FACTORS AFFECTING IMPLEMENTATION OF PUBLIC PRIVATE PARTNERSHIPS IN HEALTH SERVICE DELIVERY IN UGANDA

A CASE OF LIRA DISTRICT

BY

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DECLARATION

I Geoffrey Godffrey Maniku Olema Aluma hereby declare that the dissertation is my original work and has never been submitted for any Degree or Masters to any other higher institution of learning

Signed:……

Date:……

APPROVAL

This is to certify that this dissertation entitle “Factors affecting implementation of public private partnerships in health service delivery in Uganda” a case of Lira District was done under our supervision and is now ready for examination for the award of the Master’s Degree in Management Studies (PAM) of Uganda Management Institute (UMI)

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DEDICATION

This work is dedicated to my dear late father Gideon Maniku who struggled to bring me up and trained me with good and desirable philosophies of life while growing up so as to face the challenges of life and to my beloved mother Albertha Onzia who encouraged me for success in difficult times. She toiled day in, day out denying herself even the basic necessities of life to collect every coin from hard earned local crops for my school fees, which enabled me to acquire the knowledge necessary to appreciate the world and to be of some use to myself and my fellow country men. This prepared and inspired me to academic excellence.

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LIST OF ACRONYMS AND ABBREVIATIONS

CBO:	Community Based Organization
CSO:	Civil Society Organization
FBO:	Faith Based Organization
INGO:	International Non-Governmental Organization
LNGO:	Local Non-Governmental Organization
M&E:	Monitoring and Evaluation
MOH:	Ministry Of Health
NEPAD:	New Partnership for Africa's Development
NGO:	Non-Governmental Organization
PFP:	Private- for- Profit
PNFP:	Private Not-for-Profit
PPPH:	Public-Private Partnership in Health
SPSS:	Statistical Packages for Social Scientists
UCMB:	Uganda Catholic Medical Bureau
UMMB:	Uganda Muslim Medical Bureau
UPMB:	Uganda Protestant Medical Bureau
USAID:	United States Agency for International Development

ABSTRACT

This study assessed factors affecting implementation of public private partnerships in health service delivery in Uganda, A case of Lira District. This recognition originates from the realization that one third of the world population lacks access to essential medicines and health services. The study sought to; i) Establish how institutional framework in public private partnerships affect health service delivery in Lira district.; ii) Find out how institutional characteristics in public private partnerships affect health service delivery in Lira district; iii) Find out how capacity of partners in public private partnerships affect health service delivery in Lira district; and iv) Establish the effects of Government Policies on health service delivery under Public Private Partnership.

The study was done using both qualitative and quantitative approaches and data were obtained using a questionnaire, in-depth interview and document review. Data collected was analyzed using Statistical Package for Social Sciences (SPSS) and descriptive method especially the qualitative data.

Findings revealed that participation, networking and cooperation, institutional uniqueness and government policies are success factors in public private partnership in health service delivery and they contribute to achieving quality health service delivery. As supported by literature, attainment of quality services can be pledged if desired outcomes are defined, measured and improved with diligent loyalty to public private partnerships in health service delivery supported by full participation, networking and cooperation, acclimatization to institutional best-fit and government policies. It is recommended that for quality improvement, stakeholders should; 1) fully participate; 2) finances should be prioritized and; 3) institutions should assimilate M&E into the institutional strategy.

Government support in terms of increased funding and supervision of health services is of paramount importance in improving health service delivery under public private partnerships.

CHAPTER ONE
INTRODUCTION

1.1 Introduction

This chapter presents the introduction to the relationship between public private partnerships and health service delivery in Uganda using a case of Lira District. It focuses on background to the study, statement of the problem, objectives of the study, scope of the study, significance of the study and operational definitions.

1.2 Background to the Study

1.2.1 Historical Background

Since mid 1990s, in many sub Saharan Africa countries, the private sector played a vital role in public service provision and policy making, stimulating demand for new forms of regulatory oversight (Milward and Provan, 2000 and Brinkerhoff, 2002). In Uganda, the last 2 decades were characterized by substantial multi-sectoral partnering to enhance the quality of services delivered. Many government and the private sector particularly Non-Governmental Organizations (NGOs) programs have engaged in public private partnerships to achieve results.

The Public-Private Partnership in Health (PPPH) was initiated in 1997 by the Ministry of Health in Uganda with the support of a parliamentary resolution implemented in July 2000. In Uganda, the private sector can be broadly categorized into Private- for- Profit (PFP) and Private Not-for-Profit (PNFP) providers. The PFP group contains both formal and informal providers. Informal providers mainly include general merchandise, shops and traditional healers. Whereas examples of formal providers include; hospitals, schools/institutions, financial institutions like banks and telecommunication companies among others. There are also new non Ugandan systems of healthcare such as the Indian and Chinese medical systems.

In 2001, Private Not-for-Profit 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 umbrella organizations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB). By 2002, the Bureaus together

represented 78% of the 490 PNFP health units while the rest fell under other humanitarian organizations and community-based health care organizations (MOH, 2001).

1.2.2 Theoretical Background

According to Koza and Lewin (2000), the most important reason for entering an alliance is to complement and support the adaptation of strategies. Where governments have entered into partnerships with NGOs and other private agencies, the results have been impressive. Litado (2003) argues that NGOs are often praised for their innovations, aggressive approach, quality outputs and implementation structure that allows them to be at the grassroots. Hood (1991) asserts that cooperation of public and private sectors under the circumstances of reforms of new public management will ensure an increased quality of public services and enhance the efficiency of public administration. Search for collaborative benefit has well turned into a holy grail in the fields of policy, politics, strategy and planning in a wide range of national and international contexts (Gedds and Bedington, 2001).

Decentralization is one of the crucial conditions for Public Private Partnership development. Political, administrative, fiscal and market decentralization in different countries and their sectors can often vary assuming fresher and diverse forms. The nature of partnership is revealed when the public sector recognizes its dependence on other sectors and starts solving governance problems by decentralizing activity (Raipa and Backunaite, 2004). According to Pongsiri (2002) the establishment of a transparent and sound regulatory framework is a necessary precursor to private sector participation in partnerships. Public Private Partnership brings added value to the public and private sector partners, sound policy and regulatory frameworks, and complete transparency particularly with regard to financial accountability.

1.2.3 Conceptual Background

Public-private partnerships are being increasingly encouraged as part of the comprehensive development framework. The need to foster such arrangements is supported by a clear understanding of the public sectors inability to provide public goods entirely on their own, in an efficient, effective and equitable manner because of lack of resources and management issues. These considerations have necessitated the development of different interface

arrangements, which involve the interfacing of organizations that have the mandate to offer public good on one hand, and those that could facilitate this goal.

Conceptually, there are many definitions of public private partnership and many scholars have tried to study public private partnership with no universal definition as the concept is still contested (Maskin & Tirole, 2008).

Van and Koppenjan (2001) defined public private partnership as cooperation of some sort of durability between public and private actors in which they jointly develop products and services and share risks, costs, and resources which are connected with these products through an institutional lens. Public private partnership is divided into ten (10) different types that is; operational and maintenance, Design-build, Turn-key operation, Build-Operate-Transfer, Build-Own-Operate (BOO), Buy-Build-Operate (BBO), Design-Build-Operate (DBO), Design-Build-Finance-Operate-Maintain (DBFOP), Operations and Maintenance (O&M) and Lease/Purchase.

Public private partnership is further sub divided into different forms which include; Private Finance Initiative (PFI), Joint Venture/Mixed Capital Partnership, Concessions, Temporary Privatization, Contracting out/Outsourcing/Tendering out and Leasing.

The World Health Organization (WHO) defines *service delivery* as the way inputs are combined to allow the delivery of a series of interventions or health actions (WHO 2001b). As noted in the *World Health Report 2000*, “the service provision function [of the health system] is the most familiar; the entire health system is often identified with just service delivery.” The report states that service provision, or service delivery is the chief function of the health system needs to perform (WHO 2000).

Health service delivery can be defined as the way inputs are put together to allow the delivery of interventions in health sector.

Partnerships refer to public and private sector actors work together on the basis of shared objectives, strategies and agreed monitoring and evaluation criteria, usually through the

formation of a new joint entity for implementation (Ahmed, 2000). It is a contract between two partners, where the public sector plays the stewardship and regulatory role and the private sector provides services under certain conditions.

Partnership has significant potentialities for achieving effective and efficient high quality health services. It aims to establish a functional integration and a sustained operation of a pluralistic health care delivery system by optimising the equitable use of the available resources and investing in comparative advantages of the partners. It ensures the utilization of the potentials of both the public and private sectors. Partnership between public and for-profit private sector is fostered to tap into resources and efficiency in management, while the non-profit private sector for technical expertise or outreach. Thus partnership is increasingly becoming essential as both the public and the private sector recognize their individual inabilities to address emerging public health issues. Research evidence also indicates that working in isolation can result in duplication of efforts and failure to accomplish health goals, whereas collaboration among health care providers can generate synergy and facilitate the flow of information (Begum 2004).

1.2.1 Contextual Background

The study examined the contribution of Public Private Partnership with focus on the social network theory. According to (Sohail, 2003), the public private partnership approach conceptually is the cooperation between public and private sector organizations in public service delivery. In practice, partnership is commonly interchanged with the following related terms; collaboration, coalition, consortium, alliance, coordination, networking and association.

Murry (1975) mentions that, the changing situation in the 1960s seemed to have evolved towards a mixture of public-private and government-market decision making with a blurring of the lines rather than a distinct division of responsibilities. The growth in scale and scope of the private sector around the world was witnessed by growing governance and regulatory challenges for governments and donors. The use of partnership in production and distribution of goods and services became inevitable for sustainable development. The private partnership was viewed as a derivative of the privatization movement, which fascinated conservative in the west, especially the United Kingdom and United States of America. The

Central government was unwilling to trust local governments with public services and, not least, with regeneration. Instead, they turned to the business sector forming Urban Development Corporations and Enterprise Zones to administer funds (Linder, 1999: pg.36). In France, Public Private Partnership is taken as “a delegated management of public services", reflecting the long held view that public authorities and private companies should enter into a partnership for management of safe, regular and reliable public services for citizens.

Michael and Wilson (2005) argue that public private partnership is a collaborative business enterprise between government and the private sector that finds its value as a collaborative undertaking because it integrates interests and skills. Public Private Partnership does not imply “less government involvement” but a different role where more skilled participation is often needed. The initiative increases the effectiveness of partnership working by exploring common issues and building a shared understanding of how they can be resolved.

1.3 Statement of the Problem

Over the last few decades, health issues have attained worldwide recognition as a crucial component of human development and poverty eradication. This recognition springs, in part, from the realization that one third of the world’s population lacks access to essential medicines. However, the main problem is challenges in the implementation of public private partnerships in quality health service delivery in Uganda considering Lira district as a case study with all its challenges.

However, these challenges include; Lack of access to essential medicine which contributes to further poverty, motility, morbidity, and indebtedness. Delivery of medicine to health facility is also not timely. Many times it is late and the drugs get expired before being used. There is poor sanitation and lack of access to clean water, proper and adequate nutrition are lacking. There is also lack of available and highly motivated health workers who are willing to work. There are cases of abuse of rights to health. To mention, there is apparently lack of auxiliary infrastructure such as housing for health workers, access to road and solar equipment to keep vaccine in rural health centers at the right temperature are lacking.

The government of Uganda has adopted a number of strategies, and among them is the Public Private Partnership aimed at improving service delivery to her citizens. Despite the use of public private partnership arrangement through both public and private programs, the government has not fully realized its vision of improving service delivery. Pongsiri (2002) argues that improved service delivery requires collaboration of a range of actors; government, business, civil society, independent experts, communities and families.

The major factors affecting the implementation of public private partnerships include the following; first there is institutional framework for public private partnership which entails policy framework, legal framework, organisational structure, networking and cooperation. Secondly, there is institutional characteristics which involves forms of public and private partnership, size of the organisation and source of funding and lastly the capacity of partners which include staff selection, funding and technology

It can be concluded that if problems mentioned in this problem statement are not addressed, there is likely to be an increase in poverty levels, increased mortality, morbidity, increased indebtedness of the people and many death cases. There will also be increased diseases of the poor that is; communicable, maternal, prenatal and nutritional diseases.

1.4 Objectives of the Study

The main objective was to establish the factors affecting implementation of health service delivery under public private partnerships in Lira district.

1.5 Specific Objectives of the Study

The study was guided by the following specific objectives:

1. To establish how institutional framework in public private partnerships affects health service delivery in Lira district.
2. To find out how institutional characteristics in public private partnerships affect health service delivery in Lira district.
3. To find out how capacity of partners in public private partnerships affects health service delivery in Lira district.

4. To establish the effect of Government Policies on the relationship between the factors affecting implementation of Public Private Partnership and Health Service delivery in Lira District.

1.6 Research Questions

The study was guided by the following research questions:

1. How does institutional framework in public private partnership affect health service delivery in Lira district?
2. Do institutional characteristics in public private partnerships affect health service delivery in Lira district?
3. How does capacity of partners in public private partnerships affect health service delivery in Lira district?
4. Do Government Policies have an effect on the relationship between the factors affecting implementation of Public Private Partnership and Health Service delivery in Lira District?

1.7 Hypotheses

The study was also guided by the following hypotheses:

1. Institutional framework in public private partnerships has a positive effect on health service delivery in Lira district
2. Institutional characteristics in public private partnerships significantly affect health service delivery in Lira district
3. Capacity of partners in public private partnerships has a significant effect on health service delivery in Lira district
4. Government Policies have significant effect on the relationship between the factors affecting implementation of Public Private Partnerships and Health Service delivery in Lira District

1.7 Conceptual Frame Work

The conceptual framework below (Fig.1) attempts to describe that the independent variable (Public Private Partnership) has a positive effect on the dependent variable (Service Delivery). The study considered factors affecting health service delivery under partnerships,

particularly the contribution of stakeholders, Legal framework, Size of the organization, Sources of funding, Technology (ICT), Organization structure, Staff selection, level of participation, networking and collaboration and, institutional characteristics. Likewise, government policy as a mediator variable is pivotal to setting guidelines that allows beneficiaries to optimally access services and share benefits.

