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Effectiveness of Public-Private Partnerships in Improving Maternal Health in Mukono District, Uganda

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Abstract*; The Uganda National Health Policy strengthens the health system by promoting collaboration between the private sector and the public sector health-service providers. The paper established effectiveness of Public-Private Partnerships in improving maternal health in Mukono District. The study employed a cross-sectional design adapting both quantitative and qualitative data collection methods. The study targeted a total of 210 people from whom a sample size of 137 respondents was determined using Kreijece and Morgan's table for sample size determination. The study participants were selected from the 45 health facilities which were implementing maternal health interventions in Mukono District. Data was collected through Key Informant Interviews, Focus Group Discussions and a questionnaire. Qualitative data was transcribed using Nvivo software while quantitative data was analyzed using SPSS version 16. The study revealed that partnerships were effective for administration (74%), followed by financing (67%) and training (59%). The apparent level of effectiveness for utilization of ANC services was due to the satisfactory level at which partnerships are being harnessed (p= 0.006).The study concludes that, the effect of Public-private partnerships (PPPH) in Mukono is deemed to be geared towards administrative, financial support and training but actually not in service provision since the components that are mostly utilized are ANC and HIV-PMTCT services. The study recommended that service delivery should address the critical areas like caesarean section, dilatation and curettage and partnerships should address provision of emergence obstetrical care services.*

Keywords: *Effectiveness, Maternal, Maternal health, Obstetrical care, Partnerships*

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1. Introduction

Like many other developing countries there is a growing concern that efforts on maternal health in Uganda are not up-to-scale, effective or sustainable (MoH, 2015). Though the maternal mortality ratio (MMR) by the time of the study was 438 per 100,000 live births (UDHS, 2011) the current MMR at 336 per 100,000(WHO, 2020) is still high yet it had reduced to 320 per 100,000 in 2015 (NHS, 2015). In Tanzania, the low percentage of births attended by skilled professionals (51%), low incidence of postnatal care (only three in 10 mothers) (DHS, 2010), and a consistently high maternal mortality rate of 790 out of every 100,000 live births (WHO, 2011a) but had reduced to 524 per 100,000 in 2017. Burundi has a high MMR 548 per 100,000 while Kenya reading was 342 per 100,000, Rwanda has the lowest MMR at 248 per 100,000 (WHO, 2018).

At the International Conference on Population and Development (ICPD) in Cairo in 1994, it was

unanimously agreed that developing and developed countries should promote maternal health; to achieve a rapid and substantial reduction in maternal morbidity and mortality (ICPD, 1994). Improving maternal health and reducing maternal mortality have been key concerns of several international summits and conferences since the late 1980s, including the Millennium Summit in 2000. In the context of the SDG in 2015, countries have united behind a new target to accelerate the decline of maternal mortality by 2030. SDG 3 includes an ambitious target: "*reducing the global MMR to less than 70 per 100,000 births, with no country having a maternal mortality rate of more than twice the global average*". Improving maternal health is one of WHO's key priorities. Ending Preventable Maternal Mortality (WHO, 2015). WHO is working with partners in supporting countries towards:

- addressing inequalities in access to and quality of reproductive, maternal, and newborn health care services;
- ensuring universal health coverage for comprehensive reproductive, maternal, and newborn health care;
- addressing all causes of maternal mortality, reproductive and maternal morbidities, and related disabilities;
- strengthening health systems to collect high quality data in order to respond to the needs and priorities of women and girls; and
- ensuring accountability in order to improve quality of care and equity.

The Astana Declaration on PHC (2018) reiterated that PHC is a cornerstone of a sustainable health system for universal health coverage (UHC) and health-related Sustainable Development Goals. It also called for all stakeholders to work as partners while taking joint action to build stronger and sustainable PHC (WHO, 2018). It is on the basis of this commitment to maternal health, that countries were tasked to ensure universal access to Reproductive Health (RH) care for all by the year 2040. This is in order to reduce the number of women dying due to pregnancy-related causes and one of the ways to achieve effectiveness of maternal health programs is through Public-Private Partnerships for health (PPPH).

