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Challenges and opportunities in engaging health development partners in district health planning in Uganda: an exploratory qualitative study

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ABSTRACT

Objective This study aimed to explore the challenges and opportunities in engaging health development partners in planning healthcare services at a sub-national level in Uganda.

Design An exploratory qualitative study involving selected health development partner organisations and district local governments.

Setting A study was conducted in Northern Uganda, specifically in 12 districts that comprise the Lango and Acholi sub-regions. The study area has many health development partners compared with the other regions in the country.

Participants A total of 18 participants were enrolled in the study. To be considered for inclusion, a participant had to be working for a district local government in Northern Uganda and involved in planning health services or working for a development partner supporting health services in the region. Most of the participants were men aged between 41 and 50 years.

Outcome measures Factors that affect the involvement of health development partners in planning health services at sub-national levels and opportunities that can facilitate involvement.

Results The findings show that health development partners serve as a source of information and data, guide the planning and supervision of services, conduct community mobilisation and support infrastructure development. However, differing planning cycles, corruption, power dynamics and budget constraints affect their participation in district health planning. Continuous engagement, even outside budget periods, with respect to the terms agreed upon in the memoranda of understanding (MOU), equitable treatment of all partners and transparency from all parties emerged as opportunities to improve involvement.

Conclusion The involvement and importance of health development partners in planning district-level health services cannot be overstated. Therefore, addressing the challenges that hinder joint planning through a focus on open communication, mutual respect and adherence to the terms of the MOU can improve working relationships.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ Recruitment of participants from 12 districts in Northern Uganda, a region with a considerable concentration of health development partners (HDPs), enabled tapping into diverse voices, resulting in a representative dataset.
⇒ Collecting data from HDPs and district health management teams enabled triangulation, resulting in a broad range of perspectives and reduced bias.
⇒ However, relying solely on qualitative data may have limitations like strategic disclosure.

INTRODUCTION

The decentralisation of the health sector has been identified as a key factor in delivering better health services in developing economies.[1] In decentralised systems, giving responsibility to districts to plan health services can bring healthcare decision-making closer to communities and foster greater openness to community priorities.[2] Over the past three decades, several governments, particularly in Africa, have adopted decentralised health systems, where districts are granted the authority and mandate to plan and allocate resources for health service provision within their respective regions of operation.[1] Since decentralisation extends services to most of the population, it is sensitive to the contextual needs of various communities and promotes equity in healthcare.[3] In Uganda, planning for health services at the district level is primarily the responsibility of district health managers, with support from the Ministry of Health and health development partners (HDPs).[4] The implementation of decentralisation in Uganda has attracted several HDPs supporting different districts' health services based on specific areas of interest.[5] Some of the HDPs are international organisations, such as Plan International and Marie Stopes, while others are domestic, including The Aids Support Organisation and Reproductive Health Uganda. A few are religion-based organisations, like the Uganda Protestant

Medical Bureau. However, despite wide-scale decentralisation of health services in low-resource settings and an increase in the number of support partners, planning and delivery of quality health services in several areas remains a challenge[5] and has been described as ad-hoc and seldom evidence-based,[6] partly due to the lack of tools to aid priority setting and decision-making,[7 8] limited capacity to carry out evidence-based planning among the district health management teams (DHMTs) and the inconsistency in the involvement of HDPs in the planning process.[6]

Collaboration between government and non-government actors has been suggested to improve service delivery and to extend services to areas where they would be hard to access,[9] but the effectiveness of such collaborations demands a partnership approach built on mutual planning and commitment from all actors involved.[10] Support from HDPs is a vital source of funding for health service provision in low-resource settings,[11] but aligning the priorities of the HDPs and the district health teams in charge of planning health service delivery remains a challenge.[3] In studies conducted in Tanzania, factors such as differences in planning cycles between partners and government, lack of transparency and uncertainty of funding from mother donors (organisations like U.S. Agency for International Development that fund some HDPs) were identified as key challenges to a collaborative planning process between HDPs and district health teams.[3 11]