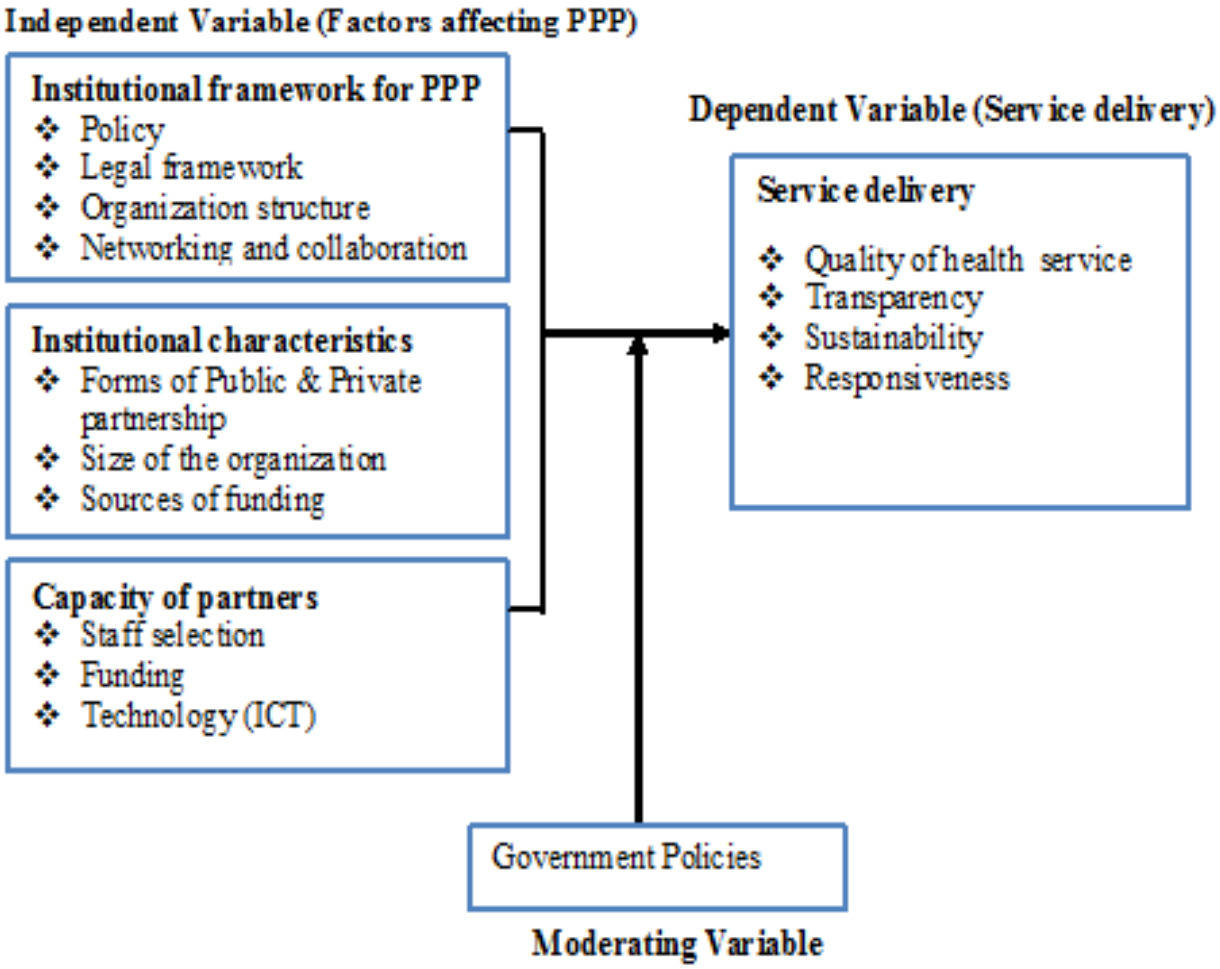


Fig 1: Conceptual framework (Source: Cabins, 1997)

1.8 Scope of the Study

The area of study was Lira District. Lira is a district in Northern Uganda. Like many other Ugandan districts, it is named after its 'chief town', Lira.

Lira District is bordered by Pader District to the north, Otuke District to the northeast, Alebtong District to the east, Dokolo District to the southeast, Apac District to the

southwest and Kole District to the west. The main municipal, administrative and commercial center in the district, Lira, is located 110 kilometres (68 mi), by road, southeast of Gulu, the largest city in Northern Uganda. The coordinates of the district are: 02 20N, 33 06E (Latitude: 02.3333; Longitude: 33.1000).

The national population census of 2002 estimated the population of the district, as constituted in 2010, at 290,600, with an annual population growth rate of 3%. Given those statistics, it is estimated that the population of Lira District in 2010, was about 368,100.

Key targets included; in charge of health facilities, Nursing officers, Service providers, Security officers, Laboratory technicians, Directors, Gender Officers, Monitoring and Evaluation Officers, A. Chief Administration Officer, District Health Officer, Clinicians, Health and psychosocial officers and overall leaders of the organizations/institutions.

The study focused on factors affecting implementation of public private partnerships in health service delivery in Uganda.

The study was conducted in September 2013 and the field work took a period of 30 days

1.9 Significance of the Study

The study will benefit Local governments, Civil Society Organizations, the private sector and other development agencies in preparing guidelines to stimulate effective health service delivery through collaborative actions. The study will assist sectors understand each others' constraints, transform their capacity, create bridges that address large scale issues and to provide strong basis for broader changes, and enhance partners' knowledge in understanding potential in collaborations, ability to anticipate problems and assess specific strength and weaknesses.

The study will shed light on public private partnership, and identify critical success factors or policy requirements for smooth partnership implementation. The research results will help programs to evaluate and review their partnership management approach of activity implementation, and also help stakeholders be more focused while initiating and maintaining partnerships. The findings and recommendations will particularly be useful to the

governments and stakeholders implementing programs through collaborative partnerships, as they endeavor to improve service delivery and performance.

Lastly, researchers and scholars who are interested in the concept public private partnership can make use of the findings, and may derive best practices and lessons from the study.

1.10 Justification of the study

The study is designed to determine the factors affecting implementation of public private partnerships in health service delivery in Uganda. The result of the study will be used to influence policy makers in Ministry of Health to develop programmes and come up with policies that can address the challenges under public private partnerships.

The community within the study area will benefit from the findings and they will have knowledge about the factors affecting health service delivery under public private partnerships.

The study will help government in planning and budgeting especially on the areas of health services. This will guide in fund allocation especially in areas where there is funding gap.

The study will also help and guide the planning units at partnership level, district level and also at the national level to plan for appropriate delivery of health services.

The study will help the different stakeholders in improving on their programming especially on areas where there are gaps. This can also improve on areas of networking and cooperation, coordination and resource mobilization/allocation.

1.11 Operational Definitions

Partnership: A formal or informal arrangement agreed upon by both parties for some kind of joint action to provide a product or service with joint decision making.

Public-private partnership: A joint venture that mobilizes ideas, efforts, and resources of governments, businesses, and civil society to stimulate economic growth, expand access to technology and develop businesses and workforces.

Public: The public sector in this paper refers to national, provincial/state and district governments; municipal administrators, local government institutions, all other government and inter-governmental agencies with the mandate of delivering 'public goods'.

Private: The word private denotes two sets of structures; the *for-profit* private encompassing commercial enterprises of any size and the *non-profit* private referring to Non Governmental Organizations (NGOs), philanthropies and other not-for-profits.

Networking: The building and nurturing of personal and professional relationships to create a system of information, support and altogether for career and personal success. It involves individuals interacting with others and establishing a network of co-operative relations.

Decentralization: Is the transfer of responsibility of planning, management and resource raising and allocation from the central government and its agencies to lower levels of government through de-concentration, devolution and delegation.

Institution: An established system forming a characteristic and persistent feature in social or national life.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of relevant literature of existing views, issues and arguments of previous researchers, analysts and program implementers. The prime aim of the review was to show how public private partnership has influenced health service delivery.

The first section explores the conceptual foundation of the public private partnership approach. The second section explores the public private partnership concept and rationale. The third section explores how stakeholders' participation in public private partnerships contributes to health service delivery. The fourth section explores how networking and collaboration in public private partnership contribute to health service delivery. The fifth section explores how institutional characteristics in public private partnership affect health service delivery, while the last section explores how government policy moderates the relationship between public private partnership and health service delivery.

2.2 Conceptual Foundation

Within the broad conceptual framework and nature of partnerships, the social network theory was dwelt on to describe and explain how public private partnerships work, and contribute to health service delivery in Uganda; a case of Lira district. The social network theory views partnerships as nodes and ties. Nodes referring to individual actors within the partnerships, and ties are relationships between the actors. Rowley (1999) argues that with increasing influence of the role of partnerships, it becomes significant to view firms as net works of stakeholder relationships that extend beyond the organization's boundary. The power of social network theory therefore, stems from its difference from traditional sociological studies, which assume that it is the attributes of individual actors, whether they are friendly or unfriendly, big or small for that matter. Social networks are used to examine how companies interact with each other, characterizing the many informal connections that link executives together, as well as associations and connections between individual employees at different companies.

Boeckel and Westerholf (2007, pg.6) observed that partners in development aid arena have difficulty in applying their relatively mature partnerships and concepts to achieve results. These networks provide ways for companies to gather information, deter competition, and even collude in setting prices or policies. Oxenbridge and Brown (2004) highlights the need for further research, given limited knowledge of outcomes of networks or partnerships in practice.

2.3 Public Private Partnership Concept and Rationale

Public private partnership evolved over the past two decades as an important aspect of donor-country development thinking and a central component of foreign policy toward developing countries (Mitchell and Manning, 1991). Partnership practices are witnessed across the board in all sectors; public, voluntary and private (Wilson and Charlton, 1997).

Public private partnership has increasingly emerged as an imperative development strategy in response to current development trends; like devolution of national government powers to lower local governments and entities, heightened involvement of the private sector in service delivery, and an increasing number of civil society actors. They are an ingredient in the general move to modernize the public service and local government, providing greater efficiency and effectiveness and ultimately a better quality customer service (Penell *et al.*, 1998). Both parties in partnership have to agree on a common goal and be open to being influenced by the other. This collaborative partnership is built on mutual appreciation, clear communication about shared values, and only can be maintained with constant dialogue and organizational commitment (Johnson and Ludeme, 1999).

Mohr and Spekman (1994) mentioned that partnerships are purposive strategic relationships between independent firms who share compatible goals and strive for mutual benefit or

interdependence. Carroll and Steane (2000) believe that public private partnership is a system in which a government service or private business venture is funded and operated through a partnership of government and one or more private sector organizations or companies.

Keihangwe (2006) refers to Public Private Partnership as a working arrangement planned to bring various resources and abilities from the Government, civil society and private sector to achieve specific results in service delivery that none of the parties working alone would get. Public Private Partnerships imply a sort of alliance to pursue common goals, while leveraging joint resources and capitalizing on the respective competences and strengths of the public and private partners (Widdus, 2001; Pongsiri, 2002 and Nijkamp *et al*, 2002).

Samii *et al*, (2002) highlighted key formation requirements of effective Partnerships; including resource dependency, commitment symmetry, common goal symmetry, intensive communication, alignment of cooperation learning capability, and converging working cultures. Miller & Savas (2000) assert that in most developing countries, the proliferation of public private partnerships has been attributed to several explicitly stated reasons, including; the desire to improve the performance of the public sector by employing innovative operation and maintenance methods, reducing and stabilizing costs of providing services, improving environmental protection by ensuring compliance with environmental requirements, reinforcing competition, and reducing government budgetary constraints by accessing private capital for infrastructure investments.

Drucker (1999) noted that very few people work by themselves and achieve results. A fundamental premise of a public private partnership is that it involves key stakeholders. The key element is that actors collaborate across sectors, ideally in ways that capture synergies from the interactions of their contemporary strengths and weaknesses, and find institutional arrangements that foster openness, honesty, and commitment. As partnerships progress, trust is built, and partners explore new opportunities in a more open way (Penell *et al*., 1998).

Wilson (2002) analyzes public and private partnership in the context of the welfare state, and argues that combining of resources of public and private sectors can result in effectively

functioning social infrastructure, defeat of economic crisis and improved life. Although it is costly and time-consuming to establish successful partnerships, all partners need to make more commitment, mutual adaptation, and contribute learning and resources. There should be many tangible and intangible benefits achieved by partnerships, and one of the main driving forces behind entering strategic partnerships is the need for a strategic development of partner companies (Hoffmann and Schlosser, 2001). The more the public private partnership is perceived by both parties, even though it may be different but with equally beneficial reasons, the more its chances of being sustainable.

2.4 Stakeholder's Participation

Participation is a collaborative partnership where stakeholders including beneficiaries work together to achieve a common goal. Mubende (2006) suggested that participation is rights-based and establishes identity and interests which are critical for achieving quality. Bakenegura (2003) as cited by Mubende (2006) viewed participation as a mechanism where stakeholders vigorously influence decisions. These views build on Desai's (2001) argument that participation enables pursuance of beneficiary empowerment, capacity building and effective intervention.

Active stakeholder participation fosters a consensus on appropriate and effective strategies for building and widening the support base for the performance of partnerships. The public service involves a wide range of relationships between policy makers and its stakeholders, and enhanced partnerships potentially provides a cost-effective way of obtaining better quality knowledge in an increasingly resource-constrained environment.

According to Miller and Lewis (1991), stakeholders can be viewed as internal and external, or primary and secondary. Internal stakeholders include functional departments, employees and interested internal parties while external stakeholders are; competitors, advertising agencies, and regulators Primary stakeholders are those whose continued participation is absolutely necessary for business survival; they consist of employees, customers, investors, suppliers, and shareholders that provide necessary infrastructure (Waddock *et al*., 2002).

ACORD (2003) noted that interests of stakeholders need to be delved into to sustain the triumph of a project. Participation in M&E is a medium through which the beneficiary is empowered to understand and manage the dynamics of M&E that fulfils their desires. This study probed how participation in different features of M&E considerably empowered attainment of quality of service, and how participation is initiated and sustained. The link between participation and dimensions of quality were examined.

In every service organization, customer participation is required throughout the entire service process and the customer role is intimately linked with the production and delivery of the service product (Chase, 1978). Effective communication between stakeholders is fundamental for developing strong and successful partnerships, while on-going stakeholders' consultation also becomes necessary for public private partnership development and evaluation of policies (Bridgman and Davis, (2004). Boselie and Paauwe (2002), affirm that client satisfaction is a performance indicator of an organization especially when aspects of choice and price sensitivity are considered.

Bettencourt (1997) argues that customers' roles in service delivery often need to be managed in the same ways as the service workers' roles are managed, have to recognize the value of customer participation and improvisation in service delivery processes.

Joby and Stephen (2006) argue that stakeholders' involvement and proximity are key to improved service delivery because the less the direct involvement and proximity to service production and delivery processes, the lesser the need for improvisation and vice-versa. Lober (1997) argues that managers should identify relevant stakeholders that influence the organization's capacity to deliver effectively. Clear and well defined functions played by stakeholders in service delivery facilitate successful partnerships interventions.

Effective service delivery in partnerships is one of the most vital concepts in the context of assessing resource allocation and organizational efficiency (Prokopenko, 1992). Partnerships deliver better quality public services by bringing in new ventures, improved management and help state-owned programs achieve their full potential. A successful partnership therefore, requires carrying out the terms of the initial agreement, maintaining communications and transparency among partners, and conducting periodic monitoring and evaluation of

partnership activities. More specifically, the benefits to be derived include greater sharing of information and resources between public agencies and civil society and business sectors whereby better coordination secures efficiencies both in terms of cash savings and improved delivery.

2.5 Networking and Collaboration

Anderson (1992) asserts that in the network approach, no sharp distinction is made between the individual actors. The seller, the environment, actors and exchange relationships are embedded in intricate networks of relationships and are highly dependent on their particular context. Iacobucci (1996, pg.13) for example, said successful companies recognize that strategic alliances can be a powerful means for adaptation in a turbulent or uncertain environment.

Networking is seen as an increased exposure to other people and organizations that enhances understanding of organizational practices and provides valuable job search information (Lankau and Scandura, 2002). Collaboration is an approach applied by organizations when developing coalitions, conducting planning and researchers who desire partnership of those being studied. Collaborative efforts can occur among individuals, among organizations, and among systems (Padgett et al., 2004). Cook and Emerson (1998), argue that network monitors on government ensure space for civil society participation in government initiated activities.

Griggs and Stewart (1996) state that when the philosophical fit is good between related programs and careful planning precedes integration, the resulting program can be stronger than any of the individual, independent programs. Partnerships are therefore on-going relationships between two or more organizations with a commitment over an extended time period, and a mutual sharing of the risks and rewards of the relationship (Hendrick and Ellram, 1993).

Public Private Partnerships provide benefits by allocating the responsibilities to either party – public or private – that is best positioned to control the activity that will produce the desired result. This is hence accomplished by specifying the roles, risks and rewards contractually, so as to provide incentives for maximum performance and the flexibility necessary to achieve the desired results for the network. This further strengthens partnership and allows

all parties to share news about partnership activities and minimizes misunderstandings and disagreements.

2.6 Institutional Characteristics

Organizations have characteristics which hold them together and influence their operations for effectiveness in service delivery and sustainability. An organization is a collection of people joining in a formal association to achieve objectives. It may be through direct and full- time employment or it may be derived from contracts to supply or purchase goods or services (Dawson (1993:43). Hall (1996) argues that an organization is a collectivity with a relatively identifiable boundary, a normative order and ranks of authority, communication systems, and membership coordinating systems.

Handy (1993) noted that the effectiveness of any institution is an effect of three major features namely; the individuals, the organization and the environment. Many organizations vary in size basing on the funding or capital available and their activity scope. They have a purpose (visions, goals and objectives) for existence, members with specific skills, processes and systems that facilitate the effective use of skills, a structure to control the members and support systems, and a culture to shape the values and behavior patterns of the members. Kanter (1994) argued that individual excellence, interdependence, investment, institutionalization, and integrity as the key ingredients of effective collaboration.

