had never used the theatre was 29 (82.9%) at these facilities. The client who have ever used these services were from Ruharo Mission hospital. Most the clients who had received operation services at this hospitals were eye related. This made the hospital more functional, active and popularly known for eye treatment. The eye department was busiest of all the departments at this hospital during the study.

**4.5.3 Clients in Inpatient department at PPP facility**

The study in this subsection gathered clients view about visiting inpatient department facilities either public or PPP. Areas explored here included days spent admitted, accessibility of medical personnel at night, cleanliness of the facilities used by clients IPD like urinals, wards, and space availability in wards.

**Clients' admission at a PPP health facility**

| <b>Admission at PPP facility</b> | <b>Frequency</b> | <b>Percentage</b> |
|----------------------------------|------------------|-------------------|
| Yes                              | 22               | 62.9              |
| No                               | 13               | 37.1              |
| Total                            | 35               | 100               |

**Source: Field data, 2017**

22 (62.9%) patients revealed having been admitted while 13 (37.1%) had never been admitted at one of the PPP facility. Although the study did not go further to ask the number of times a client had been admitted, the number of days spent in the hospital were of interest in this study.

Number of days spend in the hospital the last time of admission.

**Days spent admitted at PPP facility****One-Sample Statistics**

|                                              | <b>N</b> | <b>Mean</b> | <b>Std. Deviation</b> | <b>Std. Error</b> |
|----------------------------------------------|----------|-------------|-----------------------|-------------------|
| How many days did you spend to be discharged | 18       | 3.50        | 1.618                 | .381              |

**Source: Field data, 2017**

These statistics applied to those who already the expected date of discharge. Out of 22 clients who have ever been admitted at one of the PPP hospital, only 18 knew the days they were likely or had spent admitted at the health facility. Others did not know the date they are likely to be discharged.

### One-Sample Test

|                                                 | Test Value = 0 |    |                 |                           |                                              |       |
|-------------------------------------------------|----------------|----|-----------------|---------------------------|----------------------------------------------|-------|
|                                                 | T              | Df | Sig.<br>tailed) | (2-<br>Mean<br>Difference | 95% Confidence Interval of<br>the Difference |       |
|                                                 |                |    |                 |                           | Lower                                        | Upper |
| How many days did you<br>spend to be discharged | 9.178          | 17 | .000            | 3.500                     | 2.70                                         | 4.30  |

#### Source: Field data, 2017

From the statistics in the above table, the mean days spent by clients in the hospital (IPD) was 3.5 days, with the lowest range being 2.7days and the highest being 4.3 days. The few days spent on admission were a result of endless care given to clients including checking on them at night. This was not a common practice in public facilities leading to longer stay admitted in a public facility. This also contribution to clients' satisfaction with services offered at PPP facilities.

#### Accessing medical personnel at night

| Medical personnel availability at night | Frequency | Percentage |
|-----------------------------------------|-----------|------------|
| Yes                                     | 20        | 90.9       |
| No                                      | 2         | 9.9        |
| Total                                   | 22        | 100        |

#### Source: Field data, 2017

At PPP facility where the clients were admitted, the health workers were coming around to check on patients, giving them late night doses where applicable. 20 (90.9%) revealed having seen the medical personnel at night while 2 (9.9%) responded having not seen these personnel at night. The clients who have been admitted before and during data collection expressed their satisfaction with the work of health workers as they checked on them more often. For example at Holy Innocents Children's hospital, every section in the ward has a desk for medical personnel and they are always present all the time. This research found out that 2 medical personnel are placed here to take care of clients and remind them of their timely doses. This enabled admitted clients to take their medicine in time and appropriately with the advice and help of a health worker. The committed personnel are replaced at night with another team of committed personnel who comes to continue providing care. Cases of absenteeism were not common and were not heard of from all the 4 facilities visited as it is a trend in public health facilities. Absenteeism in public facilities is a response by workers to deal with a problem of inadequate pay (Bariyo, 2004). This practice has become common in Uganda especially among public servants (Pearson, 2009). In urban setting

among the public health workers, work is divided and time for own clinic is created (Berman and Cuizon, 2004). In a study by Bariyo (2012), health workers in south western Uganda frequently absentee themselves from duty for example in Ntungamo district absenteeism stood at 55% and in Bushenyi it was estimated at 50%. At Mbarara regional referral hospital, it was the most highly reported case of indiscipline among the nurses and midwives in the financial years 2006/2007, 2007/2008 and 2008/2009. It was further noted that 75% of the private clinics in Mbarara municipality were owned by public health workers most of whom work at Mbarara Regional Referral Hospital (Bariyo, 2012).

#### **Cleanliness at PPP health facilities**

| <b>Rating cleanliness</b> |    |      |
|---------------------------|----|------|
| Very clean                | 24 | 92.3 |
| Clean                     | 2  | 7.7  |
| Total                     | 26 | 100  |

**Source: Field data, 2017**

Clients appreciated the effort of the health workers in ensuring cleanliness of these facilities. 24 (92.3%) revealed that the facilities were very clean while 2 (7.7%) revealed to the study that the facilities were clean. The areas of interest in terms of cleanliness were wards, toilets and urinals, compounds, laboratories and pharmacies. The researcher also used the observation checklist to document the level of cleanliness at PPP facilities based on the mentioned areas around the facility. These facilities had dustbins where to throw any waste material. Cleanliness was a key aspect that contributed to satisfaction of clients with the health services offered at PPP health facilities. The clients expressed that receiving services from a clean premises restored their hope of getting healed quickly and reduced chances of contracting other diseases.

#### **Space availability in wards**

| <b>Bed spacing at PPP facilities</b> | <b>Frequency</b> | <b>Percentage</b> |
|--------------------------------------|------------------|-------------------|
| Not crowded                          | 23               | 88.5              |
| Crowded                              | 3                | 11.5              |
| Total                                | 26               | 100               |

**Source: Field data, 2017**

In the ward, beds were well spaced and clients compare the situation of wards in public health facilities where clients reach an extent of sleeping on the floor including occupying spaces in

corridors. 23 (88.5%) revealed to the study that the bed were not crowded at all while 3 (11.5%) reported that the beds were crowded a bit. The level of crowding was minimal, and would happen when many clients are admitted in the facility. The wards according to the researcher's observation were constructed in a way that made clients feel comfortable as they accommodate an average of 15 patients which is not a very big number and none patient was found sleeping on the floor. The comfort that found in the wards was a significant contributor towards clients' satisfaction. The situation in IPD at PPP facilities greatly varied with how IPD in public facilities were. For example, at Kawolo hospital in Buikwe district the hospital has been revamped to accommodate the overwhelming number because the hospital that was opened in 1968 with a capacity of 100 beds today (2017) receives between 250 and 300 patients daily. It should be noted that patients sleep on the floor because of the number of those who turn up daily seeking healthcare (The New Vision, Friday, March 13, 2017). Another study by Bariyo (2012) documented that majority poor people cannot afford to pay for expensive healthcare provided by private providers hence many end up in public health facilities. This leads to big numbers of patients waiting for long hours at OPD and patients who are admitted usually struggle for limited space available in the hospitals and other public health units which leaves patients who no option other than sleeping on congested floors (Bariyo, 2012).