The prerequisite is that some degree of private participation in the health service delivery of the traditionally public domain services (MoH, PPPH Policy, 2008). Traditionally studies indicate that partnerships have been developed with NGO or CSOs (Stroreng et al ,2018) to assist governments extend health care and include immunization, blood donation and HIV treatment Stroreng & Behague 2016 emphasis that partnerships should promote maternal health (Stroreng & Behague 2016) Currently, public health sector planning and prioritization of activities is done without the full involvement of the private sector. Equally, many of the maternal health private sector programmes are not supported by the government. WHO (2002) recommends that the two sectors should collaborate in order to enhance the effectiveness of maternal health programmes. Public-Private Partnership for Health (PPPH) is an important guiding principle of the National Health Policy (NHP) and a key element (reform) for strengthening Uganda's health care delivery system (MoH, PPPH Policy, 2008). However, despite the documentation, Public-Private Partnership does not appear to exist when it comes to maternal health programmes.

The earliest recognized form of Public-Private Partnership for Health in Uganda is the relationship between Ministry of Health and the facility based Private-Not-For-Profit (PNFP) sector dating back to the early 1960s under the general notice 245 of 1961, which is the tool government used to provide support to the voluntary sector as the PNFPs. This support however, dwindled and eventually stopped during the crises of the 70s (Bataringaya and Lochoro 2002). The 1987 Health Policy Review Commission Report recommended integrating the private sector into the national health care system. This Report formed the basis for the 1993 government White Paper on Health Policy which highlighted the need for a higher profile for the private sub-sector in health. However, it was not until 1996 that this issue actually got squarely on the health policy agenda. This has been attributed to a more sympathetic sector political leadership at the time, and the financial crisis that had hit some of the PNFP institutions and led to meetings between Ministry of Health leadership and the proprietors of these institutions (Birungi, *et al.*, 2001).

The process of institutionalizing PPPH was set in motion with the appointment of the NGO health sector panel which was assigned the role of formulating methods for collaboration between the government and the private sector. The recommendations of the panel were incorporated into the National Health Policy and the Health Sector Strategic Plan 2000/01 to 2004/05 (HSSP I). Subsequently the role of the panel was taken up by the PPPH Working Group which is one of the Technical Working Groups (TWGs) that operate under the Health Policy Advisory Committee (HPAC) for the implementation and monitoring of the SSP.

The PPPH Desk and Desk Officer for the coordination of PPPH activities were put in place in 2000. The areas for partnership were identified as: policy development, coordination and planning; resources management including financial resources mobilization and allocation, and human resources for health development and management; services delivery including management and provision of health services and community empowerment and involvement (MOH, 2003). Ministry of Health of Uganda, to this effect, formed the advisory

committee in April 2016 following the passing of the PPPH strategic plan by cabinet in September 2012 (PPPH, 2013).

Poor maternal health remains a major reproductive health concern in most parts of less developed world, including sub-Saharan Africa and Uganda in particular. Compared with achievements in the reduction of fertility and infant mortality in the last few decades, less progress has been made in the area of maternal health (Magadi, *et. al.*, 2003).

Despite the fact that Uganda has experienced slight improvements in maternal health indicators between 1995 and 2006; for instance, MMR reduced from 505/100,000 live birth to 438/100,000 live births. Currently MMR stands at 336/100,000 live births (WHO, 2020), down from 375/100,000 in 2017 (UNICEF/WHO, 2018).Contraceptive prevalence increased from 15% to 30%. Between 2006 and 2010 the proportion of deliveries at health facilities increased to 58%, post-natal care within the first week of delivery stood at 26% and attendance for 4 visits improved to 47% while teenage pregnancies reduced from 32% to 25% (UBOS, 2006; UDHS, 2011). Currently, deliveries at health facilities, especially urban areas stands at 54% ANC coverage stands at 55% (UDHS,2016). Teenage pregnancies have however increased because of the COVID 19 pandemic has more girls(in rural areas) have stayed at home 60% (RHU, 2021) There still exists a huge gap in effectiveness of maternal service delivery, and maternal health indicators still remain unacceptably high. Therefore, there is need to strengthen collaboration between the two sectors to ensure effective maternal health care service delivery. It is against this background that the this study sought to assess the effectiveness of Public-Private Partnerships on maternal health programmes which is also given less attention.