Although authors are not agreeing on the basic elements of an organization's purpose (vision, mission, goal and objectives), Coles (1997) limit the purpose to a mission. Mattessich and Monsey (1992), view it as the vision, goals and objectives, while Coles (1997) observes that a mission statement of an organization provides a vision of why the institution exists, where it intends to operate and how it intends to achieve goals. Cabanis (1997) defines organizational objectives as the steps identified that move an institution towards the accomplishment of its goal to attain effectiveness. Gautam and Batra (1995) assert that organizational members have specific characteristics, which are likely to influence their contribution in achieving organizational purposes.

Mattessich and Monsey (1992:19) indicate that membership characteristics consist of skills, attitudes, and opinions of the individuals. Handy's framework of organizational effectiveness cites individuals' abilities being very important (Handy, 1993), and continuous changes of human behavior influences the organization itself. Since the organizations need to survive and grow irrespective of their members, Gautam and Batra (1995) concede that the institutionalization of organizations is necessary. For an organization to exist and achieve its purposes there must be people or human to run it.

Hall (1996) asserts that an organizational structure may be simple or complex and formal or informal. An organizational structure is the skeleton of the organization, which controls the individual members and supports the various systems and processes. Gautam and Batra (1995) argue that the existence of informal structures and processes in a formal organization are not imperfections but rather a reflection of organizational dynamics. Processes are put in place to facilitate efficient use of the skills of the partners and other non-human resources, and smooth communication within organizations is central for other processes of power, leadership and decision making (Hall, 1997).

2.7 Public – Private Partnership and Hospital Service Delivery Outputs

Reich (2002) argues that partnerships result into innovative strategies and positive consequences for well-defined public health goals, and they can create powerful mechanisms for addressing difficult problems by leveraging the ideas, resources, and expertise of different partners. Such line of thinking is the same enshrined in the objective of PPPH in Uganda which is — to establish functional integration and to sustain the operation of pluralistic health care delivery system by optimizing the equitable use of available resources and investing in comparative advantage of the partners (MOH, 2007).

In Sub-Saharan Africa, for example, the number of people receiving HIV/AIDS treatment increased more than eight-fold from about 100,000 to 810,000 between 2003 and 2005 and more than doubled in 2005. This massive improvement would not have been possible without key public-private partnerships in the HIV/AIDS sector (UNAIDS, 2006). Other studies have reported increased access and reversal of the decline in utilization of health services immediately after the introduction of government subsidies to PNFP sub sector.

There was an upward trend in utilisation of composite units of output (SUO) and this rise in utilisation has continued at an even steeper pace into the present day. This is attributed to the effect of the government subsidy in replacing user fees and allowing the charges to be gradually pushed downwards (Giutsi et al, 2004).

Singapore appears to be getting good value from its adoption of the public private partnership for health in its health care system. Patients enjoy complete freedom of choice between easily accessible private (80%) and public (20%) clinics for outpatient care, and public (80%) and private (20%) hospitals for inpatient care. Singapore doctors enjoy a high reputation, as attested by the steady streams of well-heeled foreign patients (150,000 in 2000) who fly in from the surrounding region for medical treatment. Average length of stay in a public hospital is 5 days. A recent nation-wide survey of patients discharged from all the corporatized public hospitals revealed a high overall patient satisfaction (Meng Kim Lee, 2003).

2.8 Government Policies

There has been swift in promoting the notion of Public private partnership, not only to increase strategic flexibility but also to facilitate knowledge creation and utilization, especially in the firms competing in dynamic environments. Public private partnerships entail a sharing of responsibility between government and the private sector (Lang, 2001). Johnson and Ludeme (1997) stress that "a partnership is not just a written agreement to work together; the alliance must be structured as an independent identity that requires resources and changed behavior among partners and the leadership". Such relationships entail comprehensive planning and well defined regulatory communication channel functional at all levels.

The role of government agencies is to design and provide clear guidance on how to work in partnership and can adhere to standards and terms of reference in service delivery (Ngowi, 2006). Isles and Aulick (1990, pg.161) state, "given that the partners are members of other teams, some degree of conflict is inevitable". The private and public partners' respective roles are neither antagonistic nor identical, but complementary (Zouggari, 2003). It is easier for government to reach NGOs through a network than contacting each individually (Stella Keihangwe, 2006). The government needs to maintain its involvement, whether in its

capacity as a partner or regulator especially where true accountability is critical (Spackman, 2002).

In 1987 the Uganda Health Policy Review Commission recommended the integration of public and private health sector in a larger, pluralistic, national health sector. In the Government White Paper of 1993, the recommendation made by the Health Policy Review Commission is stated as an objective. In two subsequent occasions, three years later, the Catholic and Protestant Medical Bureaux submitted a memorandum to the Ministry of Health, reminding the Ministry about the urgency to address the recommendation of the Commission and of the White Paper. Among others, the Bureau's memoranda stated the commitment of the sector they represented (the PNFP sector – private not-for-profit sector) to pursue the national policy objective.

In 2010 Government of Uganda promoted a new health reform that encourages public-private partnership in health (PPPH) as a way to achieve economic growth, poverty eradication and to increase geographical access to health care. This initiative is intended to strengthen partnership with private sector in order to facilitate rapid and equitable development, supporting private initiative in health service delivery. The policy was inspired by the World Development Report 1993 (World Bank), refers to three different private partners: private health non for profit health providers; private health practitioners; and traditional and complementary medicine practitioners.

This health reform encouraged reflection and change on role of the State in health; the changes on individual and social tactics of access and usage of health facilities; and which kind of integration of traditional medicine the Government wants to promote. In 2001 the Government eliminated the "user fees" for public health services. Therefore, Ugandan example is useful to observe national rhetoric; alliances and entanglements between public and private sector and the relevance of concept of governance in health at national and international level.

2.9 Summary of Literature Review

On analysis, literature suggested that participation, networking and cooperation, availability of finance, government policies and institutional characteristics play a vital role in health service delivery under public private partnership. However, there was need to investigate how stakeholder participation is made functional and sustained? What proportion of financial resources is appropriate and how this proportion directly influences quality of health service? And how institutional characteristics, government policies, networking and cooperation impels and impedes the attainment of quality health service delivery in public private partnership?

Participation creates an understanding of the direction public private partnership in health service provision should take as a constituent for achieving quality. Literature reviewed however does not wholly synthesize and present information on how meaningful beneficiary participation in public private partnership in health service provision should be initiated and sustained and, how the rules for participation can be determined, thus a gap that could be explored. Literature evidently indicated the usefulness of beneficiary participation in capacity building, empowerment and ability to influence public private partnership to harmonize the realization of quality.

Financial resource allocation can no longer be under looked. Finance is an impelling force behind a thriving plan. A number of institutions fail to inform quality of service due to financial constraints.

Institutional characteristics are visibly a hinge that holds the bondage between public private partnership in health and quality of health service. Literature fairly showed that institutions

tailor their public private partnership in health service provision demands to their quality terms and it is generally cumbersome to amalgamate a system that fits all.

Increased responsibility and level of resources at the disposal of institutions have hoisted the query of beneficiary capacity. Public private partnership in health justifies appropriate accountability for meager resources and breeds the much needed thrust for effective control intended at quality perfection. To pledge the realization of health service quality, desired outcomes must be identified, monitored and improved with careful allegiance to public private partnership in health supported by steady financial support, meaningful participation, networking and cooperation, government policy and adaptation to institution's way of working, thus the basis for this study.

CHAPTER THREE
METHODOLOGY

3.1 Introduction

This chapter describes the research design techniques that were used to obtain the required data. It comprises of research design, study area and population, sample selection and size, study instruments, pre-testing, data collection and data analysis.

3.2 Research Design

Research design was cross-sectional in nature and employed both qualitative and quantitative research methodology to ensure triangulation. Qualitative data provided detailed information about the phenomenon being studied and therefore enabled the study to establish patterns and relationships among variable. While quantitative data allowed for the distribution of variables using standard statistical procedures such as frequencies, percentages and measures of variability.

Quantitative approach measured incidences in order to describe current conditions and explore the relationship between the independent and dependent variables using information got through questioning. Qualitative approach gives explanation of events and descriptions based on interview and document analysis (Sekaran, 2003). Relevant reports were obtained and information pertinent to the study was extracted to inform the research questions.

3.3 Study Area

The study was conducted with focus on Lira district with particular emphasis to Barr and Amach Sub Counties. The justification for choosing these areas was that they have witnessed huge health service delivery by both the public and private partners. The highest number of these have however concentrated in urban areas.

3.4 Study Population

The study was carried out in Lira District with target respondents of 90 which included; Lira District Local Government (11), Reproductive Health Uganda (14), Ministry of Health (7), Lira Regional Referral Hospital (10), Medical Department (5), Top management (7), Gender

Department (2), Project management (5), Administration (4), Ayago H/C III (5), Lira medical centre (3), Lira Pentecostal Church Health Centre (5) and Ronam medical centre (5).

These are the people who provide health services; influence policies and make decisions in those institutions.

3.5 Sample Size and Selection

In order to obtain a representative sample the research involved all categories of staff that is established and contract staff. The study used stratified sample, random and purposive sample techniques to determine the sample size. Stratified sampling was used to categorize the employees into senior, middle and junior level staff using their appointments (positions) either head of department or in-charge of the organization.

Simple random sampling was used to select 90 respondents from Lira district. Simple random sampling is defined by Robson (1993) cited in Rwabogo (2001) is a selection at random from a list of population (staff) of local government and health workers in Lira district as at August (2013) of the required number of respondents for the sample. The researcher adopted this method because it was easy to use and gives very representative selection of senior officials according to their responsibilities. The Chief Administrative Officer and Heads of Organizations were selected by virtue of their office and position. This method was adopted because it was convenient and saved time

The key informants comprised of District Executive, departmental heads, extension workers, CSO heads and representatives of the private sector.

Table 1: Accessible population and sample size

Study population	Target population	Sample	Sampling technique	Justification for the design
Lira District relevant health technical staff (chief administration office, community based services department, education sector, health sector, political representative, planning unit, production department and child and family protection unit)	40	38	Simple random and Purposive sampling	A probability design in which all 40 targeted individuals had known and equal chance of being selected
Civil Society Organizations (non governmental organizations, community based organization and faith based organization) members & staff.	30	20	Simple random and Purposive sampling	A probability design in which all the 30 individuals had known and equal chance of being selected
Other private institutions	20	17	Simple random and Purposive sampling	A probability design in which all 20 targeted individuals had known and equal chance of being selected
Total size	90	75		

3.6 Data Collection Methods

Making choice among the different data collection methods involves considering appropriateness and relative strength and weaknesses of the various methods. To ensure accurate data collection and convenient methods for respondents, the researcher used questionnaire, interview guide and document review. The questionnaire was the major instrument of data collection as it covered a big percentage of the respondents. Questionnaires were administered to 90 respondents and interviews scheduled were given to

a sample of 15 senior staff plus managers. The respondents were given ample time to complete the questionnaire.

3.7 Data collection instruments

3.7.1 Questionnaire:

Hursey (1997) defined questionnaire as a list of carefully structured questions chosen after considerable testing with a view of enticing reliable responses from chosen sample. This was the main instrument used by the researcher. A structured questionnaire contains a list of all possible alternatives from which respondents select the answer that best suits the situation (Mugenda and Mugenda, 1999 pg.72).

The questionnaire used was closed ended. The closed ended questions based on Likert scale were used to elicit uniformity in the answers given and to make it simpler to transform the data into questionnaire data for ease of analysis. Closed ended questions were used because they were easy to complete and time saving. The open ended questions were used to enrich the answers given to the closed ended questions. Respondents were assured from the beginning of the exercise of confidentiality of information given. Names or any kind of identifications were not required in the exercise. Questionnaires were used because it is appreciated that they work best with standardized questions that one is confident will be interpreted the same way by all or majority of the respondents (Robson 1993). It is further considered that questionnaires work correctly, requires less skills and sensitivity to administer than semi-structured interviews. The questionnaire used is attached as appendix I.

3.7.2 Interview Guide

Open ended interview guides were used to get in-depth information from senior staff who are key in human resource management in the organizations. This was useful because it enable the researcher to probe deeper into answers of respondents as they gave their opinion on the matter. This was good for triangulation of the results generated from the questionnaires. The interview guide used is attached as appendix II.

3.7.3 Document Review

During the study, document review was used to provide easy analysis of the contents of documentary material, such as textbooks, journal articles, newspapers and speeches.

The study was further enriched by documentary review of documents such as Health Guidelines, Annual reports of the organizations, health manuals pus several other health related documents and reports. These were in forms of books and pamphlets which could not be attached to this report.

3.8 Pre-testing of instruments

3.8.1 Reliability:

To determine the content validity and reliability of the instruments, the list of objectives and research questions were used to guide the construction of the questionnaire and interview guide. Questionnaires were designed and pre-tested among 10 officers from Lira district and some NGOs. After careful consideration of their responses, those questions that seemed not clear were re-written. The questionnaires were then resubmitted to the same group to ensure that they were easily understood by all. This was done to publish the questions and make them friendly to the respondents

According to Sekaran (2000), reliability of less than 0.6 is considered as poor, those in 0.7 ranges tend to be acceptable while those over 0.8 are good. The study therefore utilized a variable coefficiency of 0.7 as the minimum accepted for social research. A reliable instrument yields consistent results and validity depended on the status of evidence of occurrences.

3.8.2 Validity:

The validity consideration was taken care of to ensure accuracy of the data obtained from the study. To ascertain the validity in the study under review questions were carefully selected and were reviewed by an expert/specialist in the area of Health services and UMI supervisor and also peer review by colleagues undertaking similar research. This was done to ensure that the instruments were suitable for the study.

Validity is measured by the formula

$$CVI = \frac{\text{Total rated by the judge}}{\text{Total No. of items in the instruments}}$$

According to Amin (2005). You need a CVI of 0.7 to be sure that the instrument will collect valid data

3.9 Procedure in Collecting Data

Before conducting study, the researcher got permission through a letter of introduction from Uganda Management Institute which was given to the authorities of the different district departments and identified institutions through which the study was carried out. The letter of introduction also inspired the respondents to cooperate with the researcher. The selected respondents were requested to complete and return the questionnaires within a given period of time (8-10 days) without inconveniencing them at any point of data collection. The distributed questionnaires were accompanied by the letter clearly stating the purpose of the study and stressing a statement of confidentiality of the information given.

3.10 Data Analysis

Bell (1997) stated that data collected by means of questionnaires, interview guides or any other methods means little until it is analyzed. Accordingly, the raw data from research instruments were organized, cleaned and edited to eliminate errors. For the purpose of data cleaning, editing of questionnaires was done immediately after the questionnaires were handed back to the researcher. This was done in order to ensure that all the questions were answered and free of errors. These were identified and categorized accordingly. Coding was done so that responses to open-ended questions are meaningfully, exhaustively categorized for purposes of data entry and analysis.

The data collected was analyzed by using both qualitative and quantitative methods. Descriptive methods were used for qualitative data in order to answer the research questions which were open ended by describing in details.

Data analysis was done using SPSS (Statistical Package for Social Sciences) statistical software by generating frequency and percentages for the different variables at the univeriate level analysis. Bivariate level analysis was done to establish the statistical significance of the relationship between the variables. Pearson's correlation coefficiency, regression analysis was also carried out to determine the impact of the correlation. The qualitative data was summarized and categorized according to the created themes and sub themes.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF RESULTS

4.1 Introduction

This chapter presents analysis and interpretation of results. It has been structured into five parts;

Part I presents background information about respondents and institutions reached; Part II presents extent to which stakeholder participation in public private partnerships affect health service delivery; Part III answers how networking & cooperation in Public Private Partnership in Health Service Delivery contributes to the quality of services, Part IV answers how institutional characteristics affect quality of health service delivery and lastly; Part V looks at how government policies affects health service delivery.

4.2 Background Information about Respondents and Institutions reached

4.2.1 Gender of Respondents

Table 2: presents the gender composition of respondents who participated in the study.

