

PRIVATE SECTOR CONTRIBUTIONS TO MATERNAL AND REPRODUCTIVE HEALTH

EXCERPT FROM THE 2016 UGANDA PRIVATE SECTOR HEALTH ASSESSMENT



A JOINT INITIATIVE BETWEEN



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Bibliography

Acronym

ANC	Antenatal Care
BST	Business Skills Training
IEC	Information, Education and Communication
FP	Family Planning
GFF	Global Finance Facility
HaaB	Health as a Business
HIV/AIDS	Human immunodeficiency virus infection and acquired immune deficiency syndrome
HRH	Human Resources in Health
HSD	Health Sector Development Plan
LARC	Long Acting Reversible Contraceptives
MDG	Millennium Development Goal
MH	Maternal Health
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MRH	Maternal and Reproductive Health
NHA	National Health Accounts
NGOs	Non-Government Organizations
OECD	Organisation for Economic Co-operation and Development
OOP	Out of Pocket
PHS	United States Agency for International Development Private Sector Support Program
OTC	Over the Counter
PNFP	Private Not for Profit
PFP	Private for Profit
PHP	Private Health Providers
PPD	Public-private dialogue
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SMP	Safe Motherhood Programme
SPA	Service Provider Assessment
SSA	Sub-Saharan Africa
THE	Total Health Expenditure
UDHS	Uganda Demographic Health Survey
UGX	Uganda Shilling
USAID	United States Agency for International Development
WHO	World Health Organizations

1. Background

Uganda's Vision 2040 proposes a vision of a *"A Transformed Ugandan Society from a Peasant to a Modern and Prosperous Country within 30 Years"*. It aims to move the country from a low-income country with per capita income \$506 to a competitive upper middle-income country with per capita income \$9,500 by 2040 (Uganda Vision 2040).

Many Ugandans envision a country in which all its citizens can enjoy a productive life with gainful employment, access to education and the right to quality healthcare. Uganda, however, will struggle to reach its middle income status. Although Uganda is one of the fastest growing economies (four point eight percent - 4.8%) in East and Sub-Saharan Africa (SSA), there is still a large percentage (thirty percent - 30%) of the Ugandan workforce that are not fully employed in the formal sector. As result, the average Ugandan struggles to make ends meet with an average annual income per capita income at \$435 US dollars compared to the average in SSA at approximately to \$2,000 US dollars (See Table 1). There is great income disparity – as measured by the GINI coefficient – among the Uganda population with an estimate nineteen point seven percent (19.7%) living below the poverty level (Supre, 2015).

Moreover, Uganda's health system confronts many challenges. Rapid population growth fuelled by high fertility, continues to strain the current health system with increasing demand for health services. Although life expectancy has been increasing to its current levels of 57.8 years, it is still lower than average of 59.5 years in SSA. Child and maternal mortality remain high at 55/1,000 live births and 343/100,000 live births respectively when compared to the SSA averages. And Uganda has one of the highest HIV/AIDS prevalence rates on the continent at seven point four percent (7.4%) despite its pioneering and aggressive response. With Uganda's extensive health challenges, making this vision a reality will require a collaborative health system that capitalizes on the resources and abilities of *all* health system actors.

Table 1. Private Sector References in Uganda's Economic Development Policies

Indicator	Data Source	Uganda	Year	SSA Average	Year
GDP per capita (constant 2005 US\$)	WDI-2015	435.50	2014	2029.67	2014
GDP growth (annual Percent)	WDI-2015	4.8	2014	4.7	2014
Adult literacy	WDI-2015	70.0	2012	59.0	2012
Labour participation rates	WDI-2015	75.0	2014	72.0	2014
GINI index (World Bank estimate)	WDI-2015	42.4	2012	42.2	2011
Per capita THE at international dollar rates	WDI-2015	59.10	2013	135.98	2013
Life expectancy at birth, total (years)	WDI-2015	57.8	2013	59.5	2013
Maternal mortality (per 100,000 live births)	WDI-2015	343	2015	310	2015
Under 5 mortality (per 1,000 live births)	WDI-2015	55	2015	85	2014
HIV/AIDS prevalence rate	UNAIDS-2015	7.4	2014	4.7	2014

Source: World Bank Indicators Database, Created from: World Development Indicators

Against this background, the United States Agency for International Development (USAID) commissioned the USAID/Uganda Private Health Support Program (herein referred to as the PHS Program) to conduct an assessment of the private health sector in Uganda. The Global Finance Facility (GFF) supporting the UN Secretary-General's *Every Woman Every Child* initiative joined USAID's initiative to conduct the PSA as part of their initiative to develop an Investment Case for RMNCAH. They both committed funds to support the PSA.

2. Public-Private Mix in Health Service Delivery

2.1. Basic Concepts

Intuitively one can observe that market forces are more dominant in certain health activities than others. For example, retail pharmacies, medical equipment and distribution of health supplies are subject to more market forces while disease surveillance and national referral hospitals are shaped more by government policy. Review of the policy research on Organisation for Economic Co-operation and Development (OECD) health systems shows that governance structure and regulatory frameworks are different in each sub-sector, allowing for greater market forces or more government structure to shape a health market (Harding, 2015). When a government opens up to more private sector participation, many private not for profit (PNFPs) and private for profit (PFPs) health care providers quickly enter into and dominate these health markets. For example, many aspects of the medicine supply chain and primary health care are delivered almost exclusively by the private sector in OECD countries. While in sub-sectors that are heavily regulated, it is more difficult for private providers to enter and stay in these markets. For example, in most OECD countries, governments restrict hospital ownership to public and/or PNFP only.

Yet, policymakers, development partners and international experts often treat all health sub-sectors the same and do not recognize that the private sector can play a larger role in certain sub-sectors while the government in others. This section examines the public-private mix by a select number of sub-sector – or health markets – to understand why the private sector is more active – or less as the case maybe – in different health areas. Understanding the market dynamics is critical to formulating appropriate policies and strategies that can harness private sector when needed (e.g. deliver more primary health care) or crowd them when dangerous (e.g. close down unlicensed facilities).

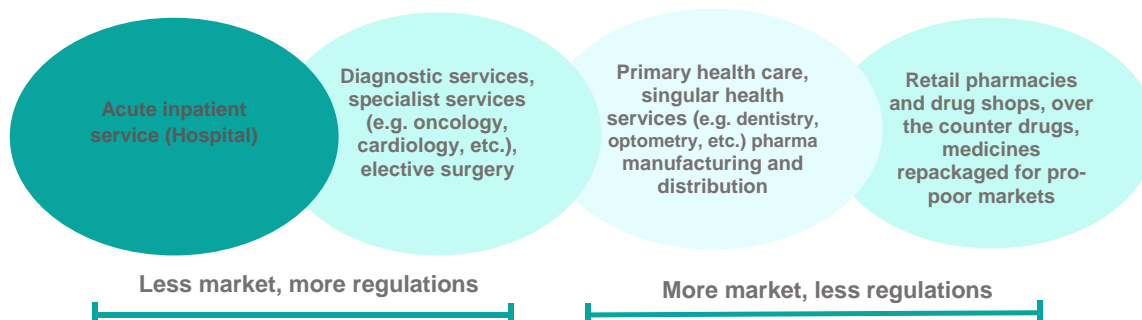
Box 1 Definition of Health Market

A set of arrangements by which buyers and sellers are in contact to exchange goods or services in health; the interaction of demand and supply for a health service or product.

2.2. Public-Private Mix in Different Health Markets

A review of OECD country health systems exhibits certain patterns of public-private mix in health sub-sectors (Harding, 2015). Certain health activities tend to be governed in ways that permit more market forces while others are consistently governed in ways that strongly limit or remove market forces (see Figure 1). Drug shops and retail pharmacies, over the counter (OTC) drugs and health products are subject to

Figure 1: Health Markets Organized by Less or More Market Forces

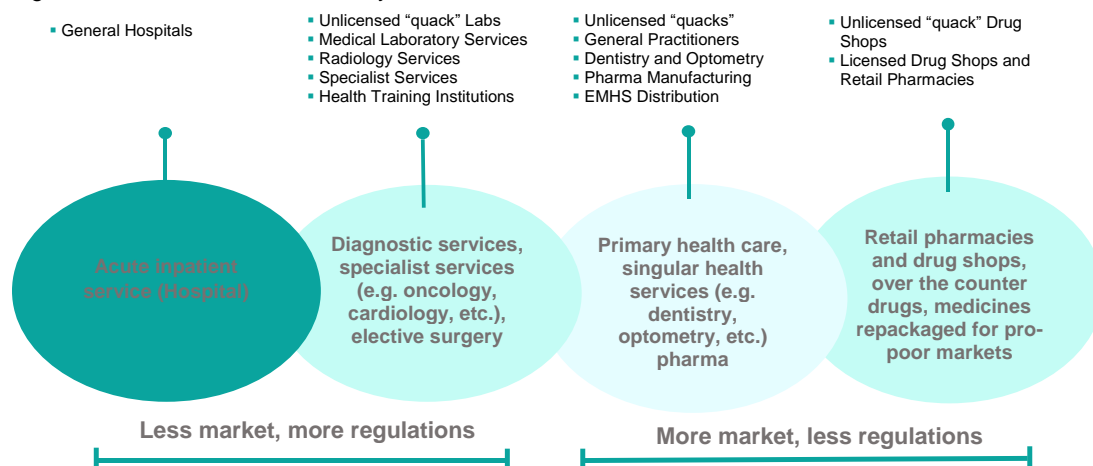


Source: Harding, 2012.

moderately strong market forces – customer competition, price, entry barrier – compared to other health markets such as acute inpatient care in hospitals which is highly regulated by the government. Certain conditions – or market system dynamics – determine whether a health market is influenced more by markets or shaped by government policy. These dynamics include: operational autonomy, customer competition, price influence, entry barriers, social funding and performance tension.

Synthesizing the Uganda data on private facility levels, human resources in health (HRH), site visits and stakeholder interview, one can see the markets in which the private sector operates. As Figure 2 shows, the Uganda private health sector is concentrated in the sub-sectors that are more market driven, such as retail pharmacies, distribution and primary health care. Although there is some private sector presence in the more structured markets, such as diagnostics and hospital care, it is in much smaller numbers. Unlike OECD and middle income countries, Uganda lacks the governance structure to manage a mixed health delivery system and as a result, still has a largely unregulated private sector with quack labs, drug shops and health providers that operate outside of the health system.

Figure 2 Private Sector Activities by Health Markets



Source: Adapted from Harding, 2012.

3. Background on Maternal and Reproductive Health (M/RH)

The health of a mother impacts the family and entire community. Her ability to access and receive necessary health care greatly determines health outcomes for herself and her baby. Uganda is one of ten countries globally which contribute to the highest maternal, newborn and child mortality rate in the world (WHO, 2011). With maternal and prenatal health conditions accounting for over twenty percent (20%) of

Table 2: Maternal Health Indicators over Time

Indicator	2000/01	2006	2011	2014 WHS estimates
Life expectancy at birth (years)	48.9	53.4	58	
Under 5 mortality rate (per 1000 live births)	157	137	90	69
Neo natal mortality rate	33	27	27	23
Infant mortality rate (per 1000 live births)	88	76	54	45
Child mortality rate	69	67	38	
Immunization coverage (% receive vaccine 12-23 months)	29	36	40	
Maternal mortality ratio (per 100,000 live births)	524	435	438	360
Birth assisted (%)	--	41	57	
Modern contraceptive rate (% of married women who use)	4.9	14.8	22.8	
Total fertility rate	6.9	6.7	6.2	
Unmet need for FP (%)	35	38	34	

Source: Health Sector Development Plan 2015/16-2019/20 and UDHS 2011

the total disease burden in Uganda, more needs to be done to ensure safe motherhood¹.

There are vast inequalities across maternal and infant mortality with the developing world accounting for the majority of the burden. These inequalities are linked to health care service delivery. Although Uganda has made significant investments to improve the health of its citizens, health indicators remain a concern. Challenges remain in ensuring that women, children, families, and communities have access to high-quality health services, whether it is safe delivery for pregnant mothers and their newborns or reproductive health counselling and contraceptives for individuals and couples.

¹ Source: http://www.newvision.co.ug/new_vision/news/1326493/promote-maternal-health-uganda

3.1. Maternal

Mortality

The maternal mortality ratio (MMR) has fallen by approximately twenty percent (20%) over the past twenty years, but still fell short of the Millennium Development Goal (MDG) target which called for a reduction of at least seventy-five percent (75%) in MMR (see Figure 3). WHO estimates that estimated 5,700 maternal deaths will occur in Uganda in 2015, yielding an overall MMR of 403 maternal deaths per 100,000 live births. Almost half of maternal mortality determinants lie outside of the health sector. In order to accelerate MMR reduction, there is equal need to invest in social determinants including girl child education, women empowerment, and water and electricity in health facilities.

Immediate cause of maternal death is haemorrhage – accounting for forty-two percent (42%) of deaths – followed by obstructed or prolonged labor twenty-two percent (22%) and complications from abortion eleven percent (11%). Indirect causes include malaria, a factor in thirty-six (36%) of maternal deaths recorded, anaemia at eleven percent (11%) and HIV/AIDS at seven percent (7%) (See Figure 4).

3.2. Antenatal Care

There is universal access to Antenatal Care (ANC) services in Uganda, with ninety-five percent (95%) (UDHS 2011) all-pregnant mothers receiving ANC services from a skilled provider. However, only 21% of women made their first ANC visit before the 4 month of pregnancy in 2011 and the median gestation age for the first antenatal visit was 5.1 months. Attendance of at least four ANC visits between 2006 and 2011 has stagnated at 47% (See Figure 7).

3.3. Institutional Delivery

Figure 3: Trends in Maternal Mortality Rate (MMR)

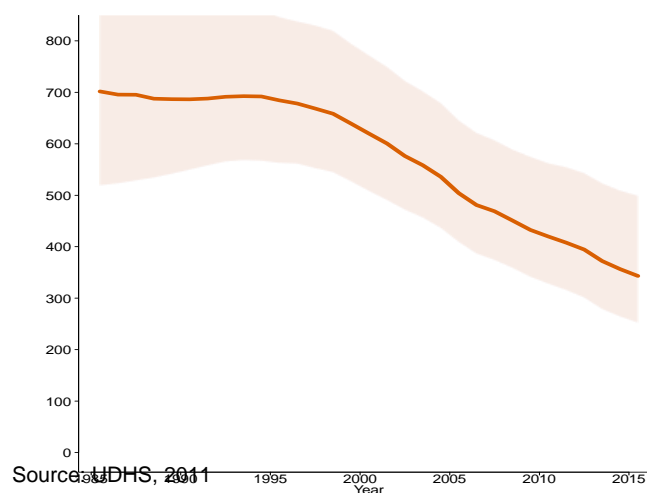
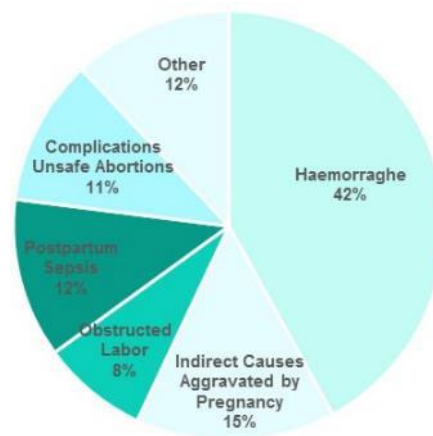


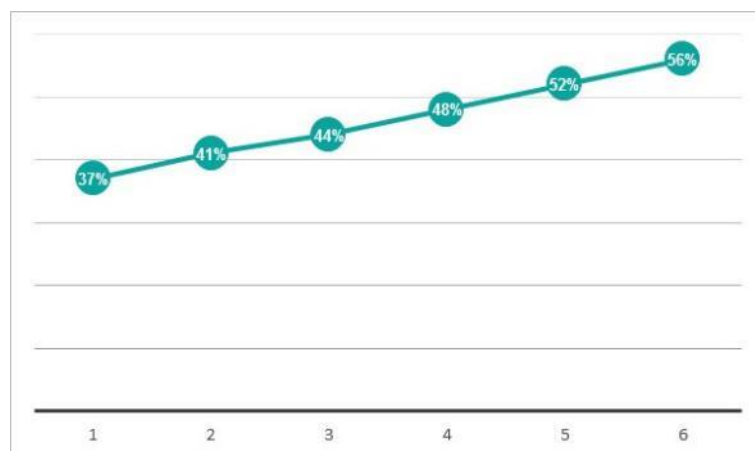
Figure 4: Direct Causes of Maternal Mortality



Source: Based on MPDR 2013/14

The proportion of births supervised by a skilled health worker rose from thirty-eight percent (38%) in 1995 to fifty-six percent (56%) (See Figure 5) in 2011. Between 2006 and 2011, there was a large increase from forty-two percent (42%) to fifty-eight percent (58%) across all regions of the country. Although almost ninety percent (90%) of all births in urban and fifty-three percent (53%) of births in rural areas are by skilled birth attendant, regional disparity still exists. Karamoja (31%) and the South-Western (42%) regions experience the lowest coverage of deliveries supervised by a skilled provider. A significant number – forty-two percent (42%) – deliver at home.

