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# 7

# How is the Partnership between the Public and Non-Public Sector Evolving to Strengthen Universal Health Coverage?

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## Key Messages

- A strong legal and policy framework for Public-Private Partnerships (PPP) exist in Uganda, which prioritises strengthening partnerships in health to accelerate progress towards the achievement of Universal Health Coverage (UHC).
- However, country-wide implementation of PPP for health is weak and poorly coordinated. Donors and actors are less aligned with national priorities; and there is inadequate involvement and regulation of private providers, sub-optimal sharing of data, lack of transparency, and few resources to operationalise the policy up to district level.
- In order to contribute to achieving UHC, the Public-Private Partnership in Health (PPPH) needs to pay critical attention to quality and optimal service provision and the minimisation of duplication.
- PPP should contribute to joint responsibility for policy implementation and planning by way of mobilising financial and other resources for the health system to enhance the sustainability of health programmes, continuity of services and equity.
- Transparency and accountability should be improved if providers' autonomy and self-regulation are to be expected from PPP.

- Increasing public financing and provision of health services is the best way to ensure UHC, including affordability of health care for all people. A well-managed strategic purchasing arrangement can support the realisation of UHC through PPP.

## Introduction

Governments in both low- and high-income countries are grappling with the challenge of efficiently delivering quality health services to their populations. Owing to rising health care costs and the high demand for health services, health care progressively commands an increasing share of already constrained national budgets. Consequently, governments (both globally and locally) are turning to the non-state (private) sector as a "partner" to share the financial, administrative and implementation responsibility of providing health care (1). When partnerships are created amongst communities, civil society organisations, and the private and the public sectors, health in developing countries can be improved (2, 3).

To ensure UHC, health systems need to maximise health outcomes and deliver equitable, good-quality services to entire populations, with low out-of-pocket expenditure. As countries strive for UHC, there are important gaps or constraints that public-private partnerships in health may be able to address. The World Health Report 2010 identified the following challenges to achieving UHC: inadequate resources; inefficient and inequitable use of available resources; and over-reliance on direct payments for health care (4). A key element in health system governance for achieving UHC is establishing partnerships, collaboration and coalition-building with external partners (5). Further, the resilience of health systems is core to UHC, and both the public and the private sectors should contribute to resilience. As traditional ways of working independently have shown limited impact on health challenges in low- and middle-income countries, the role of partnerships is becoming more important (6). There is broad recognition that partnership with the private sector can increase resources and efficiency, leading to improved health outcomes.

This chapter discusses the potential of a more resilient health system through PPP in Uganda; the evolution of PPP; and the opportunities and challenges this presents for achieving UHC. Areas for improvement are highlighted.

We discuss partnerships in health from the UHC perspective. The goal of UHC is to ensure that all people have access to the full range of quality health services when they need them, without the fear or risk of impoverishment from accessing these services. The dimensions of UHC include: health service

coverage; population coverage; financial risk protection; and health system strengthening.

## Public-Private Partnerships in Health

PPP are initiatives that establish a contract between a public agency and a private entity (for-profit or not-for-profit) for the provision of health services, facilities and/or equipment. A PPP in health is thus "any formal collaboration between the public sector at any level (national and local governments, international donor agencies, bilateral government donors) and the nonpublic sector (commercial or non-profit) in order to jointly regulate, finance, or implement the delivery of health services, products, equipment, research, communications or education." (7)

A PPP exists when members of the public sector join with members of the private sector in the pursuit of a common goal (2). PPPs go beyond just public-private interaction and dialogue to involve formal agreements between the public and the private sectors with clearly defined roles and responsibilities around the joint implementation of an activity. Finally, it is important to note that PPPs are not divestiture of public interests or entities and that they are distinct from privatisation.

## Justification for engaging in PPP in health

Partnerships are most "justified when traditional ways of working independently have a limited impact on a problem." This is because engaging in PPP requires great investment in dialogue and negotiation owing to the numerous ethical and operational risks involved in their creation. These risks include: possible conflict of interest between parties, including financial conflict of interest from the business sector; distortion of viable health markets by the creation of an unfair advantage for particular private entities in a competitive market; and the possibility of unforeseen negative effects on a health system. All this is compounded by the fact that there are no global norms around PPP creation (7, 8).