Table 2: Gender composition of respondents			
Gender	Frequency	Percent	Valid Percent
Male	43	57.3	57.3
Female	32	42.7	42.7
Total	**75**	**100.0**	**100.0**

A total of 75 respondents participated in the interview. 57.3 % of the respondents were male and 42.7% were female as illustrated in table (Table 2). This analysis means that men dominate key positions in the institutions sampled much as the gap between them is not so wide. This gender disparity had little or no statistical influence on the study.

4.2.2 Education Level

Table 3 shows that out of 75 respondents, 10.7% had post graduate qualifications while 5.7% specifically had Post Graduate Diploma in Public Administration and Management (PGDPAM) and 45.3% were graduates. 34.7% of the respondents interviewed attended

tertiary institutions and 4% attended A-Level education. Key informants were largely managers and senior officers with high levels of education. This could mean that the positions occupied by respondents sampled require high level of education and this could as well have affected responses to the research questions since the researcher dealt with intellectual respondents. Much as most stakeholders have qualified staff employed, issues of refresher training for staff kept coming during the interview.

Table 3: Level of education of respondents

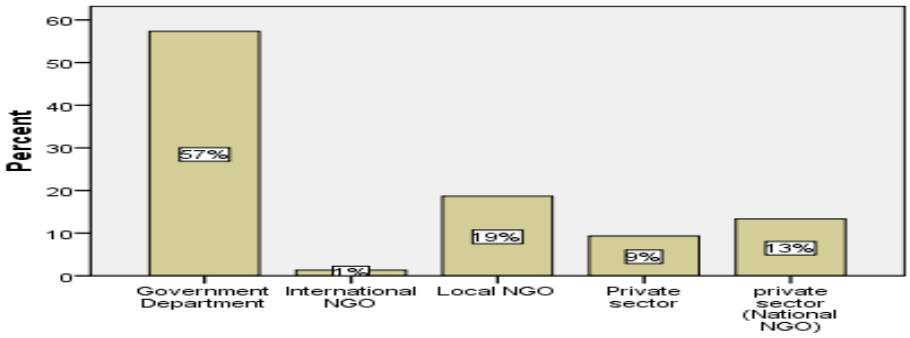
Education level	Frequency	Percent
A-Level	3	4.0
Institution	26	34.7
University	34	45.3
Other(PGDPAM)	4	5.3
other (Post graduate school)	8	10.7
Total	**75**	**100.0**

4.2.3 Years served in the organization/department and Job titles of the respondents

Overall there is a good balance in the years of service in the organization/department which ranges between 1 and 10 years with majority serving for at least more than five (5) years. People interviewed include; in charge of health facilities, Nursing officers, Service providers, Security officers, Laboratory technicians, Directors, Gender Officers, Monitoring and Evaluation Officers, A. Chief Administration Officer, District Health Officer, Clinicians, Health and psychosocial officers and overall leaders of the organizations/institutions.

In terms of departments/types of organization, figure 2 shows that 57.3% of the respondents out of 75 interviewed were from government departments. 18.7% were from local NGOs, 13.3% from national NGOs followed by 9.3% from private sector and 1.3% of the respondent interviewed came from international NGO.

Figure 2: Type of the organization/department

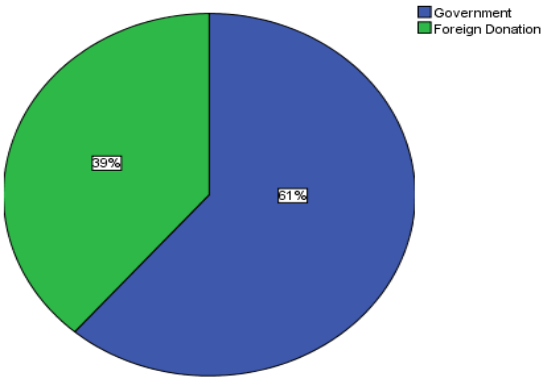


These Respondents were drawn from the following organizations/departments; Lira District Local Government (11), Reproductive Health Uganda (14), Ministry of Health (7), Lira Regional Referral Hospital (10), Medical Department (3), Top management (3), Gender Department (2), Project management (4), Administration (4), Ayago H/C III (5), Lira medical centre (3), Lira Pentecostal Church Health Centre (1) and Ronam medical centre (1).

As shown on Figure 3 below, majority (61.3%) of institutions relied on government funding to execute programmes since majority of them were from government departments. Thirty eight point seven percent (38.7%) get funds from foreign donations. Most institutions relied on one source of funding, and this means that resources are inadequate and only one source of funds may not satisfy an institution's needs and the reason most are government dependent.

A key informant noted that, sufficient finances for public private partnership in health can lead to continued quality health service provision because it makes a project to be implemented according to plan. Efficient finance allocation to relevant partners promotes improvement in relevancy, effectiveness and efficiency of implementation and greatly improves quality of service.

Figure 3: source of funds



4.3 Part II: Institutional characteristics

This section examines the extent to which Stakeholder participation in Public Private Partnership in Health Service Delivery affect health service delivery. A number of indicators were analyzed as shown on Table 4; which presents a list of indicators with their percentage scores showing how institutional characteristics in public private partnerships affect health service delivery;

Table 4: Stakeholder participation in Public Private Partnership in Health Service Delivery

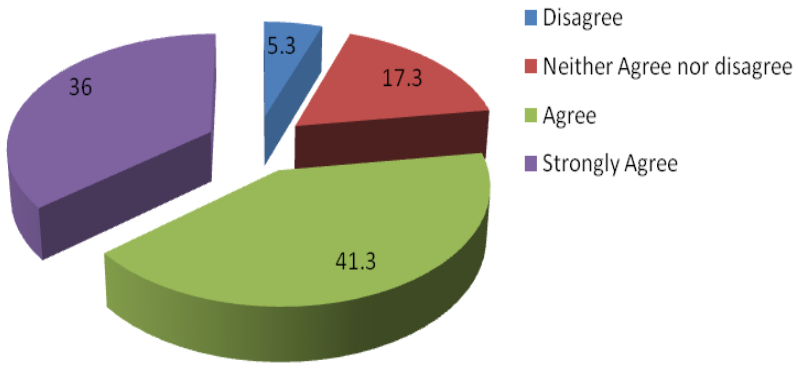
Variable	Response (%)				
	Strongly disagreed	Disagreed	Neither agreed nor disagreed	Agreed	Strongly agreed
9. Our organization had partnership building experience before	0	5.3	17.3	41.3	36.0
10. The goals set were clear and realistic to members	1.3	5.3	9.3	26.7	57.3
11. Members agreed on how the partnership was to be Run	10.7	12.0	29.3	29.3	48.0
12. The partnership goals set were related to our own organizational objectives and plans	1.3	5.3	13.3	38.7	41.3
13. Agendas for meetings are distributed in advance and minutes for all meetings availed to all members	4.0	10.7	17.3	29.3	38.7
14. Areas of responsibility /roles played by stakeholders are clearly defined	5.3	5.3	12.0	30.7	46.7
15. The collaboration goals were very instigating to all partners	0	5.3	16.0	41.3	37.3
16. Partners present their plans/ agendas, honestly and openly	2.7	4.0	26.7	32.0	34.7
17. Partners fully contribute to the design, management and evaluation of projects	2.7	9.3	16.0	33.3	38.7

Table 4: Stakeholder participation in Public Private Partnership in Health Service Delivery					
Variable	Response (%)				
	Strongly disagreed	Disagreed	Neither agreed nor disagreed	Agreed	Strongly agreed
18. When conflicts arise among partners, are resolved amicably Without blaming each other.	1.3	20.0	12.0	28.0	38.7
19. Partnership membership/ or stakeholders are well defined	0	1.3	12.0	38.7	48.0
20. Partnership management policies reflect equality	4.0	18.7	16.0	33.3	28.0
21. Resources are planned for and allocated properly	2.7	13.3	14.7	36.0	33.3
22. Partner organizations were aware right from inception what the partnership would entail	2.7	16.0	12.0	38.7	30.7
23. Working arrangements/ systems in the partnership are flexible i.e. Can be easily changed whenever appropriate	5.3	16.0	16.0	29.3	33.3
24. Partner organizations' duties in the partnership were discussed optimally and agreed upon	0	16.0	20.0	25.3	38.7
25. Partner organizations' duties in the partnership do not interfere with their other non- partnership activities	5.3	16.0	22.7	34.7	21.3
26. All stakeholders are treated with respect and always consulted when making decisions	0	13.3	16.0	26.7	44.0
27. My organization utilizes partnership resources and creativity for accomplishing its goals.	0	13.3	8.0	30.7	48.0
28. Stakeholders plan and deliver services through the existing local government structures.	0	20.0	12.0	22.7	45.3
29. Partners receive timely reports on the jointly implemented activities	1.3	16.0	21.3	33.3	28.0
30. Partners are satisfied with the progress the partnership is making.	2.7	16.0	24.0	22.7	34.7

The result shows that in overall 41.3% of the respondents agreed that their organizations had partnership building experience before. This was followed by 36% of the respondents who strongly agreed that their organizations had partnership building experience before. 17.3% of the respondents neither Agreed nor disagreed with the statement while 5.3% disagreed when asked whether their organizations had partnership building experience before. With prior experience in partnership building, it was easy for most stakeholders to adjust their programming.

Results from the interviews indicate that most times, key partners are invited to participate in planning which means that most partners are participating in planning for health service delivery under Public Private Partnership in Health Service Delivery.

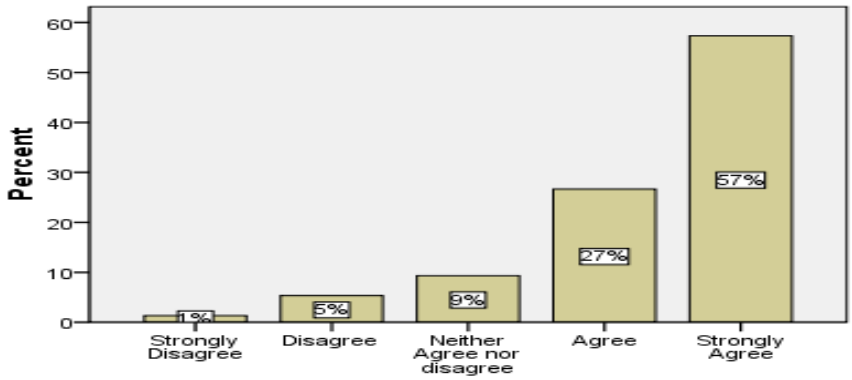
Fig 4: Partnership building experience



On goal setting, 57.3% of the respondents strongly agreed that goals set were clear and realistic to members meanwhile 26.7% of the respondents just agreed with the statement. Much as 5.3% of the respondents disagreed with the statement, 1.3% strongly disagreed that the goals set were clear and realistic to members. It is also interesting to note that 9.3% neither Agreed nor disagreed with the statement. This explains why partners are committed in providing health services to the people because they are fully aware of what they are supposed to do and what is expected of them.

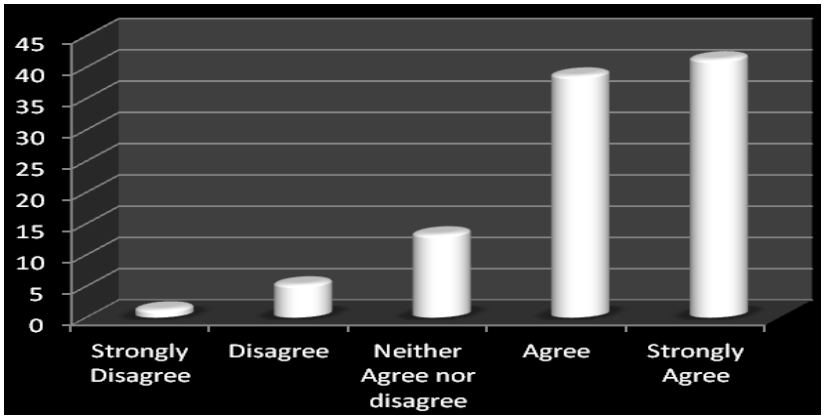
This further means that majority of institutions have a well expressed and clear institutional goals which clearly and concisely convey the direction of the organization.

Figure 5: Shows how goal set were clear and realistic to members



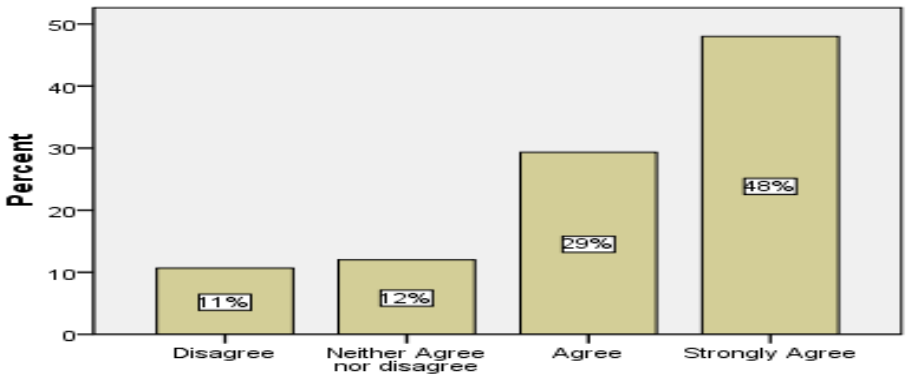
When asked whether the partnership goals set were related to their own organizational objectives and plans, 41.3% of the respondent strongly agreed with the statement while 38.7% of the respondent interviewed just agreed that partnership goals set were related to their own organizational objectives and plans as shown in figure 6. Much as 13.3% of the respondents neither Agreed nor disagreed with the statement, 5.3% disagreed and 1.3% strongly disagreed that partnership goals set were related to their own organizational objectives and plans. This finding further explains reasons as to why these organizations bought in partnership ideas and blended it into their own organizations' plans.

Figure 6: Partnership goals set were related to our own organizational objectives and plan



On agreement how partnership was to be run; findings (Fig 7) indicates that a total of 48% of the respondents strongly agreed that members agreed on how partnership was to be run while 29.3% just agreed with the statement. However, 11% of the respondents disagreed that members agreed on how partnership was to be run and 12% neither agree nor disagree.

Fig 7: agreement on how partnership was to be run

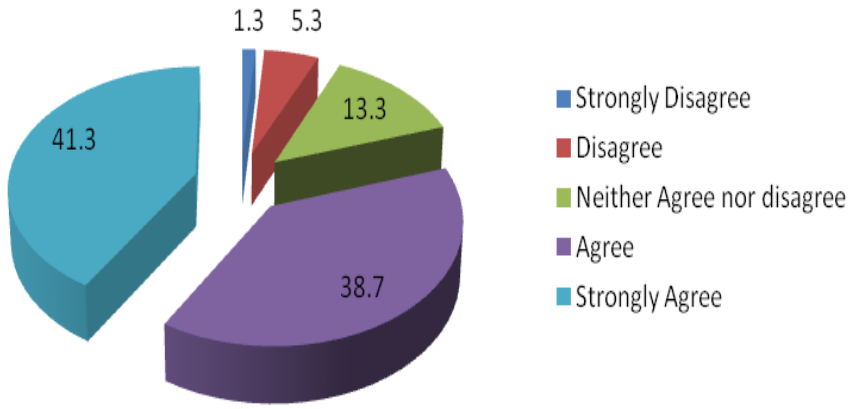


Concerning the agenda for meetings; 38.7% of respondents strongly agreed that agenda for meetings are distributed in advance and minutes for all meetings availed to all members while 29.3% just agreed. 10.7% disagreed and 4% strongly disagreed that agenda for meetings are distributed in advance and minutes for all meetings availed to all members. Meanwhile 17.3% of the respondents neither agreed nor disagreed that agenda for meetings are distributed in advance and minutes for all meetings availed to all members as shown in table 4 above. From the key informant, at least majority of the respondents agreed that partners have meetings always much as there were different views on the agenda for the meeting but it should be noted that top managers are given agenda for the meeting in advance.