In Uganda, several studies have documented the challenges and barriers to health service delivery in the country.[5 12 13] Limited attention has been paid to exploring the intricacies of the relationships and engagement between HDPs and district health planning teams, along with the challenges and opportunities for joint planning to improve health service delivery. Since the delivery of health services involves multiple actors, identifying barriers to successful engagement and opportunities to enhance participation in district health planning can help strengthen the working relationships among partners, eliminate duplication of services and wastage of resources and result in better use of the few available resources.[3] Effective delivery of health services at the sub-national level requires evidence-based planning, but many district health managers lack the skills to do this independently and need support from expert partners.[4] Therefore, close collaboration between district health teams and support partners is essential to improve service planning and delivery.[4] This study aimed to engage key stakeholders in district health planning to identify challenges to collaborative engagement and planning and to identify opportunities that can enhance the involvement of HDPs in the planning of health services at the sub-national level, thereby improving service delivery.

METHODS

Study settings

This was an exploratory qualitative study conducted in the northern region of Uganda. The region comprises the Lango sub-region, with nine districts, and the Acholi sub-region, with eight districts, totalling 17 districts. We randomly selected 12 districts for participation, with seven from the Lango sub-region and five from the Acholi sub-region. In the Lango sub-region, the selected districts included Alebtong, Dokolo, Otuke, Lira, Kole, Oyam and Apac. In the Acholi sub-region, the selected districts included Gulu, Kitgum, Amuru, Agago and Nwoya. Northern Uganda was an ideal setting for the study because the region has many HDPs supporting the health system in response to the wreckage caused by civil conflicts that lasted over a decade in the area.[14]

Participants

We targeted n=24 participants from the 12 districts for interviews. We contacted each district to share a list of HDPs with a history of participating in district health planning for potential interviews. However, since the names suggested were almost the same across the districts, we aimed for a varied sample of 12 representatives. After recruiting HDPs, we contacted districts to arrange an interview with a representative from the DHMT. 18 participants out of the 24 agreed to participate. The six participants who declined participation cited lack of time as the main reason. However, a sample between 9 and 50 is considered sufficient to reach saturation in an exploratory study.[15] Thus, we were still within the recommended range of interviews for an exploratory study and were confident that we had sampled HDPs and DHMTs appropriately and captured a representative dataset. Recruitment started on 2 February 2023 and ended on 1 March 2023. Participants were contacted either face-to-face or by phone using telephone contacts provided at the district level. The criteria for inclusion were working for a district local government in the study region or for an HDP, being involved in the planning or delivery of healthcare services, being 18 years of age or above, and being willing to provide written informed consent.

Data collection, management and analysis

Data were collected through one-on-one, in-depth interviews conducted with the participants. The interviews were conducted by two female members of the research team, EBN and RFM, who hold master's degrees in public health and are career researchers. The interviews, which lasted between 40 and 50 min, were guided by a semi-structured interview guide developed by the research team and piloted with a DHMT in Eastern Uganda. Sample questions in the interview guide include "*Does your organisation get involved in planning health services at the district level? If yes, how do you participate? Are all HDPs in your area of operation involved in district health planning? If not, why? What are the considerations of having a health development partner involved in district health planning?*

What needs to be done to have all partners involved in planning health services at the district level?"(online supplemental text S1). Interviews were conducted in English and were audio recorded. Participants' consent was obtained before recording. All 18 interview recordings were transcribed verbatim by two research assistants at a master's degree level. The lead researcher, KM, who holds a PhD in health sciences, sampled the transcripts, listened to the accompanying audio recordings and reviewed field notes to ensure accuracy and consistency. Participants also read through their transcripts to ensure there was no misrepresentation. Once the transcripts were tested for accuracy, data analysis began.

Two research team members, KM and GCR, inductively analysed the data in six steps. First, they read through all the transcripts to familiarise themselves with the data and identify relevant demographic information. In step 2, the analysts selected two transcripts, which they independently open-coded to generate initial codes. In step 3, the analysts reviewed and discussed the emerging codes, defined and agreed on the code definitions and developed a set of final codes to be used for the final analysis. In step 4, the analysts developed an analysis framework, which was then applied to the remaining transcripts. In the next step, the analysts used ATLAS.ti, version 23, to analyse the remaining transcripts. The analysts, however, remained open to including other codes that emerged as the analysis proceeded. Given that new information was still being revealed by the 16th transcripts, we opted to analyse all 18 transcripts. In the final step, once the analysis was completed, the interpretation of the results commenced.