#### **Cleanliness of Urinals and toilets/latrines at PPP facilities**

| <b>Rating cleanliness of toilets and urinals</b> | <b>Frequency</b> | <b>Percentage</b> |
|--------------------------------------------------|------------------|-------------------|
| Strongly agree                                   | 24               | 68.6              |
| Agree                                            | 4                | 11.4              |
| Neutral                                          | 1                | 2.9               |
| Missing response                                 | 6                | 17.1              |
| Total                                            | 35               | 100               |

#### **Source: Field data, 2017**

As clients seek healthcare services from facilities, they at times use urinals and toilets/latrines, these places determined the level satisfaction of the clients with the services they receive at PPP health facilities. 24 (68.6%) strongly agreed that these places are ever clean while 4 (11.4%) agreed that the places are always clean and only 1 (2.9%) was not sure and remained neutral about cleanliness of these places at PPP facilities. The 17.1% with missing response were those who had never visited such places and had no idea about cleanliness of these places.

Availability of water in these places and for general purposes like washing was also found to be a key determinant of satisfaction of friends visiting health facilities. The clients expresses that water

was always available although there were cases when it would go. Interestingly was that even when it would go, it would not take long to flow again. It always took between 10-20 minutes.

#### 4.5.4 Opinion on limiting factors, next visit preference and value for money at PPP facility

##### Limiting factor towards healthcare improvement at PPP facilities

| Factor                                                | Frequency | Percentage |
|-------------------------------------------------------|-----------|------------|
| Long waiting hours to get services                    | 1         | 2.9        |
| Low levels of staffing                                | 1         | 2.9        |
| Charging a lot of money                               | 12        | 34.3       |
| Everything was okay, very satisfied with the services | 21        | 60         |
| Total                                                 | 35        | 100        |

##### Source: Field data, 2017

Opinions were generated by the research about factors limiting access to improved healthcare delivery at PPP facilities where the study was conducted. These opinions included; uncaring, rude, lazy staff; long hours of waiting to get services; low levels of staffing; charging a lot of money; poor/communication and information gap; personal opinion not listed in the above and everything being okay, client very satisfied with all the services.

From the table above, 21 (60%) of the clients revealed that the study that everything was okay and were very satisfied with services delivered, 12 (34.3%) raised a concern of the money charged was high, 1 (2.9%) was in agreement that long waiting hours and 1 (2.9%) revealed that low levels of staffing hindered improvement in healthcare delivery at PPP facilities. From the data collected from the field, this specifically applied health centre level where patients waited for long hours because of few health workers at this facility. Although patients were always few in numbers, service delivery would delay at every point of service.

12 (34.3%) that raised a concern of the money charged by PPP health facilities was high stemmed from Ruharo mission hospital where clients paid a lot of money to have their eyes operated. The package for eye operated was specific, non-negotiable that is 230,000/= for one eye and 350,000/= for both eyes. In a society where poverty is endemic, sickness makes poor households more vulnerable and this leaves such households with few alternatives apart from selling off some of the assets they have to seek medical treatment or go to poor public health facilities (Girard *et al.*, 207). The study noted that such services were not in the partnership arrangement, this explains why cost for such a service was higher. This was found to be expensive for clients who sought

services at this hospital. This was also a case with services that were not supported in the partnership. Although some services were indirectly accessed at a lower cost due to partnerships, to some of the services this never applied.

#### **Client's preference for next visit**

| <b>Type of facility</b> | <b>Frequency</b> | <b>Percentage</b> |
|-------------------------|------------------|-------------------|
| Public facility         | 1                | 2.9               |
| PPP facility            | 34               | 97.1              |
| Total                   | 35               | 100               |

#### **Source: Field data, 2017**

To ascertain satisfaction of clients with services at PPP facilities, the study further inquired about the next visit preference of clients in case of a health problem. Only 1 (2.9%) expressed visit a public health facility and 34 (97.1%) said that they would come back to PPP health facility. The 2.9% gave reasons of convenience, and a public health facility being near her home. The client was a resident of a district, far from Mbarara where access to services that she was seeking from a PPP hospital could not be accessed in client's home district.

97.1% gave reasons like getting adequate attention from the health workers at a PPP health unit compared to a public health unit, spending less time to get high quality health care and above all spending comparably less compared to when they go to entirely private facilities. The findings concur with a study by Cheraghi et al (2008) found out that healthcare quality dimension influences patients' choice of hospital to visit the next time a patient gets a health problem. Findings indicated that no patient opted to visit a private For Profit (PFP) health facility according to the study results. Cheraghi (2008), asserts that cost of healthcare influences the choice of clients. Bearing in mind that the cost of health care in PFP facilities are higher compared to PPP which are referred to as PNFP. The findings also agree with a study by MeTA (2014) which pointed out that patients were asked for bribes at a public health facility to access healthcare services before they could be attended to. The payment process in PPP (PNFP) facilities was clear with no bribes as evidenced by receipt issued after making a payment for the services received by the patient unlike un receipted bribes at public facilities. This made the patients prefer the PPP compared to both public and PFP health facilities.

#### **Clients' Value for money aspect**

The study went ahead to value the cost of healthcare at PPP facilities using clients' opinion. The study tried to equate the fee paid by the client and the receive services. Very many aspects were

considered including drugs receive, attention from the medical personnel, cleanliness and facility infrastructure among others.

#### **Equating amount paid with the services received**

| <b>Response</b> | <b>Frequency</b> | <b>Percentage</b> |
|-----------------|------------------|-------------------|
| Strongly agree  | 15               | 42.9              |
| Disagree        | 9                | 25.7              |
| Undecided       | 11               | 31.4              |
| Total           | 35               | 100               |

#### **Source: Field data, 2017**

Clients seeking services from PPP health facilities incur some costs, directly to the health facility. The value for money is a key measure and aspect of clients' satisfaction with the services. In this regard, 15 (42.9%) of the clients strongly agreed that the services they received matched the money paid at PPP health facility, while only 9 (25.7%) agreed. 11 (31.4%) of the clients were undecided with the services received vis-a-vis the cost incurred to access the services at PPP facility. Decision to remain undecided depended on the time taken by the client to recover from the illness. Since some clients were receiving services for the first time from these health units and therefore they were not sure if the medication given was appropriate and if they would recover soon. Others who received services that do not guarantee quick improvement in health conditions also remained undecided for example those that were operated. Much as majority of the clients strongly agreed that the amount paid match the services offered, it not clear on who regulates the amount to be paid; whether the principal or the agent. The noted with concern that there is low supervision support from the principal and this may clients at the risk of being cheated by the agent since the clients lack information about service delivery and the costs involved.