Five main reasons for engaging in PPPs include:

- The need to improve health sector output and efficiency.
- The need to expand access to better quality health care.

- The opportunity to leverage private investment (including financial and technical capacity) for public health benefit.
- The need to formalise arrangements with the non-profit sector which delivers an important share of public health services.
- The availability of more potential partners for the government, as the private health sector matures.

The PPP model provides a big opportunity to improve efficiency, sustainability and even equity in the health system.

## Public-Private Partnerships in Uganda

### *The PPP Act and policies*

In Uganda, the government promotes and encourages PPP as a way to achieve poverty eradication and economic growth. The PPP Act (2015) provides the legal mandate for implementing PPP by all sectors (9). There is a generic PPP policy of the Government of Uganda, which is meant to enable the public and private sectors to work together to improve service delivery (10). The policy expresses the government's commitment to increase private sector investment and participation in the provision of public services and infrastructure. It encourages various forms of PPP in the implementation of the National Development Plan, Medium Term Expenditure Framework and annual budgets.

Within health, the government seeks to strengthen partnership with the private health sector for equitable and improved health outcomes, guided by the national public-private partnership in health (PPPH) policy (11). This health policy fits within the generic PPP policy framework of the government.

### *The National Policy on Public-Private Partnership in Health (2012)*

The 2012 National Policy on Public-Private Partnership in Health (11) provides a general framework for partnership with the private sector as a whole, as well as the three categorised private health providers in Uganda: the private-not-for-profit (PNFP) health providers; the private health practitioners (PHP); and the traditional and complementary medicine practitioners (TCMP).

The PPPH policy identifies these essential principles that should guide partnerships:

1. Minimisation of duplication and promotion of complementarities.
2. The provision of services and output orientation.
3. Joint responsibility for policy formulation and planning.
4. Transparency and accountability while preserving partner autonomy.
5. Self-regulation and effective representation at the Ministry of Health (MoH).
6. Sustainable health care with continuity of services across different levels of health facilities.
7. Equity.

Even before the final release of the PPP policy, formal collaboration was already happening in Uganda (see Box 7.1). Collaboration was facilitated by the Sector-Wide Approach (SWAp) reform that was rolled out in 2000, as a mechanism to coordinate partners and promote government leadership of the national health strategic plan. Many health development partners, including NGOs and the PNFP sector, signed a memorandum of understanding (MOU) with the government. The SWAp partnership structures, which included both state and non-state partners, became the recognised governance structures for the PPPH. The highest coordination structure is the Health Policy Advisory Committee and its technical working groups. The private sector partners participate in all these committees and other health policy and performance review fora of the Ministry of Health.

**Box 7.1: The history of PPP in health in Uganda**

The history of public-private partnership in Uganda predates independence and is well elaborated by Orach Sam (2009) (12). The origins of the first formal partnership can be traced to the Frazer Commission of 1954 that recommended the establishment of public subsidies for the "voluntary health sector". The colonial government appreciated the work done by the voluntary sector to complement government efforts. This also paved the way for the creation of the faith-based coordination structures – the medical bureaus. The Uganda Protestant and Catholic Medical Bureaus were then formed and gazetted as channels for disbursing grant-in-aid to church-owned health facilities.

This formal partnership dwindled and died in the 1970s owing to the political and economic turmoil of the time. From 1970 to 1990, Uganda was plagued by political disruption characterised by repeated military coups and related poor economic performance. There was also disruption in the health care system with minimal government expenditure on health, poor management in the public sector and irregular supplies of drugs and supplies at health facilities. In the 1980s, Uganda's health care system was in crisis, "reduced to a state where the care delivered may have been worse than no care at all." (13)

With the new political stability in the 1990s, there was an exponential growth of private health care, which posed a new challenge for legislation, regulation and control. By 1998, it was estimated that 79 per cent of curative health care in Uganda was provided by the private sector, compared to 21 per cent by the public health sector (14). On one hand, the PPP in health policy in Uganda was a result of the need for the government to assume stewardship over the great proliferation of non-state actors and private-oriented healthcare providers - including private clinics, drug shops, home care and self-medication (13, 15, 16). There was also a need to influence the development of the private sector through health sector reform, in order to improve access, and provide quality, equitable, efficient and sustainable health services (17).