2. Literature Review

Studies from South Africa show that the partnerships between the public and private sectors as a policy objective in health are already engaged in a number of projects that are closely aligned to current health system reform priorities especially maternal health. Factors that increase the likelihood of interactions being successful include: increasing the government's capacity to manage public-private relationships; choosing public-private interactions that are strategically important to national goals; building a knowledge base on what works, where and why; moving from pilots to large scale initiatives; harnessing the contracting expertise in private providers; and encouraging innovation and learning (Kula & Fryatt, ,2013).

Between 1996 and 2004 the effect of Public-Private Partnership for Health (PPPH) in Uganda over the last decade had shown a significant improvement. However, a number of challenges still exist which need to be addressed. These include challenges in conceptualization of the partnership; resource mobilization and allocation as well as information sharing (Euro Health Group, 2005). Following the development of the SDG goals a number of priorities have since been looked into especially SDG 3 (Good health and Well-being) by 2015 MMR was 343 per 100,000 births, Proportion of births attended by skilled professionals stood at 47% while still births read at 21% NNM stood at 30 per 1000 babies born (UNICEF,2016).

The development of the PPPH policy was guided by the 1995 Constitution of the Republic of Uganda and the government's liberalization policy, which gives strong incentive for government to collaborate with and support private initiatives in health care delivery. *"Strengthening the collaboration and partnership between the public and private sectors in health"* is an important guiding principle of the National Health Policy (1999) and a key element for strengthening the health care delivery system in the Health Sector Strategic Plan (HSSP).

Private sector providers contribute to effectiveness by maintaining complementary networks of facilities and services that can withstand social, political and economic shocks that may adversely affect the public sector. By working in partnership with government, the mixed system of public and private services thus created is stronger and can compensate for short-comings in either provider. Majority of the Reproductive Health (RH) interventions implemented so far have focused exclusively on improving the quality of care and Behavior Change interventions as they relate to maternal health issues. Nevertheless, it is now increasingly recognized that in order to achieve improvements in Reproductive Health outcomes in general and maternal health in particular government should harness Public-Private Partnerships as a way of leveraging resources from the private sector. By leveraging resources from the private sector, the public sector can expand access to maternal health services to new client populations, increase the overall pool of funding for the health sector, and better focus scarce public sector resources on populations in greatest need.

The national budget framework paper 2007/2008 – 2009/10 looks at the overall goal of the health sector as "The attainment of a healthy productive lifestyle and a reduction in morbidity and mortality from major causes of ill health and premature death, and the disparities their-in" (National Budget Framework, pg. 82). To that end, Public-Private Partnerships are an excellent model to help the Government of Uganda (GoU) through the Ministry of Health and other line ministries achieve its goal Uganda's Public Private Partnership Act of 2015 defines. This study describes a framework for assessing the effectiveness of Public-Private Partnerships on maternal health programme a strategy that policy makers

can use to improve equity, access, quality, efficiency, and sustainability of maternal health programmes.

Sustainable strategies for implementing maternal health programmes ought to include;(i) Development of an integrated health care system, ii) Formalization of responsibilities through an arrangement of Memoranda of Understanding (MOUs) spelling-out the roles and responsibilities of each partner, iii) Accreditation of private for health care facilities to offer comprehensive care, (iv) Registration of Non-Governmental Organizations (NGOs) and Community Based Care Organizations (CBOs).

Literature reviews show that there is awareness of the general sustainability for maternal health programs in Uganda, little work has been done on quantifying the impact. There is a strong legal and policy frame work for PPP which existing following the passing of the draft in 2012. Country wide implementation is weak and poorly coordinated, Donors including USAID, SIDA, DFID are less aligned to national priorities (Including care for the refugees and political stability) inadequate involvement and regulation of private providers not enough sharing of date, lack of transparency, few resources for operational policy at the district level (PPPH review report MOH,2019). This has hindered strategic formulation and appropriate response to maternal health issues. While there is awareness that there is need for reducing maternal mortality, there is concern that strategies are not put in place, and that this could undermine the great strides that Uganda has made in achieving economic growth and development.