Trustworthiness of data

We employed several techniques to ensure the validity and reliability of the study results. First, the development of the data collection tool, specifically the interview guide, was supervised by an expert in qualitative research. Second, the study team kept close contact with the participants after transcribing. Participants had a chance to review their transcripts to ensure there was no misrepresentation. Furthermore, to enhance the credibility of the results, the data collection team attended two training sessions on interviewing participants before deployment. This level of preparation ensured that every team member was sufficiently competent to collect high-quality data. Relatedly, we also held daily debriefs after data collection to discuss the process and share experiences. Furthermore, to ensure that our findings can be replicated, we developed a detailed codebook that guided the analysis and is available on request. Finally, to enhance the transferability of the study results, we worked within the recommended range in which saturation can be achieved and believe our results to be generalisable to other settings.

Patient and public involvement

The study did not involve patients, but the public was at the centre stage. We worked closely with the participants to incorporate their feedback into the research proposal. As a requirement by the Uganda National Council of Science and Technology, we obtained administrative approval from potential participating organisations before data collection. We designed a summary proposal, which we shared with all 12 participating districts, and they provided their input before granting approval letters. Furthermore, we piloted the interview guide in a nearby district involving both DHMTs and selected HDPs, and the feedback guided the refinement of the tool. Our initial plan was to collect data through focus group discussions, but stakeholders preferred interviews because they believed this approach would elicit deep-seated opinions, and this is what we ultimately settled on. Furthermore, the districts guided us on the HDPs to approach for participation, as identified in their database, who had a history of involvement in district health planning. Finally, we agreed with all participants to hold a joint dissemination workshop where they could hear the results.

FINDINGS

Characteristics of the participants

The age ranged from 30 to 54 years old, with a median of 41.5 (SD = 7.10); 10 individuals were identified as males and eight as females based on the sex assigned at birth. 11 participants were working with HDPs, whereas seven were working for local district governments. The majority held a bachelor's degree as their highest level of education (n=12). Participant characteristics are shown in table 1.

From the data analysis, three themes emerged: forms of involvement, challenges to participation and chances for improving involvement. The study findings are reported in accordance with the Consolidated Criteria

Table 1 Sociodemographic characteristics of the participants

Demographic characteristic	N	%
Sex		
Female	8	44
Male	10	56
Age (years)		
30–40	7	39
41–50	8	44
>51	3	17
Highest educational level		
Bachelor's degree	12	67
Master's degree	6	33
Organisation		
HDP	11	61
DHMT	7	39

DHMT, district health management team; HDP, health development partner.

Table 2 Themes and codes identified from the analysis

Theme	Code
Forms of involvement	Information and data support
	Human resources support
	Monitoring and supervision of services
	Infrastructure development
	Planning health services
	Financial and technical support
	Specialised healthcare
	Community mobilisation
Challenges to participation	Coordination and cooperation
	Poor planning
	Differing interests
	Lack of transparency
	Planning cycles
	Budget constraints
	Power plays
	Corruption
Chances for improving involvement	Regular engagement
	Proper coordination
	Communication
	Realistic expectations
	Mutual respect
	Sticking to the memorandum of understanding
	Equitable treatment of partners
	Transparency

for Reporting Qualitative Research, organised under three themes, as shown in table 2.

Forms of involvement

The study findings indicate that HDPs and DHMTs collaborate in various ways to support health services in the districts. The most notable forms of involvement are outlined below.

Information and data support

Participants indicated that HDPs constitute a significant source of information, which is used as a basis for making decisions at the district level. Given their level of operation, HDPs have the capacity and ability to collect day-to-day data in real time and often share these data with the district, as illustrated in the quote below:

> …we share information about the family planning status of the district because every single day we get information first-hand of what is going on with family planning needs, and the unmet needs… (Participant # 1, HDP)

> We have been very close to them, and we have also been supporting each other in the bio-statistical work, and that is the management of the health sector data (Participant #2, DHMT)

Through information sharing, the HDPs and DHMTs discuss pressing issues such as challenges experienced, where there is a need for more support, and map out areas where services are most needed, as stated below:

> …if some sub-county wants something to be done for them either under health or under education or any department, they bring it out, and people discuss it in that meeting to ensure that if partners are willing, they can help us… (Participant #8, DHMT)