On roles played by stakeholders, out of the 75 respondents interviewed, 46.7% strongly agreed and 30.7% just agreed that areas of roles played by stakeholders are clearly defined. However, 10.3% of the respondents disagreed that areas of roles played by stakeholders are clearly defined. 12% of the respondents interviewed neither Agreed nor disagreed that areas of roles played by stakeholders are clearly defined. This means that partners are fully aware of their roles under public private partnership and health service delivery in Uganda with majority of the respondents agreeing that roles played by stakeholders are clearly defined.

Looking at how partners present their plans/agenda, honestly and openly, 34.7% of the respondents out of the 75 interviewed strongly agreed and 32% of the respondents just agreed that partners present their plans/agenda, honestly and openly. 4% disagreed and 2.7% of the respondents interviewed strongly disagreed that partners present their plans/agenda, honestly and openly. However, 26.7% of the respondents neither Agreed nor disagreed that partners present their plans/agenda, honestly and openly as shown in figure 8 below.

Figure 8: Partners present their plan/ agendas, honestly and openly

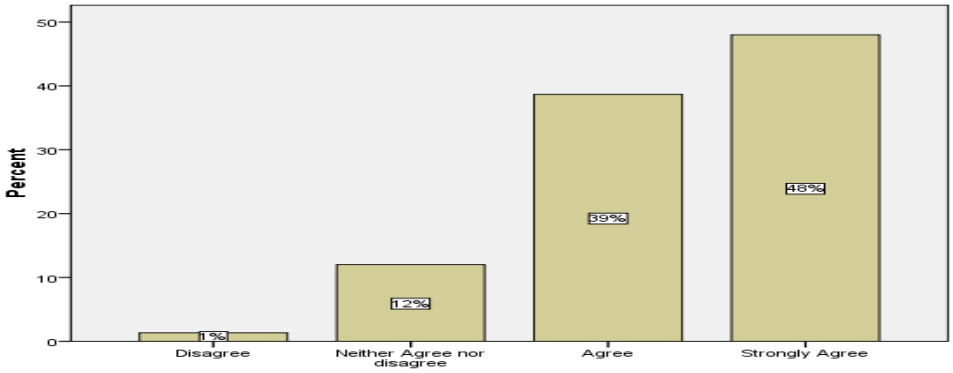


On full contribution in the design, management and evaluation of projects, 38.7% strongly agreed that Partners fully contribute, 33.7% just agreed, while 9.3% disagreed. 2.7% of the respondents interviewed strongly disagreed while 16% neither agreed nor disagreed that partners fully contribute to the design, management and evaluation of projects.

In terms of conflict resolution among partners, table 4. Shows that out of the 75 respondents interviewed; 38.7% strongly agreed and 28% just agreed that when conflicts arise among partners, it is resolved amicably without blaming each other. However, 20% of the respondents interviewed disagreed that conflicts among partners are always resolved amicably without blaming each other and 12% neither agreed nor disagreed with the statement.

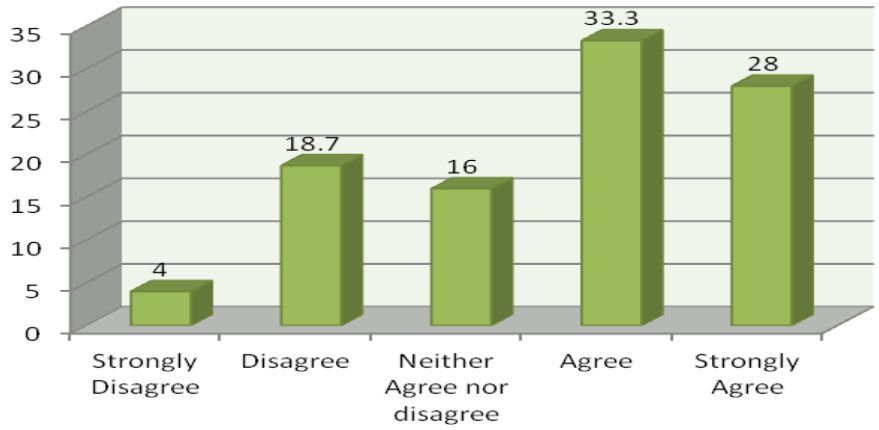
The study also looked at whether partnership membership/ or stakeholders are well defined and figure 9 indicates that 48% of the respondents strongly agreed while 38.7% of them just agreed that partnership membership are well defined. Much as 1.3% of the respondents interviewed disagreed, 12% of them neither agreed nor disagreed that partnership membership are well defined.

Figure 9: Partnership membership/ or stakeholders are well defined



When asked whether partnership management policies reflect equality, out of 75 respondents interviewed, 33.3% of the respondents just agreed and 28% strongly agreed that partnership management policies reflect equality. However, 18.7% of the respondents disagreed with the statement while 4% strongly disagreed that partnership management policies reflects equality. 16% neither agreed nor disagreed that partnership management policies reflects equality as shown in figure 10 below. Majority of the respondents interviewed seems ignorant as to whether partnership management policies reflect equality and this could affect the delivery of health services under public private partnerships in one way or the other.

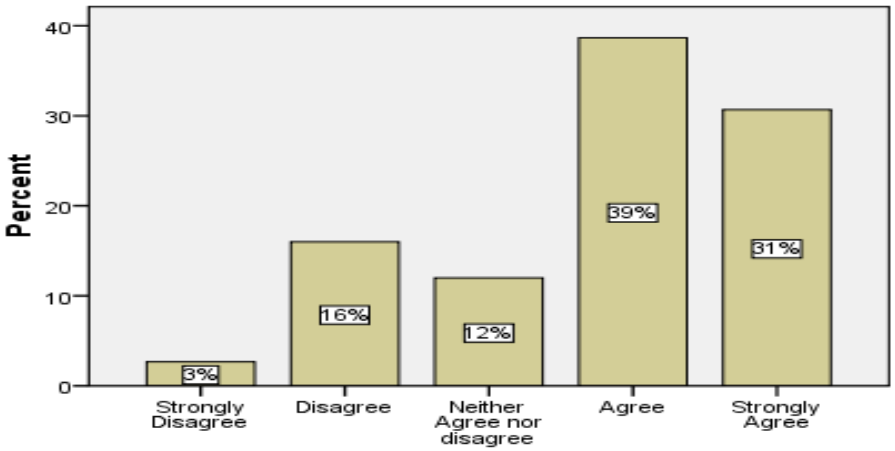
Figure 10: Partnership management policies reflect equality



The findings further shows that 36% of the respondents agreed that resources are planned for and allocated properly while 33.3% out of 75 interviewed strongly agreed with the statement. Much as 13.3% of the respondents disagreed that resources are planned for and allocated properly, only 2.7% strongly disagreed and 14.7% of the respondents neither agreed nor disagreed with the statement.

When asked whether partner organizations were aware right from inception what partnership would entail, 38.7% of the respondents out of the 75 interviewed agreed that partner organizations were aware right from inception what partnership would entail and 30.7% strongly agreed with the statement. Much as only 2.7% of the respondents strongly disagreed and 16% disagreed with the statement; figure 11 shows that 12% neither agreed nor disagreed that partner organizations were aware right from inception what partnership would entail.

Figure 11: Partner organizations were aware right from inception what the partnership would entail



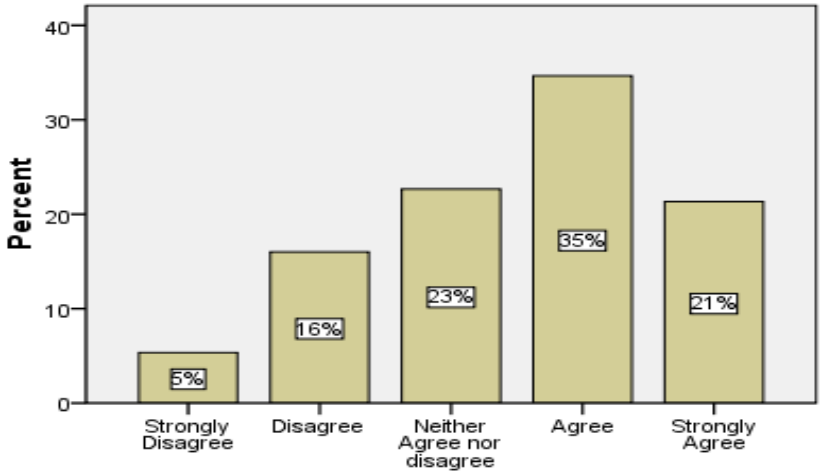
Out of the 75 respondents interviewed, 33.3% strongly agreed that working arrangements/ systems in the partnership are flexible and can be easily changed whenever appropriate and 28.3% just agreed. However, 16% of the respondents disagreed with the statement and 5.3% strongly disagreed with the statement that working arrangements/systems in the partnership are flexible and can be easily changed whenever appropriate. A total of 16% of the respondents neither agreed nor disagreed that working arrangements/systems in the partnership are flexible and can be easily changed whenever appropriate

From the analysis, it was found that 38.7% of the respondents interviewed strongly agreed that partner organizations' duties in the partnership were discussed optimally and agreed upon while 25.3% just agreed. It is interesting to note that 20% of the respondents neither

agreed nor disagreed with the statement that partner organizations' duties in the partnership were discussed optimally and agreed upon while 15% disagreed with the statement.

34.7% of the respondents interviewed agreed that partner organizations' duties in the partnership do not interfere with their other non-partnership activities while 21.3% strongly agreed. However, 16% of the respondents disagreed and 5.3% strongly disagreed that partner organizations' duties in the partnership do not interfere with their other non-partnership activities meanwhile 22.7% of the respondents neither agreed nor disagreed with the statement as shown in figure 12.

Figure 12: partner organizations' duties in the partnership do not interfere with their other non-partnership activities



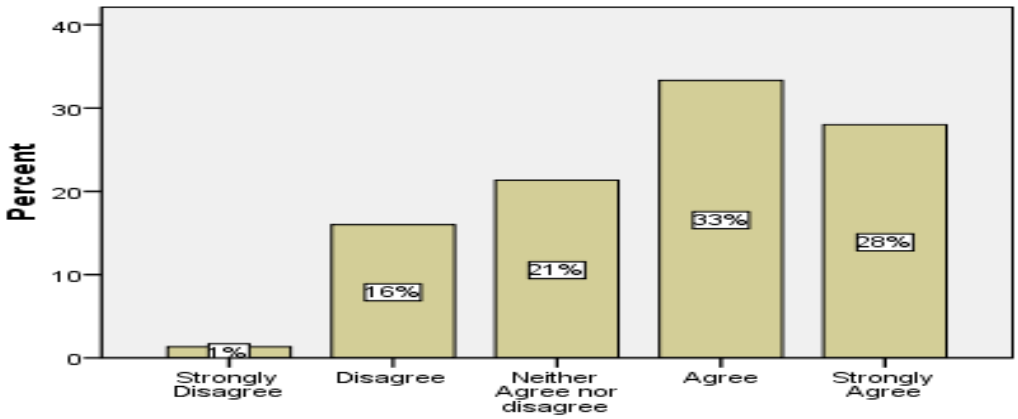
When asked whether all stakeholders are treated with respect and always consulted when making decisions, 44% of the respondents interviewed strongly agreed while 26.7% just agreed. 13.3% of the respondents out of the 75 interviewed disagreed with the statement that all stakeholders are treated with respect and always consulted when making decisions and 16% neither agreed nor disagreed.

Out of the 75 respondents interviewed, 48% strongly agreed and 30.7% just agreed that their organization utilizes partnership resources and creativity for accomplishing its goals. However, much as 13.3% of the respondents interviewed disagreed that their organization utilizes partnership resources and creativity for accomplishing its goals, 8% of the respondents out of the 75 interviewed neither agreed nor disagreed.

45.3% of the respondents out of the 75 interviewed strongly agreed that Stakeholders plan and deliver services through the existing local government structures while 22.7% of them just agreed. While 20% disagreed, 12% of the respondents interviewed neither agreed nor disagreed that Stakeholders plan and deliver services through the existing local government structures.

In terms of partners receiving reports on jointly implemented activities, 33.3% of the respondents just agreed and 28% strongly agreed that partners receive timely reports on the jointly implemented activities. 16% of the respondents interviewed disagreed and only 1.3% of them disagreed strongly that partners receive timely reports on the jointly implemented activities. 21.3% of the respondents neither agreed nor disagreed that partners receive timely reports on the jointly implemented activities as shown in figure 13 below.

Figure 13: Partners receive timely reports on the jointly implemented activities



The study also went ahead to find out whether partners are satisfied with the progress that partnership is making and out of the 75 people interviewed, 34.7% said that they strongly agreed that they are satisfied with the progress that partnership is making and 22.7% just agreed. However, 16% of the respondents disagreed, 2.7% disagreed strongly that they are satisfied with the progress that partnership is making and 24% neither agreed nor disagreed that partners are satisfied with the progress that partnership is making.

4.4 Part II: Networking & Cooperation and how it affects service delivery under public private partnership

Another aim of the study was to establish how institutional framework in public private partnerships affects health service delivery in Lira district. A number of indicators to establish how Networking & Cooperation affect service delivery under public private partnership are here in Table 5 below;

SECTION 11: NETWORKING & COOPERATION

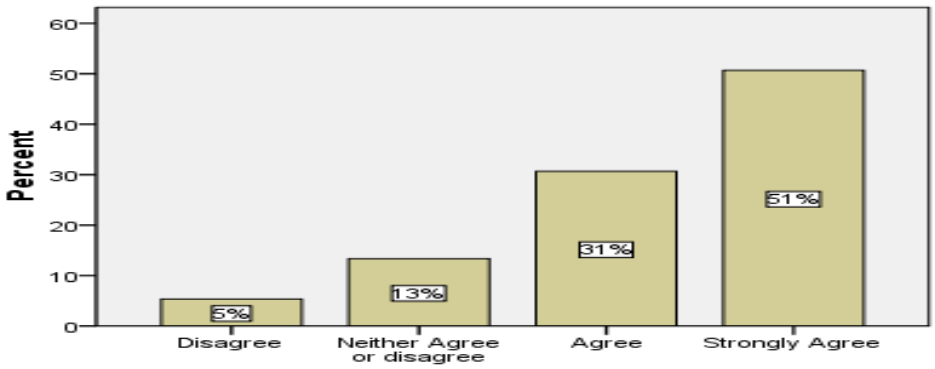
Table 5: Networking & Cooperation and how it affects service delivery under public private partnership

	Strongly Disagree	Disagree	Neither Agree or disagree	Agree	Strongly Agree
31. Our organization had networking/ cooperation ties before	0	5.3	13.3	30.7	50.7
32. The top leadership in our organization/department are supportiv to networking and cooperation	0	6.7	5.3	48.0	40.0
33. We receive timely and clear reports on the impact and updates c networking/ cooperation	0	6.7	22.7	28.0	42.7
35. Our organization gives us chance to share and review c strengths, weaknesses, and recommend way forward together	1.3	13.3	14.7	37.3	33.3
36. Our organization optimally participates in the planning collaboration activities	0	14.7	14.7	25.3	45.3
37. Members always meet to review/ affirm the vision-missi strategy		12.0	9.3	34.7	44.0
38. Partners share information in proactive manner	2.7	13.3	17.3	32.0	34.7
39. There is clear understanding and communication vision/priorities	1.3	9.3	21.3	42.7	25.3
40. Our organization gets more partners as a result of this partnersh		2.7	26.7	41.3	29.3
41. Partners are frequently helped to find and obtain resources	1.3	5.3	16.0	28.0	49.3
42. There is an updated list of partners with which our organization works with and what has been done together so far	0	5.3	13.3	34.7	46.7
43. There is promotion of equal opportunities among partners	1.3	12.0	16.0	33.3	37.3
44. Information flow is both bottom up and up down	2.7	10.7	13.3	28.0	45.3
45.Partnership's objectives and goals are understood by stakeholder		5.3	9.3	40.0	45.3

On whether partner organizations had networking/cooperation before, 50.7% of the respondents out of the 75 interviewed strongly agreed and 30.7% just agreed that their

organizations had networking/ cooperation ties before. Much as 5.3% of them disagreed, 13.3% of the respondents interviewed were not sure whether their organizations had networking/ cooperation ties before as shown in figure 14 below.