3. Methodology

3.1 Research design

The study was cross-sectional and analytical. The study engaged a set of methodological pluralism with emphasis on triangulation. Qualitative research design using focus group discussions and key informant interviews were used to explore a range of issues with regards to public-private partnership, including challenges or barriers to implementation, collaboration and sustainability. describe and explain what maternal health programme implementers perceive to be the barriers in the collaboration between the public and private sectors. The study was descriptive, aimed at generating in-depth understanding of programme implementers' views, perceptions on public-private partnerships and the effectiveness of maternal health programmes.

3.2 Study Population and Sample size

The study targeted a total of 220 people from health facilities implementing maternal health programs in Mukono District. The study determined a sample of 135 through purposive and simple random sampling techniques.

3.3 Inclusion and Exclusion Criteria

The researcher included the programme managers of health facilities implementing maternal health programmes in Mukono District. In choosing these health facilities, the following criteria were taken into consideration: Only those health facilities submitting the HMIS data were considered eligible for the study.

3.4Data Collection Methods

3.4.1 Interviews

The Key informants included top management for example; District Health Officer (1), District CAO, in-charges of the family planning unit (1), Delivery unit (1), Postnatal care unit (1), Abortion/post-abortion care unit (1), Laboratory head (1). These were randomly selected from both within the public and private sector and at least a Programme manager/officer working in an NGO collaborating with health facilities or providing maternal health services. These were purposively selected from the different health facilities in the District and number of interviews to be conducted depended on mini saturation. However, the need for representation from the public and private sectors was considered based on the different forms of services offered to enhance maternal health care.

3.4.2 Focus group discussions

The researcher conducted three (3) FGDs, each with at least 8 members, with direct programme beneficiaries (clients) including both public and private health facilities in a group. The first FGD targeted mothers aged 15-34 years and the other, 34 year and above. The purpose of grouping responses according to age was to avoid bias that could have resulted into difference in reasoning capacities since it is believed that different age groups think differently. The third group included mothers outside the health facilities who were randomly selected by accidental sampling. From these, general questions, recommendations and problems faced were derived This allowed for an unbiased reflection of service delivery while controlling for confounding factors (it also served as a validation of the effectiveness of maternal health programmes).

3.4.3 Questionnaire

With regards to the quantitative approach, three interviews/questionnaires from each health facility were administered as follows: 1- to top management, 1- to support staff/head of facility and 1- medical personnel

directly handling the clients (— mothers in this context). Forty five (45) health facilities were sampled from Mukono District with 3 questionnaires for each, making total of 135 questionnaires (i.e. 45x3), being administered to the respondents based on a purposively selected sample. This enabled the researcher to tap into information such as; (i) what forms of partnership exist if any (e.g. referrals, STI/HIV managements, (ii) Continued professional development, (iii) Leadership, (iv) Technical support, (v) Resource mobilization and supplies and (vi) Maternal health services provided (Family planning, antenatal care, delivery care, postnatal care, abortion/post abortion care, management of teenage pregnancies, STI/HIV management etc) and later ranking the above in order of priorities.

3.5Data Analysis

The audio recordings from the FDGs and KIs were transcribed using Nvivo software. Transcripts from the focus group discussions and key informant interviews were analyzed using thematic analysis based on key themes and codes generated from the narratives transcribed while taking note of conflicts (differences), consensus (similarities) and omissions (emerging issues that were ignored). Transcripts were organized into manageable segments, or chunks of meaning that corresponded to the ways the programme managers perceived the concept of Public-Private Partnerships. Data analysis was an inductive process of organizing the findings into identified categories. The categories and the patterns were not predetermined, but emerged from the data. Relevant information from the interviews and from source documents were put into small segments according to identified categories and meanings. Areas of diversity were identified as well as areas of recurring themes and commonality. In order to ensure accuracy, the findings obtained through the various sources were discussed with the respondents. This helped to establish whether the recorded data accurately represented their responses. The quantitative data was entered using Epi data (version 3.1) and exported to Statistical Package for Social Scientists (SPSS version 20) and STATA (version 11) for further analysis. This produced descriptive analysis using percentages and frequencies of the study population and maternal health service delivery.