Figure 5: Trends institutional Delivery

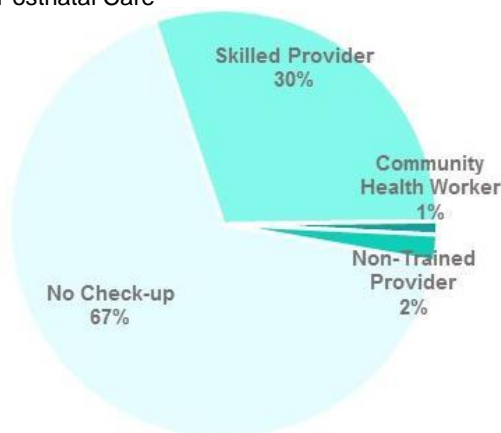


Source: Based on MPDR 2013/14

3.4. Postnatal Care

In addition, more than two thirds of mothers do not receive any postnatal check-up (sixty-seven percent - 67%) (See Figure 6) Yet over sixty-seven percent (67%) of maternal deaths occur 23-48 hours after delivery, mostly due to haemorrhage and hypertensive disorders or after 48 hours because of sepsis.

Figure 6: Postnatal Care

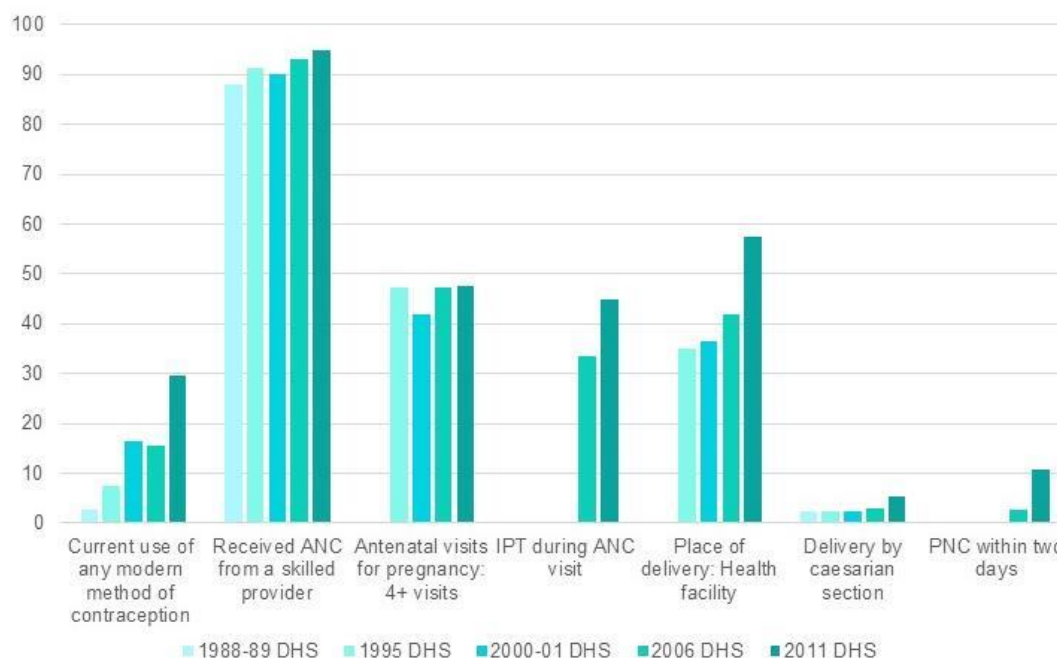


Source: Based on MPDR 2013/14

3.5. Family Planning (FP)/ Reproductive Health (RH)

Uganda has one of the highest rate of unmet need for family planning (FP) in Sub-Saharan Africa – it is above thirty-four percent (34.3%) which translates to approximately 1.6 million women (PRB Brief, 2011). Of these women, about sixty percent (60%) want to space their next birth and the other forty percent (40%) do not want any more children. More than half (64%) of non-users married women intend to use FP in the future; this proportion has not significantly changed for the last decade. The Uganda Demographic Health Survey (UDHS) 2011 also shows that Ugandan women, on average, give birth to nearly two children more than they want (6.2 vs. 4.5). Moreover, approximately forty-three

Figure 7: Coverage Trends Across Continuum of Maternal Health Care in Uganda



Source: UDHS, 1989, 1995, 2001, 2006, 2011

percent (43%) of all pregnancies were unplanned. Although contraceptive use among all married women or those with a partner doubled from fifteen percent (15%) in 1995 to thirty percent (30%) in 2011, contraceptive prevalence is still very low compared to other SSA countries. Figure 7 provides an overview of the trends in key maternal health indicators from 1988 to 2011.

4. Maternal Health at the Policy Level

The reasons for poor health outcomes for mothers and children in Uganda is well documented. Health system challenges and poor social determinants negatively impact maternal child health. Difficult access to quality services, shortages of trained and motivated health professionals and shortages of essential drugs contribute to high mortality and morbidity rates. Access to life-saving services and medicines is also inequitable.

When examining the policy and regulatory framework governing maternal health, regulations supervising of private health providers (PHPs) delivering maternal health is shared between governmental statutory bodies and non-government professional associations. This regulatory arrangement is unique for MH when compared to HIV/AIDS. The most relevant actors are the Uganda Nurses and Midwives Council, the Uganda Nurse and Midwives Examination Board. The Uganda Private Nurse Midwives Association also plays an increasingly important role in ensuring their members are compliant with Uganda's regulations and observe clinical standards and guidelines. Unfortunately, the reach of most of these organizations does not extend far beyond the capital city.

The government has put in place several initiatives in an attempt to improve women's status in Uganda (See Table 3). The National Population Policy seeks to slow down population growth and reduce fertility by promoting informed choice and increasing access to quality health services. The policy also involves other sectors such as education, health, agriculture and the economy, as strategies to promote changes in cultural practices that influence reproductive health decisions. In 1996, the government adopted universal primary education as a strategy to improve the population's literacy and to increase girl's enrolment and retention in school. In response to lower status of women, the government adopted a gender policy in

1997 with the goal of integrating gender into community and national development. There have also been several attempts to legislate against negative social practices such as domestic violence, polygamy, and inequity in family resources but with limited success (Health Sector Development Plan [HSDP], 2003).

In the health sector, the Ministry of Health (MOH) put into place a number of policies with implications for maternal services. The National Health Policy in 1996) sets maternal and reproductive health as a priority area. Maternal and Child Health are identified as key elements of the minimum health package in the second National Health Policy (July 2010). And the elimination of user fees at public facilities in 2001 was another effort to increase mother's access to health services by removing the economic barrier.

The national Safe Motherhood Programme (SMP-1999) is the foundation of Uganda's strategy to achieve significant reductions in maternal, neonatal and child mortality. Several changes occurred with the introduction of SMP Programme, such as establishing comprehensive training and curricula to expand and integrate midwifery, public health and clinical nursing skills; updating, standardizing and disseminating clinical guidelines for maternal/reproductive healthcare; instituting maternal death audits to raise provider awareness and highlight facility-level improvements; and involving communities to identify high risk pregnancies and prepare for an emergency. It is interesting to note that at this point in time, SMP only focused on public delivery of maternal services.

Table 3: Policy and Plans Supporting MCH

Policy or Plan	Key Points and Private Sector References
National Population Policy (1998 and 2008) National Population Policy Action Plan	<ul style="list-style-type: none"> The policy seeks to reduce population growth and develop human capital through multi-sectoral approach. Policy divided into five categories – 3 directly influence women's health Population and Development: The NPP is directly linked to the National Development Plan. Actions include improving the quality and retention at primary and post primary education levels, reducing infant, child and maternal mortality rates and increasing people's control over the size of their family. Sexual and Reproductive Health: Informed choice and mutual and equitable gender relations are the underpinning to sexual and reproductive health. Actions include increasing access to safe, affordable and acceptable FP methods and reproductive health services. Gender and Family Welfare: Socio-cultural influences and weak economic power limit both men and women's reproductive rights. Actions include providing appropriate information, advocating for positive change in gender and family welfare issues.
Safe Motherhood Programme (1999)	<ul style="list-style-type: none"> Reduce MMR by 30% in 2001 through comprehensive quality RH services Reduce IMR by 30% through accelerated reduction in neo-natal component of MR Interventions included: establishing clinical guidelines, adopting Baby-Mother Package, creating of traditional birth attendant network, strengthening referral system, improving forecasting of high-risk obstetric events, and producing more midwives, etc. No mention of private sector role.
Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda (2013)	<ul style="list-style-type: none"> In the Roadmap's Foreword, the President of Uganda admonishes all stakeholders, including the private sector, to use the Roadmap to achieve national goals of reducing maternal and neonatal deaths One of the strategies– among many – are partnerships that promote coordination and joint programming to improve collaboration, maximize resources and avoid duplication. Partnerships are defined narrowly to be corporate responsibility with private companies, encouraging them to subsidize government services or to “undertake social responsibilities in health” such as fundraising activities and private donations for the Road Map Other forms of partnership include: (i) partnership with media, (ii) regular meetings with stakeholders, and (iii) provide TA and support professional associations in MCH areas
DRAFT: Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda (2016)	<ul style="list-style-type: none"> The plan is aligned with the Health Sector Investment Plan 2014/15-2019/20 In addition to strategies outlined in the Roadmap, the plan further prioritizes investments in adolescent SRH component, civil registration and vital statistics, and framework to monitor RMNCAH results. The plan also costs the strategies and proposes the medium-term investment needed, in addition to an increase in operational expenses, to ensure that the required human resources, infrastructure, inputs and governance structures can deliver essential interventions. The plan does not include references to PNFP or PFP role in achieving reductions in maternal and neonatal mortality and solely focuses on investments in public services.
Health Systems Development: Maternal Health Review	<ul style="list-style-type: none"> HSD acknowledges that in order to expand maternal health services, the government will need to engage the private sector. The National Health Policy and PPPH Policy provide a framework by which the government can partner with the private sector Strengthening collaboration and partnership with the private sector is an important principal in the NHP to help strengthen national health system and to maximize attainment of national health goals
Health Sector Development Plan (HSDP) II 2015/16 – 2019/20	<ul style="list-style-type: none"> The HSDP II prioritizes reduction of maternal, child and newborn mortality The HSDP II acknowledges that poor results are due not to lack of appropriate policies but rather inadequate implementation of the existing policies and plans

Still struggling to achieve its MDG goals in maternal and child health, the Ugandan MOH updated the SMP in 2013 and drafted the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Uganda. A quick review of the Roadmap shows that the government encourages all stakeholders in society, including the private sector, to work together to reduce maternal and neonatal deaths. But the Roadmap offers few concrete recommendations on how to leverage private sector capacity resources except for corporate responsibility with private companies to subsidize government services and/or raise funds to donate to government programs.

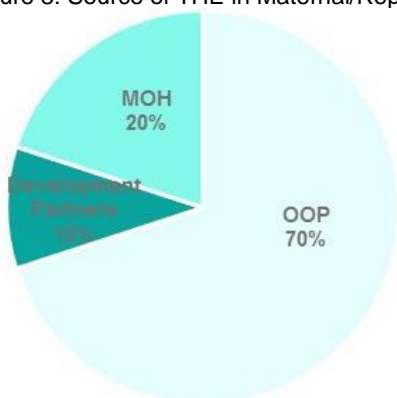
Currently, the MOH is developing a sharpened plan/investment case for RMNCAH with funds and technical assistance from the Global Financing Facility in Support of Every Woman Every Child. The draft plan - *Reproductive, Maternal, Newborn, Child and Adolescent Health Sharpened Plan for Uganda* - aims to accelerate reduction in mortality targets set in the HSDP II. Overall, the analysis assumes only the MOH delivers and responds to the country's MNH challenges. The draft Plan does not include in the analysis other stakeholders' contribution to maternal and child health services, particularly private not for profit

5. Financing of Maternal Health Services

This section analyses trends financing for and products as well as who funds M/RH services. All the data in this section is based on National Health Reports in Uganda.

There are inadequate financial resources for M/RH. There are three principle sources of financing for maternal health services: (i) MOH funds, (ii) donor funds and (iii) out-of-pocket expenses. The 2011/2012 NHA report states that 566,404 billion Ugandan shillings were spent on maternal and reproductive health which is approximately the same level from the prior year (See Table 4). Figure 8 shows that individual households paying out-of-pocket (OOP) (seventy percent – 70%) is the principal source of financing for RH services. Public funds account for twenty percent (20%) followed by Development Partners (DP) at ten percent (10%).

Figure 8: Source of THE in Maternal/Reproductive Health



Source: NHA, 2011/12 Table 8.6

Table 4: Total Health Expenditures on Maternal and Reproductive Health Services

Type of RH Service	Public	Private OOP	Donors	Subtotal
Maternal Health	60,192	230,281	15,955	306,428
Peri-natal	21,876	161,289	1,465	184,630
Family Planning	16,575	753	21,312	38,640
Other RH conditions	15,832	774	20,100	36,706
Subtotal	114,475	393,097	58,832	566,404

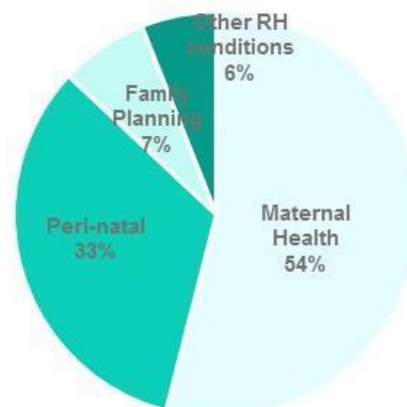
Source: NHA 2011/2012 Table 8.6

Clearly women bear the financial burden of paying for their maternity services. Table 4 shows that individuals pay less for FP and other RH conditions (approximately one percent for each of total OOP spending) compared to maternity (fifty-eight percent - 59%) and forty percent - 40%) newborn services. Moreover, Development Partners are the principal funders for FP and other RH conditions when compared to the MOH.

In examining how Total Health Expenditure (THE) is allocated across M/RH services (Figure 9), more than half of all expenditures (fifty-four percent – 54%) are spent on maternal health services while one third (thirty-three percent – 33%) is expended on newborn care. FP and other RH conditions received very little funds; seven percent (7%) and six percent (6%) respectively.

To put the amount of resources spent on RH in perspective, more than thirty-seven percent (37.5% - 1,783 billion UGX) was spent on HIV/AIDS, while only twenty percent (20% - 945 billion) to twelve percent (12% - 566 billion) were spent on RH services. More than three times was spent on HIV/AIDS compared to all RH services and almost six times more was spent on HIV/AIDS than on maternal health services. When comparing who pays for HIV/AIDS services, Development Partners funded almost seventy percent (69.4%) of HIV/AIDS services while the public financed seventeen percent (17.1%) and individuals, spent seven percent (7.2%).

Figure 9: Distribution of THE in M/RH Services



Source: Based on MPDR 2013/14

DP are striving to bring more resources to M/RH but it is still not enough. To help remove economic barriers to maternity care, several donors have earmarked funds specifically for maternal and reproductive health programs (see Table 5). The two voucher programs actively include both PNFP and PHPs providers but the PSA Team struggled to get in-depth information on how they will engage and interact with private providers (e.g. claims process, payment terms, etc.). In addition, the PSA Team wanted to examine the voucher program design, its benefit package and reimbursement levels to determine if the programs are complementary and will not distort markets (e.g. one pays private providers at a higher rate even though they deliver the same benefit package). As a result, the team cannot say anything conclusive about these programs other than that they provide much needed financial resources to decrease OOP costs.

Table 5: Summary of Donor Projects Supporting Maternal/Reproductive Health Programs

Program	Duration	Amount	Activities / Geographic Focus	Implementing Partner
World Bank Reproductive Health Voucher Project	5 years	\$13.5m	<ul style="list-style-type: none"> 4 ANC visits Delivery Post-natal including post-partum IUD 	Marie Stopes Uganda
USAID Maternal Health Voucher Program	5 years	\$24m	<ul style="list-style-type: none"> Service package: 4 ANC visits, Facility delivery, 1 post-natal visit for normal birth and 2 post-natal visits for C-section, EMTCT, Post-partum FP 	Abt Associates
Global Finance Facility	3 - 5 years	\$30m	To be determined	To be determined

The Global Finance Facility (GFF) – a multi donor initiatives that also includes the World Bank and USAID – is in the process of developing an Investment Case to analyze opportunities to leverage funds to strengthen the health systems delivering maternal, neo-natal, child and adolescent health. A preliminary review of the GFF draft Investment Case revealed no plans to work with the private health sector. GFF is currently in discussions with the Uganda World Bank Team and the MOH to revise the Investment Case to include private sector opportunities.

6. Public-Private Mix of Maternal and Reproductive Health Services

Many factors limit the utilization of M/RH services in developing countries. These factors include the availability, accessibility, and quality of services as well as the characteristics of the users and communities in which they live. Key socio-economic factors of include: (i) education level of both mother and father^{2,3,4} (ii) place of residence⁵, (iii) decision-making autonomy⁶, (iv) cultural values^{7,8,9,10}, and (v) ability to pay^{11,12,13}. The 2011 Uganda Demographic Health Survey (UDHS) provides a wealth of information on where women seek their M/RH services.

