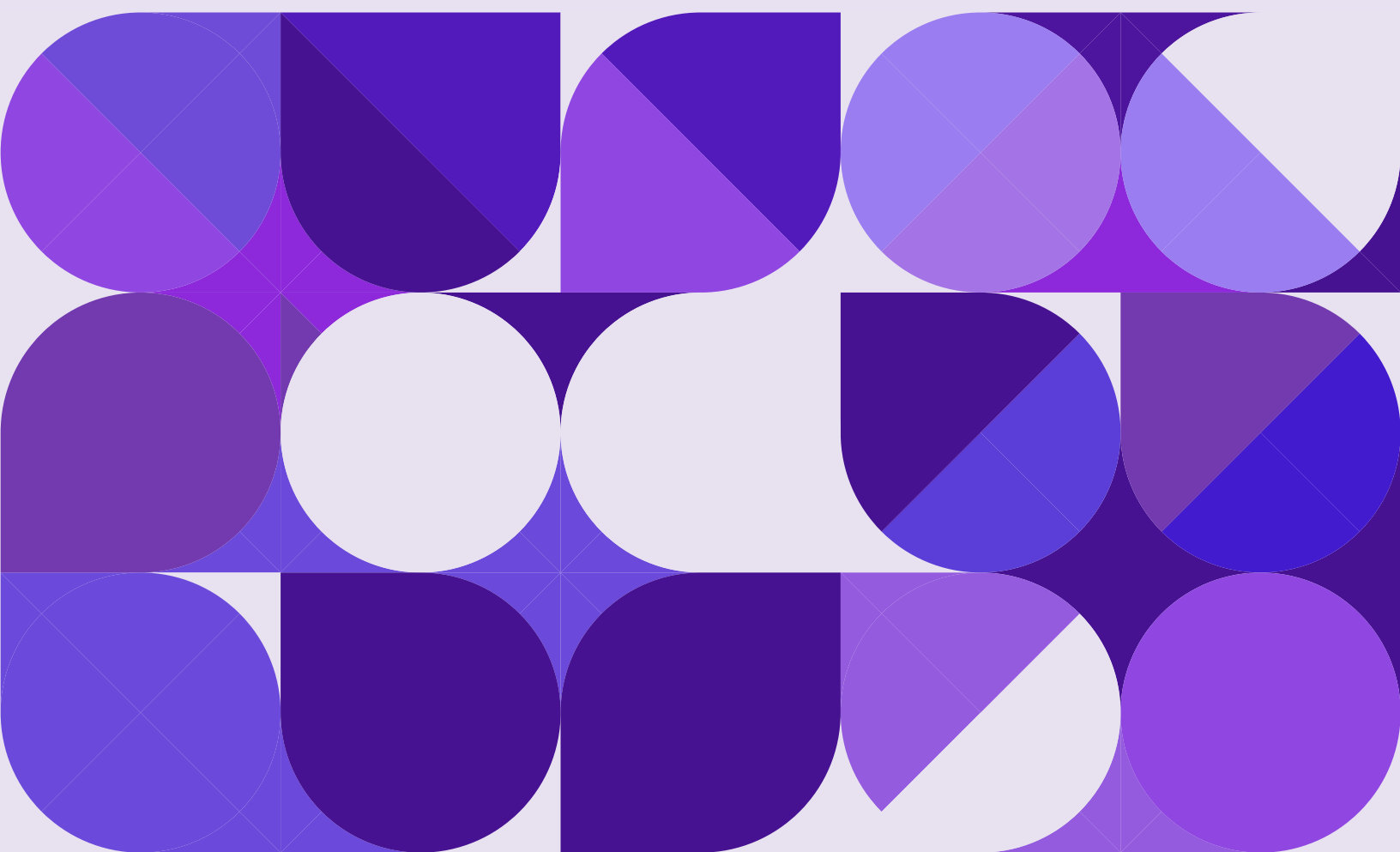


# **Private sector engagement to deliver maternal, newborn, child health and family planning services during COVID-19 in Uganda**





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## Abbreviations & Acronyms

<b>EHS</b>	essential health services
<b>FP</b>	family planning
<b>LMIC</b>	low- and middle-income country
<b>MCA</b>	department of maternal, newborn, child and adolescent health and ageing
<b>MNCH</b>	maternal, newborn and child health
<b>MoH</b>	Ministry of Health
<b>PHC</b>	primary health care
<b>SGS</b>	WHO's system governance and stewardship unit
<b>SME</b>	small and medium-sized enterprises
<b>UHC</b>	universal health coverage
<b>UHF</b>	Uganda Healthcare Federation
<b>WHO</b>	World Health Organization

# Definitions

## Private sector

The private sector includes all individuals and organisations that are neither owned nor directly controlled by governments and are involved in the provision of health-related goods and services. These consist of formal and informal healthcare providers ranging from drug shops to specialised hospitals, comprising for-profit and not-for-profit entities, both domestic and foreign. For the purposes of this brief, we focus on domestic private sector entities (1).

## Health system governance

Health system governance refers to how governments ensure that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability (2).