### **4.6 Strategies to improve beneficiaries' satisfaction levels in PPP facilities**

The study in this objective tried to ascertain the different measures put in place to respond to some of the challenges faced by these health facilities. The study highlighted the challenges before exploring the strategies to improve beneficiaries' level of satisfaction in PPP health facilities

#### **4.6.1 Challenges faced by the PPP health facilities**

From the study, it is evident that these health facilities are not adequately financed. In this view, the study analysed the budgets of these facilities and compared the budget with the funding that the facilities get from a partnership.

### PHC funding received by hospitals under PPP

| Facility                           | Amount of PHC fund annually | Annual budget |
|------------------------------------|-----------------------------|---------------|
| Ruharo Mission Hospital            | 62Million                   | 5Billion      |
| Holy Innocents Children's Hospital | 37Million                   | 2Billion      |
| Mbarara Community Hospital         | Withdrawn                   | Not revealed  |

**Source; Field data, 2017**

For instance, at Holy Innocents Children Hospital, the hospital gets only 37Million support from the government annually compared to the 87Million monthly budget, comparably this is less support to enable the hospital deliver and improve health care and increase clients' satisfaction. Ruharo mission hospital receives only 62Million annually from the government inform of PHC support. This PHC support compared to the 2Billion and 5Billion annual budget for these hospital respectively was a peanut. Comparing the government support given to public facilities, it is evident that these PPP facilities are underfunded. For example in this financial year (2017/2018), Mbarara regional referral hospital was allocated 6.219 billion, Naguru hospital 6.293 billion and Gulu hospital 5.466 billion (The Daily Monitor, Thursday, April 20 2017, pg.6). The PPP facilities have been crippled and this has affected service delivery with such funding that cannot sustain them for one month.

Mbarara Community hospital's PHC support was withdrawn. Last year the hospital did not get support from the government which an official in the DHO described as "an accident". The reason for withholding the support for this facility was not explained and lacked proper explanation. The hospital has continued to deliver the expected services with the promise to re-instate the support in this financial year. Although the hospital has continued to deliver most of the services as agreed in the partnership, it has found it difficult to continue with outreach programs as earlier planned for this year and last year. This is a clear evidence that the health sector is underfunded. For instance in the financial year 2017/2018, out of 28.9 trillion, only 1.8 trillion was allocated to the health sector compared to other sectors like works and transport which took a lion's share of 4.6 trillion, education 2.4 trillion and energy 2.3 trillion (The New Vision, Thursday, June 1, 2017). Health sector underfunding has greatly affected the performance of public health facilities for example in Arua hospital, high cases of maternal mortality have been

documented. According to the hospital Director Bernard Odwe in the financial year 2014/2016 15 mothers died during child birth, in 2015/2016 26 mothers died and in 2016/2017 11 mothers had died in the last 9 months (The New Vision, May 3, 2017). Among the factors that contributed to high maternal mortality were inadequate funding and human resource (The New Vision, May 3, 2017). Whereas this is more evident in public facilities, the private facilities is not an exception as Mbarara community hospital is a clear example of this form of underfunding in PPP arrangement. This has greatly crippled the hospital's performance in terms of client expectations.

The health facilities operate as private entities. They find it difficult to change people's perception that private health facilities under partnership are not as expensive as they assume. It should be noted that from the study that clients expressed their fear that they don't have enough money to pay in private hospitals which they tended to assume that facilities are operating like entirely private hospitals. The clients who visited these facilities for the first time were surprised when they checked their bills and found it relatively affordable for example at Holy Innocents' Children Hospital it was at 12,000 shillings. These results are a replica of what patients experienced as they visited public health facilities near Katosi landing site. Most of the patients found no drugs and end up buying from drug shops. Most of the residents at this landing site are poor and end up buying half a dose since can't afford buying a full dosage of medicine. According to Coalition for Health Promotion (HEPS), it is dangerous for a patient to take half a dose (The New Vision, Monday, May 1, 2017, pg.15). The resident revealed that the private outlets which offer quality services are too expensive and that is why the residents end up buying half the dosage of medicine (Ibid).

The study found out that some PPP facilities offer credit based health services. For example at Ruharo mission hospital, some clergy and other trusted clients are given credit to access health services and collecting payment from those who get such services on credit hardly pay back. The hospital management faces challenges in collecting the debts since most of the people who get health services on credit are "*their own*". The executive director expressed a concern that such people cripple the hospital more in addition to the less funding from user fees and the government.

*"We offer credit facilities to some clients but paying is not easy. People who default are not tracked on record. The church people, closer to the church get services and don't pay although others respond positively. This makes the hospital a bit inefficient in delivering to patients' expectations"* (Field data: Key informant, 2017)

The study found out that health facilities lacked fully fledged theatres to handle complicated cases. These health facilities refer patients to other hospitals in case they can't handle the cases. These facilities expressed their willingness to reduce referral cases, to be recognized as significant contributors to the healthcare system, reducing such cases is their desire. In Holy Innocents hospital, the theatre was non-functional and incomplete, it has not started operating. The case was not different from Mbarara Community where the theatre lacked most of the machines to treat clients who come to this hospital seeking health services. The findings are in agreement with health demographic survey report 2016 that reported that skilled birth attendants stand at 74% up from 58% and 26% mothers are still delivering in the hands of traditional birth attendants (The New Vision, Friday, May 12, 2017 pg.13). To scale up the skilled birth attendance there is a need to fully staff these facilities, with the required number of midwives at these facilities and improving the facilities like theatres and adequate space in the maternity wards.

From the study, only 2 PPP facilities out of 4 had ambulances. Holy Innocents Children's hospital and Mbarara Community hospital has ambulances. Holy Innocents had 3 ambulances while Mbarara Community had 1 ambulance. Clients' use of ambulance services was low and only one client had used the ambulance out of 35 clients who were interviewed. Ruharo mission had no ambulance but was using a van to transport clients who needed ambulatory services. A key respondent from Ruharo mission expressed how having a van never helped them as an ambulance would do.