A more urgent reason occurred after the mid-1990s when the PNFP sub-sector was on the brink of collapse (18). An emergency situation was declared by the PNFP hospitals. Decreased inflow of external resources to aid the faith-based PNFPs, the rising cost of health services delivery and the need to keep user fees affordable led many PNFP hospitals to consider shutting down operations.

The Health Policy Review Commission of 1987 recommended the revival of the collaboration between public and private providers, and this recommendation was reaffirmed by the Government White Paper of 1993 (12). The partnership was reactivated in 1997-98 and the government budget subsidy to faith-based organisation (private-not-for-profit (PNFP)) facilities was resumed. The first articulation of a public-private policy in health was within the draft health policy for the period 1997/98 – 2006/7. The health policy stressed the integration of the previously isolated private sector into the national health care system in order to extend services to under-served areas and avoid unnecessary duplication and wastage of services and resources. Decentralisation was an overarching policy within which the government rekindled support to the PNFP.

***Source:*** *Authors' analysis*

## How Is the Partnership Managed and Rolled Out in Uganda?

The private health sector in Uganda is heterogeneous and diverse, including: the PNFP, private health practitioners (PHP), and traditional and complementary medicine practitioners (TCMP).

### The case of the private-not-for-profit (PNFP) sector

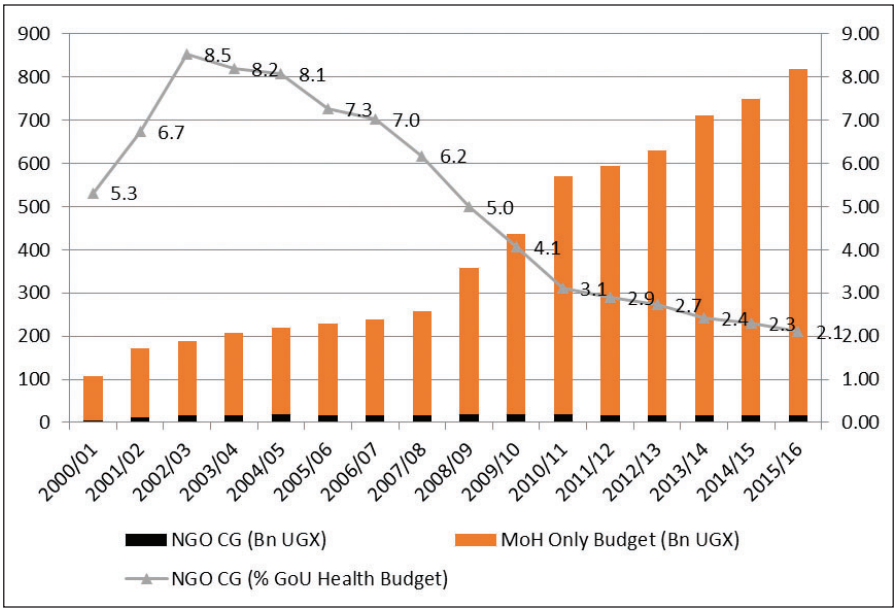
This sector is guided by concern for the welfare of the population and is categorised into the facility-based PNFP (works within facility-based units)w and the non-facility-based PNFP, including development partners, NGOs and civil society. The facility-based PNFP sector is largely organised, monitored and represented by four medical bureaus, including the Uganda Protestant Medical Bureau, the Uganda Catholic Medical Bureau, the Uganda Muslim Medical Bureau, and the Uganda Orthodox Medical Bureau.

The formal involvement of the PNFP in health governance fora was first seen in 1999 when representatives of the PNFP health sub-sector participated together with the MoH and other partners in the launching of the SWAp at WHO, Geneva. The partnership was then enshrined in the National Health Policy of 1999 – where it was observed that "the existing collaboration and partnership shall be strengthened between the public and private sectors in health, including NGOs, private and traditional practitioners, while safeguarding the identity of each". In 2000 the PNFP representatives officially became members of the Health Policy Implementation Committee (HPIC), later renamed the Health Policy Advisory Committee. Through this committee and its sub-committees, the private sector partners got involved in the development of the Health Sector Strategic Plan (HSSP). A joint review mission of the health sector in 2000 made an undertaking to develop the PPPH policy and in the same year a desk was established at the Planning Department of the MoH to coordinate programmes and develop the partnership policy.