6.1. Overall Supply of Maternal Health Services

As the 2011 Service Provider Assessment (SPA) shows (Table 7), just over seventy percent (70%) of *all* facilities nationwide provide ANC services; fifty-three percent (53%) offer normal delivery services and only five percent (5%) can perform Caesarean section. There are regional disparities in maternal and newborn services. Kampala, Central and East Central have the most health facilities providing a range of maternal health services while Northeast and Eastern regions have the least.

Table 7: Percentage of Facilities with Select Maternal Health Services

Region	Ante Natal Care	Normal Delivery	C- Section	Emergency Transportation	Postnatal or Postpartum Care
Central	93	65	5	41	39
Kampala	76	63	26	69	67
East Central	72	58	4	51	31
Eastern	66	52	7	29	19
Northeast	51	46	4	46	33
North Central	67	60	6	80	39
West Nile	78	56	5	85	34
South West	61	39	4	38	27
Total	71	53	5	47	31

Source: USPA Policy Briefs 2007

6.2. Source of ANC Services

The majority of women – eighty-three percent (83%) – receive ANC care in a public facility (see Figure 10). Another seventeen percent (17%) seek care in a private health facility, ranging from Non-Government

² Source: <http://www.bioline.org.br/pdf>

²⁶ Rutaremwa G, Wandera SO, Jhamba T, Akiror E and Kiconco A. Determinants of maternal health services utilization in Uganda. BMC Health Services Research (2015) 15:271

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⁸ Kyomuhendo G. Low Use of Rural Maternity Services in Uganda: Impact of Women's Status, Traditional Beliefs and Limited Resources. Reprod Health Matters. 2003; 11:16–26.

⁹ Kabakyenga JK, Östergren P-O, Turyakira E, Pettersson KO. Knowledge of obstetric danger signs and birth preparedness practices among women in rural Uganda. Reprod Health. 2011;8.

¹⁰ Rutaremwa G, Wandera SO, Jhamba T, Akiror E and Kiconco A. Determinants of maternal health services utilization in Uganda. BMC Health Services Research (2015) 15:271

¹¹ Rutaremwa G, Wandera SO, Jhamba T, Akiror E and Kiconco A. Determinants of maternal health services utilization in Uganda. BMC Health Services Research (2015) 15:271

¹² Asiimwe, K.J. 2010. Utilization of antenatal services among adolescents in Western Uganda, 2007

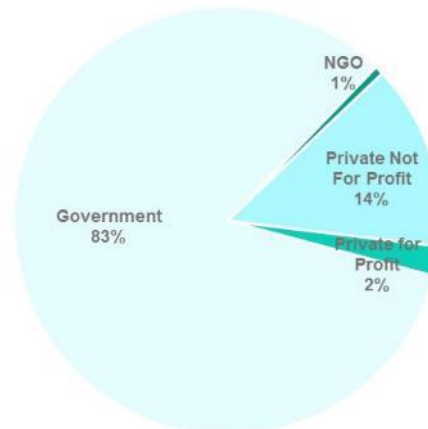
¹³ Source: <http://www.bioline.org.br/pdf>

Organizations (NGOs) at (one percent – 1%), PNFP at (fourteen percent – 14%) and PFP at (two percent – 2%). Although attendance in ANC services is almost universal, there is much room for improvement. Women start their ANC visits late in the gestation period and few complete the four recommended visits.

When examining location of ANC services, one observes that the public sector delivers the majority (seventy-nine percent – 79%) of ANC services in urban areas compared to nineteen percent (19%) by urban private providers (both PNFP and PHP) (See Figure 11). The MOH is also the largest provider of rural ANC services: eighty-eight percent (88%) public compared to nine percent (9%) private. The private facilities are mostly likely PNFP facilities in rural areas.

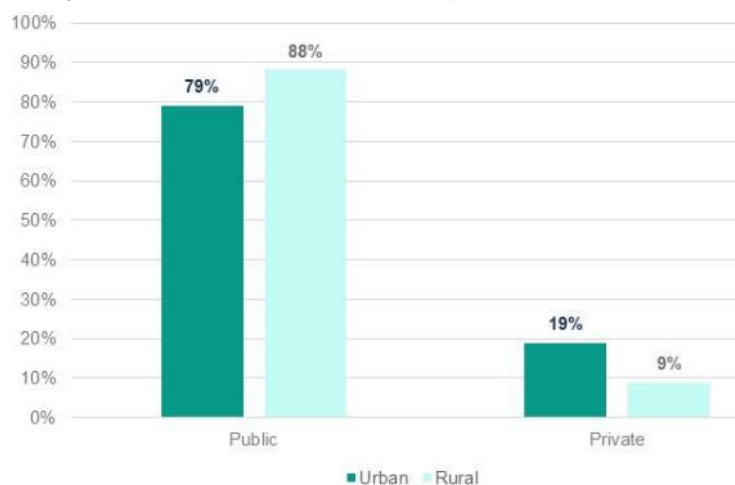
The MOH is the principal service provider for ANC visits across all income groups (see Figure 12). Appropriately, almost all of the poorest and poorer women (ninety-three percent – 93% and eighty-eight percent – 88%, respectively) receive free ANC visits in a public facility. However, the MOH is subsidizing significant percentage (above seventy-seven percent- 77%) of women who can afford to pay for ANC visits. There may be opportunity to redirect these women who can afford to pay to PNFPs and/or PHPs depending on their income level, thereby freeing up scarce public resources that could be used to help decongest public maternity services.

Figure 10: Public-Private Mix of ANC Services



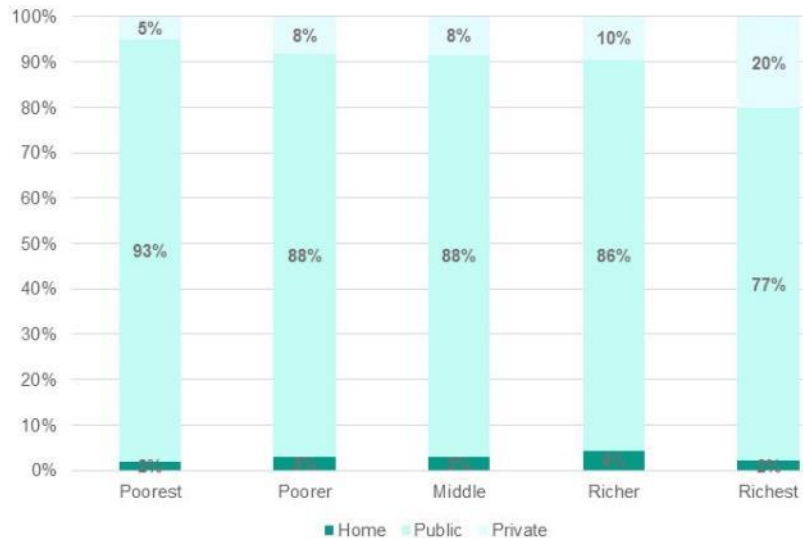
Source: DHIS2, 2015

Figure 11: Location of ANC Services by Provider



Source: UDHS, 2011

Figure 12: Type of ANC Provider by Income Quintiles



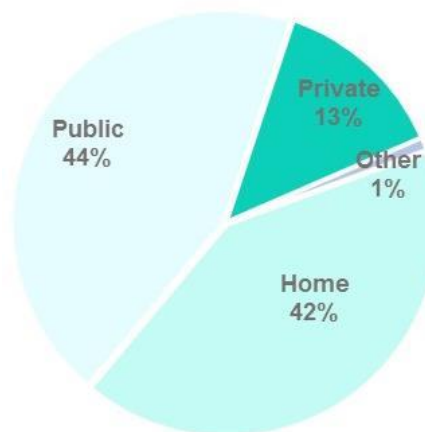
6.3. Source of Delivery

Figure 13 indicates where women deliver their babies. The majority of mothers, forty-four percent (44%) of women deliver in a public facility. A significant percentage, forty-two percent (42%), still deliver at home, mostly with unskilled attendants. A small percentage, thirteen percent (13%) deliver in private – either PNFP or PNFP – health facility.

Figure 14 shows where women deliver by geographic location. In urban areas, ten percent (10%) still deliver at home but the majority (sixty-three percent – 63%) deliver in a public facility compared to twenty-six percent (26%) in a private hospital or clinic. Clearly the majority of home deliveries occur in rural areas – almost half (forty-seven percent – 47%). Most rural mothers deliver in a public facility (forty-one percent – 41%) while a small percentage – eleven percent (11%) – deliver in a private hospital or clinic which is most likely a PNFP facility.

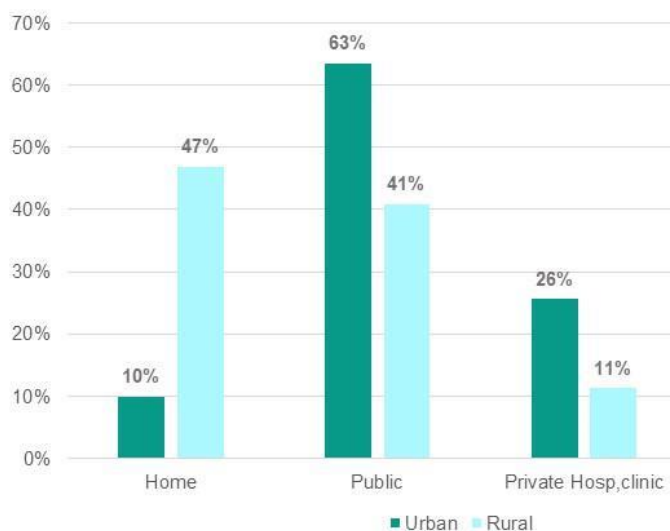
When examining where a woman delivers by income group, the majority of the poorest and poorer women deliver at home; fifty-seven percent (57%) and fifty percent (50%), respectively. Even a significant portion of middle income women deliver at home – forty-five percent (45%) (See Figure 15).

Figure 13: Public-Private Mix of Delivery Services



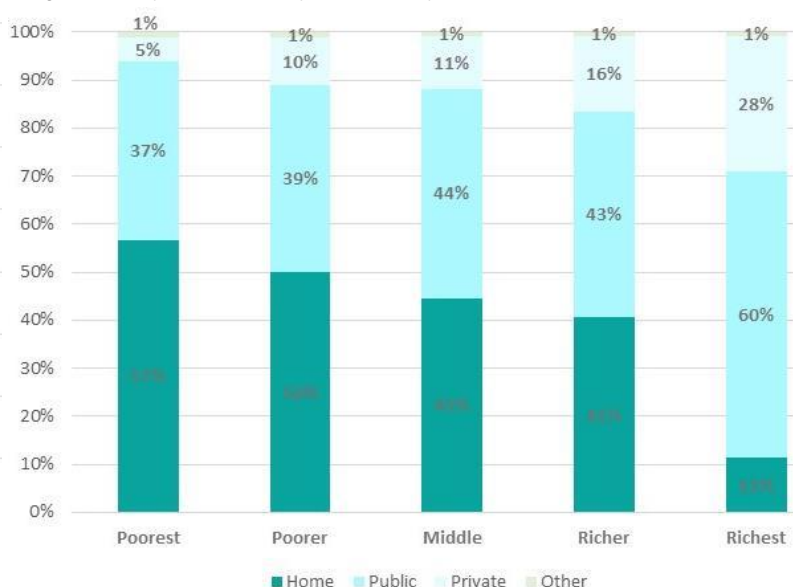
Source: DHIS2, 2015

Figure 14: Public-Private Mix of Delivery Services



Source: UDHS, 2011

Figure 15: Type of Delivery Provider by Income Quintiles



The persistently high levels of home deliveries, particularly among the lowest income quintiles, underscores the urgent need to focus efforts on bringing these women into the formal health system to deliver their next child. Of these women, the MOH is the most important provider; thirty-seven percent (37%) for poorest and thirty-nine percent (39%) for poorer. It is interesting note that a small percentage of the poorest and poorer – five percent (5%) and ten percent (10%), respectively, deliver in a private facility which are once again, mostly PNFP ones but sometimes PFP ones as well.

As expected, a growing number of women in the top three income groups – middle, richer and richest - deliver in a private facility: eleven percent (11%) of middle, sixteen percent (16%) of richer, and twenty-eight percent (28%) of the richest. But the MOH is still the most important service provider for all three of these income groups: forty percent (40%) middle, forty-three percent (43%) richer and sixty percent

(60%) richest deliver in a public facility. The MOH is subsidizing those income groups that have the greatest ability to pay for their delivery in a PNFP or PHP facility. Directing women who can afford to pay to a private facility could free up much needed public resources to focus on the poorest income groups.

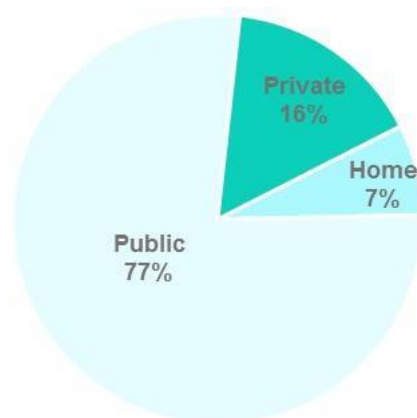
6.4. Post Natal Care

Follow-up visits after a delivery are critical to the survival and well-being of both the mother and child, attributing to sixty-seven percent (67%) of maternal mortality. Yet very few, twelve percent (12%), attend a post-partum visit. Cost and convenience as well as the fact a large majority deliver at home are key reasons why a mother does not return to a health facility.

Figure 16 shows that of the women who do attend a postnatal visit, three quarters (seventy-seven percent – 77%) go to a public facility while only sixteen percent (16%) seek care in a private facility. A small percentage – seven percent (7%) receive a postnatal care visit at home, presumably with a non-skilled provider.

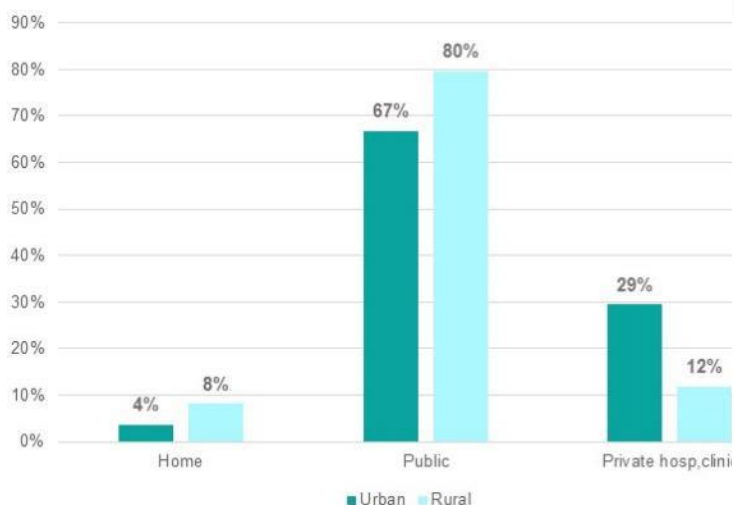
Of the women who attend a post-natal visit deliver in an urban setting, sixty-seven percent (67%) are in public facilities while twenty-nine (29%) are in private ones (see Figure 17). The percentage of rural mothers receiving post-natal care in public facilities is even greater – eighty percent (80%). The percentage of urban mothers who seek a post-natal visit in a private hospital or clinic drops by half to twelve percent (12%).

Figure 16: Public-Private Mix of Postnatal Care



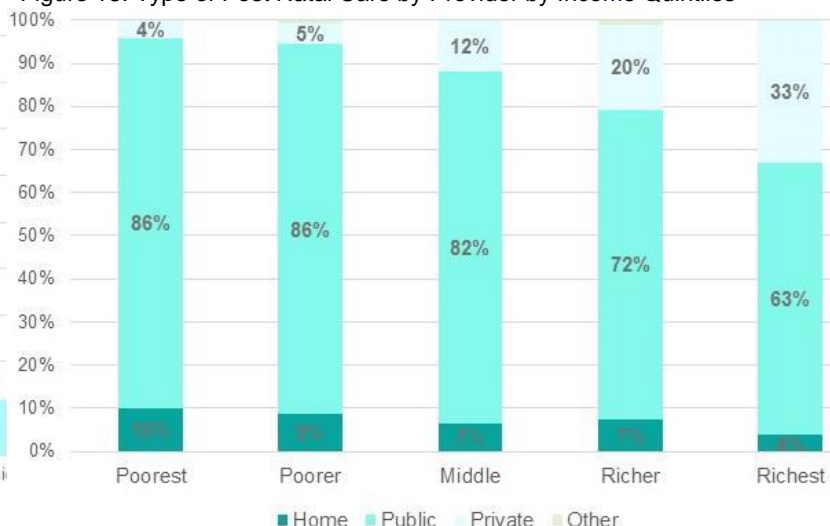
Source: UDHS, 2011

Figure 17: Location of Post Natal Care Service by Provider



Source: UDHS, 2011

Figure 18: Type of Post Natal Care by Provider by Income Quintiles



One observes a similar trend in type of provider by income group for post-natal visit compared to delivery services (see Figure 18). The MOH is the prominent provider among all income groups, including those who can afford to pay. The private sector serves all income groups, including the poor and poorest albeit in smaller numbers - four percent (4%) and five percent (5%), respectively. And the MOH subsidizes

significant portion of middle (82%), richer (72%) and richest (63%) mothers when these funds could be redirected to serve the lower income groups who are the most likely not to seek post-natal care.