*"We only use a van, which is not an ambulance. A van is not equipped like an ambulance to handle emergencies, no provision for treatment, no oxygen facilities. We risk losing lives without an ambulance"* (Field data, 2017).

The findings relate to factors that hamper effective and quality service provision in public facilities among which there is lack of an ambulance, inadequate staff accommodation, lack of post-natal ward, and interrupted water supply (The New Vision, Monday June 19, 2017 pg.19).

Nyamitanga health centre II had no ambulances because at its level it is not expected to have an ambulance since it does not handle emergencies and complicated cases.

Cultural aspects from different community members. These facilities were concerned with cultural beliefs and associating these beliefs to diseases for example false teeth "*ebyiino*"-local name, false

millet “*obuuro*”-local name among others which give health workers hard time to explain to the less educated clients to understand them.

The PPP health facilities complained of low staffing levels. For example at Holy Innocent Hospital, the number of health workers was established at 65 members (those involved in direct provision of services to clients) making the ratio of 1:10. The hospital revealed it plan to reduce this ratio from 1:10 to 1:5 to improve health care delivery and increase clients’ satisfaction. This would require extra 30 clinical staff at this hospital. According to 2016 demographic health survey report, maternal mortality reduced from 506 death in 2001 to 336 death per 100,000 live birth in 2016. Midwives at Mulago hospital decried the lack of proper and inadequate housing, poor pay and limited number of midwives yet deliveries are many at public health facilities (The New Vision, Monday, May 8, 2017, pg.8). At Nyamitanga health centre II, one of the health workers handed over tools of work after two days of data collection, although the reasons for leaving were unclear, health worker complained of not being formally appointed, was not fully aware of his duty after 3 months of work. This left the health centre with only 2 health workers.

*“If we could get more support from the government, we would be in position to increase on the number of our staff and improve the quality of health services to the communities surrounding us”* (Field data: Key informant, 2017).

Some clients are assessed to be unable to access some services. The study found out that some clients are poor and cannot afford the cost of services offered by these PPP health facilities. These cases were common with services that are not supported under the partnership. This at times makes clients feel that these facilities are not offering the best services even when it’s not the case.

*“Healthcare is expensive, not easy to break even. You can’t increase the medication fees because people are generally poor”* (Field data: Key informant, 2017)

Since these facilities operate as Private Not for Profit (PNF), they have been in position benefit much from volunteers and international donors. The study found out that there were few volunteers willing to provide charity to these health facilities. This makes it more difficult for clients from less privileged families to access the desired healthcare from these hospital since they cannot afford the cost of health care offered at these health facilities. This was common with the healthcare services not supported under the partnership for example surgery, cancer treatment among others. Charities and international donors have not only helped PPP facilities in Mbarara, 2,000 residents

in Omoro county received free treatment through a medical outreach sponsored by Rotarian and Rotaract clubs in Kampala, Naguru, Bukoto and Gulu, services offered included general clinic, malaria treatment, laboratory services, pharmacy, ear, nose throat, eye clinic, dental services and blood donations (The New Vision, Monday, May 1, 2017, pg.15).

Some diseases or ailments required clients to spend many days admitted (more than the average 3 days) in the hospital. This increased the cost of maintenance while in the hospital in addition to the cost of seeking healthcare in a relatively low-cost private setting. The clients expressed spending many days, more than 3 average days as per the study finding. A health worker responded to this anomaly and explained. The health worker is quoted:

*“At times clients spend many days admitted to put them in a situation of getting specific healthcare package he/she has not been ready for previously. A client who is severely ill and requires an operation, he/she is admitted and advised on what to feed on to get ready for an operation. Getting such a patient to other patients who have passed through the same kind of treatment makes him/her ready and prepared to receive the treatment. Patients who come seeking treatment that require operation of both eyes stay longer admitted in the hospital. It is not possible to operate both eyes at the same time, one eye is operated, left to heal a bit then another eye can be operated thereafter”* (Field data, 2017).

In some cases clients spend long days more than 3 days as they waiting for specific days. For instance clients seeking eye operation services at Ruharo hospital may spend more days depending on the day of admission. Operation services are available only on Tuesday of every week and this means that a patient admitted on Wednesday had to wait until next week on Tuesday for an operation.

Good political will is lacking towards PPP. Political leaders have played insignificant role in changing the health situation. They have not advocated for health care system strengthening and this hinders the performance of PPP in the municipality. In some circumstances political figures influence and sabotage such partnership including government programs even in public facilities as noted by Bariyo (2012). This is a challenge posed by the principal-agent relationship where most influential politicians may sabotage the program as they assume superiority and belonging to the principal's side. This influence can deter donors from supporting certain projects leading

confrontational discussions and critical reviews leading to reduction in donor funding (Ortendahl, 2007; cited in Bariyo, 2012).

There are inconsistencies in funding health facilities under the partnership. A case in point is the withdrawal of funds for Mbarara Community hospital. The circumstance leading to withdrawal of funds was not explained, and this has hindered the hospital in delivering health care. Although the hospital did not receive PHC fund last year, it has continued delivered the prescribed services as clearly defined in the partnership. In addition, the hospital experience lack of data tools for example files and registers. Inconsistencies in health sector funding are partly a result of lack of political will and corruption. For example, the Global Alliance for Vaccines and immunization fund worth 1.6 billion was embezzled by three ministers in the ministry of health and up to now, they have never refunded that money and there is no hope for these former ministers to do so. They were arrested and temporarily imprisoned and no follow up has been done on recovering the funds. The funds were meant to benefit the poor and ended up in the hands of corrupt rich politicians and officials (Bariyo, 2012). Therefore one wonders where the funds that were meant for Mbarara community hospital ended and in any case whether there will be a refund for this money since the facility continued to deliver some of the health packages under the partnership without funding from the government as it used to be. Inconsistencies in health sector funding will remain until the country implements the Abuja declaration of 2001 which suggested that African countries should allocate 15% of their national budget to the health sector excluding donor contributions (Pearson, 2007). Up to today, Uganda has not funded the health sector to this tune of 15% for example, in the financial year 2009/2010 Uganda allocated only 10% of the national budget to the health sector, in financial year 2015/2016 only 6.9% was allocated to the health sector and in this financial year (2017/2018) only 6.3% of the national budget has been allocated to the health sector (Bariyo, 2012 and The Daily Monitor Sept 23 2009; MFPED, 2015; The New Vision, Friday, June 19, 2017, pg.8). This clearly shows that Uganda is far below the target and cannot solve the health sector challenges with such a funding strategy where the budget allocated are decreased after every financial year.