Owing to its role in service delivery, the government allocated subsidies to the PNFP sector, in order to reduce costs incurred by patients and to support the viability of PNFPs, especially in rural settings. The percentage of the health budget provided to the PNFP sector increased slightly between 2000 (5.3 per cent) and 2005 (8.5 per cent) but gradually reduced to 2 per cent in 2014 (Figure 7.1). This funding gap is currently transferred to the patients. User fees contributed up to 50 per cent of the total PNFP budget in

the 2014/15 financial year. This directly implies that there is increasing out-of-pocket expenditure by patients attending these health facilities. Optimum government contribution to the PNFP sector is important and should be maintained, in order to ensure that poor people continue to access care at PNFP facilities near them.

**Figure 7.1: Private-not-for-profit (PNFP)/NGO funding as a fraction of total MoH budget allocation**




***Source:*** *Author's analysis, From MoH Annual Health Sector Performance Reports (2000, 2016)*

## The case of private health practitioners (PHP)

The private health practitioners (PHP) encompass all cadres of health professionals who provide private health services outside the PNFP group. These are largely for-profit, have a peri-urban and urban presence and mainly offer primary curative services. The PHP are represented by a number of umbrella organisations: the Uganda Private Medical Practitioners Association (UPMPA) represents doctors, and the Uganda Private Midwives Association (UPMA) represents midwives.

All the private practitioners should be registered by the professional health councils which regulate all health providers. These professional councils include: the Uganda Medical and Dental Practitioners Council (UMDPC), the Uganda Nurses and Midwives Council (UNMC), the Uganda Pharmacists Council (UPC), and the Uganda Allied Health Professionals Council (UAHPC). These councils collaborate with the MoH to carry out inspections of health care and related services in the interest of the public. Registration and licensing of health professionals and health units to the councils is compulsory and necessary for the regulation of the PHP sector. This contributes to ensuring quality of care that is provided by this sector.

Exemplary interventions involving the engagement of PFP health facilities that are contributing to improved service delivery:

a) In 2013, formal collaboration between the government (MoH) and the Federation for Private Health Professionals (FPHP), a PFP umbrella organisation, was established through signing of an MOU under a PPPH arrangement (19). The specific undertaking was to strengthen quality of immunisation and disease surveillance in the private sector (PFPs) through interventions supported by the Global Alliance for Vaccines and Immunisation (GAVI) under the Health System Strengthening (HSS) support (20). Following the launch on 12 March 2014, the FPHP, as the implementing partner on behalf of the PFP sub-sector, kick-started nationwide free immunisation and disease surveillance interventions, initially in Kampala district (20). By December 2015, joint public-private capacity-building (through quality improvement training) and two rounds of support supervision activities were implemented. Up to 86 PFP health facilities were equipped with cold-chain equipment (immunisation fridges + vaccine carriers), vaccines plus supplies and reporting tools. At the time of writing this chapter, no project evaluation had been conducted to appraise the achievement of the intended outputs. However, progress reports indicate satisfactory implementation of the planned activities of the project.

b) In the period 1995 to 1999, the UPMA, a PFP professional body, organised private midwife facilities in 10 districts to benefit from USAID support through the Delivery of Improved Services for Health (DISH) project that focused on improving reproductive health interventions in Uganda (21). Grants were provided to private midwifes to establish or expand community-level maternity services. Private midwife facilities

that provided integrated reproductive health services at community level also received DISH support in training for family planning, safe motherhood and clinical life-saving skills. Other areas of support included advocacy skills development involving information, education and communication activities to mobilise communities to use family planning and maternity services; HIV counselling; clinical management of post-abortion care; and sexually transmitted infections. The 1999 aggregated DISH evaluation recorded up to a 20 per cent increase in the number of women receiving delivery care (skilled attendant deliveries) from nurses/midwives' (UPMA members inclusive) facilities located in communities within the DISH project districts. UPMA also attained a 25 per cent growth in membership within the same period (21).