## Stewardship

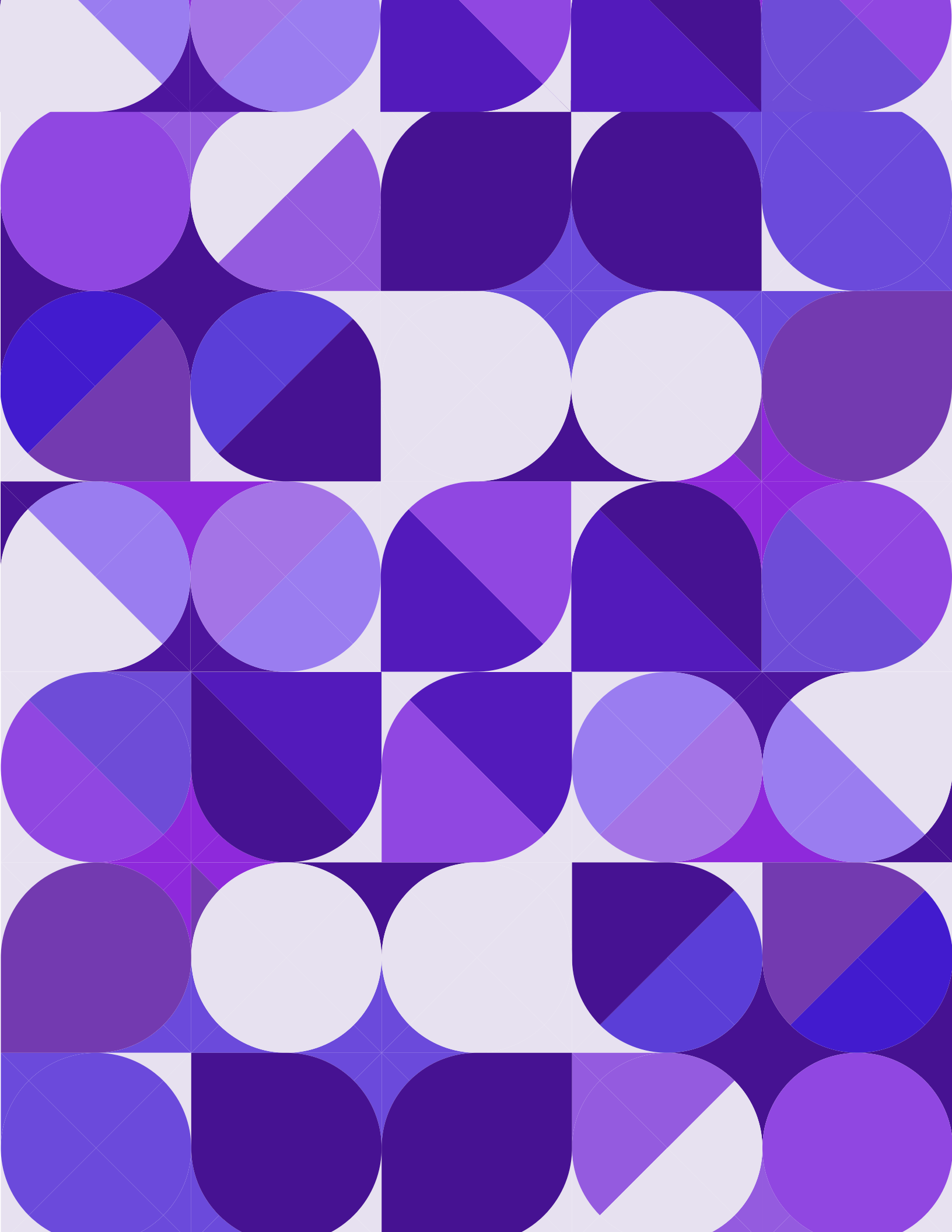
Stewardship refers to how government actors take responsibility for the health system and the well-being of the population, fulfil health system functions, assure equity, and coordinate interaction with government and society, including the private sector (3).

# Abstract

This case study documents the experience, benefits, challenges, and lessons learnt of engaging the private sector in health to maintain the delivery and use of essential maternal, newborn and child health (MNCH), including family planning (FP) services during the COVID-19 pandemic in Uganda. A case study methodology was employed, drawing on desk review and key informant interviews, which were conducted between November and December 2021. Several opportunities were raised by respondents, to seize momentum, to 'build back' and nurture trust in the health system eroded by COVID-19 pandemic, harnessing all health sectors. While these were specific to Uganda, they are applicable to a wider audience and contexts.



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# Introduction

In many low- and middle-income countries (LMICs), health systems comprise both public and private entities, with the private sector in health playing a large and expanding role in healthcare service delivery (4). This represents a mixture of both opportunities and threats for the provision of essential health services (EHS) and for health system governance. The way the private sector is organised and operates is significantly influenced by the organisation and behaviour of the public sector, with a well governed and competent public health system generating complementary private healthcare service delivery (1). In contrast, countries with weak governance and an unregulated private sector in health may also have an inefficient and inequitable public health system (1).