6.5. Family Planning

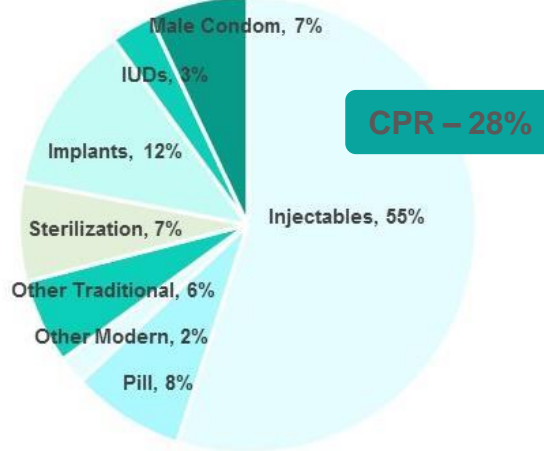
Contraceptive prevalence is still very low in Uganda compared to other SSA countries. Only twenty-eight percent (28%) of woman of reproductive age or in union use some form of contraceptive, of which twenty-six percent (26%) are modern methods.

Uganda women overwhelmingly prefer long-acting reversible contraceptive (LARC) methods such as injectables (fifty-five percent - 55.1%) and implants (twelve percent - 12%) (See Figure 19). Pills (almost eight percent - 8%) and IUDs (almost three percent) are much less popular. The type of method preference has implication for the private sector. Medical dependent methods such as LARC are more difficult to deliver through private channels, such as private pharmacies and drug shops, without modifications in scope of practice and robust quality assurance measures in place to ensure safe delivery and management of counter-indications.

In Uganda, family planning is a different market compared to HIV/AIDS and MH. Although the public sector is the major source of modern contraceptive methods in Uganda (forty-seven percent - 47%), the private sector also plays a significant role (forty-five percent - 45%) in delivering FP methods (see Figure 20). Within the public sector, women receive their methods in government hospital (forty-four percent - 44%) and health centers (twenty-nine percent - 29%). In the private sector, women obtain their methods from a private hospital (forty-five percent - 45%) and a private clinic (forty percent - 40%).

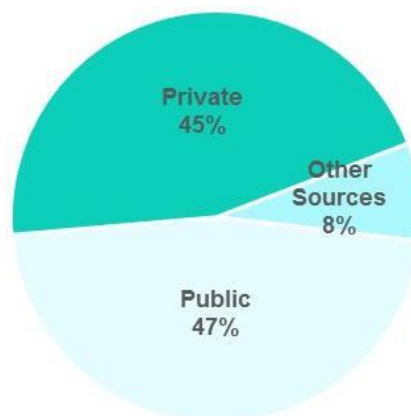
Urban women rely less on public facilities for their source of FP methods (thirty percent - 30%) compared to private hospitals and clinics (fifty-one percent - 51%) (See Figure 21) and other private sources (eight percent - 8%) such as pharmacies. Conversely, the majority of rural women obtain their FP methods at a public facility (fifty-three percent - 53%). Still, a considerable percentage - thirty-seven percent (37%) and

Figure 19: Modern Method Mix Among Married Women



Source: UDHS, 2011

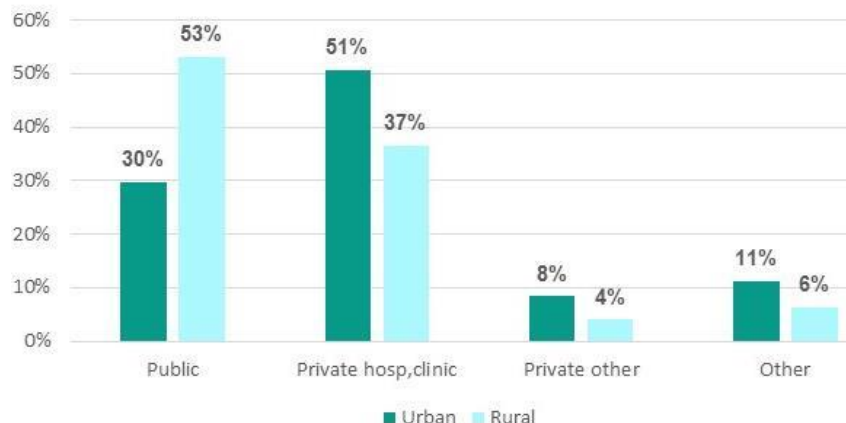
Figure 20: Public-Private Mix of FP Methods



Source: UDHS, 2011

eight percent (8%) of rural women get their FP method at a private hospital or clinic and/or private pharmacy, respectively.

Figure 21: Location of FP Source by Provider



Source: UDHS, 2011

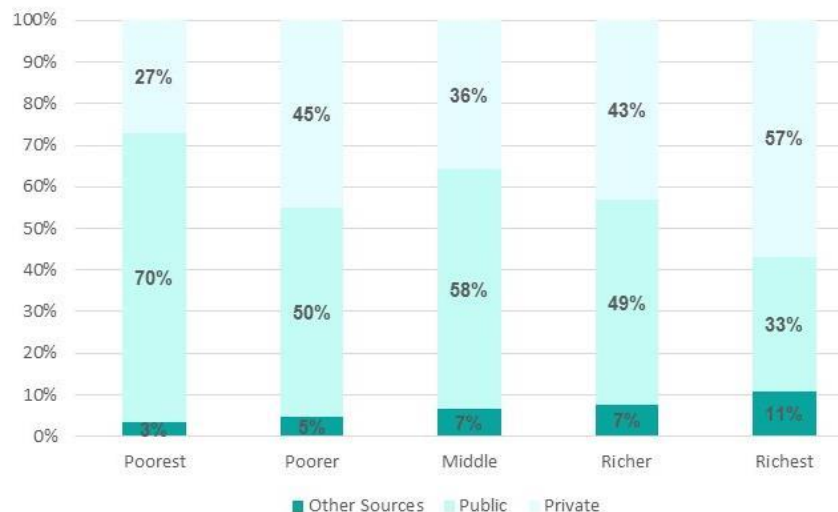
A breakdown in where women source their choice of contraceptive method by public and private providers does not reveal a clear cut trend in provider preference.

- Government hospitals and health centers (fifty-three (53%) and twenty-four percent (24%), respectively) perform female sterilizations.
- Pill users go to both the public and private sector in equal numbers as their source. One out of four pill users (twenty-five percent – 25%) use the social market brand Pilplan while four in ten (thirty-eight percent – 38%) use Microgynon: these brands are available through private channels.
- For implants, most women obtain them from public sources (eighty-five percent – 85%) while the majority of woman using injectables get them at a private hospital or clinic (fifty-seven percent – 57%).
- Condoms are widely available in different locations, but the majority are sold in shops (thirty-three percent – 33%). More than half (fifty-four percent – 54%) use a social market brand (Engabu, Lifeguard, or Trust) while about one third (twenty-nine percent – 29%) use Protector.

It is important to note that forty-three percent (43%) of all FP users discontinue their method within twelve months of starting it use, mostly due to fear of side effects or health concerns.

The FP market is better segmented by income group compared to HIV/AIDs and MH services. As Figure 22 shows, the majority of poorest (seventy percent – 70%) and poor (fifty percent – 50%) women get their FP method for free in a public facility. And wealthier women rely more on the private sector for their FP method. Yet a large percent of poorest (twenty-seven percent – 27%) and poorer women (forty-five percent – 45%) still get their FP method in a private facility, primarily because of the constant stock-outs in public facilities. For example, a significant percentage of (forty-six percent – 46%) of public facilities do not have pills in stocks. There are fewer public facilities experiencing stock-outs for IUDs and implants; five percent (5%) and thirteen percent (13%), respectively. Public facilities have constant supplies of injectables (almost 100%) and condoms (93%).

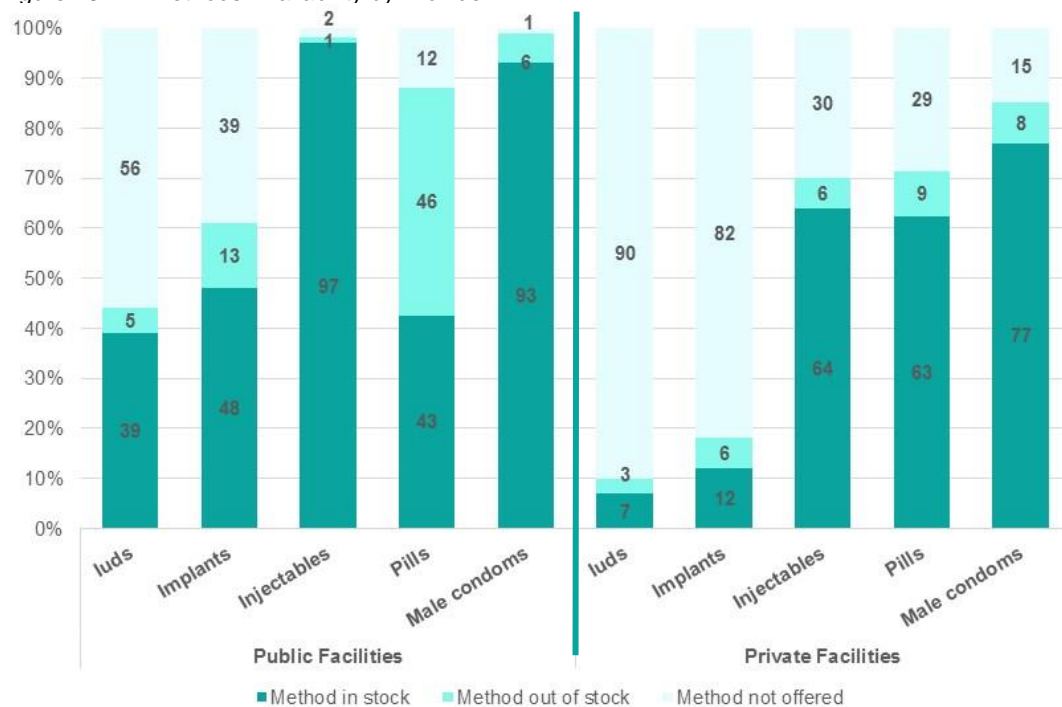
Figure 22: FP Source by Income Quintiles



Source: UDHS, 2011

The private sector is a missed opportunity for expanding access to FP methods (See Figure 23). The private does not offer Ugandan women's preferred methods – implants (eighty-two percent – 82%) and injectables (thirty percent – 30%) due to regulatory barriers. Yet other LMIC country examples show that women can receive Depo safely in a private pharmacy (see Recommendations Section). Increasing access to FP through the private sector can be a stop gap measure to address stock outs in public sector (e.g. most private facilities (sixty-three present – 63% have a steady stock of pills) while the MOH improves its public supply chain.

Figure 23: FP Methods Availability by Provider



Source: SPA, 2016

7. Key Findings on PHPs Role in M/RH Services

The PHPs have established private healthcare businesses in communities with relatively higher incomes. Private midwives have set up private maternity homes in the communities with the assistance from MOH and international donors who have provided start-up capital and equipment. In such examples, these private providers offer quality services. However, these PHPs struggle to invest in essential, yet costly care options such as emergency surgery / Caesarian section or blood transfusion.

The MOH policy is to collaborate with non-government providers to deliver maternal health services. The MOH, in large part, has focused its partnership with FBO hospitals and provide financial and in-kind support through condition grants. The MOH collaboration with PHPs delivering maternal and reproductive health services is very different from its working relationship with PHPs delivering HIV/AIDS services. Through PEPFAR funds, the MOH has been able to scale up its collaboration with the private health sector to accredit private facilities and to regularly monitor their quality of care. As a result, the majority (80%) of PHPs collaborate with the MOH to deliver HIV/AIDS services. In contrast, the PHPs delivering M/RH services remain outside of the MOH orbit and operate mostly independently of the public health system.

7.1. Challenges among Private Sector Providers Delivering RMNCAH Services

However, both PHP healthcare businesses face similar challenges. Figure 24 shows the challenges identified by M/RH stakeholders. They are discussed in greater detail below.

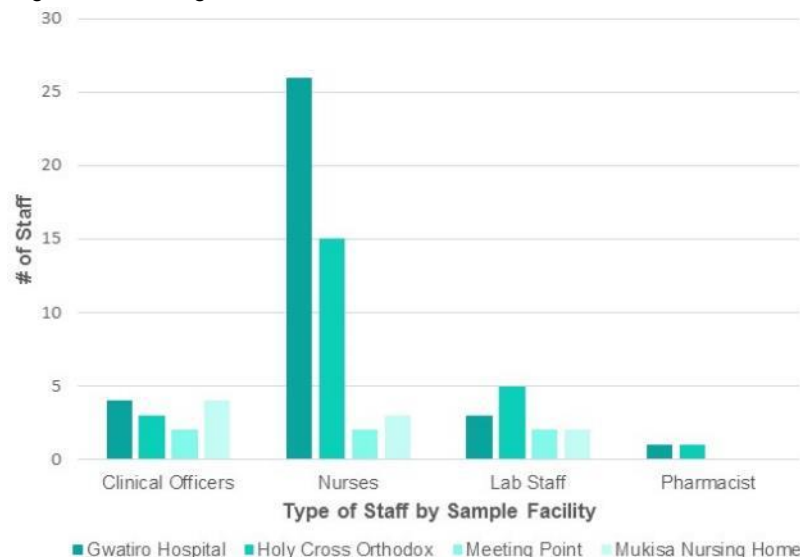
Figure 24: Challenges Faced by Private Health Facilities



Key informant interviews affirmed that most PHPs facilities delivering maternal health services are small- and medium-sized entities. Given their size, they are mostly staffed with one to two nurses or clinical officers. The larger facilities, such as a small hospital or nursing home, have full-time or part-time physicians on staff (See Figure 25). But the key challenge is lack of access to specialist staff in case of complicated delivery and/or obstetric emergency. As the HRH section in the Ugandan Private Sector Assessment shows, PHP healthcare businesses experience the most difficulty in recruiting and retaining staff compared to the public and PNFP sector facilities. Although the working conditions are better in PHPs

in terms of quality of facilities, availability of equipment and accessibility of medicines, PHP businesses cannot compete with public salaries and benefits.

Figure 25: Staffing Patterns in PHP Facilities



Quality of maternal and reproductive health services varies widely among PHPs¹⁴. Health facilities in both the public and private sectors are under-equipped and under-financed to provide quality services to women and newborns. The Ugandan Service Provider Assessment (SPA), showed up to thirty-five percent (35%) of health facilities lack basic supplies for ANC visits, and less than thirty percent (30%) perform needed diagnostics that can alert providers of potential complications. Three-quarters of all facilities do offer needed ANC medicines.

Normal delivery services are available in fifty-three percent (53%) of all facilities. Only one-half of these facilities have a trained provider on site 24 hours a day. Only thirty-three percent (30%) have all the necessary supplies to support routine delivery. Even fewer – eleven percent (11%) – have additional medicines to manage obstetric complications. Health facilities also have limited capacity to provide emergency support for newborns. On average, only forty-five percent that provide delivery services have an external health source and perform potentially harmful practices (e.g. full immersion bath). Poor transport infrastructure is a hindrance for service uptake; with ambulance services being largely absent, makes hospitals less responsive to the needs of maternal and newborn emergencies.

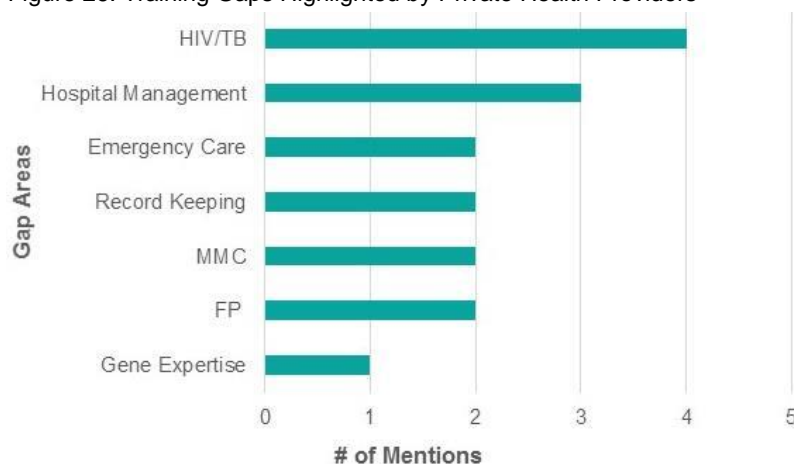
Almost all of the private health facilities interviewed for the PSA reported having little or no quality checks or support from the MOH. The few that received a visit stated the MOH staff came only once, and rarely twice a year. Lack of supervision and regular interaction with MOH has reportedly led to poor patient management and low quality of services as well as outdated practices still being in place in many of these facilities.

PHPs experience skill gaps in key areas such as FP methods and counselling. Private providers interviewed routinely said they lacked access to clinical training and training updates. The majority of stakeholders indicated that training in HIV /TB care was the biggest gap followed by

¹⁴ All the data in this section is taken from Uganda Service Provision Assessment, 2011. <http://dhsprogram.com/pubs/pdf/PB3/PB3.pdf>

counselling in FP methods and counselling, and medical male circumcision (MMC) (See Figure 26). Strengthening business skills, such as hospitals management, record keeping and financial administration, were also noted as a significant gap. Many of the stakeholders observed they are not invited to MOH- or donor-sponsored trainings. And when they do participate in trainings, PHP staff experience challenges, such as the training content is too heavy or extends over too many days. Also, other reasons for low participation in the trainings include lack of staffing to cover for those who are away for training as well as “scraping” for per diem so staff can attend the training. A few of the stakeholders suggested a modular approach to training in order to balance work related demands with the the need to keep oneself updated on the latest medical advances.