c) Between 2009 and 2016 private drug shops in 10 districts in Uganda were engaged in the Integrated Community Case Management (iCCM) of malaria, pneumonia and diarrhoea strategy for the community management of children with these illnesses. With support from UNICEF, the Global Fund and the Affordable Medicines facility (for malaria), quality-assured drugs and diagnostics were made available through drug shops; also, training of drug shop attendants was done and operational research was conducted. The introduction of the iCCM strategy among community-level drug shops resulted in high levels of appropriate care for sick children and high adherence to treatment protocols (22-24).

## The case of the Traditional and Complementary Medical Practitioners (TCMP)

Traditional medicine practitioners comprise all types of traditional healers including herbalists, bone-setters and traditional birth attendants (TBAs), amongst others. While there are traditional healer associations registered at district level, many such providers operate outside formalised associations. Recently Chinese, Ayurvedic, reflexology and homeopathy medicine providers (non-indigenous groups) have been introduced in Uganda as complementary medical providers.

The challenge with the TCMP group within the Ugandan health system is that very little is known about their treatment mechanisms and how they operate. Beyond being recognised as traditional and complementary

providers, little support and oversight is provided over this sector and limited partnership exists between this sector and the MoH.

## Benefits and Challenges of PPP to the UHC Agenda in Uganda

Collaboration between the government and the private sector (especially the PNFPs) has generated a number of remarkable benefits to the health system (12). There are also challenges that arise from engaging in these partnerships. We discuss these benefits and challenges from the UHC perspective. The goal of UHC is to ensure that all people have access to the full range of quality health services when they need them, without the fear or risk of impoverishment from accessing these services. The dimensions of UHC include: health service coverage; population coverage; financial risk protection; and health system strengthening.

### Coverage of health services (service coverage and population coverage)

Public-private collaboration paved the way for the government to extend subsidies to support PNFP health facilities, which received up to USh. 17.7 billion in 2009 (12). This resulted in PNFP facilities increasing the scope of health services they provided (to cover the Minimum Health Care Package (UNMHCP)) and reduce user fees. Both effects resulted in increased access to health services by Ugandan communities, including the hard-to-reach and under-served poor areas, as 85 per cent of PNFP facilities are located in poor rural areas (11, 12).

Through a PPP arrangement, the MoH has been able to engage the private health practitioners sub-sector in strengthening immunisation services (a NMHCP public health intervention) through partnership with the Federation for Private Health Professionals (19).

The PNFP sub-sector has also demonstrated 'value-for-money' for the public subsidies they receive from the government. Out of the combined documented public and PNFP health service outputs, the FB-PNFPs produce 35 – 40 per cent of output (12). Private sector health service outputs (majorly from faith-based PNFP health facilities and some PHP facilities) are reflected in the Health Sector Strategic and Investment Plan (HSSIP), thus contributing to the national health outcomes, and used in evidence-based health planning nationally (12).

### Challenges related to coverage of health services

While the PPPs have greatly contributed to increased access and coverage of health services, there are important challenges that need to be addressed. Particularly, the challenge of regulation of the private health providers is huge. There are over 20,000 private clinics and drug shops in Uganda and more than half of these are illegal/unlicensed. The medical associations, the National Drug Authority (NDA) and the MoH need to strengthen the district health systems to regulate and support the private sub-sector. The quality of care provided in these unregulated facilities is also known to be poor. There is urgent need for innovative regulatory mechanisms in the PFP sector, including decentralised administrative authorities and community participation in regulation and peer supervision.

High attrition rates from PNFP to government facilities also remain a challenge, with up to 60 per cent of health workers leaving respective PNFP facilities to join local governments in the recent years (12, 25). This is attributed to unilateral decisions by the government to recruit health workers into the public system – a situation that depletes and cripples the PNFP sub-sector that is a major partner contributing to the same health sector goals. Efforts by the MoH to support the PNFP workforce directly to stabilise it will go a long way in ensuring that the partnership gets strengthened. Avoiding unhelpful direct and indirect competition between the public and PNFP sectors will go a long way in improving the UHC goals.