Bivariate analysis of the selected independent variables was analyzed vis-à-vis the dependent variables to examine the relationship and inequalities in service delivery between and within variables using ANOVA (Pearson's Chi square test). Where necessary, a multivariate analysis based on an appropriate model was used to analyze and to determine the likelihood of predictions and whether there existed any statistical association at p-value = 0.05 between the predictor variables and the key dependent variable while controlling for confounding factors.

3.6Quality Control of the Data

The questionnaire was pretested for clarity to ensure that it is in context with the research objectives, quantitative data entry tool was checked to minimize data entry errors and a validation entry procedure was employed to clean the data to reduce discrepancies, the researcher tried to remain open-minded to guard against all personal orientations that might have influenced the research as well as its interpretations, efforts were made to control subjectivity, biasness, mindset, experiences, feelings, competencies and assumptions, data from interviews and focus groups was audio recorded and transcribed to make it possible to cross-check the data analysis and to confirm the accuracy of the data.

3.7Ethical Considerations

Confidentiality was ensured and the respondents were assured that the results obtained will not be used for any other purpose other than the study and that the responses recorded are indicated in the findings. The researcher sought informed consent from the respondents and assured of confidentiality and anonymity, with a clear indication of voluntary participation in the study. The researcher also sought clearance from the District Health Officer (DHO) of Mukono district for study authorization, and the researcher adhered to the Uganda Christian University's ethical committee standards.

4. Results and Discussion

4.1Public-Private Partnerships for Health (PPPH) for different partners

The study revealed that generally partnerships were effective (59%) as far as maternal health service delivery is concerned. Partnerships were mostly effective for administration (74%) followed by financing (67%), training (59%) while service provision was the least effective with only 20%. Other areas where partnerships were effective included advisory and consultancy services. Similar findings of PPPH interventions in Turkey show positive contribution in financial crises management as a result of rising costs and provision of non-clinical services on the technical aspect having greatly improved (Ahmed et.al. 2019). Similar findings on PPPH success in SSA countries of South Africa and Zambia reveal that PPPH projects have formulated and improved medical trainings institutions in South Africa the Limpopo Academy and Nelson Mandela medical schools and a state vaccine centre in Johannesburg have been well refurbished and manned while in Zambia medical training school for Nurses have been built train

more midwives following high maternal mortality rates ten years ago (Mangimela, 2012).

The study findings tally with similar PPPH targets in East African Rwanda which has seen an improvement in efficiency in the health system with cost containment, greater accountability as noticed in one hospital King Faisal hospital (Maureen, 2019). Following this success in Uganda and according to Jokozela, 2011 interactions between the public and private sector had put pressure on the government of Tanzania to pass specific regulation to initiate PPP projects (Jokozela, 2011) However findings by Bwana, 2014 show that there is a weak regulations due to mistrust, commitment and no accountability in the health sector(Bwana,2014).

Table1: PPPH for different partners

Role of partners	Effectiveness of partnerships on maternal health (%)		Total
	Poor	Good	
Administration	26.1	73.9	**100.0**
Financing	33.3	66.7	**100.0**
Service Provision	80.0	20.0	**100.0**
Training	41.5	58.5	**100.0**
Others	0.0	100.0	**100.0**
Total	**41.4**	**58.6**	**100.0**

4.2Effectiveness of Maternal Health Programmes in Mukono District

To assess the effectiveness of maternal health programmes in Mukono District, a ranking of the effectiveness of maternal health components was done on a scale of 1 being poorly, 3 being somewhat poorly harnessed and 5 being very well harnessed as indicated in Table 2. The study revealed that maternal health was somewhat poorly harnessed in Mukono district with highest percentage of 82%.