Figure 26: Training Gaps Highlighted by Private Health Providers



The poor disproportionately rely on “quack” health workers. The MOH has inadequate and weak regulatory system that to regulate and close unlicensed health centers/clinics administering substandard services and medicines. A large percentage of Ugandans, especially the poor, seek healthcare from unqualified and ‘traditional and spiritual’ healers because they cannot afford health services in the public sector created by drug stock-outs and non-functioning laboratory equipment forcing them to seek these services in the private sector. Also, the high cost of accessing services for pregnant women (both in terms of time and fees for maternal services)¹⁵ prompts women to deliver at home instead of in a health facility.

PHPs interviewed, particularly those in small facilities, offer services at highly reduced fees because they recognize many of their clients cannot afford to pay while in the case of the larger facilities, they often exempt or let the woman pay what she can afford. Several providers interviewed stated that a national health insurance program would greatly relieve this economic barrier as well as help PHPs make ends meet. Several referred to the OBA program as a model and complained that they were ineligible to participate because they are not located in the priority districts despite the fact that they also see many poor mothers.

PHPs providers are more efficient and experience under capacity compared to public M/RH services. On one hand, private health services are more efficient than public one. A study on MH services showed that NGO/FBO providers delivered, on average sixty-eight (68) babies per year compared to thirty-

¹⁵ Ministry of Finance, Planning and Economic Development. *Learning from the Poor: Uganda Participatory Poverty Assessment*. 2000.

eight (38) babies delivered in public health facilities (Levin et al, 1999). The problems of short disappearances from duty, short working hours and dual practice (MOH staff in private practice) contributes to low staff productivity in government facilities. The same study concluded that these numbers, however, are significantly below potential capacity. On the other hand, there is poor planning of public and private HRH. In some cases, there is a surplus of public midwives in relation to the maternity workload (Levin et al, 1999), while in other, such as the two maternity hospitals in Kampala, there is an insufficient number of MOH midwives. Yet in the same catchment area, there are private – both FBO and NGO – midwives that are underutilized and have demonstrated capacity to deliver affordable, quality maternity care (See Box 2).

Box 2. Overcrowding of MOH Maternity Wards

Mulago hospitals now records about 110 deliveries a day – three times more than it is intended for, says Dr. Kiggundu, who has worked at this hospital for 22 years. “There is a lot of overcrowding in this hospital,” he continues. He shares the story of a recent patient, Jane Mugendawala who lives in a Kampala suburb about five kilometres from Mulago Hospital. Since she could not afford to deliver her baby in a nearby private clinic more convenient to where she lives, she opted to go to Mulago. She checked in at 2AM and successfully delivered her baby by 8AM. However, I found her lying outside the ward’s veranda because she had to create space for other expectant mothers. She was not allowed decent rest on a bed in the ward.

Dr. Chris Mugerwa, a medical intern interviewed, explain that the hospital has tried to cope by making modifications to create more ward space but even then some mothers are asked to sleep on the floor or even to share a mattress with another mother. “A room designed to accommodate six beds now has 18, which are still not enough for the hundreds of patient were receive each day.”

Government funding is part of the problem, share both doctors. But the reluctance of the MOH to work with the private providers to relieve some of the stress on public facilities or to establish a national health insurance to remove economic barriers allowing mothers choice in providers are other factors contributing to the overcrowding in Mulago.

Donor programs using market incentives do not necessarily follow community demand and private provider supply. Donors programs and their implementing partners focused on addressing MR/H challenges are located in geographic areas of donor interest as opposed to those of the community. Stakeholders often referred to mismatch between the World Bank and USAID maternal health projects with the supply of PHPs offering maternal health services. Moreover, as the Mulago example illustrates, there is still need to remove economic barriers for women living in peri-urban areas in order to decongest public facilities, yet none of the voucher programs address this challenge.



Box 3. Private Midwife Network

In 2008, PACE established a social franchise network of clinics named ProFam. There are two hundred clinics in the franchise, of which eighty-five percent (85%) are private for-profit. They are located in 54 districts in all five regions of the country. A ProFam clinic is licensed by the MOH and owned and managed by a certified midwife, clinical officer or a medical doctor. In addition to the owner/manager, a typical ProFam clinic has 3 staff comprised of nurses, midwives, clinical officers, and nursing assistants. On average, a ProFam clinic will attend 11 deliveries, 41 ANC visits, offers 40 women with long term family planning method and tests 25 women for cervical cancer per month.

ProFam's goal is to reduce maternal mortality by providing high-quality, affordable, integrated family planning and comprehensive maternal health services. The ProFam providers offer a wide range of reproductive health services such as long-acting reversible contraceptives, short term methods and cervical cancer screening).

PACE invested in strengthening ProFam's clinical capacity, demonstrating that with guidance and support, private providers can adhere to MOH service provision protocol in both family planning as well as maternal health, including labor and delivery. An evaluation of ProFam providers showed that eighty-one percent (81%) complied with PSI global standards, seventy-five percent (75%) had the required equipment and supplies needed, and seventy-four percent (74%) adhered to infection prevention practices. Between 2013 and 2015, the number of pregnant women coming back for 4th ANC visits increased greatly from 36% to 57%,

The majority of clients seventy-one percent (71.5%) felt that the ProFam provider offered high quality care, delivered good customer services, and that the services were convenient (e.g. location, hours).

7.2. Public-Private Interactions in M/RH Sector

As mentioned before, private providers delivering HIV/AIDS services have a closer working relationship with the MOH. Although there is a greater focus on PNFPs, the MOH is open and willing to work with PHPs. In the case of the M/RH health services, however, stakeholders interviewed acknowledged that the government is more open to working with PNFPs compared to PHPs. Private practitioners confirmed this finding and reported that the MOH and external donor funders are generally “closed” to the participation of the private sector in M/RH delivery. Still, PNFPs stated that at the policy level, there may be MOH commitments to engage the PNFPs in planning and service delivery, but in terms of operationalization, and particularly financing, these pledges are often vague or inadequate (see Section on Conditional Grants).

A few stakeholders interviewed pointed to a few private sector champions in the public sector, but these are rare and affiliated with certain health areas, such as HIV/AIDS. Indeed, interviews with the M/RH Department demonstrated their reluctance to work with PHPs. PHPs expressed hope that if a national health insurance scheme materializes, this may open lines of communication and engagement between the public and private sectors.

When asked their opinions on who “speaks” for the private sector, all PHP respondents wanted to see a unified PHP representative to engage with government. Many interviewed supported the excellent work the Medical Bureaus performed to address fragmentation and standardize quality among PNFPs. Some also cited other associations, such as UPNMA and UHF, as possible candidates to represent PHPs perspective and interests with the government similar to the PNFPs.

While no PHP respondents has formal agreements with the MOH or government, almost all stated that

they would welcome greater partnership and more formal engagement. Most respondents encouraged service contracts, future NHIS contracts, grants, vouchers, subsidies and tax breaks were encouraged by most respondents. PHPs particularly preferred subsidies for equipment (especially diagnostic equipment) or drugs, as they often perform lab functions and other services for public sector referrals.

Box 4. Take Home Messages on M/RH Services and the Private Sector

- Uganda health sector is not delivering on the promise of safe motherhood despite its multiple policies and strategies. The NHA clearly demonstrates that both the government and donors are not investing enough funds and technical assistance to address the shortcomings in M/RH services.
- As a result, most of the financial burden has fallen on expectant mothers and their families, as demonstrated by the high OOP cost for maternity services. FP, on the other hand, is highly subsidized in both the public and private sector and therefore, women pay less OOP for their FP method.
- The World Bank voucher program and Jinja RBF experience have demonstrated that the MOH can quickly expand MR/H service through existing PNFP and PHPs providers. Most PNFP and PHPs providers welcome the opportunity to increase their MR/H services through financing mechanism like vouchers, service contracts and NHIs but these policy tools are not widely used in Uganda.
- There is general consensus that PHP midwives offer convenience and a possible strategy to decongest public facilities. Women prefer PHPs providers because access is easier since they are often located in the expectant woman's community, offer longer clinic hours and shorter waiting times, and are highly respected by the community for the work their services.
- Private maternity wards offer quality services. They are staffed with a wide range of trained and licensed health professionals and in some cases, they have specialists who are able to care for obstructed labor and emergency deliveries. Also, their facilities are modern, equipped and have consistent supply of needed medicines.
- The PSI and MSI experience demonstrate that networks of solo practitioners can offer affordable, quality health services. Both networks have established systems in place to assure quality by providing regular training, donating supplies and medicines, and supervising network providers.

8. Recommendations to Leverage the Private Health Sector: *Quick Wins, Longer Gains*

8.1. Strategies to Harness the Private Sector to Address RMNCAH

Stakeholder interviews with private sector stakeholders and MOH officials prioritized the potential opportunities in which to integrate private providers - PNFP and PHPs alike - to compliment MOH efforts to improve mother and child health conditions in Uganda. The private sector interventions are organized into four strategies (see Figure 28).

Figure 28: Strategies to Leverage the Private Health Sector in RMNCAH



Strategy #1: Strengthen dialogue and cooperation between public and private sector stakeholders to reach a common vision of priority RMNCAH issues and consensus on programs to address them that include a private sector role. In addition, this strategy strives to *strengthen coordination of public and private resources* – infrastructure, equipment, human resources, financial, technical – to increase access to RMNCAH services and programs. Concrete activities for Strategy #1 are listed below.

Strategy #1: Strengthen public-private collaboration to improve RMNCAH conditions	<ul style="list-style-type: none"> ▪ Help change the MOH mindset on working with the private health sector on RMNCAH <ul style="list-style-type: none"> ▪ Gather and present the evidence on private sector contribution in Uganda starting with the PSA ▪ Gather and present international experience in PSE in the areas of RMNCAH ▪ Organize domestic and international study tours to observe successful PPPHs in RMNCAH ▪ Facilitating greater interaction and dialogue ▪ Establish RMNCAH activities in an appropriate Country Platform (e.g. HPAC) <ul style="list-style-type: none"> ▪ Strengthen HPAC as sector-wide coordinating body <ul style="list-style-type: none"> ▪ Update HPAC's mandate to become the forum for all public-private dialogue including RMNCAH ▪ Establish HPAC's terms of references to formally integrate all key stakeholder groups, including PHPs, and HPAC open membership ▪ Agree on "rules of engagement" ▪ Improve information flow and communication between sectors ▪ Support PPPH Node to serve as Secretariat ▪ Build participating HPAC public and private stakeholders' partnering skills ▪ Build Professional Associations' to represent their constituents <ul style="list-style-type: none"> ▪ Strengthening internal structure and organizational effectiveness ▪ Strengthening capacity to carry out key member activities
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Strategy #2: Build government capacity to effectively engage the private sector. As the PSA shows, the government lacks key policies, systems and institutional arrangement to engage the private sector. This strategy aims to leverage the technical resources and international best practices in building these government systems and policy tools. As the Box below illustrates, many of the recommended policy tools to harness the private sector focus on financing mechanisms, such as performance based contracting, service, vouchers and national health insurances as well as quality monitoring.

Strategy #2: Build Gov't capacity to partner with the private sector supporting RMNCAH	<ul style="list-style-type: none"> ▪Strengthen PPPH Node's capacity to partner with the private sector <ul style="list-style-type: none"> ▪Institutionalize PPPH Node by staffing, and establishing operating systems ▪Build PPPH and MOH staff knowledge and capacity to engage the private sector ▪Support Node to communication and share information on PSE in RMNCAH ▪Assist Node to coordinate private sector resources for and broker partnerships in RMNCAH ▪Generate data needed to regulate and monitor the private health sector. ▪Assist MOH to create financial tools to incentivize the PS <ul style="list-style-type: none"> ▪Pressure the MOH to approve and implement the HFS and National Health Insurance bill ▪Take "baby steps" towards SHI including <ul style="list-style-type: none"> ▪Segment those who can afford to pay and "steering" them to the private sector ▪Start now to grow MOH experience in performance based finance ▪Harmonize the two maternal health voucher programs, expand to include KCCA and then scale nation-wide ▪Create a drug benefit plan for the poor that covers RMNCAH drugs and products ▪Institutionalize financial tools (e.g. contracting, PBF, vouchers, NHI, PPPHs, etc.) ▪Use financing tools to shape RMNCAH markets and structure private sector providers ▪Build the "policy toolbox" to govern non-state actors external to the MOH <ul style="list-style-type: none"> ▪Standardize, collect and consolidate data on all private sector activities in health ▪Streamline QA system by institutionalizing SQIS in private sector entities ▪Modernize facility registration, professional licensing and CPD credit systems ▪Assist the MOH to "co-regulate" non-state actors with 3rd party organizations
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Strategy #3: Foster favorable market conditions supporting private sector providers active in RMNCAH. Private providers face harsh market conditions, ranging from cumbersome regulations, to government inability to close down "quacks", to limited access to capital. This strategy aims to work with the MOH to make regulations more conducive to private sector healthcare businesses as well as increasing

Strategy #3: Create a more enabling environment and favorable market conditions	<ul style="list-style-type: none"> ▪Strengthen RMNCAH private providers' business skills <ul style="list-style-type: none"> ▪Institutionalize business skills training (BST) and business advisory services in multiple organizations PPPH Node by staffing, and establishing operating systems ▪Offer grants to these organizations so they offer scholarships to key provider segments (e.g. nurse, midwives, clinical officers) ▪Offer grants to organizations so they provide business advisory services to network managers (e.g. Medical Bureaus, Social Franchises, hospital / clinic hub and spoke network, etc.) ▪Increase RMNCAH private providers access to affordable financing <ul style="list-style-type: none"> ▪Assist commercial banks to design and offer products targeted to health sector ▪Assist private providers apply for loans ▪Increase PNFPs access to affordable financing for capital investments ▪Strengthen private sector network managers to become sustainable <ul style="list-style-type: none"> ▪Invest in Medical Bureaus systems (e.g. management, financial, quality) to manage network of FBO facilities ▪Provide TA to Network management entities (e.g. PACE, MSI, Pharmacy Network) to administer providers and become financially sustainable ▪Create capacity in Medical Bureaus, Network managers and other large RMNCAH facilities to train own network providers in BST and to offer business advisory services
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PHPs and PNFPs access to business skill training, capital and business advisory services to help them grow their RMNCAH services and ensure their long-term sustainability.

Strategy #4: Increase private contribution to and activities in RMNCAH Build government.

The private sector is already active in many aspects related to RMNCAH – delivering services; manufacturing and retailing essential RMNCAH products; producing key health professionals; and, generating health system innovations and technologies. The challenge is to harness and direct these resources to priority RMNCAH areas. The PSA recommends several discrete opportunities for public private coordination, collaboration and partnerships.

Strategy #4: Increase private sector role in RMNCAH service and programs	<ul style="list-style-type: none"> ▪ Create strategic purchasing capacity within MOH to contract private providers <ul style="list-style-type: none"> ▪ Implement PBF Strategy ▪ Modify and approach ▪ Identify contracting unit within MOH; Align with PPPH Node ▪ Design contracting systems and operations ▪ Staff and build contracting unit's capacity ▪ Assist MOH to purchase RMNCAH services <ul style="list-style-type: none"> ▪ Decongest maternity services at KCCA public hospitals by initially contracting private providers in KCCA and expanding to private providers in environs ▪ Modify Cordaid PBF experience to include private providers and to scale it throughout Jinja ▪ Build on Jinja PBF experience and replicate in two to three priority regions ▪ Expand clinical scope of service provider contracts to include PMTCT ▪ Contract private providers to establish FP/RH mobile units and community outreach in priority regions ▪ Link maternal health voucher programs to contracting unit and PBF reforms and gradually scale nationwide ▪ Link to SHI if approved ▪ Implement opportunities for strategic purchasing of RMNCH good <ul style="list-style-type: none"> ▪ Assist private entity to network private pharmacies and drug stores to offer a “basket” of RMNCAH medicines and products ▪ Assist Node to coordinate private sector resources for and broker partnerships in RMNCAH ▪ Build private network organizations' capacity to assist member providers “ready” for contracting/vouchers (Refer to Strategy #3)
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8.2. Pace of Implementation

The 4-pronged strategy is ambitious and will require all the stakeholders – public and private alike – and Development Partners to come together and prioritize them. In the meanwhile, below is a proposal on how to pace implementation of key components of each strategy over the next five years. Figure 29 on the following page serves as a “road” map to guide the reader through this section.

“Quick Wins”: Short-Term Activities (less than one year)

Strategy #1: Strengthen Public-Private Dialogue and Cooperation

The PSA revealed that working relations between public and private sector, particularly between public sector and PHPs, is still plagued by mistrust and suspicion. To overcome these challenges and move towards a more trusting working relationship, the PSA Team recommends the following actions that can garner quick wins in the short-term.