Figure 14: Our organization had networking/ cooperation ties before



From the study, 48% of the respondents interviewed agreed and 40% agreed strongly that top leadership in their organization/ department is supportive to networking and cooperation. Only 6.7% of the respondents out of 75 people interviewed disagreed that top leadership in their organization/ department is supportive to networking and cooperation while 5.3% of them were not sure.

Majority of the people interviewed reported receiving timely and clear reports on the impact and updates of networking/ cooperation with 42.7% agreeing strongly and 28% just agreeing. However, only 6.7% of the respondents disagreed and 22.7% of them were not sure about receiving timely and clear reports on the impact and updates of networking/ cooperation.

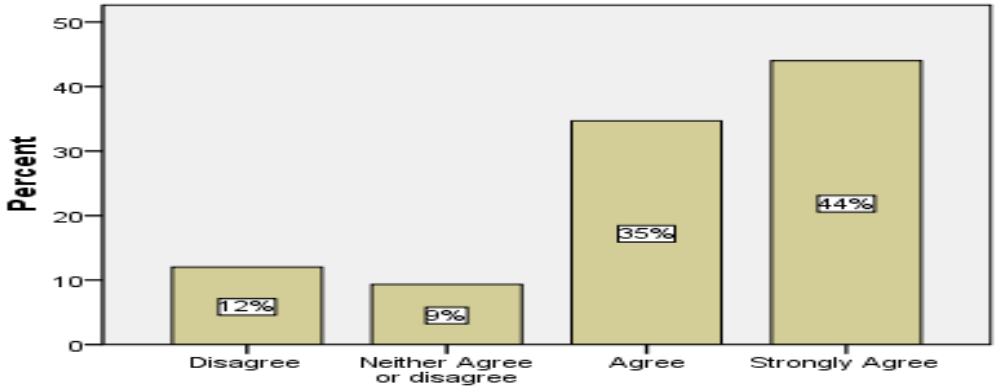
Out of the 75 people interviewed, 37.3% agreed and 33.3% agreed strongly that their organizations give them opportunity to share and review their strengths, weaknesses and recommends way forward together. 13.3% disagreed and only 1.3% disagreed strongly that their organizations give them opportunity to share and review their strengths, weaknesses and recommends way forward together while 14.7% were not sure.

When asked whether their organizations optimally participate in the planning of collaboration activities, 46.3% out of 75 respondents interviewed strongly agreed and 25.3%

just agreed that their organizations optimally participate in the planning of collaboration activities. Much as 14.7% disagreed, 14.7% of the respondents interviewed neither agreed nor disagreed that their organizations optimally participate in the planning of collaboration activities.

A total of 44% strongly agreed and 34.7% just agreed that members always meet to review/ affirm the vision- mission strategy. Figure 15 shows that 12% of the respondents interviewed disagreed and 9.3% neither agreed nor disagreed that members always meet to review/ affirm the vision- mission strategy.

Figure 15: Members always meet to review/ affirm the vision- mission strategy



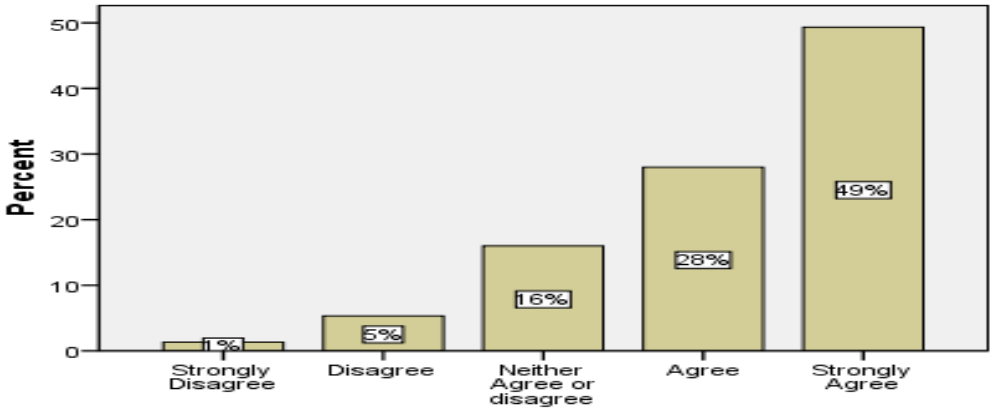
In terms of information sharing, 34.7% of the respondents interviewed strongly greed and 32% just agreed that Partners share information in proactive manner. However, 13.3% of the respondents disagreed and 2.7% disagreed strongly that Partners share information in proactive manner. Meanwhile 17.3% of the respondents out of the 75 interviewed were not sure whether Partners share information in proactive manner.

The study further explored whether there is clear understanding and communication of vision/ priorities among partners. 42.7% of the respondents agreed and 25.3% agreed strongly that there is clear understanding and communication of vision/ priorities. Much as 21.3% of the respondents interviewed were not sure whether there is clear understanding and communication of vision/ priorities, 9.3% of them disagreed and 1.3% strongly disagreed with the statement.

41.3% of the respondents agreed and 29.3% agreed strongly that their organizations get more partners as a result of this partnership. While 26.7% neither agreed nor disagreed, 2.7% of the respondents interviewed disagreed that their organizations get more partners as a result of this partnership.

In terms of support to partners, 49.3% of the respondents out of the 75 people interviewed strongly agreed that partners are frequently helped to find and obtain resources and 28% just agreed. However, 5.3% disagreed and only 1.3% of the people interviewed disagreed strongly. Figure 16 shows that a total of 16% of them were not sure whether partners are frequently helped to find and obtain resources.

Figure 16: partners are frequently helped to find and obtain resources



The study had also intended to find out whether there is an updated list of partners with what they are doing and the findings shows that 46.7% of the people interviewed strongly greed that there is an updated list of partners their organization works with and what has been done together so far and 34.7% just agreed. Much as 5.3% of them disagreed that there is an updated list of partners their organization works with and what has been done together so far, about 13.3% of the respondents interviewed were not sure.

When asked about promotion and equal opportunities among partners, a total of 37.3% of the respondents strongly agreed and 33.3% just agreed that there is promotion of equal opportunities among partners. Even if 16% of the respondents out of the 75 interviewed were not sure whether there is promotion of equal opportunities among partners, only 12% of them disagreed and only 1.3% disagreed strongly.

A total of 45.3% of the respondents agreed strongly and 28% of them just agreed that Information flow is both bottom up and up down. It was 10.7% of the respondents who disagreed and 2.7% disagreed strongly meanwhile 2.7% of the respondents were not sure whether Information flow is both bottom up and up down.

The study also explored whether partnership's objectives and goals are understood by stakeholders and the finding shows that 45.3% of the respondents agreed strongly that partnership's objectives and goals are understood by stakeholders while 40% of them just agreed. Even if a total of 5.3% of them disagreed, 9.3% of the respondents were not sure whether partnership's objectives and goals are understood by stakeholders.

4.5 Institutional Characteristics and how it affects service delivery under public private partnership

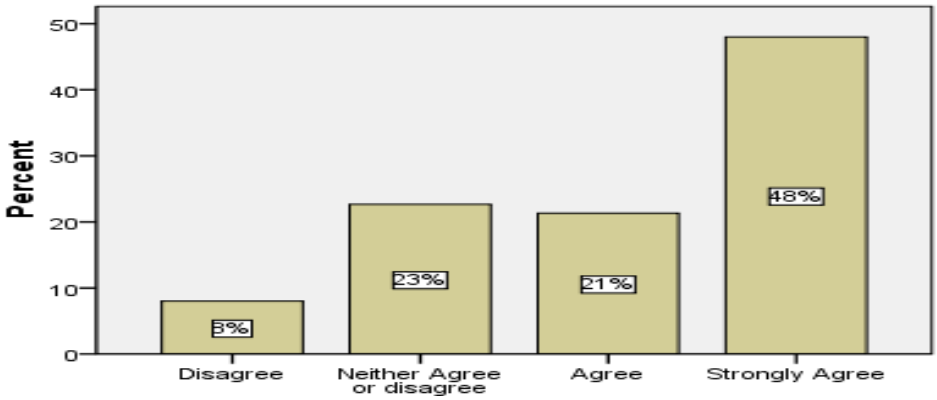
Table 6:Institutional Characteristics and how it affects service delivery under public private partnership

	Strongly Disagree	Disagree	Neither Agree or disagree	Agree	Strongly Agree
46. Our organization has clearly articulated mission/goals	0	8.0	22.7	21.3	48.0
47. Organization has a committee/board that meets & makes decisions that guides it's development	1.3	5.3	25.3	34.7	33.3
48.Our organization has an organizational structure/ chart with clearly defined lines of authority, roles, functions and responsibilities	1.3	2.7	21.3	30.7	44.0
49. Organization's purpose is clearly understood and approved	2.7	1.3	34.7	24.0	37.3
50.Planning/strategies are aligned with mission/goals	1.3	6.7	17.3	24.0	50.7
51. Team work is utilized effectively to achieve our organizatio objectives		5.3	5.3	41.3	48.0
52. Information is routinely shared on progress in achieving the the organization's purpose	2.7	6.7	13.3	42.7	34.7
53. Feedback from stakeholders and staff is routinely utilized to improve performance	1.3	8.0	13.3	26.7	50.7
54.Our organization ensures that staff and volunteers support and motivate each other and have sufficient skills	1.3	9.3	12.0	29.3	48.0
55. All stakeholders and staff are consulted when making decisions	0	5.3	16.0	37.3	41.3
56. Our organization is a member of other big NGO networks	1.3	9.3	9.3	45.3	34.7
57. Stakeholders/ staff are ever ready and open to learn new ideas techniques		5.3	8.0	50.7	36.0
58. Job descriptions in our organization are clearly defined	2.7	5.3	8.0	30.7	53.3
59. Clear lines of staff accountability in our organization are adhered to		14.7	6.7	36.0	42.7

Table 6:Institutional Characteristics and how it affects service delivery under public private partnership					
	Strongly Disagree	Disagree	Neither Agree or disagree	Agree	Strongly Agree
60. Human dignity and worth in our organization are respected	2.7	5.3	18.7	36.0	37.3
61.Resources are planned for and allocated properly	2.7	9.3	10.7	32.0	45.3
62. Relevant sectoral expertise exists in the our organization	0		8.0	52.0	40.0
63. Our organization regularly engages relevant policy makers & other institutions in dialogue related to our mission	4.0	4.0	13.3	45.3	33.3
66.Our organization has got plans to access additional resources to finance activities.	0	6.7	14.7	34.7	44.0

48% of the respondents interviewed strongly agreed while 21.3% just agreed that their organization has clearly articulated mission/goals. However, figure 17 shows that out of the 75 people interviewed, only 8% disagreed and 22.7% of the respondents were not sure whether their organizations had got clearly articulated missions/goals.

Figure 17: our organization has clearly articulated mission/goals



The study further found out that majority of the organizations had got committees/boards that meet and make decisions pertaining to the development of the respective organizations. From the analysis, 34.7% of the respondents interviewed agreed and 33.3% agreed strongly that their organizations had committees/boards that meet and make decisions that guide their development. Much as 25.3% of the people interviewed were not sure whether their organizations had committees/boards that meet and make decisions that guide their development, 5.3% of the respondents disagreed and only 1.3% of them disagreed strongly.

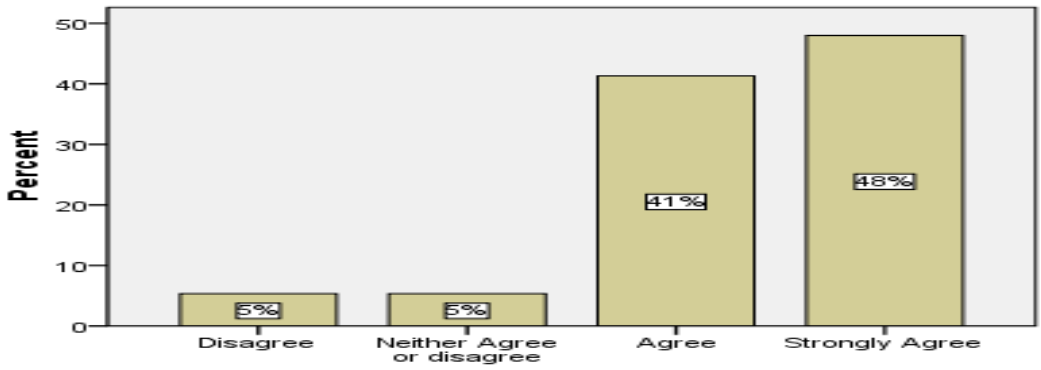
44% of the respondents strongly agreed that their organizations have an organizational structure/ chart with clearly defined lines of authority, roles, functions and responsibility and 30.7% just agreed. 2.7% of the respondents out of 75 interviewed disagreed and 1.3% disagreed strongly when asked whether their organizations have an organizational structure/ chart with clearly defined lines of authority, roles, functions and responsibility meanwhile 21.3% neither agreed nor disagreed.

The study further found that out of the 75 people interviewed, a total of 34.7% of the respondents were not sure whether organization's purpose is clearly understood and approved. Even though 37.3% of them strongly agreed and 24% just agreed that organization's purpose is clearly understood and approved, 1.3% of the respondents disagreed and 2.7% strongly is agreed when asked whether organization's purpose is clearly understood and approved.

In an attempt to find whether planning strategies are aligned with mission/goals, 50.7% of the respondents strongly agreed and 24% just agreed that planning/ strategies are aligned with mission/ goals. However, 6.7% of the respondents interviewed disagreed, 1.3% disagreed strongly and 17.3% neither agreed nor disagreed that planning/ strategies are aligned with mission/ goals.

Figure 18 shows that a total of 48% of the respondents interviewed strongly agreed and 41.3% just agreed that team work is utilized effectively to achieve their organizational objectives. However, 5.3% of them disagreed and equally 5.3% of the respondents were not sure whether team work is utilized effectively to achieve their organizational objectives.

Figure 18: Team work is utilized effectively to achieve our organizational objectives



In terms of information sharing among, 42.7% agreed and 34.7% agreed strongly that information is routinely shared on progress. 13.3% of the people interviewed were not sure whether information is routinely shared while 6.7% of the respondents disagreed and 2.7% of them disagreed strongly when asked whether information is routinely shared.

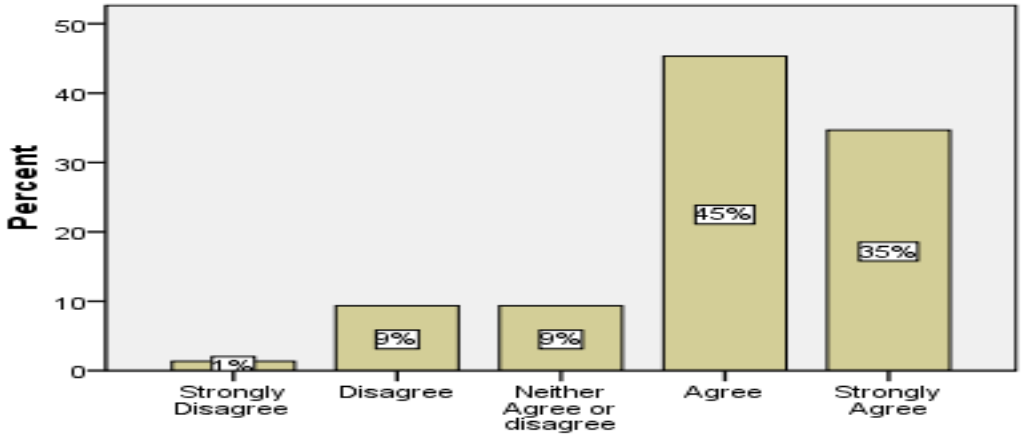
When asked whether feedback from stakeholders and staff is routinely utilized to improve performance, 50.7% of the respondents strongly agreed and 26.7% just agreed. However, 8% disagreed and only 1.3% of the respondents disagreed strongly meanwhile13.3% out of the 75 people interviewed were not sure whether feedback from stakeholders and staff is routinely utilized to improve performance.