### Financial risk protection

In terms of financial risk protection, government subsidies to the PNFP health facilities, as previously discussed, have contributed to both increased access to health care for Ugandans and reduced cost of seeking health care in PNFP facilities. However, over the years government subsidies to the PNFP sector have greatly reduced (see Figure 7.1), resulting in higher operational costs, which are, in turn, transferred to the patients. This increases the costs borne by PNFP facilities in providing care, and results in higher out-of-pocket expenditure by patients and increased risk of catastrophic health expenditure in the communities.

## Health system strengthening

Private sector representatives (PNFP and PHP) have jointly contributed towards the development of national policy and health strategic planning frameworks, including: the Uganda National Health Policy (I and II); the Health Sector Strategic Investment Plan (HSSIP) (26); the Uganda Health Sector Development Plan (HSDP); and the PPPH policy (11). They have facilitated and contributed towards various health systems functions including: joint public-private planning for health service delivery; financing for health; infrastructural development; medicines/supplies management; and health management information systems.

The private sector (especially PNFPs) has been able to jointly monitor health service provision and management through participation in joint-monitoring area teams nationwide, thus giving civil society the opportunity to have a 'watchdog eye' on public health system performance in order to enhance public accountability (27-29). By 2007, 13.5 per cent of the national health sub-districts were headed by PNFP facilities, providing a key resource in leadership, technical expertise and governance to lower levels (including public health facilities) (25, 30).

In addition, 63 per cent of nursing and midwifery training schools are owned by PNFPs, which contribute up to 60 per cent of the total country annual output of nurses and midwives, who are subsequently deployed in the public health sector (11). In order to ensure UHC in Uganda, increased government expenditure on health is important, in both the public and the private sectors, especially for the PNFP sub-sector which provides up to 40 per cent of health services in Uganda and makes a vital contribution to medicines security through the Joint Medical Stores (JMS) and workforce development, especially the training of most nurses and midwives in the country (see chapter 12).

## Challenges related to health system strengthening

A number of health system challenges arise from the implementation of the PPPH policy and related interventions in Uganda. Some of the challenges are dependent on how actors interact, behave or execute the respective PPP interventions.

Against a background of an under-resourced MoH and professional councils (in terms of financing and human resources), the stewardship of actors, enforcement of regulations and maintenance of quality standards in both the public and the private sectors are areas of weakness in PPP

implementation (31). Among other factors, this is related to the proliferation of private health facilities and the ever-increasing number of districts, which have over-stretched the resource capacity of both the MoH and professional councils to execute their respective mandates (27, 28).

PPPs, especially donor-supported ones, have been implicated in straining the operations of beneficiary entities such districts and hospitals owing to non-aligned programming (vertical programmes) and parallel reporting systems. The multiple financing streams – especially at the district level – assist the districts in accessing non-government actors with additional resources albeit with limited sustainability, a situation that negatively affects health system functionality (12, 28, 29). Programmes designed to support the private sector, such as the voucher programme for maternal health in western Uganda, deliberately steered communities to bypass the public sector providers where government resources are invested (32). In 2008/09, off-budget donor funding constituted US$ 440 million, which was 40 per cent of the overall health budget (26). The resultant health system effects include resource wastage, duplication of services and non-prioritised service provision (27, 28).

In the private sector (excluding faith-based PNFPs) issues such as non-reporting, uncoordinated and non-aligned services, weak records management, unqualified health staff and lack of access to continuous professional development undermine health systems improvements and the overall health sector performance (13, 25, 33, 34).

High operational costs of donor-funded PPP programmes with sub-optimal ownership by the government are known to have limited scale-up and plans for sustainability. This is partly due to the small fiscal space available for governmnet financing of health – only $9 per capita in comparison with the US$28 per capita required for delivering the UNMHCP (35).

Overall stewardship and coordination of PPPs at district level remains weak. Key challenges that have hampered the capacity of districts to adequately coordinate PPP activities and implement policies include: resource constraints; failure to articulate and operationalise the PPPH policy due to capacity gaps; and weaknesses in leadership (26, 27). Such factors have negatively affected service delivery and resource planning at local government level, further weakening the translation of policy into action (27-29).