- **Help change the MOH mindset on working with the private health sector.** There is growing and rich experience in both OECD and developing countries on the benefits and mechanics of working with the private sector to achieve UHC and address RMNCAH issues. The PSA Team recommends

assisting the PPPH Node, in their capacity as the nexus between public and private sectors, to strengthen their capacity to make the case on private sector engagement. This will entail: 1) identifying core themes on PSE that will help change the MOH mindset on working with the private health sector, 2) gathering and presenting the evidence on private sector contribution in Uganda starting with evidence emerging from the PSA, 3) gathering and presenting international experience in PSE in the areas of RMNCAH, 4) organizing domestic and international study tours to observe successful PPPHs in RMNCAH, and 5) facilitating greater interaction and dialogue between MOH leadership and private sector PHP representatives to build trust (See below).

- **Establish RMNCAH activities in an appropriate Country Platform.** The GFF has developed guidelines to establish public-private dialogue and coordination through existing country policy mechanisms. In the case of Uganda, the most appropriate platform would be Health Policy Action Committee (HPAC). But for HPAC to work as the RMNCAH Country Platform, several changes are needed: 1) updating HPAC's mandate to become *the* forum for *all* public-private dialogue initiatives including RMNCAH; 2) establishing HPAC's terms of references to formally integrate all key stakeholder groups, including PHPs; 3) opening HPAC membership and officially extending invitation to PHPs representatives; 4) convening the fully representative membership to agree on the ground rules for the Country Platform; 5) holding regular (e.g. quarterly) HPAC meetings; and 6) making a concerted effort to interact and engage the private health sector through many of the policy and planning initiatives listed below.

To fulfill the spirit of the GFF Country Platform – inclusiveness, transparency and cooperation – the PSA Team recommends piggy-backing on and accelerating several on-going initiatives that include: i) expanding HPAC membership to include PHPs, ii) reviewing HPAC's terms of references and operations to re-energize it as the public-private dialogue (PPD) mechanism; and iii) supporting the PPP-TWG to serve as the secretariat to start convening regular meetings (which as of now has not happened in the last two years).

Donors, as demonstrated by PPD efforts in Kenya, Tanzania and Malawi, can play a critical role by offering financial resources to jump start HPAC and maintain the PPD process, provide technical assistance to establish ground rules for PPD, help build participants' capacity to work together, and grant seed money to support joint projects to demonstrate ability to work together (see below).

Figure 29. Road Map to Pace Implementation of Recommendations

Quick Wins 6 to 12 months	<p>Strategy #1: Strengthen Public-Private Dialogue and Cooperation</p> <ul style="list-style-type: none"> ▪Help change the MOH mindset on working with the private health sector on RMNCAH ▪Establish RMNCAH activities in an appropriate Country Platform <ul style="list-style-type: none"> ▪Strengthen HPAC as sector-wide coordinating body ▪Improve information flow and communication between sectors ▪Support PPPH Node to serve as Secretariat <p>Strategy #3: Create an Enabling Environment and Favorable Market Conditions</p> <ul style="list-style-type: none"> ▪Institutionalize business skills training and advisory service in several local organizations ▪Increase access to affordable financing ▪Explore financing mechanisms targeted to PNFPs ▪Strengthen Networks' capacity to manage and become more financially sustainable <ul style="list-style-type: none"> ▪Medical Bureaus' capacity as a "network manager" of PNFPs ▪Strengthen PHP networks to manage facilities and assure quality <p>Strategy #4: Increase the Private Sector Role in RMNCAH</p> <ul style="list-style-type: none"> ▪Decongest maternity services at public hospitals by contracting private providers
Low Hanging Fruits 2 to 4 years	<p>Strategy #1: Strengthen Public-Private Dialogue and Cooperation</p> <ul style="list-style-type: none"> ▪Build participating HPAC public and private stakeholders' partnering skills ▪Build Professional Associations' capacity to represent their constituents <p>Strategy #2: Build Government Capacity to Effectively Engage the Private Sector</p> <ul style="list-style-type: none"> ▪Invest in PPPH Node's capacity to partner with the private sector <ul style="list-style-type: none"> ▪Institutionalize Node by staffing, designing and establishing operating systems ▪Train MOH staff in basic PPPH concepts and skills ▪Support Node to share information on private sector contribution and partnerships ▪Assist Node to broker PPPHs in RMNCAH ▪Generate data needed to regulate and monitor the private health sector ▪Create financial tools to incentivize the private sector to play a greater role in RMNCAH <ul style="list-style-type: none"> ▪Pressure the MOH to approve and implement the Health Finance Strategy and National Health Insurance bill ▪Segment those who can afford to pay and "steering" them to the private sector ▪Scale maternal health voucher program nationwide and link to PBF ▪Modify PBF proposal and expand contracting of RMNCAH services <p>Strategy #3: Create an Enabling Environment and Favorable Market Conditions</p> <ul style="list-style-type: none"> ▪Provide grants to local BST institutes to be used as scholarships or advisory services to strategic RMNCAH providers / networks ▪Experiment with creative financing (e.g. gov't back guarantees, gov't lending, etc.) <p>Strategy #4: Increase Private Sector Role in RMNCAH</p> <ul style="list-style-type: none"> ▪Expand access to family planning and other RMNCAH products in a "health basket" <ul style="list-style-type: none"> ▪Network drug stores and drug stores to deliver "health basket" ▪Experiment with pooled mechanisms to finance drug costs ▪Increase the number and scope of service contracts in RMNCAH <ul style="list-style-type: none"> ▪Use contracting to grow and manage competition in maternal health market ▪Integrate PMTCT into private midwives' clinical scope in service contracts ▪Establish / scale FP mobile services and outreach through services contracts
Longer Gains 3 to 5 years	<p>Strategy #1: Strengthen Public-Private Dialogue and Cooperation</p> <ul style="list-style-type: none"> ▪Gradually withdraw support as HPAC stands on its own feet <p>Strategy #2: Build Government Capacity to Effectively Engage the Private Sector</p> <ul style="list-style-type: none"> ▪Continue investing in PPPH capacity to engage private sector ▪Provide TA to MOH to deepen analysis of private sector activities in RMNCAH ▪Build MOH's policy toolbox to regulate and monitor private sector <ul style="list-style-type: none"> ▪Streamline QA process, modernize systems ▪Update and create missing regulations identified in PSA ▪Invest in Council's systems to modernize them ▪Allocate budget and staff for enforcement ▪Institutionalize MOH capacity to implement financial tools to incentivize Private Sector <ul style="list-style-type: none"> ▪Leverage financial tools to shape key health markets ▪Leverage financial tools to "organize" private providers <p>Strategy #3: Create an Enabling Environment and Favorable Market Conditions</p> <ul style="list-style-type: none"> ▪Gradually withdraw support to Bureaus' and PHPs networks to manage facilities and assure quality as they institutionalize management and financial skills <p>Strategy #4: Increase the Private Sector Role in RMNCAH</p> <ul style="list-style-type: none"> ▪Continue building PPPH pipeline in RMNCAH ▪Implement all aspects of HFS strategy

Strategy #3: Create an Enabling Environment and Favorable Market Conditions

Much focus is given to health care providers' clinical skills and competencies. But in the private sector, many physicians, nurses, and pharmacists are also business owners who lack the necessary skills to run a small company. Smaller clinics, need more basic assistance in simple tasks such as applying for a loan or understanding their cash/flow. While larger sites – such as small hospitals – require more sophisticated support, for example, how to produce financial data to enable strategic level decision making.

- **Strengthen private providers' business skills.** The lack of business skills is a detriment to a healthcare business' expansion of services and coverage. Doctors and clinic owners recognize this weakness and are very open to financial management training and support. The PSA Team recommends building on and expanding the USAID Private Health Support (PHS) Program *Health as a Business* project (HaaB) project (see Box 6). The focus of the second generation of BST would be to institutionalize capacity among several local institutions to enable them to deliver business skills training (BST) and advisory services to small- and mid-size healthcare businesses. The goal is to create sustainable capacity locally that these institutions are no longer reliant on a Development Partner to deliver these services. The local institution can be professional associations, service provider networks, a university, or a professional training institution. The key characteristics needed to be successful organization are: legitimacy among the health business community, ability to deliver training and services affordable and apply adult training techniques and are flexible in their training and advisory services approach.

Box 6. USAID/PHS Health as Business Project

The USAID/PHS has introduced Health as a Business (HaaB) project, a business training and counselling initiative aimed at strengthening the operations of the private healthcare sector for growth and sustainability. The HaaB has to date supported a network of 209 private health clinics around the country with intensive business management training, accounting support and business mentoring. A mid-term survey conducted at the end of 2015 shows that the two hundred-nine (209) clinics that received training and business counselling under this programme have registered an upward trend in revenue and stable-to-decreasing trend in operating expenses. Their mean monthly expenses have also decreased. Secondly, remarkable improvements in the calibre of health care human resources and health care equipment were noted, a positive development for the quality of care provided by the private health sector. Many participating clinics also undertook space expansion projects and introduced new services (including laboratory services, antiretroviral therapy, and dental services), a positive development for the availability of health services in the private sector.

- **Increase access to affordable finance.** The 2010 International Finance Corporation study provided insight on the need for short-, medium-, and long-term financing requirements of Uganda's health sector. This study noted a potential \$427 million financing needs for short- and long-term borrowing from the health sector making it a significant potential market segment for Uganda's commercial banks. While a large portion on this demand is from hospitals (eighty-four percent - 84%), a projected \$30 million is still needed by Uganda's private health clinics to meet their growth and expansion goals (see Box 7). However, there is a mismatch between PHP demand and commercial bank supply. Banks are often uncomfortable working with doctors who do not have much business

management experience and cannot show loan officers the true profitability of their businesses. The PSA recommends addressing this mismatch by assisting both the lender and

Box 7. Loans Benefit Health

The USAID funded Private Health Support Program in Uganda works with Centenary Bank to offer loans to private health providers. A nurse in the Kabwohe Clinical Research Center in South West Uganda received a \$35,000 loan.

With this loan, she was able to hire more staff which increased the Center's capacity to treat 4,600 more AIDs patients. (Source: PHS Bi-Annual Report, 2015).



lender:

Strategies to assist Commercial Banks

- **Increasing lenders knowledge of the health sector to develop relevant products.** Providing targeted technical assistance to banks expressing an interest in the health sector can be an important strategy to furthering capital flows to these businesses. Targeted assistance can include: i) conducting market analysis of the health sector to disaggregate demand by location, business type and loan sizes, ii) supporting financial institutions to develop a strategy targeting the health sector, iii) offering tailored technical assistance to align their corporate interests with lending to the health sector, and iv) providing training for line workers (marketers, loan officers) on health sector characteristics, how to market and offer products that will address the sector's needs.

Box 8. USAID/Uganda PHS Program's Technical Assistance to Commercial Banks

The USAID/PHS has offered multiple levels of assistance to its two DCA banks. At the highest levels, this included broad understanding of current market opportunities of lending to the health sector. The project has undertaken multiple market assessment studies to ascertain details regarding specific challenges and constraints within the health sector market which have enabled the two DCA participating banks to more securely lend to the health businesses. Support has also included direct training to loan officers regarding health sector lending – and in particular lending to female-owned businesses. In addition, USAID/PHS has assisted the banks to identify qualified health businesses for lending, including rural and first time health clinics.

- **Offering credit guarantees.** Credit guarantees can be part of a solution to expand lending to the health sector. Donors have developed guarantee mechanisms to partially off-set the risk of lending to the health sector in Uganda. For example, USAID and SIDA are co-guaranteeing two Development Credit Authority (DCA) guarantees for Ecobank and Centenary Banks for health lending for \$7 million and \$2 million, respectively. Centenary bank has to date utilized sixty-five point four percent (65.4 %) of its total guarantee amount amounting to \$1,962,353. Meanwhile Ecobank has utilised seven point two percent (7.2%) of its limit amounting to \$50,980. This guarantee is one part of the scenario that is needed to support and expand lending to the private health care sector. The annual review 2015 of the USAID/SIDA health guarantees noted that dedicated technical assistance for monitoring, reporting and utilization for the participating DCA guarantee banks (Centenary and Ecobank) has been critical (PHS Bi-Annual Review, 2015). This training support has been further buoyed by the project providing a pipeline of clients from which the bank could choose clients to lend. The PSA team recommends exploring the feasibility

of scaling up the DCA loan program to further encourage commercial banks to lend to small- and medium-PHPs.

- **Reforming collateral requirements.** Issues around collateral also need to be evaluated and creative solutions derived for clinic owners who lack ownership of land or property. In Uganda, banks uniformly require significant collateral for all loans – even those supported through a guarantee. One example offered by an innovative African commercial bank is the development of a series of graduated loans to enable expanded lending to female entrepreneurs. In this case, the bank offered female borrowers ‘entry level’ loans to purchase land that could later be used as collateral. Once those initial loans were repaid, clients were offered larger, longer-term loans for construction and equipment purchase. This graduated approach to serving female entrepreneurs could also work to address some of the constraints faced with expanding financing to Uganda’s health sector, which often lack basic collateral required for borrowing.

Strategies to assist PHPs

- **Helping private healthcare businesses become “bankable”.** Any effort to address access to financing also has to focus on individual healthcare business’s ability to submit a “bankable” application. However, this entails more than filling out the form. Each business has to be able to demonstrate that they are credit worthy by having the necessary management and financial systems in place as well as using them to make sound business decisions. The PSA Team recommends that in addition to BST training, the local institutions offering the training also provide one-on-one business advisory services to not only help small- and medium-size businesses apply for loans, but also help them establish and use key financial systems that are required by banks to pay back the loans.
- **Leveraging leasing to purchase equipment private sector.** The interviews conducted for the PSA revealed that lack of equipment is a major constraint for most small- and medium-sized private health businesses to expand and grow. The traditional approach is to outright purchase the equipment. Yet leasing has become an economically viable option. Equipment leasing – both for the public and private sectors – is an important next step for governments and Development Partners interested in supporting Uganda’s health sector growth. The PSA Team recommends developing partnerships with medical equipment suppliers, like Philips/Uganda, to develop co-guarantee arrangements as well as standardized maintenance contracts. These partnerships could address bank concerns of using equipment as collateral (i.e., and the issue of who will re-purchase used equipment) along with building the health sector’s ability to use the full capacity of new equipment. In addition, the PSA Team recommends identifying 1-2 Micro-Finance Institutions already exploring the viability of launching a “micro-leasing” program and providing technical assistance and training to the MFIs to accelerate their efforts.
- **Explore financing mechanisms targeted to PNFPs.** Although much of the focus in access to capital is focused on PFP healthcare businesses, many forget that PNFP health organizations are also a business with their own capital needs. As the PSA showed, many of the FBO hospitals are old and in disrepair; they also have out-of-date medical equipment; and they are cash constrained from expanding their services to rural areas. Also, the Joint Medical Stores has plans to establish a regional warehouse system but is struggling to raise the capital needed to carry out this initiative. Due to the

not-for-profit nature, FBOs and NGOs are not eligible to seek loans from a commercial bank despite their obvious need.

The PSA recommends the *MOH transform Primary Health Conditional Grant programs*. As noted in the PSA financing section, the Medical Bureaus, although appreciative of the financial support from the MOH, would encourage the government to use a different financing mechanism to contract them to deliver services. This mechanism, should be linked to performance and the true cost to deliver health services. The PSA Team offers several recommendations on how to transform the PHC Grants into a more effective financing mechanism that would benefit the Medical Bureaus.¹⁶ The recommendations related to access to capital for PNFPs like the Medical Bureaus, proposed the MOH:

- **Convert the use of PHC Grant to capital for infrastructure improvements.** The MOH no longer uses the funds allocated for the PHC Grant to apply towards service delivery but instead, use them for capital investments for PNFP facilities. The MOH can use a competitive process in which the Bureaus would apply for these “capital investment” grants. The MOH would award the grants to the Bureaus whose facilities best match MOH priorities (e.g. underserved location, target population groups, and/or priority health services).
- **Loan funds to JMS.** Since a commercial bank will not lend capital to JMS to build the regional warehouse network, the MOH can serve as lender. This is a win-win situation for both JMS and the MOH. The loan allows JMS to raise the needed capital at below market rates. JMS would pay back the loan with modest interest with the revenue it earns from their operations. Also, JMS would build the regional warehouse network – a major gap in the public and private supply chains. The MOH could then “lease” space from JMS for their use and/or discount the loan repayment schedule.
- **Strengthen network organizations’ capacity to manage and become more financially sustainable.** Fragmentation and atomization of private providers is a major challenge for the MOH when trying to govern and regulate the private sector. One of the reasons why the MOH freely partners with the Bureaus is their trust in the Bureaus management capacity to ensure their entire network of facilities comply with government policies. Although the Medical Bureaus are well established networks of FBO service providers, they shared with the PSA Team the need to further build their business and financial administrative capacity and to extend their quality systems. They also expressed a desire to add Business Skill Training to their current training curriculum offered to their network facilities in recognition that each member facility also has to worry about the bottom line.

The Medical Bureaus is a network model to build on and could be replicated among other PNFPs networks. Other networks, like UNPMA and the social franchises such as MS-Uganda and PACE, need similar assistance. They need technical assistance to not only strengthen their capacity as a network manager but to also make their network become fully sustainable. They also requested assistance to help their network providers become “voucher” ready so they can participate in the World Bank and USAID maternal health voucher programs.