48% of the respondents strongly agreed and 29.3% just agreed that their organizations ensure that staff and volunteers support and motivate each other and have sufficient skills. 12% of the respondents were not sure whether their organizations ensures that staff and volunteers support and motivate each other and have sufficient skills while 9.3% disagreed and only 1.3% of the respondents disagreed strongly when asked whether their organizations ensures that staff and volunteers support and motivate each other and have sufficient skills

The study also went ahead to explore whether all stakeholders and staff are consulted when making decisions and from the analysis, 41.3% of the respondents interviewed strongly agreed and 37.3% just agreed that all stakeholders and staff are consulted when making decisions. Much as 5.3% disagreed, a total of 16% of the respondents interviewed neither agreed nor disagreed when asked whether all stakeholders and staff are consulted when making decisions.

Figure 19 shows that a total of 45.3% people interviewed agreed and 34.7% strongly agreed that their organization is a member of other big NGO network. However, out of the 75 people interviewed; 9.3% disagreed and only 1.3% disagreed strongly when asked whether their organization is a member of other big NGO network. It was 9.3% of the respondents who were not sure whether their organization is a member of other big NGO network

Figure 19: Our organization is a member of other big NGO network



The study also explored whether Stakeholders/staff are ever ready and open to learn new ideas & technique; and from the analysis, 50.7% of the respondents agreed and 36% strongly agreed that stakeholders/staff are ever ready and open to learn new ideas & techniques. Much as 8% of the respondents were not sure, 5.3% disagreed when asked whether stakeholders/ staff are ever ready and open to learn new ideas & techniques

On job description, out of the 75 people interviewed, 53.3% strongly agreed and 30.7% just agreed that job descriptions in their organizations are clearly defined. However, 5.3% of the respondents disagreed, 2.7% strongly disagreed and 8% neither agreed nor disagreed that job descriptions in their organizations are clearly defined.

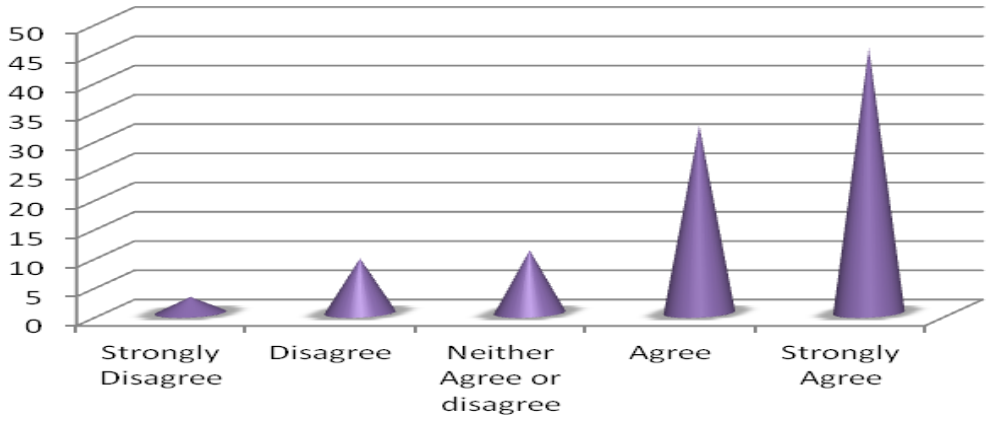
Looking at clear line of staff accountability, 42.7% of the respondents strongly agreed that clear lines of staff accountability in their organizations are adhered to meanwhile 36% just agreed. 14.7% of the people interviewed disagreed and 6.7% were not sure whether clear lines of staff accountability in their organizations are adhered to.

From the analysis 36% of the respondents agreed 37.3% agreed strongly that Human dignity and worth in their organizations are respected. Much as 18.7% of the respondents were not sure whether human dignity and worth in their organizations are respected, 5.3% disagreed and 2.7% strongly disagreed when asked.

In terms of resource allocation, 46.3% of the respondents out of 75 interviewed strongly agreed that resources are planned for and allocated properly and 32% just agreed when asked. However, figure 20 shows that 9.3% of the people interviewed disagreed and only

2.7% disagreed strongly when asked whether resources are planned for and allocated properly. A total of 10.7% were not sure whether resources are planned for and allocated properly

Figure 20: Resources are planned for and allocated properly

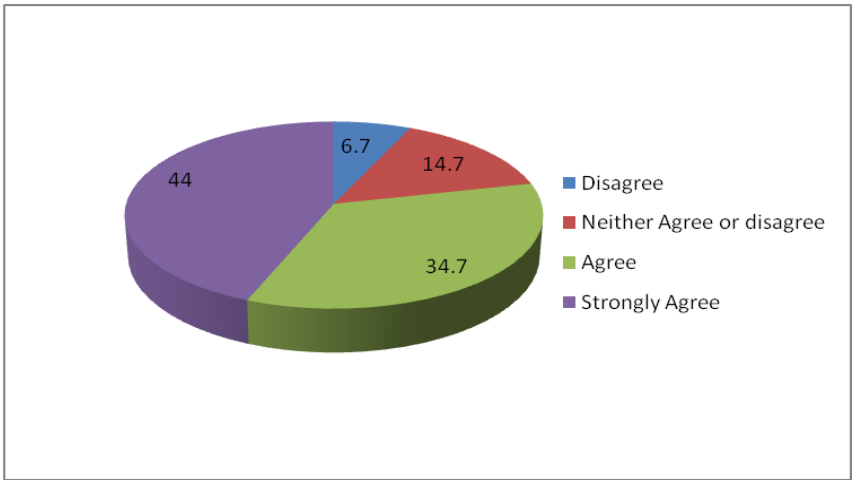


When asked whether relevant sectoral expertise exists in their organizations, 50% agreed and 40% agreed strongly that relevant sectoral expertise exists in their organizations. Out of the 75 people interviewed, a total of 8% were not sure whether relevant sectoral expertise exists in their organizations. Existence of such expertise

45.5% of the people interviewed agreed and 33.3% agreed strongly that their organizations regularly engage relevant policy makers & other institutions in dialogue related to our mission. However, 4% of them disagreed and equally 4% strongly disagreed when asked whether their organizations regularly engage relevant policy makers & other institutions in dialogue related to our mission. 13.3% of the respondents neither agreed nor disagreed.

Looking at access to additional resources to finance activities, 44% of the respondents strongly agreed and 34.7% just agreed that their organizations have got plans to access additional resources to finance activities. Much as 6.7% of the respondents disagreed when asked, figure 21 show that 14.7% of them were not sure whether their organizations have plans to access additional resources to finance activities.

Figure 21: Our organization has got plans to access additional resources to finance activities



4.6 Government policies and Health Service delivery under Public Private Partnership

According to the key informant, late delivery of drugs is one of the factors affecting health service delivery under public private partnership.

Key informants interviewed agreed that there are documented guidelines/rules for service delivery under such partnership in place.

> "*there are guidelines for example HIV/AIDs management and all areas of management like drugs, family planning, maternal and child health"* CAO Lira district

According to the Ugandan government's health policy, every parish is supposed to have health centre II. A health centre II facility, serving a few thousand people, should be able to treat common diseases like malaria. It is supposed to be led by an enrolled nurse, working with a midwife, two nursing assistants and a health assistant. It runs an out-patient clinic, treating common diseases and offering antenatal care. However, the findings revealed that most parishes in the study area do not have health centre II while the existing ones are faced with many challenges.

From the government side, lack of managerial efficiency at both the central and local level is one of the key barriers to the success of the partnership. The government officials interviewed opined that this mismanagement was due to the discontinuity of donor fund. Frequent discontinuity of fund and changes in the programme direction affect the managerial

capacity at the central level. At the local level also, programme lacks a strong management and monitoring capacity.

The findings further reveal that the quality of health services is affected by the quality of personnel, lack of required drugs, health equipments, lack of running water in most health units and high rate of staff absenteeism.

> *"Not all the required personnel and drugs are available in all the health facilities"* CAO Lira district

The first contact for someone living in a rural area would be a community medicine distributor or a member of a village health team (VHT). Each village is supposed to have these volunteers but it was found that in many cases they are either non-existent or they do not have basic drugs for diseases such as malaria.

CHAPTER FIVE
SUMMARY, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents summary to key findings onto the factors affecting implementation of public private partnership in health service delivery in Uganda taking a case of Lira District. It discusses the results based on cross referencing, personal opinions and draws conclusions and recommendations based on the findings.

5.2 Summary of Findings

5.2.1 Stakeholder Participation in public private partnership and its effects on health service delivery in Lira district.

Findings largely revealed that relevant stakeholders do fully participate in public private partnership activities. Averagely, 72% of relevant stakeholders fully participate in critical public private partnership activities including; planning; organizing; implementing, decision making and project design, management and evaluation of projects.

This revelation was confirmed by key informants that, relevant stakeholders fully participate in critical public private partnership activities and; secondary data reviewed, further discloses full stakeholder participation in public private partnership activities and thus, a positive effect on enriching quality of health service delivery.

A total of 84% of the respondents agreed that goals set were clear and realistic to members and this explains why majority said that all stakeholders are treated with respect and are always consulted when making decisions. Partners reported their satisfaction with the progress the partnership is making.

Key informants agreed that stakeholder participation in public private partnership improves quality of service and dimensions of quality namely; effectiveness, efficiency, appropriateness; continuity; sustainability and relevance are all enhanced by participation.

5.2.2 Networking and cooperation and its effects on health service delivery under public private partnership

In total, 81.4% of respondents were on agreement that their organizations had networking/ cooperation ties before and that top leadership in their organizations/departments supports networking and cooperation. 85.3% of the respondents believe that Partnership's objectives and goals are understood by stakeholders and that members always meet to review/ affirm the vision-mission strategy.

Interview with key informant reveals that members always meet to review/ affirm the vision-mission strategy and share partners share information in proactive manner. The study further found that there is there is an updated list of partners with which they organization works with and what has been done together so far. There is promotion of equal opportunities among partners under this initiative.

5.2.3 Institutional Characteristics and how it affects health service delivery under public private partnership

On average, 69.3% of respondents noted that their institutions have clearly articulated vision, mission and goal and that their organizations have organizational structure with clearly defined lines of authority, roles, functions and responsibilities. 78.6% of the respondents believe that all stakeholders and staff are consulted when making decisions and they also said that stakeholders/staffs are ever ready and open to learn new ideas & techniques. Findings further show that Job descriptions in most organizations are clearly defined and there is a clear line of staff accountability that staff adheres to.

Findings revealed that organizations regularly engage relevant policy makers & other Institutions in dialogue related to their mission and, 89.3% agreed that team work is utilized effectively to achieve their organizational objectives.

5.2.4 Government policies and Health Service delivery under Public Private Partnership

Physical access versus actual access: Much as government investment in HCs (II- IV) dramatically improved physical access to the health facilities. Finding from the study shows challenges in terms of physical access to improved services and effective access to medicines. Evidence shows that utilization is limited because of inadequate medicines and health supplies, worsened by the low functionality of wards at HC IVs, the shortage of qualified health workers, and the de-motivation of the few that exist.

The creation of districts is placing more responsibility for support supervision and monitoring on the Ministry of Health. Yet budget for the ministry is not necessarily increasing proportionately to cater for the rising need for more field staff, vehicles and time. Within the newly created districts, the weak institutional and human resource capacities have compromised the procurement, distribution and use of medicines. For example, VHTs are important in deepening health awareness and promoting the use of health services. However, few government health centres have trained VHTs.

5.3 Discussion on the Findings

5.3.1 Stakeholder Participation in public private partnership and its effects on health service delivery in Lira district.

A larger portion of the sample notified the study that stakeholders are fully participating in public private partnership activities like planning, decision making, project design, project implementation, project management and evaluation.

Majority of stakeholders are always consulted and are aware of Public private partnership activities.

Respondents generally accepted that stakeholder participation improves quality of service. Participation was noted to improve effectiveness, efficiency, continuity, appropriateness, relevance and sustainability of project quality. This finding concur with the results of an eye opening study in Thailand, where it was reported that increased stakeholder participation enhances effectiveness of the HIV/AIDS programmes (Chandran, 2004). Therefore in terms of implementation, there is need to involved not only the stakeholders but also the

beneficiaries in order to realize effectiveness, efficiency, continuity and sustainability of project and quality.

Difficulties in stakeholder participation occur as a result of; differing philosophical and theoretical approaches, cultural differences, competing organizational goals, political agenda and history of a project and start-up (Berger-Bartlett & Craig, 2002).
Joby and Stephen (2006) state that stakeholders' involvement and proximity are key to improved service delivery because less direct involvement and proximity to service production and delivery processes, the lesser the need for improvisation and vice-versa.

Stakeholder management is critical to the success of a project by engaging the right people in the right way. Opinions of stakeholders can be used to shape a project at an early stage. Not only does this make it more likely that they will support you, their input can also improve the quality of a project. Joby and Stephen (2006) argues that stakeholders' involvement is key to improved service delivery and this is in line with the argument of Lober (1997) that managers should identify relevant stakeholders that influence the organization's capacity to deliver effectively.

Clayton *et al* (1994) as cited by Karl (2000) summarizes widespread hypotheses of the benefits of participation in rural development projects and programmes, which are in agreement with opinions of respondents. It is expected that participation can: 1) Increase the efficiency of development activities by involving local resources and skills and thereby make better use of external costs, 2) It also increases effectiveness of activities, by ensuring that they are based upon local knowledge and understanding and are more relevant to local needs and, 3) It builds local capacities and develops ability of local people to mange and negotiate development activities and helps to ensure sustainability of activities as beneficiaries assume ownership.

5.3.2 Networking and cooperation and its effects on health service delivery under public private partnership

The concept of networking/ cooperation seems not to be a new thing to most organizations and top leadership in the organizations/departments supports networking and cooperation.

Majority of the respondents agreed that their organizations optimally participate in the planning of collaboration activities. On the contrast, a big number of partner staff (26.7%) was not sure whether their organization gets more partners as a result of this partnership.

The ability of partners to guarantee effective and efficient delivery of health services depends on having the required technical knowledge and adequate institutional framework. This includes not only dedicated teams, but also empowerment and effective links with other public sector stakeholders, allowing for good and timely decision making.

5.3.3 Institutional Characteristics and how it affects health service delivery under public private partnership

Mission statements and goals are inspiring words chosen to clearly and concisely convey the direction of the organization. They powerfully communicate intentions and motivate an institution to realize an attractive and inspiring common vision of the future. Most respondents noted that their institutions do have clear mission and vision, wholesomely accepted statement of faith, constitution and guidelines and this is affecting quality of service. When shared with staff, institutional characteristics shape staff understanding of why they should work with the institution.

Organizations have different goals and objectives as to why they exist (in terms of targets, stakeholders and expected outcomes). This is somehow affecting successful partnerships and achievement of public private partnership in health service delivery.

Results indicated that institutional characteristics like; clearly articulated mission/goals, organizational structure/chart with clearly defined lines of authority, roles, functions and responsibilities, Planning/strategies being aligned with mission/goals, effective utilized of team work to achieve organizational objectives, routine sharing of Information, feedback from stakeholders and staff is routinely utilized to improve performance, all stakeholders and staff are consulted when making decisions organization regularly engages relevant policy makers & other institutions in dialogue related to our mission among others can impede project implementation and quality of service.

Capacity of private partners and public sector officials towards managing the partnerships is yet to be fully developed. Public sector managers may perceive the new initiative as a burdensome task, requiring them not only to placate their subordinates but also to seek better performance from their private partners. This is a daunting task. Private partners, who are known for their informal and flexible systems and organizational processes, are uncomfortable with the rigid organizational and managerial processes and procedures of the public sector.

Findings noted that institutions are usually at different levels of growth and what is ideal to one is often not ideal to another and, this is affecting the usefulness of such partnership.
Staff understanding of a partnership plays a big role in quality of service and output under public private partnership.

Many people can have different influences in partnership; some influencers are obvious and easy to spot while others are less obvious but significant. If a partner fails to recognize and manage these influencers, it most likely experiences unexpected resistance to project implementation, and sometimes bewildering failure.

Findings further revealed that quality of service is positively affected by institutional characteristics like norms, values, mission, goals and vision. Guidelines and vision statements when well designed; communicates both the purpose and values of the organization and, it gives direction about how partners are expected to behave and it inspires them to give their best.