## Conclusions

There is a strong legal and policy framework which supports PPPs in Uganda. This has promoted the participation of the PNFP sector and, more recently, the PFP sector in strategic management and the provision of an expanded package of health services to Ugandans. The benefits of PPP in health for improving access to health care, human resource production and health sector management are well documented and will contribute towards the goal of achieving UHC in Uganda.

However, some challenges to engaging in PPPs in health come to light and need to be addressed. These challenges include: weak capacity for leadership and coordination of partners; non-alignment of priorities amongst partners; weak reporting-sharing of information; and sub-optimal-fulfilment of expectations and obligations by the government and the non-state actors.

## Recommendations

In order to harness the potential of PPPs and strengthen the contribution of non-state actors to the resilience of the health system, the following recommendations are made:

1. Additional resources (financial, infrastructural and human) should be mobilised over and above current provisions to support regulation, coordination, and stewardship of the rapidly growing set of actors and partners.
2. The stewardship and regulatory role of MoH, the professional councils and the district leadership should be strengthened through the integration of strategies to enforce regulations and quality standards in both the public and the private sectors. Strategies to empower local governments to take the lead in facilitating PPPH policy implementation should also be included.
3. Health information and reporting systems in the private sector should be strengthened to facilitate information synthesis and data use for planning and continuity of care.
4. Joint public-private health system strengthening interventions and strategies should be instituted. These should include health planning; capacity-building and monitoring; and resource mobilisation and allocation at all levels. This is vital as it facilitates ownership,

transparency and public accountability and utilises the comparative advantages of the different actors to increase efficiency and improve overall health system functionality.

5. Empirical evaluation of the extent to which private actors have contributed towards efforts to achieve UHC should be conducted. More empirical data regarding health service outputs from NFB-PNFPs, PFPs and TCMPs actors is needed to understand their contribution.
6. A comprehensive monitoring and evaluation framework should be developed and implemented. The framework should have clear implementation guidelines and indicators for performance monitoring of PPPs in health.

## References


1. Ratzan, SC 2007, 'Public-private partnerships for health', *J Health Commun.*, vol. 12, no. 4, pp. 315-6.
2. WHO 2017, *Public private partnerships (PPP)*, WHO, Geneva, http://www.who.int/intellectualproperty/topics/ppp/en/.
3. Buse, K & Waxman, A 2001, 'Public-private health partnerships: a strategy for WHO', *Bull World Health Organ.*, vol. 79, no. 8, pp. 748-54.
4. WHO 2010, *The World Health Report 2010. Health system financing: the path to universal coverage*, World Health Organisation, Geneva.
5. WHO 2014, *The World Health Report 2014: health systems and governance for unviersal health coverage*, World Health Organisation, Geneva.
6. Widdus, R 2001, 'Public-private partnerships for health: their main targets, their diversity, and their future directions', *Bull World Health Organ.*, vol. 79, no. 8, pp. 713-20.
7. Barnes, J 2011, *Designing public private partnerships in health*, Shops Project, Abt Associates, Bethesda, MD.
8. Nishtar, S 2004, 'Public - private 'partnerships' in health - a global call to action', *Health Res Policy Syst.*, vol. 2, no. 1, p. 5.
9. GoU 2015, 'The Public Private Partnerships Act 2015, The Republic of Uganda, Kampala.