¹⁶ PSA Team recommends moving away from the grant mechanism to *performance based service contracts* to cover recurring costs to deliver health services (see Strategy #2: Mid-term recommendations).

The PSA Team recommends that Development Partners also extend TA and funds to invest in the key organizations that are managers of a group of facilities and to build the capacity as network managers. Capacity areas include: facility management and administration, procurement, quality assurance, financial management, human resources, and compliance. Increasing their capacity to ensure quality services will greatly assist the MOH in regulating a significant percentage of private providers.

Strategy #4: Increase the Private Sector Role in RMNCAH

There is a window of opportunity **NOW** to break through old mindsets. The private sector, including PHPs, despite all the challenges they confront, are looking to the MOH to immediately demonstrate leadership and commitment to public-private partnerships in health (PPP/H). First and foremost, the PSA Team recommends the MOH immediately broker one to two PPP/Hs to assure the private sector that the MOH is serious about implementing the PPP/H policy. Possible PPP/H opportunities include

- **Decongesting maternity services at public hospitals by contracting private providers.** PNFPs already play in critical role in expanding M/RH services on behalf of the MOH. However, there is room for PHPs to also expand their health services to “pull” public patients away from congested MOH maternity wards. KCCA has announced its interest in exploring service contracts with PROFAM providers to help decongest maternity wards in the capital area. The PSA Team recommends supporting KCCA to draft and issue its first round of service contracts and providing technical assistance to private provider groups, like PROFAM, to respond to KCCA’s request for proposal for a service contract. KCCA does not have to start from scratch – there are several country experience on which to build.
 - Tanzania and Malawi have experience in service level agreements that can serve as a proto-type.
 - The Philippines have experience in contracting private midwives under a national health insurance program (see Box 9).

– Uganda has experience in performance based contracts with the Cordaid pilot in

Box 9. Contracting Private Nurses and Midwives in the Philippines

To address the high, unmet need for public health services, the DOH launched the Universal Health Care (UHC) Program, also known as Kalusugan Pangkalahatan (KP). UHC provides every Filipino of the highest possible quality of health care that is accessible, efficient, equitably distributed, adequately funded, and fairly financed through PhilHealth - the national health insurance fund.

PhilHealth has created a system to accredit, empanel and reimburse private practice midwives (PPMs). To expand the number of service providers, PhilHealth coordinates with the DOH to train PPMs to become eligible as a PhilHealth. The training is comprehensive and includes all FP methods, IUD insertion, pre-natal and delivery, and EMOC. The DOH also trains helps PPMs establish basic QA and reporting system as well as conducts regular supportive supervision visits. Expectant mothers and their families receive a predefined set of health services at no cost. In exchange, PhilHealth reimburses the PPMs. PPM representatives are involved in negotiating the fees with PhilHealth.



The program has become increasingly popular with mothers. The PPMs offer convenient hours, easily accessible location and no waiting time. In addition, they appreciate the customer service and perceived quality of care.

(Source: http://pdf.usaid.gov/pdf_docs/PA00K7F3.pdf)

Jinja.

- **Harmonize and expand the maternal health voucher programs.** The draft 2016 Health Financing Strategy in Uganda acknowledges vouchers as an important instrument in its “toolkit” of health financing mechanisms. Currently the World Bank Voucher program is focused in the Western and East central regions covering 14 and 12 districts respectively while the USAID Voucher program focuses in the far East and Northern regions. Vouchers have been an effective first step towards a national health insurance in several SSA countries, making it feasible for governments to contract private providers because they enable the government to: i) select eligible providers through empanelment, ii) assure quality through contract performance indicators, iii) monitor and track of payments, and iv) assess value for money by linking payments with quality. The PSA Team recommends two actions that will better leverage the two voucher programs.
 - **Harmonize the two voucher programs.** The MOH, with assistance from the World Bank and USAID programs, can harmonize the two programs to assure they cover the same M/RH health benefits to avoid confusion among consumers. Similarly, the two Voucher Management Agencies can harmonize and standardize their approaches and reimbursement levels to manage competition between private providers and avoid distorting the market.
 - **Expand the voucher program to include KCCA.** The KCCA contracts with private providers will have limited success in decongesting MOH maternity wards if it not accompanied with financing to remove mother’s economic barriers. The KCCA contracting partnership has great potential if the voucher scheme can be expanded to include KCCA region and its environs.

“Low Hanging Fruit”: Medium Term Activities (Years 2 and 3)

Strategy #1: Strengthen Public-Private Dialogue and Cooperation

In the short-term, PPD and cooperation focuses on identifying the appropriate country platform, making needed modifications and establishing the rules of the road on how the public and private stakeholders will work together. In the medium-term the focus changes to intensifying dialogue to promote greater cooperation by building the Country Platform's participating organization's capacity to be effective collaborators and partners in specific PPPs. Also, the PSA Team recommends organizing the private sector representative organizations and strengthening their capacity to unify the private sector voice.

- **Build public and private stakeholders' partnering skills participating in the RMNCAH Country Platform.** There are two sets of skills needed to manage an inclusive, consultative process between public and private stakeholders. First, the partner organizations in a Country Platform will need partnering and collaboration skills, such as facilitation, communication, quality conversation, conflict resolution and action-learning (Tennyson, 2005: 20-24). Some of these skills may come naturally while others may need to be acquired. Second, partner organizations will also need technical skills required to design and implement the Investment Case. They include: advocacy, communication, health financing and economics, RMNCAH program design, RMNCAH clinical skills, monitoring and evaluation to name a few.

Development Partners have can help a Country Platform by providing resources for organizational development (OD) expert(s) to serve as "honest brokers" to coach and mentor a Country Platform's Partner Organization to strengthen their leadership and partnering skills as well as help them perform as a single entity – not a group of individual organizations. The OD experts, can, if needed, also help the Partner Organizations resolve conflicts as they arise while trying to reach consensus on Investment priorities and funding allocation. In addition, Development Partners can provide resources for a Country Platform to identify and hire technical experts to assist them and the TWGs to carry out the analytical aspects of designing the Investment Case, implementing priority investments and finally, evaluating priority investments success/impact.

- **Build Professional Associations' capacity to represent their constituents.** Understandably, Development Partners have not invested much in building capacity of professional associations and industry groups because of all the challenges. Growing a Professional Associations require a large investment of time and resources. Yet they have limited staff and weak leadership to drive this growth. These associations and industry groups are, initially, plagued with high financial uncertainty because of small membership numbers and low membership dues. For these reason, Professional Associations in the health sector has been a neglected area for DP support.
- The benefits, however, of building professional associations' capacity are evident in the long-run (McQuide, 2007). At the macro level - the policy arena - professional associations and industry groups: i) represent the private sector perspective in health policy and planning, ii) unify the private sector voice to advocate for key policy reforms such as national health insurance, and iii) help organize the private sector by serving as a third party entity to implement proposed policy reforms. At the micro level - patient-provider interactions - the professional associations are an important bridge between health consumers, the healthcare profession and government. A strong professional association ensures the public of high standards of care while motivating health professionals to continually improve quality of care.

The PSA Team recommends also building private associations' and industry groups' capacity so they can more effectively advocate on behalf of their constituents and provide member services that are valued. Although there is no formula for strengthening professional associations, experience shows that successful strategies fall into two board categories strengthening a professional associations internal structure and organizational effectiveness, and technical capacity to carry out key member activities (e.g. legislative affairs, continuing medical education and accreditation to name a few). Most successful strategies focus on both components simultaneously (McQuide, 2007). Key associations that merit further support include: i) Uganda Private Nurse Midwife Association, ii) Uganda Healthcare Federation, and iii) Uganda Nurses Union. Also, organizations that serve as network managers – such as the Medical Bureaus and Social Franchises – can also play an important role in advocating for their group of providers in policy and program decisions related to RMNCAH.

Building private professional associations and industry groups entails providing technical assistance to: 1) strengthen their organizational capacity; 2) become more financial sustainable; 3) enable the Board to assume their governance responsibilities; and 4) build staff's competency to carry out membership services. In addition, competitive grants will help these different associations hire staff, carry out activities to earn credibility with their members, and to perform policy analysis and communication to better represent their constituents in policy and planning initiatives.

Strategy #2: Build Government Capacity to Effectively Engage the Private Sector

The responsibilities of monitoring private sector quality, shaping health markets, incentivizing private sector and engaging the private sector are spread out through the Ministry, requiring interventions with different departments. Specifically, the PSA Team recommends investing in: 1) the PPPH Node's capacity to engage and partner with the private sector, 2) assisting the MOH Department of Policy and Planning to generate much needed data of private health sector and health markets relevant to RMNCAH, and finally, 3) providing technical assistance to the same department to develop and implement financing policy tools outlined in the HFS.

- **Strengthen PPPH Node's capacity to partner with the private sector.** Building the Node's capacity is a worthwhile investment for the GFF as the PPPH Node is the designated actor within the MOH to facilitate public-private coordination and to implement a wide range of PPPHs. The PPPH Node, despite its big mandate as outlined in the PPPH Policy, is woefully under-funded and understaffed. The USAID PHS Project currently supports the PPPH Node to build its capacity but it is not sufficient. The PSA Team recommends additional support to:
 - **Institutionalize the PPPH Node.** There are many bits and pieces of the PPPH Node in place, such as draft terms of references, partial staffing plan, skills gap analysis, etc. The PSA Team recommends pulling all of these tasks together to develop an action plan to operationalize and institutionalize PPPH Node's scope. DPs can once again play a critical role in supporting the number and type of staff needed to fulfill its mandate. The Node requires staff with skills and expertise not usually found in a MOH, such as finance, contract law, contract management economics which may require hiring from outside the government sector. The TORs for the PPPH Node will have to map to the current decentralization initiatives and clearly outline what roles

and responsibilities will be performed at the HQ level and district level including the PPPH Focal Persons.

- **Provide TA to Node to design and establish operating systems and procedures.** There are many examples of PPP units operating system and manuals from South Asia (e.g. India and Bangladesh) and African countries (e.g. South Africa, Tanzania) that can serve as a template for the PPPH Node. Tasks include i) designing and building operating systems, ii) developing an operational manual, iii) training PPPH Node staff in the new operating systems, and iv) educating MOH on the PPPH Node's functions, roles and responsibilities.
- **Build PPPH and MOH staff knowledge and capacity to engage the private sector.** Experience has identified five critical skills areas needed: costing, contracting, performance based financing, conflict resolution and negotiation. Also, PPPH Node staff need to learn how to identify, design, compete and monitor contracts and PPPHs. This will require building knowledge on PPPHs. There are three strategies to build this knowledge: 1) conduct study tours to countries with successful PPPHs; 2) carry out an inventory of current PPPHs in health and document them; and 3) as Uganda experiments with different types of PPPHs, evaluate them to develop lessons learned and best practices going forward with future PPPHs. Once again, this knowledge and information should be widely shared within the MOH and among the professional associations and industry groups.
- **Support Node to communicate and share information on private sector engagement in RMNCAH.** One of a PPPH node's most important functions is to ensure constant and transparent communication and information exchanges between the public and private sectors. The PSA team recommends: 1) supporting the PPPH Node to become the HPAC secretariat; 2) building a website to push out information on the private sector and PPPH opportunities as well as share changes in MOH policies and regulations; 3) building capacity to produce policy briefs on key issues relevant to private sector role in health generally and RMNACH specifically; and 4) providing support to help the PPPH Node convene private sector associations and leaders to participate in all the policy and regulation reforms related to RMNCAH.
- **Assist the Node to broker partnerships in RMNCAH.** The PSA recommends potential areas for partnerships of which several are proposed to expand the private sector's role in RMNCAH. The PPPH Node will initially require specialists to help initiate the PPP process, conduct due diligence and financial analysis of each PPP project, and to negotiate and finalize the terms of the contract.
- **Assist MOH to generate data needed to regulate and monitor the private health sector.** The PSA underscored the lack of data on the private health sector, making it difficult for the MOH to regulate but to also make strategic decisions on how engage and partner with them. DPs could support the Department of Planning and/or PPPH node to carry out analyses that would address information gap, including: a) updating and reconciling MOH statistics on all HRH and facilities, b) developing an inventory of existing PPPHs to serve as the pipeline for PPPHs, c) conducting a health equipment inventory in both public and private facilities to identify opportunities to rationalize expensive equipment (e.g. ultra-sounds, CD4 labs, X-ray, MRIs, oxygen, etc.), d) expanding the KCCA provider census to cover the entire country, and e) conducting targeted analysis of quality levels among key private providers to identify potential partners for PPPHs for RMNCAH.

▪ **Assist MOH to create financial tools to incentivize the private sector to play a greater role in RMNCAH.** The draft HFS goes beyond risk pooling and the NHIS to address the challenges confronting funding the health sector. The HFS also proposes increasing government contribution to reduce its reliance on donor funds and establish strategic purchasing function in the MOH. Although comprehensive, the HFS has failed to garner the necessary support and commitment to both approve and implement it. Equally important is the draft National Health Insurance bill. The bill, the centerpiece of the HFS, has been languishing in the MOH for the last two years. Although great certainty remains on whether the government will act on its NHIS proposal, it is a necessary condition in every evolving health system. Stakeholder groups – both in and out of the MOH – can compel the MOH to approve and accelerate implementation of the HFS. Towards that end, the PSA Team proposes two programmatic areas:

- **Pressure the MOH to approve and implement the Health Finance Strategy and National Health Insurance bill.** The PSA Team recommends bringing together both public and private stakeholders together to pressure the MOH to approve the HFS and NHI Bill. Suggested activities to support these two efforts include:
 - Working with NHI point person in the MOH to: i) draft a summary of the NHI proposal, ii) draft a policy brief on the benefits of NHI using examples from OECD and LMIC countries and iii) disseminate this information widely among MOH staff and private provider organizations.
 - Conducting consultative forums between public and private sector stakeholder groups to discuss the strengths and weaknesses of the HFS and NHI proposal, identify concerns arising from the proposed NHI and give technical input on how to surmount the challenges.
 - Assisting UHF and other private sector representative bodies to advocate and lobby MOH and government for the passage of the NHI Bill and HFS.
 - Assisting the a public-private coalition to rally the general public’s support through a full-court press including but not limited to a public awareness campaign, op-ed pieces in the press, policy dialogue between government and consumers.
- The **MOH can take “baby” steps in health reforms that create the foundation for national health insurance** while stakeholders are advocating the government to approve the HFS and implement the NHIS. The following are steps they MOH can experiment with while building systems for a NHI.
 - **Segment those who can afford to pay and “steering” them to the private sector.** As the PSA shows, PHPs currently play a small role in PMTCT services yet private physicians and midwives have expressed interest in expanding services in this area as a strategy to offer comprehensive services for all their mothers. Similarly, the MOH greatly subsidizes a significant percentage of middle and upper income in delivery care. Significant percentages of pregnant women in the top three income groups (middle – 92%; richer 87% and richest 77%) receive highly subsidized services in public and PNFP facilities yet they have some ability to pay.

 As a cost-saving measure, the PSA Team recommends a strategy to “steer” women from the top income groups to private providers. Directing those who can afford to pay will free up scarce public resources that could be redirected to reach under-served pregnant women.

Strategies to direct women to PNFP and PHPs providers include: i) establishing pricing guidelines for PMTCT and delivery services to influence PNFP and PHP prices; ii) charging higher income women these full prices when they come to MOH facilities for PMTCT and delivery services; and iii) transferring this segment to pre-approved PNFPs and PHPs through a formal referral mechanism.

- **Start now to grow MOH experience in performance based finance** and not wait until all the systems are designed and in place. The Cordaid experience in Jinja demonstrated to both the government and private providers that PBF can work in the Ugandan context. The MOH can move immediately on its PBF Proposal developed with assistance from the World Bank by building on the Cordaid experience, recognizing that it will take several rounds of contracts to work out all the kinks in the MOH system and to gain the local experience in how to design, negotiate and manage a performance based contract. The MOH can experiment now with smaller PBF contracts before going big.

In the meanwhile, the DPs can provide the necessary technical assistance for the MOH to: i)

Box 10. Performance Based Contracting Plan in Uganda

The World Bank is assisting the MOH to develop its Performance Based Contracting Plan. PBF has the potential to become a powerful incentive for the MOH to influence private provider behaviour and to shape specific health markets. The PBF program is in draft form and the MOH is still receiving comments from stakeholders. We recommend the MOH involve more private sector stakeholders to provide feedback on the current PBF proposal. Also, we urge the MOH to rapidly conclude and finalize the PBF proposal in the short-term. Some of the proposed modifications to the current PBF design include: i) expand the PBF program governance structure to include representatives from both the PNFP and PHPs to speak on behalf for the principal source of providers, ii) remove the transition period and instead establish a clearer purchaser/provider split under the PBF program, iii) establish clear, consultative processes by which to establish reimbursement levels and design transparent terms of provider payments, and iv) linking supply side financing (PBF) with demand side initiatives (such as voucher, awareness raising campaigns) similar to successful examples in Gujarat, India, with maternal health voucher and performance based contracting.

quickly establish the institutional arrangements (e.g. regulations, systems, staffing, etc.) for a Contracting Unit, ii) design a modern (e.g. web-based, streamlined) contract and provider payment systems that conforms to international best practices, iii) provide training to MOH staff *and potential private provider networks* in critical skill areas such as costing, skilled negotiation, conflict resolution, partner management and contract evaluation, and finally iv) mentor both public and private partners through the initial rounds of PBF contracting until they can perform these tasks independently.