In sub-Saharan Africa, 35% of outpatient care is delivered by the private-for-profit sector and an additional 17% is delivered by informal private providers (4). Consequently, national health policies increasingly recognize the importance of engaging the private sector in health. The impacts of these contributions however depend on appropriate governance prerequisites, including institutions, management capacities, a culture to collaborate, amongst others to allow effective partnerships and delivery designs that target the needy and underprivileged (5). A change in mindset across the healthcare value chain is thus needed to position the

private sector as a co-investor and partner in healthcare systems (6). This has been particularly emphasised by the outbreak of the COVID-19 pandemic. Putting all health systems under constraints, the emergency particularly exacerbated the need for governments to deploy whole-of-government and whole-of-society approaches to respond to health crises. This has been seen in many LMICs, where the private sector played a crucial role in supporting governments in the fight against the pandemic, bringing resources, skills and capacities to maximize the national response, and filling the public sector needs in maintaining essential health services (7).

Building on the existing work of the WHO Health Systems Governance and Stewardship unit and the department of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA), this case study documents the experience, benefits, challenges and lessons learnt of engaging with the private sector in health to maintain the delivery and use of essential maternal, newborn and child health (MNCH), including family planning (FP) services<sup>1</sup>, to protect universal health care (UHC) outcomes (quality, access, financial protection) during the COVID-19 pandemic in Uganda. Uganda has been selected as a case study as the private sector in health has long played an important role in the healthcare system, particularly for MNCH services (8).

1: the case study we refer to MNCH services as inclusive of FP.

# Methodology

## Design

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A case study methodology was employed using key informant interviews, as it allows exploration of the “richness of actual cases” (9) and reinforces adaptive and shared learning. A literature review was not conducted as part of the case study however background articles relevant to the context have been referenced in the paper. A specific focus of the case studies was on the delivery and use of EHS with a specific focus on MNCH and FP services during the COVID-19 pandemic.

## Ethics and consent

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Written consent was sought for the interviews. Respondents’ information was anonymised as part of data analysis and presentation of findings. Quotations are referenced as international, private sector, academic, government and umbrella organisation respondent. Because the case study involved data collection only from persons working in their official capacity on issues in the public domain, the protocol [ID: CERC.0147] was exempted from further WHO ethical review. Ethical clearance was provided by Makerere School of Public Health Ethics Committee [SPH-2021-133].

## Key informant interviews

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Semi-structured, in-depth interviews were conducted with 18 respondents from international (3), private sector (3), academia (3); government (5) and umbrella organisations (5).<sup>2</sup> Some respondents worked across respondent categories, for example, respondents working

both in the public and the private sectors. Designation is therefore based on how respondents self-identified and were recruited into the study. Interviews were conducted over the period of November and December 2021. Targeted sampling was employed where respondents were selected by the Ministry of Health and WHO Uganda Country Office. Interviews were conducted in English and led by the primary and second authors. All interviews were conducted remotely using an online meeting application. Interviews were audio recorded to facilitate note taking and transcription.

## Analysis

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A coding frame was developed for data extraction, based on the semi-structured interview guides. A framework matrix was developed by the primary author for the analysis using Microsoft Excel 2016. The matrix was constructed horizontally with the key themes and vertically by respondent. Interview notes were condensed, with information arising from data sources inserted into the matrix. Quotes from the transcripts were inserted as part of data extraction. Where needed, the authors compared notes and understandings to ensure completeness of information and consistency of interpretation. The completed framework matrix was reviewed by the primary and secondary authors. The primary author drafted the paper, and the other authors reviewed the drafts and final manuscripts.

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2: Umbrella organisations were professional in nature.

# Framework

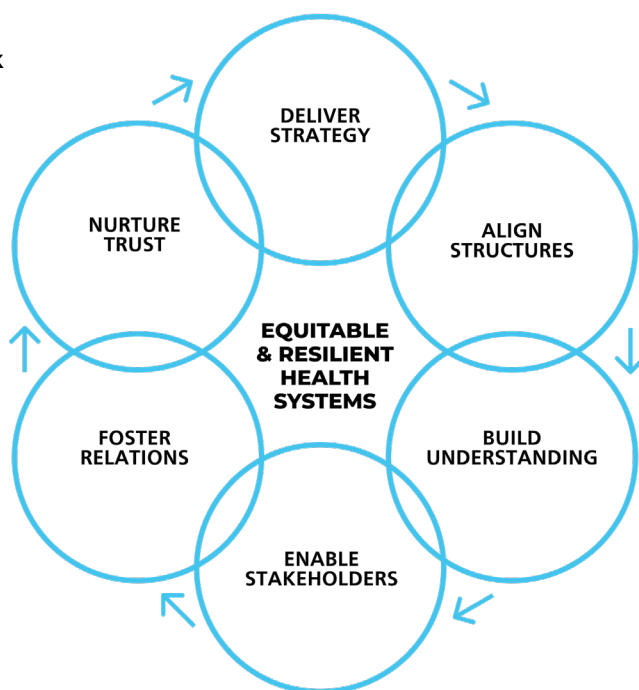
Findings have been structured using the WHO governance behaviours, a framework adopted in the WHO strategy report, "[Engaging the private health service delivery sector through governance in mixed health systems](#)". Behaviours have been operationalized for essential MNCH services as follows:

**Nurture trust:** recognition and management of competing and conflictive interests for continuation of essential MNCH services during the COVID-19 emergency.