Staff accommodation was found a challenge to health workers. In all the facilities visited, health workers expressed trekking long distances coming to work. In a health facility setting where working at night was unavoidable, those working night shifts found it hard to commute at night. On average, less than 5 staffs at every hospital visited were given accommodation. This

compromised their ability to perform efficiently. These findings indicate that the situation in PPP facilities is not very different from what is happening in public facilities. For example, in Tororo counties, a visit by legislators Annet Nyaketcho and Frederick Angura to Mukuju health centre IV to ascertain level of service delivery and understanding challenges that hamper effective and quality service provision found out that inadequate staff accommodation was one of the challenges (The New Vision, Monday June 19, 2017 pg.19). Other challenges that hinder service delivery at this facility included weak door of the medical store which pose a big risk to drugs, limited space for OPD, lack of post-natal ward, weak door locks on most doors, lack of an ambulance, broken down solar system and interrupted water supply (The New Vision, Monday June 19, 2017 pg.19).

#### **4.6.2 Strategies to improve patients' satisfaction receiving healthcare in PPP health facilities**

From the study findings, PPP health facilities have put and are putting in place various mechanisms to ensure improvement in patients' satisfaction receiving health care in these facilities.

The health facilities have deeply engaged in community outreaches to extend services closer to their clients. Community outreaches waived of transport costs for clients and these outreaches were based on national data for instance the prevalence of HIV made such facilities participate in community outreaches to reduce on the crisis and increase the coverage of service provision. Outreaches were also based on service demand. For instance nutritional services, local leaders influence and churches and communities. This is one of the strategies that have kept the PPP stronger and ranked averagely higher in terms of client satisfaction.

The PPP facilities have ensured close supervision of staff. In Holy Innocents Children's and Ruharo mission hospitals, the wards have a health workers' desk, where at least 2 health workers are always available on the desk. This increased the chances of health workers' availability to attend to patients even during night hours. One aspect of clients' satisfaction was attending to patients fully even during night hours.

In addition, the departments have heads who are responsible for overall supervision of the staff under their respective departments. These heads report to the medical superintendent or the executive director. This has made the departments more active in terms of supervision. Interestingly, the study found out that absenteeism levels were lower, than in public health facilities. The clients supported the view that these health workers were always available, this reducing the time spent by the clients to be attended to by the first health worker (medical

consultation). 82.9% of the clients revealed having spent less than 20 minutes to seek the first health worker. This contributed towards high satisfaction levels among clients seeking healthcare services in these health facilities.

The health facilities compile reports weekly, monthly and quarterly to compare performance levels. This has made it easy to identify gaps in terms of performance and informs the health facilities on the best strategy to improve on service delivery. These reports avails data for district health office and national health statistics (MoH) in identifying appropriate interventions to respond to health crisis.

*“At least every quarter, a team from district or ministry of health to see what we do. We also do much communication on phone regarding service delivery although this is informal”* (Field data, 2017).

This kind of supervision has made it possible for health care delivery improvement in these health facilities.

These facilities are involved in various programs for instance at Mbarara community hospital, Marie Stops runs a baby program. This program extends services closer to the villages and at times receive clients from the villages and take them by surprise with relevant services. This has helped the clients to keep their date of appointment and has made the hospitals to retain their clients in the care system. This has built a relationship and strong collaboration with various health care partners.

Cost of healthcare services in these facilities have been kept fairly low. For clients seeking HIV care, they were charged a fair cost of 20,000/= consultation fee and the clients receive the subsequent services free. However the same fee is met for re-evaluation visit. The study found out that clients without money or can't afford the cost of seeking healthcare are not neglected without being attended to.

*“Clients who can't afford the cost at the time of visiting the facility cant exit without care, for example, they are enrolled, preliminary treatment done, then given time to reorganize and come back well prepared to receive more care”* (Field data, 2017).

*“Other services apart from immunization have a cost attached, if one walks in this facility he/she has to pay consultation fees. It is cheaper compared to when one goes to entirely private facility”* (Field data, 2017).

Previously, these facilities had programs of visiting less privileged people. These programs would enable clients from poor backgrounds to access healthcare and at free cost. At Mbarara Community hospital the programs supported free services through various partnerships by providing free medical cover to assessed clients.

*“Under these programs, one person who is assessed unprivileged would get a medical cover. There is an old man (Mzeei) enrolled on free medical cover of whatever disease. He gets free cancer, HIV screening and other services when he needs them”* (Field data, 2017).

In addition, at Ruharo mission hospital a budget 46Million is set aside to cater for clients who are unable to meet the cost of seeking healthcare in this hospital. This budget also caters for outreach programs including extending free services closer to communities. Some activities under this initiative were conducted in 2016. Free services were given to people during a health camp in Kashari, Ibanda among other places. During this exercise more than 500 people received hearing gadgets. The hospital also participates in health camps organized by different organizations.

Rationalizing staff, utilities and checking on expenses. The source of pride for these health facilities was found to be their human resource. For example in Ruharo mission hospital, human resource was treasured most and valued all the time. Considering the rate of turnover, the hospital management decided to pay staff salaries on every 22<sup>nd</sup> of every month. This has motivated the workers, kept them confident and assured of their salary before they can starve. This had indirectly contributed to client satisfaction as health workers are always available, thus reduced rate of absenteeism.

Internal quality improvement meetings are held at departmental level to discuss matters including quality service improvement. These meeting are often attended by a top administrator to note key issues that need immediate attention. These meetings help in identifying the gaps in service delivery as well as suggesting possible solutions to the gap. In addition meetings and workshops are organized at district and ministry level of which staff are invited to attend and share experience of what takes places in their facilities.

Maintaining the quality of service is what has made these health facilities stand a test of time. As earlier noted in the above paragraph, meeting at different levels of health care management take place to evaluate quality of services delivered. Again, quality of service provision is mandate of the district health office. Supervision is done by the DHO's office and gives feedback to the respective health facilities. On the other hand, patients have a direct hotline to communicate with the healthcare providers and giving them feedback on service quality. Although two out of four health facilities visited conducted bi-annual evaluation of their services through client-exit interviews, others were not active in this activity.

In addition, JMS, medical access, National medical stores and MoH supervise the medicines delivered to these health facilities and offers them registration books to keep track of the drugs. Although this was found to be manual. It has worked well for these health facilities. This has partly contributed to improved patients' satisfaction based on the aspect of medicine availability.

Continuous planning: These health facilities have continued to plan ahead of time. They forecast the health facility needs and plan ahead, for instance at Holy Innocents Children's Hospital, considering the increasing need for the clients to use theatre services, the hospital has constructed the theatre and will be operational before end of June 2017. In all the health facilities visited, the hospital management has been key in securing supplies from JMS, medical access before the medicines run out of stock. For the drugs that are not supplied by the mentioned suppliers, the health facilities under PPP plan to buy the drugs when they realize the stock levels are going low, considering the forecasted population to be served in future.