10. GoU 2010, 'Public Private Partnership Framework Policy', in Development MoFPaE, editor, Uganda Government, Kampala.
11. GoU 2012, *National Policy on Public Private Partnership in Health Government of Uganda*, Kampala.
12. Orach, S 2009, *Is religion relevant in health care in Africa in the 21st century? – the Uganda experience*, Uganda Catholic Medical Bureau, Kampala.
13. Birungi, H, Mugisha, F, Nsabagasani, X, Okuonzi, S & Jeppsson, A 2001, 'The policy on public-private mix in the Ugandan health sector: catching up with reality', *Health Policy Plan*, vol. 16, Suppl 2, pp. 80-7.
14. Hutchinson, P 1998, *Equity of access to health services in Uganda: the effect of income, gender, proximity to services and quality of care*, World Bank, Kampala.
15. McPake, B, Asiimwe, D, Mwesigye, F, Ofumbi, M, Ortenblad, L, Streefland, P et al. 1999, 'Informal economic activities of public health workers in Uganda: implications for quality and accessibility of care', Soc Sci Med., vol. 49, no. 7, pp.849-65.
16. MoH 1987, 'Health Policy Review Commission report', In *Health Mo*, editor, Kampala.
17. Okuonzi, SA & Macrae, J 1995, 'Whose policy is it anyway? international and national influences on health policy development in Uganda', *Health Policy Plan*, vol. 10, no. 2, pp. 122-32.
18. Lochoro, P, Bataringaya, J, Kirunga Tashobya, C & Kyabaggu, JH 2006, *Public-private partnership in health: working together to improve health sector performance in Uganda*, FSaVOC, editor, Kampala.
19. FPHP 2009, *Federation of Private Health Professionals (FPHP) - profile brief*, Federation of Private Health Professionals, Kampala.
20. GAVI 2009, *Uganda 2015 full country evaluation*, GAVI Secretariat in Uganda, Kampala.
21. Ssengooba, F, Neema, S, Mbonye, A, Sentumbwe-Mugisa, O & Onama, V 2009 *Uganda maternal health review*, Makerere Unviersity School of Public Health, Kampala.
22. Awor, P, Wamani, H, Tylleskar, T, Jagoe, G & Peterson, S 2014, 'Increased access to care and appropriateness of treatment at private

sector drug shops with integrated management of malaria, pneumonia and diarrhoea: a quasi-experimental study in Uganda', *PLoS One*, vol.9, no. 12, p. e115440.

23. Awor, P, Wamani, H, Tylleskar, T & Peterson, S 2015, 'Drug seller adherence to clinical protocols with integrated management of malaria, pneumonia and diarrhoea at drug shops in Uganda', *Malar J.*, vol. 14, p. 277.
24. Awor, P, Wamani, H, Bwire, G, Jagoe, G & Peterson, S 2012, 'Private sector drug shops in integrated community case management of malaria, pneumonia, and diarrhea in children in Uganda', *Am J Trop Med Hyg.*, vol. 87(5 Suppl), pp. 92-6.
25. Tashobya, CK, Musoba, N & Lochoro, P April 2007, 'Public private partnerships for health in Uganda: will HSSP II deliver on the expecttions?' *Health Policy Dev J.*, vol. 16, no. 5(1), pp. 48-56.
26. MoH 2010, *Health Sector Strategic Plan* III, 2010/11-2014/15, in *Health Mo*, editor, Ministry of Health, Kampala.
27. MoH 2011, *Annual Health Sector Performance Report,* Ministry of Health, Kampala.
28. MoH 2012, A*nnual Health Sector Performance Report,* Ministry of Health, Kampala.
29. MoH 2015, *Annual Health Sector Performance Report*, Ministry of Health, Kampala.
30. Bataringaya, J & Lochoro, P. 'The framework for public private partnership in health', *Uganda Health Bulletin*, p. 8.
31. Konde-Lule, J, Gitta, SN, Lindfors, A, Okuonzi, S, Onama, VO & Forsberg BC 2010, 'Private and public health care in rural areas of Uganda', *BMC Int Health Hum Rights*, vol. 10, p. 29.
32. Okal et al. 2013, 'An assessment of opportunities and challenges for public sector involvement in the maternal health voucher programme in Uganda', *Health Research Policy and Systems 2013*, vol. 11, no. 38, pp. 2 - 11.
33. Konde-Lule, J, Okuonzi, S, Matsiko, C, Mukanga, D, Onama, V & Nakacubo, SG 2006, *The potential of the private sector to improve health outcomes in Uganda*, Makerere University School of Public Health, Kampala.

34. MoH 2011, Uganda Health System Assessment 2011, Ministry of Health, Health Systems 20/20, and Makerere University School of Public, Kampala.
35. MoH 2011, *Uganda National Health Accounts 2011/12*, Uganda Minsitry of Health, Kampala.