5.3.4 Government policies and Health Service delivery under Public Private Partnership

At a more general level, engaging in public private partnership process requires government to define a clear legal and policy frameworks and to make certain that the appropriate capacity exist within the government, to initiate and manage public private partnership.

Ensuring an enabling environment for public private partnership also has implications from the perspective of public governance, such that the public sector needs to establish itself as a credible partner with appropriate regulatory and oversight mechanisms. This condition is

particularly important as public-private partnerships are often managed by decentralized authorities or local governments that must deal with major private sector participants.

Power Relationships between government and other private partners is very important in delivering quality health services. Distorted power relationships are a major impediment to the development of successful relationships. Governments especially in developing countries like Uganda usually tend to assume core responsibility of the joint initiative and take charge of the weaker partner.

In case of Non Governmental Organisations with outreach-related strengths, this usually takes the form of a 'contractual relationship without much regard to the participatory processes, which should be key to a public-private partnership arrangement. In case of relationships with Non Governmental Organisations with technical strength, there are issues relating to power relationships of a more serious nature with regard to who assumes the leadership role.

5.4 Conclusions

5.4.1 Stakeholder Participation in public private partnership and its effects on health service delivery in Lira district.

Meaningful stakeholder participation in public private partnership nurtures harmony on appropriate, relevant, efficient and effective strategies for achieving quality. Participation that support commitment, concentration and membership in planning, organizing, implementing, collecting and analyzing data, documenting and disseminating information, and utilizing information for decision making, guarantee realization of quality. It should be noted that participation alone does not guarantee quality of service, but should be capacitated by other factors like adequate financial resource allocation and enabling environment.

5.4.2 Networking and cooperation and its effects on health service delivery under public private partnership

Networking and cooperation plays a key role in partnership and participants interviewed agreed that their organizations optimally participate in the planning of collaboration activities.

It is critical that the driving principles for networking and cooperation be rooted in 'benefit to the society' rather than 'mutual benefit to the partners' and should center on the concept of equity in health. Objectives must stipulate that partnerships contribute to strengthening of social safety nets in disadvantaged settings and should be set within the context of 'social responsibility' as the idea is not meant for private funds to be put to public use nor to privatize public responsibilities.

In the world we live today, global agendas are being increasingly shaped by the private sector. The 'for-profit' private sectors' immense resources make it an irresistible partner for public health initiatives. These arrangements can also be mutually synergistic. Governments and international agencies can tap into additional resources to full fill their mandate and active involvement of the 'non-profit' sector and other foreign donors can help in filling the existing gaps.

5.4.3 Institutional Characteristics and how it affects health service delivery under public private partnership

An institution has unique attributes which guide and manipulate its public private partnership operations for effective, efficient and sustainable service delivery. Characteristics like public private partnership guidelines; norms; organizational structure; mission; competence of personnel engaged in public private partnership; data management practices; usage of consultants and use of partner staff are affecting public private partnership and quality of health services under public private partnership in health service delivery. Nonetheless, it should be taken into concern that institutional factors alone do not explain achievement of quality.

If public-private partnerships are not carefully designed, there is a danger that they may reorient the mission of the public sector, interfere with organizational priorities, and weaken their capacity to uphold norms and regulations. Such a shift is likely to displace the focus from the marginalized and may therefore be in conflict with the fundamental concept of equity in health.

5.4.4 Government policies and Health Service delivery under Public Private Partnership

Workable partnerships require a well-defined governance structure to be established to allow for distribution of responsibilities to all the players. Public-private partnerships may run into problems because of ill-defined governance mechanisms. According to Feachem R, Medlin C, Daniels D, Dunlop D, Mshinda S, Petko J, et al (2002) recent evaluation of the Roll Back Malaria project while acknowledging the successes of the partnership in drawing global attention to the scale of the problem posed by Malaria has outlined serious governance-related issues.

5.5 Recommendations

5.5.1 Stakeholder Participation in public private partnership and its effects on health service delivery in Lira district.

Partners should encourage and uphold meaningful stakeholder participation in public private partnership right from inception to strengthen service appropriateness, relevance, efficiency and effectiveness. Partners should ensure that participation strongly supports commitment, concentration and membership in planning, organizing, implementing, collecting and analyzing data, documenting and disseminating information, and utilizing information for decision making to guarantee realization of quality.

5.5.2 Networking and cooperation and its effects on health service delivery under public private partnership

Stakeholders should continue building strong network with other institutions delivering health service so as to improve on the quality, effectiveness and efficiency of health service delivery.

Stakeholders should emphasize on building trust and teamwork among themselves so as to improve on networking and cooperation which will lead to effective and efficient health service delivery.

5.5.3 Institutional Characteristics and how it affects health service delivery under public private partnership

Institutional characteristics like public private partnership guidelines; norms; organizational structure; mission; competence of personnel engaged in public private partnership; data management practices; usage of consultants and use of partner staff need to be thought of when planning and implementing in public private partnership. Stakeholder under public private partnership in health service delivery should assess and understand capacities of institutions and plan for strategies that suit conditions in play. Organizations need to adhere to quality improvement principles by strengthening institutional characteristics like; norms, guidelines, human resources and technical capacity for partners.

To hold partners accountable for their actions, it is imperative to have clear governance mechanisms and clarify partner's rights and obligations. Clarity in such relationships is needed in order to avoid ambiguities that lead to break up of partnerships.

Partners should understand different levels of institutional growth so as to build capacities to reach ideal position.

5.5.4 Government policies and Health Service delivery under Public Private Partnership

Many partnerships do not ensure that all players are held accountable for the delivery of efficient, effective and equitable services in a partnership arrangement. Often in public-private relationships it is unclear as to whom these partners are accountable to, according to what criteria, and who sets priorities? To hold partners accountable for their actions, it is imperative to have clear governance mechanisms and clarify partner's rights and obligations. Clarity in such relationships is needed in order to avoid ambiguities that lead to break up of partnerships.

Many developed countries have legislation to interface with the private sector. However, in the developing world, there is a general failure, to have overarching legislation relating to public-private partnerships. As a result, such arrangements develop on an *ad hoc* and opportunistic basis and may have questionable credibility; as a results of this failure, polices and specific operational strategies fail to develop hence having a major impact on health service delivery.

5.5.5 General recommendation

There is need for community sensitization about cultural beliefs like the use of traditional herbs and seeking services from traditional healers which generally hinders most people especially those in the villages from accessing health services.

It is also important that the Village Health Teams are supported in terms of knowledge and skill to improve on the quality of service that they give to people especially in areas where there is limited access to the health centre.

There is need to improve on the referral system; also need to have more and functional ambulances on ground in order to improve on health service delivery.

Funding to health sector should be improved on so as to have efficient and effective health service delivery.

Need to bring other private institutions offering health services but who not part of the partnership are on board so that there is easy supervision and inspection by government so as to realize effective and efficient heath service delivery.

5.6 Study Limitations

The study was carried out in Lira district where there is only one referral hospital with some few health centres. It would have presented even a better picture if the study had a bigger population and thus a bigger sample.

5.7 Contribution of the study to the body of knowledge

The study will help government in planning and budgeting especially on the areas of health services. This will guide in fund allocation especially in areas where there is funding gap.

The study will also help and guide the planning units at partnership level, district level and also at the national level to plan for appropriate delivery of health services.

The study will help the different stakeholders in improving on their programming especially on areas where there are gaps. This can also improve on areas of networking and cooperation, coordination and resource mobilization/allocation.

5.8 Areas for further research

There is a need to research and discover other critical success factors for public private partnership in health service delivery which guarantee achievement of quality service provision other than participation, networking and cooperation; and institutional characteristics.

There is a need to research on how participation is initiated and sustained under partnership arrangements where institutions endeavor to pursue own needs.

There is also a need to research further on financial resource impact on quality of service particularly; what amount of funds that is suitable for public private partnership in health service delivery and which public private partnership activities should be allocated what amount of finances.

Ownership of all stakeholders is very important. In order to maximize ownership, a more bottom up approach should be encouraged to ensure the involvement of all the relevant stakeholders. This across the board involvement will reduce the risk of goal deviation and facilitate the channels of dialogue, which are essential to the success of public private partnership in health service delivery.

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APPENDICES

Appendix 1: Questionnaire

Introduction

I am conducting a study on Public Private Partnership in Health Service Delivery with the objective of establishing the factors affecting health service delivery under public private partnerships in Uganda. The study is for the fulfillment for the award of Masters Degree in Management Studies (Public Administration). However, the study will also be useful to Local Governments and stakeholders to understand better the public private partnership approach and championing service delivery to the citizens.

You have been selected for this study as per your position in the district to provide us with some information to achieve the study objective. The information provided will be highly confidential and shall only be used to understand and identify factors that affect service delivery under public private partnerships.

PART 1:

Background information about the respondent and his/her organization/department

A. **Respondent's Profile**

1. Gender: □ Male □ Female (Please tick)
2. Education level (indicate highest)
   □ Primary □ O-Level □ A-Level □ Institution □ University □ Other (specify) __
3. State the years you have served in the organization/department/office _____year(s)
4. Your job title □ Overall leader □ Other (specify)_____

B. Details about your organization/Department

5. Organization/Department name _____
6. Type of organization/department □ Government Department □ International NGO
   □ Local NGO □ CBO □ FBO □ Private Sector (specify) _____
7. Indicate the number of employees in your organization /department
   □ 1-4 □ 5-10 □ 11-15 □ Over 15 (specify) _____
8. Source of funds □ Government □ Foreign Donation □ Local Donation
   □ Membership fee □ Others (specify) _____

PART 11

SECTION 1: STAKEHOLDERS' PARTICIPATION

Instructions: *From questions 9-28, tick (√) on a scale of 1-5 how strongly you agree or disagree with the statements given.*

1 = Strongly Disagree 2 = Disagree 3 = Neither Agree nor disagree 4 = Agree 5 = Strongly Agree

	1	2	3	4	5
9. Our organization had partnership building experience before					
10. The goals set were clear and realistic to members					
11. Members agreed on how the partnership was to be run					
12. The partnership goals set were related to our own organizational objectives and plans					
13. Agendas for meetings are distributed in advance and minutes for all meetings availed to all members					
14. Areas of responsibility /roles played by stakeholders are clearly					

	1	2	3	4	5
defined					
15. The collaboration goals were very instigating to all partners					
16. Partners present their plans/ agendas, honestly and openly					
17. Partners fully contribute to the design, management and evaluation of projects					
18. When conflicts arise among partners, are resolved amicably Without blaming each other.					
19. Partnership membership/ or stakeholders are well defined					
20. Partnership management policies reflect equality					
21. Resources are planned for and allocated properly					
22. Partner organizations were aware right from inception what the partnership would entail					
23. Working arrangements/ systems in the partnership are flexible i.e. can be easily changed whenever appropriate.					
24. Partner organizations' duties in the partnership were discussed optimally and agreed upon					
25. Partner organizations' duties in the partnership do not interfere with their other non- partnership activities					
26. All stakeholders are treated with respect and always consulted when making decisions					
27. My organization utilizes partnership resources and creativity for accomplishing its goals.					
28. Stakeholders plan and deliver services through the existing local government structures.					
29. Partners receive timely reports on the jointly implemented activities					
30. Partners are satisfied with the progress the partnership is making.					

SECTION 11: NETWORKING & COOPERATION

Instructions: *From questions31-42, tick (√) on a scale of 1-5 how strongly you agree or disagree with the statements given.*

1 = Strongly Disagree 2 = Disagree 3 = Neither Agree or disagree 4 = Agree 5 = Strongly Agree

	1	2	3	4	5
31. Our organization had networking/ cooperation ties before					
32. The top leadership in our organization/department are supportive to networking and cooperation					
33. We receive timely and clear reports on the impact and updates of networking/ cooperation					
35. Our organization gives us chance to share and review our strengths, weaknesses, and recommend way forward together					
36. Our organization optimally participates in the planning of collaboration activities					
37. Members always meet to review/ affirm the vision-mission strategy					
38. Partners share information in proactive manner					
39. There is clear understanding and communication of vision/priorities					
40. Our organization gets more partners as a result of this partnership					

	1	2	3	4	5
41. Partners are frequently helped to find and obtain resources					
42. There is an updated list of partners with which our organization works with and what has been done together so far					
43. There is promotion of equal opportunities among partners					
44. Information flow is both bottom up and up down					
45.Partnership's objectives and goals are understood by stakeholders					

SECTION III: INSTITUTIONAL CHARACTERISTICS

Instructions: *From questions 43-58, tick (√) on a scale of 1-5 how strongly you agree or disagree with the statements given.*

1 = Strongly Disagree 2 = Disagree 3 = Neither Agree or disagree 4 = Agree 5 = Strongly Agree

	1	2	3	4	5
46. Our organization has clearly articulated mission/goals					
47. Organization has a committee/board that meets & makes decisions that guides it's development					
48.Our organization has an organizational structure/ chart with clearly defined lines of authority, roles, functions and responsibilities					
49. Organization's purpose is clearly understood and approved					
50.Planning/strategies are aligned with mission/goals					
51. Team work is utilized effectively to achieve our organizational objectives					
52. Information is routinely shared on progress in achieving the the organization's purpose					
53. Feedback from stakeholders and staff is routinely utilized to improve performance					
54.Our organization ensures that staff and volunteers support and motivate each other and have sufficient skills					
55. All stakeholders and staff are consulted when making decisions					
56. Our organization is a member of other big NGO networks					
57. Stakeholders/ staff are ever ready and open to learn new ideas & techniques					
58. Job descriptions in our organization are clearly defined					
59. Clear lines of staff accountability in our organization are adhered to					
60. Human dignity and worth in our organization are respected					
61.Resources are planned for and allocated properly					
62. Relevant sectoral expertise exists in the our organization					
63. Our organization regularly engages relevant policy makers & other institutions in dialogue related to our mission					
66.Our organization has got plans to access additional resources to finance activities.					

Appendix II – Interview Guide

1. Identify the service providing units under public private partnership as well as the kind of services required by local communities;
   a. What service providing units are available under public private partnership?
   b. What kind of services are supposed to be provided under such partnership?
   c. What kind of services are actually provided by these units?
   d. What kind of services are most frequently demanded by the population?
   e. What are the reasons for not providing some of the services that in actual sense were supposed to be provided by the unit?

2. Determine whether there are guidelines/rules for service delivery and the degree of compliance with those rules;
   a. Are there documented guidelines/rules for service delivery under such partnership? (if available get a copy)
   b. If service delivery guidelines are there, how does the population demanding service know about these guidelines?
   c. How frequent does service delivery come up as an issue for discussion during management and staff meetings at the district/sector level?
   d. What monitoring and evaluation mechanisms are in place to ensure that service delivery guidelines are followed and implemented?
   e. Are there services that are subcontracted?
   f. Mention the services that are subcontracted and names of subcontractors
   g. Are there any changes noted in service delivery for those services that were subcontracted? What are those changes?
   h. What changes have been noted in the services that have been subcontracted
   i. Is quality of service delivery an issue in the district/sectors?
   j. What are the basic standards followed to ensure quality service is provided to the population?

3. Identify which services are poorly provided
   a. In which service areas, quality of service delivery is an issue of concern?
   b. What are the reasons for poor service delivery in those areas?
   c. How could different service areas be ranked in terms of performance effectiveness?

THANK YOU VERY MUCH

Appendix III – Introductory Letter

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15 August 2013

TO WHOM IT MAY CONCERN

MASTERS IN MANAGEMENT STUDIES DEGREE RESEARCH

Mr. Geoffrey Godfrey Maniku Olema Aluma is a student of the Masters Degree in Management Studies of Uganda Management Institute 28th Intake 2012/2013 specializing in Public Administration and Management, **Reg. Number 12/MMSPAM/28/087.**

The purpose of this letter is to formally request you to allow this participant to access any information in your custody/organisation, which is relevant to his research.

His Research Topic is: ***"Factors Affecting Implementation of Public Private Partnership in Health Service Delivery in Uganda: A Case of Lira district"***

Gerald Karyeija (PhD)
AG. DEAN, SCHOOL OF MANAGEMENT SCIENCES