Due to limited number of staff, the available staff are divided leave offs. On average each staff gets two days off every month to make the staff relax a bit and enjoy some holiday. The study found out that the load of the health workers was a lot yet staffing levels were very low. In Ruharo Mission hospital, a full time position was advertised to fill the gap in medical personnel.

## **CHAPTER FIVE**

### **CONCLUSION AND RECOMMENDATIONS**

#### **5.0 Introduction**

This chapter based on the findings made the following conclusions and recommendations. The recommendations are key for PPP stakeholders and in particular the healthcare providers, district health office, MoH, donors and clients who seek healthcare services from these facilities.

#### **5.1 Conclusions**

Public-Private Partnerships in health are making a difference. No doubt that clients appreciate the good work done by the PPP in healthcare delivery mainly focusing on illnesses like HIV/AIDS treatment, immunization, malaria among others which had been a burden with only government facilities engaged in provision of healthcare services in low developed countries like Uganda. The health facilities that have been constructed by individuals/ faith based organizations like churches have been transformed into life-saving facilities for the general public since every person who that walks in gets services provided in both PPP and non-PPP arrangement at a free and subsidized cost.

PPPs have popularized the facilities with outstanding performance in healthcare delivery. Their popularity has come up with numerous benefits including building external links with donors, especially the PPP facilities at hospital level. From the findings, the hospitals with outstanding performance in PPP are Ruharo and Holy Innocents. These have been able to solicit funding from donors for instance Holy Innocents has been able to attract funding from German, Ireland (donation of ambulances) among others. The trust of these facilities has also strengthened their internal link, firstly, the clients liking them and being attracted to the care they provide. From the finding, 97.1% of the clients revealed that the next visit they would return to a PPP health facility. This shows a bigger contributions by PPPs in health the sector.

The PPPs have used both internal and external links to improve patient satisfaction. Through internal links, the Ministry of Health through its agencies like Joint Medical Stores (JMS), medical access, National Medical Stores (NMS) have constantly supplied these facilities with drugs and vaccines. Health facilities that had functional theatre are able to provide a wide range of services, which included operation, although it is not in the PPP arrangement. The study found out that operation services are very expensive for instance operation for one eye was fixed at 230,000/= and 350,000/=

for both eyes. This partly explains less funding channeled to these facilities to deliver healthcare as much of the funds to run the facility are internally generated, PHC gives 62M to Ruharo hospital and 37M to Holy Innocents hospital while the funds for Mbarara community hospital were not released this financial year.

**Contribution to body of Knowledge:** This research contributes to the body of knowledge by engaging in the debate of healthcare system challenges, and highlights opportunities and approaches that could be useful to tackle the challenges. If these approached are sustained overtime, in addition to more funding, monitoring the quality of services offered could help the health sector improve. This study highlights partnerships as being key in the healthcare system by revealing the number of people that visit these facilities, which would end up in some other places seeking same services but would not get same satisfaction. Compared to the studies done in public facilities, the satisfaction levels in Public-Private Partnerships was found to be higher. The study identified gaps and inconsistencies in funding partnerships which other studies have not identified. The study adds knowledge on the role of monitoring and evaluation in any service delivery system.

The study highlights the need to work together (public and private). The way these work determines clients' satisfaction in the healthcare system, the study also highlight a need to reduce bureaucracies and inconsistencies in funding these partnerships to make them more effective and efficient in delivering services to clients.

## **5.2 Recommendations**

PHC support fund should be increased through lobbying the government to match the number of clients seeking healthcare services from these PPP facilities. From the findings, the funds given to PPP health facilities cannot run the facility for one month, yet the clients who walk in these facilities at times find workers overwhelmed as health workers are few, compared to clients who visit these facilities. Mbarara Community Hospital (MCH) whose PHC fund was not released in the financial year 2016/2017, the study recommends that it should be re-instated in financial year 2017/2018 to make the facility more efficient and it would be better, if the fund is doubled because MCH has continued to deliver services are per PPP arrangement. It has been rendering services under PPP arrangement even without funding meaning that with funds the facility would be more efficient.

The study also recommends that continuous monitoring and evaluation of the impact of PPP should be documented to track its efficiency and keep updating its implementation. This should be done

through continuous supervision by DHO's office and from the centre (MoH). Changes are obvious, and without documentation, a lot can go wrong. To make PPP benefit the health sector and not become victims like the public health facilities proper supervision on drug delivery and distributions at PPP have to be ensured. Through health registers, documentation is important as it contributes to overall national statistics and this should be emphasized as one of the monitoring tools. The records could be used to lobby for more funding from the government and donors. Clients should be involved as stakeholders in the planning process and funding for these facilities since they are key contributors especially raising revenue through user fees. The user fees are not regulated, this is a challenge to clients as some may be over charged unknowingly.

The Holy Innocents Children's hospital is a referral centre for pediatric cases in the western region. The study recommends that the government should support the completion and ensure functioning of the theatre at Holy Innocents Children's hospital and to enable it handle many cases than relying on referrals to CURE hospital.

Apart from the PHC fund, the facilities should tap funds from donors and organizing functions like marathon to boost their infrastructure. For instance, health workers did not have accommodation at the health facilities. Accommodation of health workers is vital for healthcare improvement and increasing satisfaction of clients seeking health care in these facilities. To ensure continued service delivery at PPP facilities, funds should be set aside to help these facilities have housing for their staff to enable them function more efficiently since majority work at night. Funds to support other services apart from HIV/AIDS, malaria, immunization that are currently being supported should be allocated to ease access to health services.

### **5.3 Areas for Further Research**

Upon completion of this research, three areas for further research were identified. The areas of research include: The effectiveness of donors funded projects in the health sector. Documentation, disbursement and accountability of funds in the private health sector setting. The other area for further research is Role of Faith based health facilities in Extending health services to communities. These areas of research will finally contribute wellbeing of the health sector.

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## Appendices

### Questionnaire for Clients

My Name is Justus Asasira (2014/MAs/187/PS), a Masters of Arts student at Mbarara University of Science and Technology. I am conducting a research study titled “Public-Private Partnership and Healthcare Delivery in Mbarara Municipality Mbarara District”. There are no direct benefits but the study will inform healthcare partners in improving healthcare delivery in the district. I request that you spare 20 minutes of your time and share with me your experience in accessing healthcare services at this health facility. Your response will be handles with highest level of confidentiality. Thank you.