**Deliver strategy:** organisational learning to improve engagement of the private sector for the delivery of essential MNCH services to support the COVID-19 response.

**Align structures:** alignment of public and private structures for the continuation of essential MNCH services during the COVID-19 emergency.

Figure 1. Analytical Framework



**Foster relations:** coordination arrangements and sectoral engagement for the continuation of essential MNCH services during the COVID-19 emergency.

**Enable stakeholders:** the development and implementation of financing mechanisms and regulations, to authorize and incentivize health system stakeholders for the continuation of essential MNCH services during the COVID-19 emergency.

**Build understanding:** private sector data captured and information exchange for the continuation of essential MNCH services during the COVID-19 emergency.

## Findings

Key findings have been framed for consideration by a Ugandan audience and for wider cross-country learning.

# Align Structures



Most respondents felt that there was inadequate attention given to essential MNCH services within the national response structure, particularly during the initial phase and lockdown periods of the pandemic, “there was disruption, and the coordination was not well done for the continuation of the essential services...the focus was basically on security” (academic respondent). In part this was due to emphasis on curtailing the pandemic from entering the country and isolating the disease once it gained entry.

***“A containment mindset detracted from preparing the whole health system” (umbrella organisation).***

It was surmised by a government respondent that the engagement with the private sector was geared towards the business community to fund the response rather than private health entities as part of the response structure.

Within the national response structure “surge capacity” mainly focused on the public sector and specialised COVID-19 care. This was not questioned by some respondents,

***“of course, government prioritized the public institutions but along the way, private sector had to be engaged” (international organisation respondent).***

Training of private health entities was funded through intermediaries, such as non-governmental and umbrella organisations. This allowed for some cascade of capac-

ity to the private sector in health and towards primary care and enabled the continuation of essential MNCH services. Social franchising networks were also able to cascade essential MNCH supplies and operational support to private health providers and offered similar surge capacity to the public sector. This conduit and the role of non-governmental partners more generally allowed donor resources to be channelled to the continuation of essential MNCH services.

Despite these efforts, there were gaps in the provision of essential MNCH services as clinics were closed and wards devoted to emergency care, particularly during waves of COVID-19 transmission. Emergency wards became overwhelmed,

***“as eventually the [routine] patients found a way of getting to hospitals” (private sector respondent).***

Private health facilities took the necessary precautions to provide essential MNCH services, but this came at a financial cost which was passed on to patients. Gaps in MNCH service provision also came at a human cost,

***“especially for the second wave, pregnancy and COVID-19 didn’t move well together” (private sector respondent).***

# Foster Relations



The national response structure included the private sector in health; however, representation was limited,

***"each of those pillars had like a task force...there were more or less the same players that are representing the private sector" (umbrella organisation respondent).***

Coordination platforms pre-existed the pandemic and were co-opted for the COVID-19 response with the Uganda Healthcare Federation (UHF) widely recognised by government and non-governmental respondents as the nodal entity for the engagement with the private sector in health. UHF membership is voluntary, making it "not the voice of all the private sector" (umbrella organisation respondent); its membership and footprint are comprised of larger private health entities mainly in Kampala and the metropolitan areas. Given this, there were concerns raised amongst respondents on how or if there was any "trickle down" of information and guidance

***"to the people on the ground, that are implementing all the different services" (international organisation respondent).***

Several respondents further suggested that the private sector in health needed to better organise itself to be effectively engaged. Government respondents viewed this task as the responsibility of UHF.

There was no explicit role defined for private health providers in the COVID-19 response,

***"the private sector continued to provide their services anyway, as they have always been providing" (international organisation respondent).***

Continuation of essential MNCH services through the private sector was not formalised,

***"it wasn't like an official message to go out, provide essential health services, it was just the space that was left" (umbrella organisation respondent).***

However, in the context of Kampala, there was greater attention to the role of the private sector in health and the development of a coordination and referral system, given that most of the health facilities in the capital are privately-owned and operated.

Base assumptions about organisation and profit orientation dictated government support for the private sector in health during the COVID-19 response. In general, this was minimal,

***"regularly people would say, but the private sector is being neglected. It needs to be there" (umbrella organisation respondent).***

In contrast, faith-based organisations retained a more privileged status with the public sector based on shared "not-for-profit" values. While this distinction was challenged,

***"as all providers need to cover their costs and make some profit" (umbrella organisation respondent),***

there was a recognised profit-driven element within the private sector in health, particularly those owned by business investors, "they are employing the professionals, making money " (umbrella organisation respondent). Within this milieu, owner-operated large and small and medium-sized enterprises (SMEs) and informal providers, mainly drug shops, continued the delivery of essential MNCH products and services, in an often-uncoordinated way.