Strategy #4: Increase Private Sector Role in RMNCAH

In the mid-term, the MOH and DPs can focus on two strategic areas to harness the private sector's capacity in RMNCAH: 1) expanding access to RMNCAH drugs and health products through a network of private pharmacies and drug stores and removing economic barriers through a drug benefit plan for population groups living below the poverty line, 2) increasing access to delivery care through a 2nd generation of service contracts that adds more private midwives and clinical officers as well as expands the scope of practice to integrate other RMNCAH services such as PMTCT.

▪ **Expand access to family planning and other RMNCAH products in a “health basket”**

- **Network retail pharmacies and drug stores to make affordable, quality drugs more accessible.** With over **XXXX** pharmacies and drugs shops located nationwide, they are able to reach even remote areas in Uganda. Pharmacies and drugs shops are often the first place people go for common health issues. They are a preferred – and sometimes the only – source of healthcare information and services in hard to reach areas in Uganda. The majority of pharmacies and drugs shops are privately owned, however, and not well integrated into the overall health system. The sheer size and number make private pharmacies and drugs shops a potential opportunity to extend not only the reach of a full range of RMNCAH products but also make available drugs needed to treat other health priorities such as HIV/AIDs and TB.

Several East African countries, including Uganda, are experimenting with different strategies to legalize, consolidate and strengthen quality of drug sellers and drug shops. In Kenya, pharmaceutical technologists are recognized as licensed profession and their drug store are registered facilities. The Kenya Pharmaceutical Association formed a for-profit arm and established a network of over 500 private drug sellers in rural areas (See Box 11). In Tanzania, the Ministry of Health and Social Welfare spent 10 years to approve regulations that legally establish ADDOs as licensed facilities and drug shop owners as a professional health cadre. Finally, in Uganda, the Clinton Foundation is attempting to network drug shops in rural areas.

Box 11. Networking Peri-Urban and Rural Drug Shops: *Pharmnet Experience*

As in Uganda, pharmacies are the first point of contact for the majority of Kenyans seeking healthcare. Yet, of the 12,000 pharmacies in Kenya only 4,000 are licensed with the Pharmacy and Poisons Board (PPB). Consumers cannot be confident in the quality, authenticity and value of the medicines they purchase. With little disposable income (KSh100-300, the equivalent of £0.60-\$2.00 per day), this low-income group is forced to pay directly out-of-pocket for healthcare and is hit by the 'poverty penalty' - paying multiple times for healthcare as the initial service from informal operators did not properly treat the illness.



The Kenya Pharmaceutical Association (KPA) - a professional association representing licensed pharmaceutical technologist - wanted to address the issue of illegal practitioners. KPA has over 7,000 paying members in this association. As an established and well-managed professional association, they offer many member services including: i) advocacy and policy with the Kenyan MOH on behalf of the members, ii) market and clinical information, and iii) CPD training and certification.

KPA created a network to increase consumer confidence in pharm techs – as they are commonly referred to in Kenya – and the quality of their products sold in pharm techs' drug stores. KPA formed a commercial entity (NTP) to become the network manager and branded it "Pharmnet".

In order to join Pharmnet, each a network member has to qualify to become an eligible affiliate. The members undergo rigorous training in GPP; counselling and customer services; reporting to the MOH; and, business and financial management skills. NTP also offers required refresher training annually.

With more branding set to take place and the rollout of Pharmnet posters in Kenya's brightly decorated matatus (buses), complemented with radio adverts blaring to passengers, KPA is scaling up the intervention, aiming to have 1,000 Pharmnet outlets reaching up to nine million people by the end of 2017.

In exchange, the Pharmnet member receives access to affordably priced quality-assured drugs, improved community pharmacy practice, supportive supervision visits, and branding and promotion of the network. NTP pools procurement on select medicines (mostly essential medicines for priority health issues such as FP, diarrhoea, cough, malaria, TB, etc.) and set price caps on these drugs. In 18 months, over 500 members nationwide have joined Pharmnet. Within three years, Pharmnet has become financially sustainable through membership fee but mostly from profits earned on pooled procurements. Pharmnet plans to expand its network to include all 5,000 members over the course of the next three years.

(Source: <http://www.psp4h.com/wp-content/uploads/2015/05/PSP4H-Case-Study-No.-7-Pharmnet-A-Sustainable-Community-Retail-Pharmacy-Network-in-Kenya.pdf>)

Other countries (e.g. Ghana with ORS, India for TB, and Ghana, Senegal and Vietnam for FP and other RH health products) are working with private pharmacies and drug shops to offer a full range of FP methods, including Depo, and to diagnose and treat opportunistic infections, malaria and TB. In these countries, the MOH establishes an accreditation process based on good prescribing practices and empanels eligible private providers. To assist the private providers, the MOH donates products,

Private pharmacist delivering Depo in Ghana



supports awareness raising on the benefits of FP and availability of quality methods at accredited facilities and reimburses the provider for “dispensing” the FP method.

The PSA Team recommends the MOH and National Drug Authority examine the different country examples to incorporate the lesson learned and best practices from each in order to design a drug shop network.

- **Establish a drug benefit plan for below the poverty line population groups.** Like the voucher program, removing the economic barrier to drugs would go a long way to improving access to RMNCAH drugs and health products. The NHA shows that purchase medicines and other health supplies is the largest (60%) contributor to out-of-pocket expenditures and the most significant driver for impoverishment. The PSA Team recommends the MOH establish a drug benefit plan – either in the form as a health savings plan and/or risk pool depending on the size – targeted for the poor only (See Box 12). The drug benefit plan would cover a defined package of medicines, diagnostic tests, and health products at no cost for below the poverty line population groups. DPs can assist the MOH by initially funding the drug benefit plan and providing technical assistance to design and roll-out the plan. While exploring the appropriate administrator for the drug plan, the MOH can consider an existing private health insurance company as they have expertise in managing health savings plan and/or micro-insurance plan, existing infrastructure and staff to process claims, and a sales force to promote and sign up beneficiaries.

Box 12. Key Features of Drug Benefit Plan for the Poor

Other developing and transitioning countries (Jamaica, Kyrgyzstan) are implementing Drug Benefit Plans as part of social health insurance scheme. While the Ugandan government waits to decide on NHIs, the MOH can start with a Drug Plan. There are some features these plans share:

- Covers a set package of essential medicines (e.g. FP methods including LARC; ORS, ZINC, micro-nutrients; malaria nets and AZT; TB DOTS; and drugs to treat opportunistic infections and manage NCDs).
- Also includes all childhood and adolescent vaccines.
- Covers rapid lab kits to test for HIV/AIDS, malaria, and TB.
- Drug package will be available through a network for drug shops (see Section 7).
- Drug plan pays a contracted service provider - in most cases a pharmacist or pharm tech and in a few instances healthcare provider - a “dispensing fee” and set price covering the cost of the drug/test. Or MOH can also donate medicines and test kits and only pay the dispensing fee.
- Drug plan is **only for the poor**. Beneficiaries do not have to pay at point of sales. Non-eligible individuals can participate in plan to access affordable drug prices but must pay dispensing fee and set (in most case lower) medicine price.
- All drugs are sourced from qualified distributors to ensure quality products and tests. Sourcing with pre-qualified distributors can also help MOH achieve economies of scale to negotiate more affordable price and distribution cost.
- MOH can outsource plan administration.

The Pharmacy/Drug Store Network could potentially become the service provider for the drug benefit plan. Instead of contracting with several hundred individual pharmacies and/or drug stores, the MOH could instead, contract the network management entity. The contract would delegate key tasks that the NDA does not have the resources or capacity to enforce. For example, the network, as is the case with Pharmnet, would be responsible for assuring compliance, quality products, and GPP. The network manager would also process and pay claims, assure drug shop owners do not charge for the drugs, and monitor for fraud. Depending on the arrangement, the

MOH/NDA could donate the drugs to reduce their cost of the program and/or require the network manager procure the drugs on the open market.

- **Increase the number and scope of service contracts in RMNCAH.** It takes several iterations of service contracts for MOH to gradually develop the capacity to compete and manage performance based service contracts. The PSA Team recommends that the MOH use the 2nd generation of service contracts to: i) grow the number of private providers assisting deliveries and ii) to organize PHPs into networks and iii) expand the scope of providers to offer a wider range of RMNCAH services such as PMTCT.
 - **Grow and manage competition in delivery health market.** With time, the PSA recommends structuring the contracting process to encourage “friendly competition”. Unlike other private provider groups, private midwives are well organized under the Uganda Private Midwives Association (UPMA) and other private midwife’s networks like PROFAM and MS-Uganda. The MOH can compete a 2nd round of service contracts to further organize private midwives by either encouraging individual midwives to join an existing network of their choice or by requiring the successful bidders to sign up a certain percentage of new private midwives to their current base. The 2nd contract generation, may, however, require technical assistance to the bidders to learn how to draft a responsive proposal, cost the scope of work, and negotiate a fair price that ensure they recuperate all their expenses.
 - **Integrate PMTCT into private midwives’ clinical scope.** Building on MOH experience in contracting private midwives to assist deliveries, the MOH can expand the private midwives’ scope in the 2nd or 3rd round of service contracts to include PMTCT. Kenya and Tanzania MOH’s have expanded the expanded the scope of nursing and midwifery general practice and promoted responsible and enhanced task sharing in order to respond to HIV/AIDs and other priority health challenges. The expanded scope of practices has opened the door to private midwives in Tanzania to offer PMTCT B+ services to women in their community (See Box 13).

Box 13. Tanzania Partnership with PRINMAT to Expand PMTCT

In response to HRH shortage and HIV/AIDS crisis in Tanzania, the Ministry of Health and Social Welfare expanded the scope of nursing and midwifery general practice and promoted responsible and enhanced task sharing in responding to HIV and other priority health challenges. Through a consultative process involving the MOHSW chief medical officer and a range of medical, laboratory and pharmacy stakeholders, the MOHSW developed a consultative draft of the first ever nursing and midwifery scope that include PMTCT. The scope was ratified in 2014.

Following its ratification, MOHSW gave PRINMAT access to its training curricula on PMTCT. The SHOPS project trained the PRINMAT providers and helped them prepare their facilities. After the training in clinical guidelines and government reporting, PRINMAT facilitated linkages between their members and the local district medical officers. PRINMAT provider quality supervision and mentorship program with physician mentors with nearby facilities.

In addition to expanding their practice to include PMTCT B+ services, PRINMAT midwives have received training to provide the full adult ART regime. Several PRINMAT have demonstrated private midwives’ ability to apply this new skills area and increase in access quickly. Through PRINMAT, their private midwives conducted 18,713 HIV test to adults and children and initiated 318 pregnant mothers on ART during the partnership’s first 9 months. (Source: <http://shopsproject.org/resource-center/tanzania-program-profile>)



▪ **Establish / scale FP mobile services.**

Marie Stopes International has a proven approach (20 countries) to successfully scale FP outreach services. Their standardized model establishes a FP mobile outreach team staffed with a clinician, counsellor and driver who work with public health community health workers and volunteers to coordinate visits and maintain community health registries. The team visits each site on regular schedule so that the community plan on the visit. During the visit, the team offers IEC, temporary and LARC methods on the spot. These

outreach programs have increase the number of new acceptors and increased use of modern methods. Moreover, the team has been able to better manage side effects, thereby increasing client satisfaction with their selected method. The model has been so successful with increasing FP use, that MSI in now integrating HIV/AIDS testing and counseling as well as ART compliance. The PSA Team recommends exploring the cost to establish a similar outreach program.

Zimbabwe FP counsellor during a site visit



Long-Term – Longer Gains

The Uganda MOH uses several policy tools and approaches that are designed to administer their network of public facilities and human resources. They are however, inadequate to govern and regulate external actors and therefore, misses many tools and systems needed to manage the private health sector. Also, MOH staff will have to rapidly acquire a range of skills to deploy the new policy tools and processes (Harding et al, 2015). The PSA highlights the critical tool gaps: 1) data needed to analyse sector wide activities; 2) streamlined QA system with private sector participation implemented fairly across the sectors; 3) user friendly licensing and registration processes; and 4) investments in self-regulatory actions by professional association and other intermediaries to monitor and supervise prices and quality in the private sector.

- **Build the “policy toolbox” to govern non-state actors external to the MOH.** The USAID PHS Program is working closely with several MOH department and agencies to help them build the policy instruments and systems needed to effectively regulate the private sector. The PSA Team recommends building on MOH’s momentum and efforts in many of these areas. Specifically,
 - **Identify, collect and consolidate data on all non-state activities.** Tasks required include: 1) convening all MOH agencies and the private health sector representative organizations to agree on the *bare minimum of indicators* needed for the MOH to understand private sector activities; 2) establish a simple reporting mechanism (preferably web-based) for private sector actors and identify incentives that will encourage or penalize private sector for not reporting; 3) consolidate data reporting and collection into a central location (preferably web-based) place that is accessible by all relevant government agencies; and 4) invest in building MOH capacity to analyze, report out regularly, and use the data to perform their regulatory tasks. As noted, there is
 - **Streamline QA system by institutionalizing SQIS in both government and private sector entities.** Build on and expand on the MOH SQIS initiative including providing continued resources to the Council so they operate and maintain the web-based platform housing SQIS and technical assistance to build their skills to collect, analyze, report and use the SQIS data to monitor private

sector quality. The next step within the public sector will entail institutionalizing district-level capacity to use the SQIS system to monitor and improve private sector quality in their respective districts. Moreover, the MOH can use SQIS as a tool to assess PHPs eligibility to become a voucher provider, and eventually, to become an eligible provider under a service contract and/or social health insurance. Similarly, continue to invest in and institutionalize SQIS in many private sector associations and provider networks to use SQIS as a tool to monitor and improve quality among their members. Also, they can use SQIS as a tool to help their members become and maintain eligibility as a voucher provider.

- **Modernize registration and licensing systems.** Build on and expand the Council’s efforts to modernizes their operations and systems. The PHS Program is scheduled to complete the design and start-up of the modern, web-based system. However, more investment is needed to institutionalize their use by both the Councils and public. Part and partial of this initiative should be training not only MOH staff but also private and industry associations to ensure all stakeholders have the knowledge of and are able to use the new systems and tools.
- **Assisting the MOH to “co-regulate” non-state actors with 3rd party organizations.** Increasingly, middle- and high-income country regulatory agencies are working with third party organizations, such as semi-autonomous agencies, professional associations or other intermediaries, to carry out regulatory functions normally performed by the MOH (Harding et al, 2015). Examples include working with professional associations to ensure professional licensing and facility registration; tapping into industry groups and trade associations for information and implementation support to ensure compliance with pricing guidelines and mark-up regulations; and third party payors negotiating and managing contractual relations with hospitals and other types of service providers such as healthcare provider networks, pharmacies, and labs. These experiences demonstrate the efficiency and efficacy of co-regulation. The PSA Team recommends exploring opportunities, such as rolling-out SQIS, modernizing professional and facility licensing and services contracting, in order to experiment and grow MOH’s experience in co-regulation.
- **Leverage financing mechanisms to influence RMNCAH markets.** As the MOH acquire more time and experience in implementing key aspects of the HFS, they can begin to use the same financing mechanisms to influence private provider behavior and shape RMNCAH health markets. In addition to the financing benefits, both vouchers and contracts can be used to structure supply by requiring private providers – both PNFPs and PHPs – to join a network entity. In the case of New Zealand and France to name a few examples, all primary health care providers are required to join a Primary Health Organization in order to be eligible for payment (See Box 14). Also vouchers and services contracts – as well as the drug benefit plan – can help keep health care costs down by moving away from fee-for-service, establishing pricing guidelines for medicines and other key inputs, and negotiating reimbursement levels across the sector. Lastly, issuing multiple services contracts for different service delivery networks to perform the same tasks can avoid unintentional monopolies, encourage customer service and quality as they compete for customers, and drive overall costs down through competition between service networks.

Box 14. Restructuring Primary Health Care in New Zealand

In 1996 the MOH combined 4 Regional Health Authorities into a single purchasing agency called the Health Funding Authority. The Primary Health Care Strategy, with the new funding mechanism, required all general practitioners to come together under Primary Health Operators (PHOs). The primary health care market was restructured to conform to the new policy approach. Initially general practitioners (GPs) operated as for-profit, independent owner-operators but under this new strategy, most joined a PHO in order to receive financial reimbursement for PHC services delivered.

The PHOs became the unit for performance monitoring as well as setting reimbursement fees linked to performance indicators. The PHOs reviewed and processed all individual GPs claims and assured they complied with national quality standards. Moreover, the PHOs were responsible for assuring each individual GP's quality of care. The PHOs had to report on a set of performance indicators each month to MOH headquarter staff and District Health Board's (DHBs). The DHBs success depended on how well the PHOs in their jurisdiction performed. As a result, all stakeholders – MOH staff, DHB management and private GPs, knew health target was being closely monitored.

In monthly meetings with PHOs, DHB Planning and Funding teams reviewed health targets and funding as well as strategies on how DHB can support their PHOs. This improved communication between the DHB and the PHO and also emphasized regular reporting on health targets and what organizations were doing to improve PHC coverage. (Source: Ashton et al., 2005)

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