Table 2: Effectiveness of Maternal Health programmes

Effectiveness of maternal health programs	**Frequency**	**Percent**
Poorly Harnessed	2	1.5
Somewhat Poorly Harnessed	22	16.3
Well harnessed	111	82.2
Total	**135**	**100.0**

61 documents examined by Nasrin et al. in January 2021 shows evidence on the use of PPPs in the provision of PHC services show Pakistan, India, Nigeria, Cambodia, Brazil, Arizona (US) and Bangladesh and include prevention, promotion**,** and medical care, including maternal and child health care, family planning, environmental health, school health, health education, immunization services, health promotion, common diseases treatment, malaria management**,** maternity services, postpartum services**,** and vaccination against influenza) was outsourced to PPPs and delivered to specific target groups (children, mothers, pregnant women, industrial workers, poor residents in the remote areas). *The provision of these basic PHC services (infrastructure, procurement, and services management) was contracted out to private sector providers to facilitate better access and coverage of the population* (Nasrin et al. 2021). The majority of studies reported that the provision of basic PHC services by private sector actors increased access to services, improved aspects of care, and resulted in various positive outcomes (Tanzil, et al,2018) However, there was also some criticism as well. For example, Baig et al. (2014) showed that the management of immunization services, health promotion, disease treatment, maternity services and malaria by PPPs could also be seriously inadequate. (Mahan et

al.,Turan,2014) also reported that due to being perceived as having poor quality by the local population, the uptake of institutional and maternal delivery provided in the private hospitals was low despite being offered free of charge.

4.2.1 Status of Effectiveness of Maternal Health Components/Programmes

The effectiveness of maternal health services as regards family planning, antenatal care, delivery care, emergence obstetric and neonatal care, postnatal care, primary health care, equity for women as well as behaviour change communication was assessed basing on the respondents' rating of the effectiveness of maternal health components/programmes by *(1) Poor, (2) Satisfactory and (3) Good* as indicated in table 3.

Table 3: Status of effectiveness of maternal health components/programmes

No	**Type of Intervention**	**Rating**		
		Poor (%)	**Satisfactory(%)**	**Good (%)**
1	Family planning	19	62	19
2	Antenatal Care	8	64	28
3	Delivery Care	10	66	24
4	Emergency Obstetrical Care	25	70	5
5	Emergency Neonatal Care	29	59	13
6	Postnatal Care	6	71	23
7	Primary Health Care	10	75	15
8	BCC Interventions	30	64	6
9	Equity for Women	27	67	7

Regarding the effectiveness of maternal health components offered, the least effective was the BCC component with the highest ranking of 30% under the category for poor implying that BCC interventions were not effective at 30%. Other interventions that were rated to be less effective were emergency neonatal care at 29%, followed by equity for women at 27%, emergence obstetrical and delivery care at 25% and 10% respectively. PHC and PNC services were somewhat effective with a ranking of 75% and 71% respectively under the category of "satisfactory". ANC was the most effective with ranking of 28% under the category for "good".

To determine whether the apparent level of effectiveness was due to the partnerships in delivery of maternal health services, a detailed analysis to determination the level of effectiveness of the Public-Private Partnerships for maternal health services was conducted using cross-tabulations as indicated in Table 4.

4.2.2 Cross-tabulation indicating the Relationship between effectiveness of the maternal health programs and the partnership

Table 4: Services and the Level of PPPH Arrangement (Harnessing)

Effectiveness of maternal health programs		Respondents' rating of maternal health service programs (%)			P-value (*c.f.* 0.05)
		Poor	Satisfactory	Good	
	Family planning				
Poor		43.5	45.6	10.9	
Good		7.7	64.6	27.7	0.000
	Antenatal care				
Poor		19.6	69.6	10.9	
Good		3.1	47.7	49.2	0.000
	Delivery care				
Poor		15.2	82.6	2.2	
Good		3.1	49.2	47.7	0.000
	Emergency obstetrical care				
Poor		34.8	60.9	4.3	
Good		24.6	69.2	6.2	0.493
	Emergency neonatal care				
Poor		52.2	39.1	8.7	
Good		21.5	60.0	18.5	0.003
	Postnatal care				
Poor		6.5	82.6	10.9	
Good		7.7	53.9	38.5	0.004
	Primary health care				
Poor		6.5	89.1	4.4	
Good		16.9	56.9	26.2	0.001
	BCC Interventions				
Poor		23.9	76.1	0.0	
Good		40.0	49.2	10.8	0.006
	Equity for women				
Poor		23.9	76.1	0.0	
Good		32.3	55.4	12.3	0.017