# Build Understanding



Prior to COVID-19, the role of the private sector in health service delivery, including MNCH, was considered large but speculative; no definitive estimate or contribution was cited,

***"the private sector probably provides not less than 40% of the health services in Uganda...they are a key part of the puzzle" (government respondent).***

The lack of information and data on the private sector in health was considered a big gap by government respondents as it was estimated that only about 30% of private healthcare providers were reporting into the national health information system. There were concerns that private sector contribution to key outputs, such as MNCH, were "missed out", and that health information was incomplete.

There were concerns voiced by most respondents about the secondary effects of COVID-19 on MNCH. All respondents indicated that there was a drop in utilisation of essential MNCH services, particularly in the initial phase and lockdown periods. This was attributed to supply and demand side factors, but principally access constraints, given Uganda's response to COVID-19 enforced some of the strictest lockdown measures on the continent. Utilisation of essential MNCH services was reported to have subsequently 'rebounded' as adaptation mechanisms were introduced, and lockdowns lifted. However, the impacts on some women and children were not reversed.

***"When we lock down, it means that people can't move, not only the patient but also the health workers...I had a midwife who was living at her facility and she said, 'in the morning, the things that you see people are birthing babies at home because they can't get to the facility and then the cord is caught badly...you just look at the baby...oh, my God, just go to the nearest hospital, I can't help you.' It was literally heart-breaking when you see what people were doing to babies and mothers while they were trying to help them in the night before they could access a facility." (umbrella organisation respondent)***

Weekly MoH-led MNCH meetings took place and a monthly update generated from the national health information system disseminated. However, trickle down of information to private health facilities was considered an issue as frontline workers often relied upon the same information that the general public had. This was not disaggregated or specific to vulnerable groups, such as mothers and children,

***"they will just say these were the number of cases, these are the number of deaths and those were acceptable" (private sector respondent).***

Several studies were commissioned during the period, however, it was unclear how or if they were used to inform the response and the continuation of essential MNCH services. A government respondent indicated that academic studies were not used as they took a long time to publish. An academic respondent indicated that "there was limited, to no opportunity to share our thoughts" with the notion that published papers might find their way into decision making echelons,

***"and then maybe [they would] reach out to us and listen to us, and probably see if our opinions had any merits whatsoever" (academic respondent).***

The most referenced study by respondents was a costing study for COVID-19 treatment; no comparative study was done to understand the additional cost of delivering essential MNCH services and effects on utilisation patterns.

# Enable Stakeholders



Adverse practices were displayed in the health sector (both public and private) but with little intervention by government. This included cost of essential medicines and equipment, sourced through the open market, "with increased demand, and a limited supply, certainly the prices went up...we do not have a law on price regulation, and therefore, even the monitoring was not done" (umbrella organisation respondent). Supply and cost constraints affected the availability and affordability of essential health products and services in the private sector, including for MNCH. Quality was rationed, for example, routine tests as part of antenatal care were not done because women could not afford them. This situation did not prompt government intervention. However, government did respond to pricing of COVID-19 treatment services when this gained media attention and resulted in public interest litigation.

***"It was hot, and the bills were going up in the sky, but the public sector were also constrained so they couldn't put the blame on the private sector. Calls for reform came from the consumers, including some parliamentarians, some of the women activists. Parliamentarians wanted to table a bill, regulating the pricing of the private sector in the wake of COVID-19." (private sector respondent)***

While there is a Uganda public-private-partnership for health policy, there is no regulatory framework for the private health sector nor were reforms introduced to improve access to care. Formal debate ensued on regulation as a result of media attention and litigation, dominated by larger healthcare actors. Amongst the private health sector, there was resistance, "you cannot regulate prices, you cannot regulate the private sector...are you going to regulate prices in [countries], where we buy these things from?" (umbrella organisation respondent). While discussion focused on pricing, private sector registration and qualification were viewed as more fundamental. The lack of regulation of the private sector in health was considered a governance failure, with limited appetite for reform, "the government has failed to do its job... it is quite problematic" (academic respondent). In the view of some government respondents, demand dictated supply as part of a "free market environment".

***"How can people provide such a service as health care, and they set up the work, they go home? Nobody's looking?" (umbrella organisation respondent).***

***"The 'hidden sector' plays according to the market forces, which is detrimental to the users of the services, they get substandard care, depending on how much they can afford. And you can't measure treatment in kilograms, it is an episode that needs treatment, it shouldn't be rationed based on ability to pay" (academic respondent).***

# Nurture Trust



The national COVID-19 response was not guided by the demand side, the needs of the population. Due to the emergency context, the population, particularly the poor in urban areas, “often feel desperate and that’s why they go out and pay for any kind of services” (umbrella organisation respondent). Self-guided navigation of the health system was considered normal, “they’ll vote where to go. Given what they find in the services, they just move” (international organisation respondent). In rural areas, the health system was viewed as less chaotic and mainly reliant on the public sector.