You will be requested to consent verbally to show that the information was shared willingly without being compelled.

#### Section A: Patients profile/ clients’ profile

Patients ID.....

Age (in complete years).....

Marital status; Married ☐ Single ☐ widow ☐ Divorced ☐

Gender: F ☐ M ☐

Education level: 1. Primary ☐

2. Secondary ☐

3. Tertiary/ University ☐

4. No education at all ☐

Occupation: 1.Farmer ☐ 2.Business/trade ☐ 3.Civil service ☐

4. Health worker/VHT ☐ 5. Student ☐ 6.House wife ☐

7. Others (Specify) .....

Health Facility

ID-F.....

For OPD: Time of entry at facility hh:mm..... ☐ am ☐ pm

Exist time at the facility hh:mm..... ☐ am ☐ pm

For IPD:

- Date of admission at facility...../...../.....
- Days spent at the facility.....
- Expected date of exit proposed by Dr...../...../.....

- Has the ealth status improvement: 1 Agree ☐ 2 Neutral ☐ 3 Disagree ☐

## Section B: Service Questions and satisfaction levels

- The last time you had a health complication/issue, which type of facility did you visit?

1 Public ☐

2 PPP ☐

3 PFP ☐

- Are you visiting this facility for the first time?

1 Yes ☐

2 No ☐

- If no, how many times?

.....

- Have you visited a public health facility before?

1 Yes ☐

2 No ☐

- If yes, how did you find the services there?

1 excellent ☐ 2 Very good ☐ 3 Good ☐ 4 Fair ☐ 5 Poor ☐

What reason do you give for the state of services received?

.....

- If yes in Qn 4, How do you compare the services you got at the public health facility that you visited with the service here?

.....

.....

- Which services did you receive today?

| Tick | Services                                                   | 1 Very satisfied | 1 Satisfied | 3 Neutal | 4 Not satisfied | 5 Not At all |
|------|------------------------------------------------------------|------------------|-------------|----------|-----------------|--------------|
|      | Medical consultations                                      |                  |             |          |                 |              |
|      | Lab services                                               |                  |             |          |                 |              |
|      | Operation (Theatre ceaser)                                 |                  |             |          |                 |              |
|      | SMC (Safe Male Circumcision)                               |                  |             |          |                 |              |
|      | Dispensing (drugs)                                         |                  |             |          |                 |              |
|      | Cervical cancer                                            |                  |             |          |                 |              |
|      | Elm of mother to child trans                               |                  |             |          |                 |              |
|      | Family planning and other SRH (Sexual Reproductive health) |                  |             |          |                 |              |
|      | Counselling                                                |                  |             |          |                 |              |
|      | Nutrition services                                         |                  |             |          |                 |              |

|  |                     |  |  |  |  |  |
|--|---------------------|--|--|--|--|--|
|  | Eye treatment       |  |  |  |  |  |
|  | Dental checkup      |  |  |  |  |  |
|  | Radiography (x-ray) |  |  |  |  |  |
|  | Others (specify)    |  |  |  |  |  |

8. In your opinion, is the staff at this health facility approachable?

- 1 Strongly agree ☐
- 2 Agree ☐
- 3 Neutral ☐
- 4 Disagree ☐
- 5 strongly disagree ☐

9. Do you see any medical personnel every time you come to this health facility?

- 1 Yes ☐
- 2 No ☐

10. If Yes, How long does it take to see a medical personnel?

- 1 1-20 minutes ☐
- 2 21-40 minutes ☐
- 3 41 minutes- 1hr ☐
- 4 More than 1hr ☐

11. Has the medical personnel attend to you well, to your expectations today?

- 1 Strongly agree ☐
- 2 Agree ☐
- 3 Neutral ☐
- 4 Disagree ☐
- 5 strongly disagree ☐

12. Were you able to get all the prescribed drugs?

- 1 Yes ☐
- 2 No ☐

13. If no, why? ☐

- 1 Drug out of stock
- 2 Others specify.....

14. Did the dispenser (pharmacist) explain to you how to use the drugs that you managed to get?

- 1 Yes ☐
- 2 No ☐

15. Have you ever been to the laboratory of this health facility?

- 1 Yes ☐
- 2 No ☐

16. If no, skip to Qn 17. How satisfied were you with lab services?

- 1 Very satisfied ☐
- 2 Satisfied ☐
- 3 Neutral ☐
- 4 Not satisfied ☐
- 5 Not satisfied at all ☐

17. Have you been admitted at this Health Facility?

- 1 Yes ☐
- 2 No ☐

18. If Yes, How many days did you spend here to recover and be discharged? If No, skip to Qn.20

.....

19. If Yes in 17, were the staff accessible here at night?

- 1 Yes ☐
- 2 No ☐

20. How much money do you need to get a full dose / medication at this facility? Ask to OPD or IPD (those on addition or have ever been admitted)

*OPD (Out Patient Department)*

*IPD (In Patient Department)*

- 1 Less than 9,900 ☐
- 2 10,000-30,000 ☐
- 3 30,050-60,000 ☐
- 4 Above 60,050 ☐

- 1 30,000-60,000 ☐
- 2 60,050-100,000 ☐
- 3 100,000-150,000 ☐
- 4 150,050 and above ☐

### Section C: Infrastructure

21. How do you rate the wards at this facility in terms of:

A) Cleanliness

- 1 Very clean ☐
- 2 clean ☐
- 3 Neutral ☐
- 4 Not clean ☐

B) Space and beds

- 1 Not crowded ☐
- 2 Crowded ☐
- 3 Patients laying on the floor ☐

22. Other places at this facility ; latrines/ toilets

- 1 Very clean ☐
- 2 Clean ☐
- 3 Neutral ☐
- 4 Not clean ☐

Water in bath rooms, taps, toilets/latrines

- 1. Always available ☐
- 2. Not reliable ☐
- 3. Never available ☐

23. Are you aware of ambulance at this facility?

- 1 Yes ☐

2 No ☐

24. Have you ever used this hospital/ facility's ambulance?

1 Yes ☐

2 No ☐

25. If yes, how much were you charged money?

.....

Ambulance is used for emergency cases

26. How urgent was the response of the transport Officer?

1 Very urgent ☐

2 Urgent ☐

3 Neutral ☐

4 Not urgent at all ☐

27. Are you aware of the theatre here at this facility?

1. Yes ☐

2. No ☐

28. If yes, have you ever been operated from this facility? If No, skip to Qn.32

.....

29. If yes, how did the theatre help you in solving your health problem and has your health status improved?

.....

.....