From table 4.4, the study revealed that the apparent level of effectiveness for utilization of ANC services was due to the satisfactory level at which partnerships are being harnessed that was significant with (p= 0.006) implying that the service is very well utilized.

This was also evidenced during the key informant interviews where one respondent indicated that;

> *… "most pregnant mothers attend ANC from either sectors but when it comes to delivery they opt to deliver with traditional birth attendants…so we have to improve on that area to ensure that the existing programs are utilized…"(Respondent A, 23/8/2013).*

PHC was very well harnessed with 96% and from the study it established that it was satisfactorily very well harnessed besides maternal health services since its p-value was (p=0.001) implying that primary health care services were properly implemented. This was also revealed by one of the respondents during the Key Informant interview:

> *"… of recent we had a gap in immunization coverage but through partnering with UNICEF, we were able to scale-up the immunization coverage…" (Respondent B, 25/8/2013).*

It is was worth noting that the effectiveness of PPPH in Mukono District is majorly *administration* and to a greater extent, the partnerships are well harnessed. In health facilities where PPPH is not well harnessed, this is attributed to; (i) Non-availability of doctors and midwives (Skilled-Birth Attendants in this context), (ii) Government not considering the private services as important, (iii) Inadequate budget allocation towards maternal health services, (iv) Increasing population growth that does not match with service delivery in Mukono District. One of the respondents noted that,

> "*We work with the public sector by offering joint services including family planning and immunization mostly, however we just work for*

free, we are not paid for the services but do the services to improve the maternal and child health in our communities" (Respondent X, 23/8/2013) The majority of PPPs projects facilitated education and health promotion initiatives and were used to increase access and to facilitate the provision of prevention and treatment services (i.e., TB, malaria**,** and HIV/AIDS,) for certain target groups. The challenges of providing PHC via PPPs were reported primarily for the starting and implementation phases of project execution. Reported challenges and recommendations on how to overcome them fell into one of five areas: education, management, human resources, financial resources, and information systems (Tanzil, et al., 2018)

5 Conclusion and Recommendations

The effectiveness of Public-private partnerships (PPPH) in Mukono District is deemed towards administrative, financial support and training but actually not in service provision since the components that are mostly utilized are ANC and HIV-PMTCT services. However, when it comes to components like caesarian section, ambulance and blood transfusion services the partnerships are not effective. Hence, the partnerships are not geared towards saving the mothers.

The paper recommended that, there is need to target service delivery to address the critical areas like caesarean section, dilatation and curettage (D&C), as well as blood transfusion not only concentrate on HIV-care services. Further, there is need to ensure that partnerships between the public and private sectors address provision of emergence obstetrical care services (EmOC) since PMTCT mothers actually need these services. *A partnership should not be formed unless the public sector is strong enough to ensure that it can provide appropriate training and health care services, monitor the outcomes, and have the ability to engage as a partner in PPPs. Before designing any partnership, clear and achievable public interest goals should be considered. A government structure should then ensure that the goals are in line with the needs of stakeholders in public-private partnerships, and tools and mechanisms to measure progress and success are well-defined. All partners should also be motivated and provided with incentives to ensure active engagement and participation* .In the author opinion to achieve a Universal health care through PPPH framework needs to pay critical attention and optimal provision and minimisation of duplication as in the case of Mukono district

- Joint responsibility for policy implementation and planning including addressing the core issues of maternal health in the district.
- Transparency and proper accountability of providers and regulation
- Tune public finances to address critical health services including improvising of more medical equipment i.e. ambulances, scanners and emergency drugs.
- Therefore, governments should consider long-term plans and sustainable policies to start such partnerships and learn from the experience of others.

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