Within the spectrum of MNCH, some services were more politicised and prioritised than others. Civic and media attention was needed to prompt intervention,

***“maternal health is political in Uganda and so many civil society organizations were making noise. If there is a problem in reduction of services, they bring it out in the newspapers” (international organisation respondent).***

Other issues elicited reaction: missed childhood immunisation schedules and concerns with re-emergence of disease; a wave of teenage pregnancy in the wake of COVID-19; and greater reliance on self-medication and informal providers, were some that were mentioned by respondents. The secondary effects of COVID-19 on MNCH were reportedly downplayed, “if you talk to a government person, they want to paint a very positive picture” (umbrella organisation respondent), limiting frank discussion and proactive intervention. Conflicting information and the lack of “hard data” may have contributed to this.

***“But when you look at the indicators, did maternal mortality in these districts go up? Did under five mortality go up? ...then we can sit down and have a conversation...” (government respondent).***

***“So, the population decided to go to the private sector, and the private sector was damn expensive. So many people died. Information is not up to date, but they died” (academic respondent).***

A blame game emerged; media and civil society blamed government and the private sector in health, national government blamed local government, national government blamed civil society and the media for stirring outcries. Effective dialogue was recognised as necessary so that protagonists, including the population, were not “squeezed into corners.”

***“If we would have listened to each other more, we could have achieved a lot more in the beginning. With practical suggestions, you can make a lot of changes” (umbrella organisation respondent).***



# Deliver Strategy



COVID-19 provided impetus to learn and improve, to deliver essential MNCH services more coherently, to re-think, redesign and regulate the health system. There was recognition that the private sector in health was a key player, “and they should be supported. That capacity should be built to complement and supplement government service delivery” (government respondent). Equally, there was recognition that the private sector in health was amorphous, “public health is not just how many outlets you have, but what do they do?” (academic respondent). There were comparisons made to the non-health private sector “which everybody loves, because they have a lot of money, they make donations...the health private sector just doesn’t have the elasticity...we’re not actually even making money on a good or bad day on essential health services” (umbrella organisation respondent). There was recognition of the need to rethink base assumptions about the private sector in health, to break down the ‘hidden sector’ into its component parts, to understand capacity and motivation of component entities, and encourage or constrain entities based on this understanding.

***“People will always tell you, the PPP framework, everybody will talk about public private partnerships, but they’re not there...we’ll talk about it, we’ll laugh about it, we’ll smile about it, but I just don’t see it happening” (umbrella organisation respondent).***

There was also recognition of the need to redesign the health system, to leverage capacity of the whole sector as a matter of routine, not event, “once the government feels that they can’t do it anymore, then yes, maybe we’ll let you [the private sector] try. But, you know, the minute the things stabilize, then you’re out again” (umbrella organisation respondent). While responsibility was seen as sitting with the private sector in health to “clean up its house, to get better mobilized, better organized and set up structures” (government respondent), there was recognition of the need for this to be stewarded by government. Equally, there was recognition of the need to get the public sector house in

order, to make it more accountable, more responsive, to create an “an osmotic shift” and a realignment of the private sector. It was recognised that this shift needed financing and regulatory reform to drive it.

***“You may find some of these backstreet clinics, placentas are being dropped into pit latrine, just to give you an example. But if you have a checklist and a team that comes to inspect and you’re not to fail, for you to be accredited, you’ll have to put things in line” (government respondent).***

COVID-19 prompted a revisit of stalled reforms. Foremost, it was recognised that this should be guided by population need, irrespective of sector, “I think government should plan in some skill sets that are available, they don’t have to be in the public sector” (government respondent). Those mentioned focused on alternative financing for the healthcare system, the use of strategic purchasing and the development of an essential health care package, discussions that had been “put aside, but because of the pandemic, were revitalized” (private sector respondent). Immunisation catch up campaigns were seen as a potential focus for reform and strategic engagement with private health providers. The adolescent health policy was also reportedly back on the policy table after years of remaining in draft form, “it had stagnated before COVID-19, it is right to ensure that this policy is concluded because I think number of people saw the challenge” (umbrella organisation respondent). The newly created MoH adolescent health division was seen as demonstrating the intent of government to see adolescent policy endorsed and enforced. Momentum for reform and greater public-private engagement was considered an opportunity that needed to be seized.

***“I think what we are facing right now is not lack of learning opportunities, those are happening...I think the problem is lack of the political will, at the Ministry of Health, but also above it [the high office] to prioritize access of essential healthcare services” (international organisation respondent).***