30. In your view what do you think has limited access to improved health care delivery at this facility? (*a client can mention a maximum of three*)

1 Uncaring, rude and lazy staff ☐

2 Long hours of waiting to get services ☐

3 Low levels of staffing ☐

4 Charging a lot of money ☐

5 Poor/communication and information gap. ☐

6 Personal opinion not listed in the above. ☐

7 Everything is okay, Very satisfied with all the services ☐

31. At which point of services do you think spent more time and why?

.....

35. What type of health would you go to the next time you have a health issue?

1 Government hospital health Centre ☐

2 Public private partnership health Centre ☐

3 Private for profit health Centre (Private hospital /clinic) ☐

And Why?

.....

36. Does the service that you receive match the amount of money that you pay at this facility?

1 Strongly agree ☐

☐

- 2 Agree
- 3 Neutral
- 4 Disagree
- 5 strongly disagree

☐

☐

☐

37. What would you recommend to improve healthcare delivery in PPP health facilities?

.....

.....

.....

## Questionnaire for Health Workers (at PPP Health Facilities)

My Name is Justus Asasira (2014/MAs/187/PS), a Masters of Arts student at Mbarara University of Science and Technology. I am conducting a research study titled “Public-Private Partnership and Healthcare Delivery in Mbarara Municipality Mbarara District”. There are no direct benefits but the study will inform healthcare partners in improving healthcare delivery in the district. I request that you spare 20 minutes of your time and share with me your experience in accessing healthcare services at this health facility. Your response will be handles with highest level of confidentiality. Thank you.

You will be requested to consent verbally to show that the information was shared willingly without being compelled.

### BIO DATA

Respondents ID.....

Age (in complete years).....

Gender; Male ☐ Female ☐

Qualification

1 Certificate ☐ 2 Diploma ☐ 3 Degree ☐ 4 Masters/postgraduate ☐

Position/Role.....

Level of health facility

1 Health centre II ☐ 2 health centre III ☐ 3 Health centre IV ☐ 4 Hospital ☐

health facility ID.....

Working schedule

Fulltime ☐ Part time ☐

Number of hours spent at health facility per day of work)

1 1-6 hours ☐ 2 6-12 hours ☐

3 12-18 hours ☐ 4 18-24hours ☐

Number of years working at the health facility

1 1-3 years ☐ 2. 3-6 years ☐ 3 6years and above ☐

Number of days worked per week

1 1-2 days ☐ 2 3-5 days ☐ 3 Whole week ☐

### SERVICE QUESTION

1. On average, how many clients does this health facility receive?

IPD: per day..... per week.....

OPD: per day..... per week.....

2. What health services do you offer to patients at this health facility?

**Circle the service offered**

|                                           |
|-------------------------------------------|
| 1 Medical consultations                   |
| 2 Lab services                            |
| 3 Operation (Theatre ceaser)              |
| 4 SMC                                     |
| 5 Dispensing (drugs)                      |
| 6 Cervical cancer screening and treatment |
| 7 Elimination of mother to child trans    |
| 8 Family planning and other SRH           |
| 9 Counselling                             |
| 10 Nutrition services                     |
| 11 Eye treatment                          |
| 12 Dental checkup                         |
| 13 Radiography (x-ray)                    |
| 14 Others (specify)                       |

3. On average, how many days does IPD (a client) spend here to be discharged?

.....

4. Do patients get all prescribed drugs when they visit this health facility?

.....

5. If No why?

6. Does the dispenser (pharmacist) explain to patients how to use the drugs?

.....

7. If No why?

.....  
.....

8. How many hours does a client spend to reach the final point of service (dispenser)?

.....

9. How many health workers does this facility have?

- Nurses.....
- Clinical officers.....
- Doctors.....
- Counselors.....
- Administrators.....
- Support staff.....
- Others (specify).....

10. On average, how many death cases do you register with in a period month?

.....  
Specify the deaths:

Mothers

Children

Others

11. What causes these deaths (According to you as a health worker)?

.....  
.....

12. In your opinion, do you think the staffing levels at this facility matches the number of patients who visit this facility seeking health services?

.....

If yes, go to Question 12

13. If no, where are the gaps in terms of human resource?

.....  
.....

14. How has the facility administration addressed the gap?

.....  
.....  
.....

15. What kind of support does this facility get from government?

1 Financial/Money

2 Infrastructure/Building

3 Support supervision

4 Laboratory equipment

5 Drug supply

6 Paying workers

“Where else does the facility get support”? **Specify the nature of support.**

.....  
.....  
.....  
.....

16. Does this facility has

|                               | Has | Expected |
|-------------------------------|-----|----------|
| • Enough beds                 |     |          |
| Big enough ward               |     |          |
| • Toilets/latrines            |     |          |
| • Ambulances                  |     |          |
| • Theatre well equipped       |     |          |
| • A-ray machine (functioning) |     |          |
| • All lab equipment           |     |          |

|                                                  |  |  |
|--------------------------------------------------|--|--|
| • Staff houses (for doctors and other staff)     |  |  |
| • Lightening conductors                          |  |  |
| • Water for daily use (both patients and workers |  |  |
| • Record (Health information management          |  |  |
| • system)                                        |  |  |
| Motor cycles                                     |  |  |
| Cars                                             |  |  |

Others specify.....

17. As a health worker, how do you help a client to be attended to immediately?

.....

18. On average, How much does it cost a client to get a full doze/ medicine medication?

.....

.....

.....

.....

19. How much is your salary ?.....

20. How do you equate it with the services that you deliver here?

.....

.....

21. In your opinion, what do you think is limiting access to improved health care delivery at this facility?

.....

22. Apart from the general health care that you provide daily, what other health program does this health facility participate in?

.....

.....

23. How do you handle cases beyond your capacity as a healthy facility to secure the life of the client.....

24. Do you follow up these cases to know how they are handled?

.....

25. How many times does this facility get supply of drugs and medical equipment in year?

.....

.....

.....

26. How does/do the doctors / Nurses respond to emergence cases?

.....  
.....  
.....

### **Interview Guide for Hospital Administrators/Health Centre In Charge/DHO's Office**

1. Give the brief history of this health facility? Who initiated the idea to start it?
2. What is the type of partnership does this health facility has with the government?
3. What services does this/these health facility offer to community?
4. How does this health facility get funding to ensure continued service delivery?
5. What enables this health facility to ensure health services are delivered?
6. Does the government monitor the services you deliver to its citizens on its behalf?
7. What is the feedback from the clients about the services that you offer?
  - a) Quality of services
  - b) Fees charged v<sup>s</sup> the poor who may not manage the cost
  - c) Corporate social responsibility
8. How do you attempt to improve service delivery where clients express dissatisfaction?