# Discussion

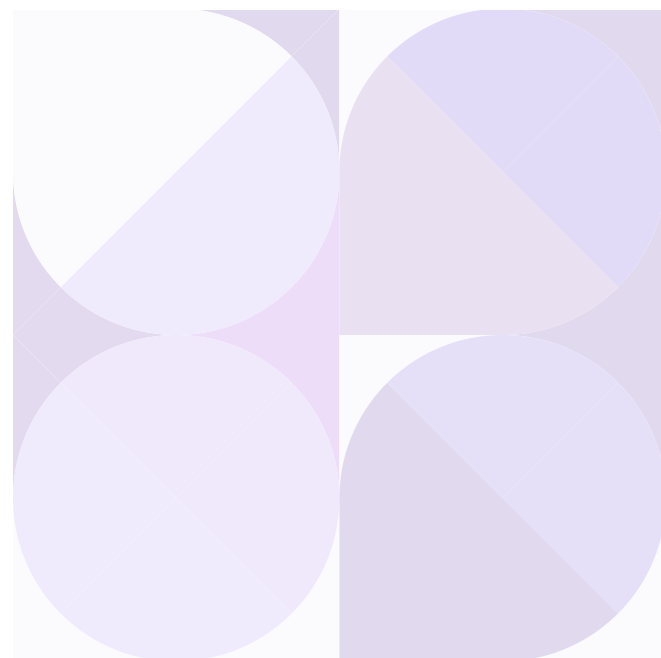
The study sought to examine how the private sector was engaged to support the delivery of MNCH services in Uganda during the COVID-19 emergency, using the WHO governance behaviours as an analytical framework. The findings of the study suggest that Uganda has an opportunity to 'build back' and nurture trust in the health system eroded by COVID-19 pandemic, by harnessing all health sectors to maximize efforts in providing MNCH services for all.

Based on the responses of the 18 respondents, the following have emerged as key opportunities for Uganda to leverage private sector capacities for public health goals and to strengthen health system's responsiveness and resilience:

- **Private sector engagement should be focused on a specific and tangible health problem.** There is need to get down to details, "to move beyond the talk, to walk the talk" (private sector respondent).
- **Problem identification should start from a planning perspective and develop models of engagement between the public and the private oriented to population health,** "right now, people are looking at the provider, but not looking at the population that they serve. I think we need to go back to the basics of public health" (academic respondent) This should take a primary health care (PHC) approach.
- **Use policy windows (such as COVID-19) to reframe the role of the private sector in health, accompanied by legal, regulatory, and institutional instruments,** "there is need to work together to say this is what accountability looks like" (umbrella organisation respondent). Foundational to this, would be the development of a master facility registry and minimum reporting standards through the national health information system, as a matter of routine.
- **Establish the fair cost of delivering an essential MNCH service package as a basis for standardisation in the private sector to address erratic patient pathways and continuity of care,** "trying to

bring standards to the private sector is good for the private sector and it's good for the community, it's good for the government, and it's good for funders" (academic respondent).

- **Strategic purchasing could provide opportunity for testing reform and addressing sectoral integration.** This could be framed around a specific MNCH 'problem', such as immunization catch-up, given that this is seen as a particular issue amongst the urban poor and a current focus of public-private engagement.
- **In the longer-term, strengthen e-governance and address the "narrow digital footprint".** This would allow for a shift from "trickle down" sectoral communications to more efficient and transparent platforms, accessible to a range of health entities and healthcare users.
- **The MoH should steward engagement and address fragmentation between sectors and partner initiatives,** "the mandate to provide health to the citizens is with government...this should not be abandoned to the private sector" (umbrella organisation respondent).





# Conclusion

How accountable a country's health system is to its population depends to a large extent on the degree of accountability between the public and private sectors. Where there is inadequate accountability, a culture of mistrust and 'blame shifting' may exist. This has been the experience in Uganda. Learning from this experience and impetus to reform should be seized.

As a follow-up to the study, the authors propose to convene a Ugandan multi-stakeholder workshop to validate findings from the case study, to further distil insights and policy recommendations. The output of the workshop may result in the formulation of a policy brief to improve engagement of the private sector for the delivery of MNCH services in Uganda.



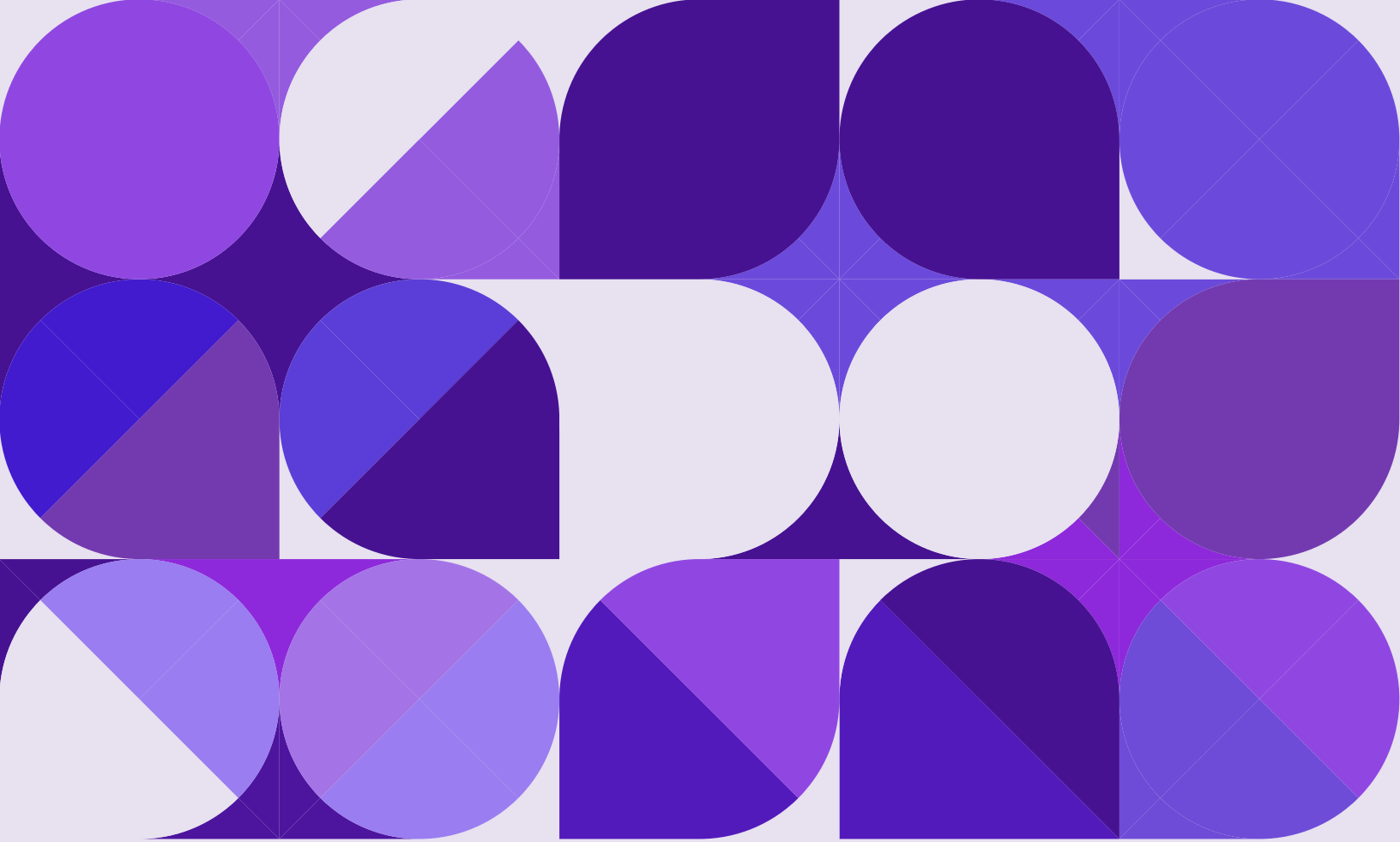


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# Annex: Interview Guide

1. Can you provide a brief summary of your role (optional: and that of your organisation)?
2. **[foster relations, deliver strategy]** How was coordination of the COVID-19 response undertaken?
  - Was the private sector involved? Were all critical voices represented? Were any left out? [probe: primary health care]
  - Did the pillar structure provide for adequate attention to the continuation of essential MNCH services?
  - In general, how do you think coordination structures have functioned? Have they facilitated communication and collaboration?
3. **[align structures]** How has the private health sector been involved in the provision of essential MNCH services as part of the COVID-19 response in your country?
  - How has MNCH service capacity been addressed? (In the public and private sectors, including services and supply chains)
  - How have MNCH services been adapted? What prompted adaptations? (In the public and private sectors)
  - How were service trends affected by new waves of transmission?
4. **[nurture trust, enable stakeholders]** Were adverse practices displayed by some segments of the health sector during the COVID-19 response in relation to essential MNCH services? [probe for specific examples]
  - Did these emerge over time, in response to emergency peaks in demand?
  - What were the root causes? What were the consequences?
  - Were there public channels available for reporting adverse behaviours and opportunistic practices? [probe examples]
  - How did government act upon such information?
5. **[build understanding]** How were essential MNCH service data and trends communicated across sectors and levels of the health system during the COVID-19 response?
  - How did data and information inform decisions in relation to the provision of essential MNCH services?
  - What other data and information sources were available/used during COVID-19 to inform the provision of essential MNCH services? [probe: the use of studies and assessments]
6. **[enable stakeholders]** What measures (regulations, financing reforms) were introduced by government to address access to essential MNCH services? [probe: if any inputs or subsidies were directed towards the private sector]
  - How was the private sector involved in the development and implementation of such measures? [probe: role of intermediaries, ability to shape regulation, etc]
7. **[nurture trust]** How was equity considered as part of the response/access to MNCH essential services?
  - How were the needs of specific populations catered for as part of the response?
  - How was affordability addressed/monitored?
  - How were consumer concerns communicated?
  - How did government act upon such information/concerns?
  - Were perspectives of frontline service providers (public and private) considered as part of the COVID-19 response?
  - Overall, do you think the response instilled trust in the health system?
8. **[deliver strategy]** As part of emergency preparedness and response, how could the organization of essential MNCH services be improved going forward?
  - What learning emerged from the response?
  - What policy changes are needed, if any?
  - What regulatory and financing changes are needed, if any?
  - What role should the academia/the private sector play?
  - What role should the public/consumers play?
9. Do you have any other recommendations and lessons for private sector engagement in essential services for other countries/regions?
10. Do you have any final comments or questions?



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