Human resource support

Findings show that HDPs boost the human resource capacity of some healthcare centres in districts where they operate. This happens when HDPs deploy their staff to fill the capacity gaps left behind by the districts due to structural challenges or budget constraints:

> We also have key cadres at those facilities that the project has recruited and employed. You know that the government does not have counsellors in their structures, yet implementing comprehensive chronic care of HIV needs a lot of psychosocial care (Participant #6, HDP)

Relatedly, participants indicated that in areas where HDPs cannot deploy their staff, they train and empower healthcare workers who are hired by the district. With this arrangement, the competence of healthcare workers is enhanced, which helps with the delivery of quality services, as shown below:

> …we provide mentorship to health workers, but we first review the data to see where there are gaps, so we mentor them. Some of them could be trained in the use of some of the tools (Participant #13, HDP)

> They also provide capacity to district staff through training to ensure that they provide quality service and ensure that there is effectiveness of service delivery (Participant #3, DHMT)

Monitoring and supervision of service provision

The involvement of HDPs and DHMTs further enhances the integration of monitoring and supervision of health service delivery across districts. The joint monitoring is a commitment to ensuring the provision of high-quality healthcare services in all the district health facilities, as evidenced below:

> They keep moving down to check on the activities done in the district or health facilities and even having community Barraza (meetings) where they ask the community to tell them how they are receiving service (Participant #11, DHMT)

Infrastructure development

Participants further indicated that some HDPs extend infrastructure support to districts through the construction of wards, laboratories and other facilities. The facilities are intended to cover the infrastructural gap that is

found in most health facilities, as reported in the quote below:

> Like here, they built for us a state-of-the-art laboratory. The EU, sometime back around 2011 to 2013, built for us a maternity ward, also ENABEL, is helping us to construct some of the health infrastructure (Participant #2)

On top of infrastructure support, some HDPs also provide materials and health products that are used in the district facilities, as indicated below:

> Commodities like family planning commodities and other health products have been supplied by Marie Stopes and Reproductive Health Uganda directly to the health facilities (Participant #2)

Planning for health service delivery

Furthermore, some participants identified involvement in planning health service delivery as a key area of engagement. This is done either through HDPs sharing their micro plans with the district or sitting in the district planning meetings, as indicated in the quotes below:

> We also have forums where we have to submit our plans to the district so that they can be captured (yes sir) in the district plans (yes sir), but as an organisation, we have to plan for the activities we need to implement, summarise everything and then share with the district to consolidate those plans in the district plan (Participant #9, HDP).

> We have a meeting that is held annually, and we usually call all partners to come and engage with the district in planning (Participant #3)

Financial and technical support

Similarly, participants noted that HDPs, either directly or indirectly, provide financial support to districts. The funds can either cover the wages of some staff or be used to fund specific projects. In addition to financing, HDPs also provide technical support through consultancy in their areas of specialisation.

> As a district, we appreciate funds for wages for employed staff, doctors, nurses and laboratory technicians, etc. Second, we appreciate [the funds] spent on drugs and support in several projects (Participant #3)

> They facilitate our staff in the district by giving money, logistics like chemicals and protective gears and facilitating fuel for transportation. They also assign a consultant to work with us and support us through processes (Participant #2)

Specialised Healthcare support

Some HDPs are involved in providing specialised healthcare in the districts. This can span several areas, such as reproductive health, HIV/AIDS care and mental health, as typified in the quotes below:

> We are involved in the provision of these sexual and reproductive health services directly to the people and then also through the private health workers and government health workers (Participant #1)

Community mobilization

Finally, the HDPs and DHMTs collaborate to conduct community mobilisation for health services. Community engagement takes on different aspects of community life, including economic empowerment and skilling of youth in the community to enhance holistic healthcare, as exemplified below:

> We offer sensitisation because we, as an organisation, always mobilise people, carry out sensitisation, and then we integrate it with the health services on behalf of the district (Participant #9)

> PACE supports mentorship and skilling of young girls, and it has provided hands-on training in terms of tailoring services by targeting schoolgirls (Participant #8, HDP)

Challenges to participation in planning

The second theme emerged from the data related to challenges affecting the involvement of HDPs in district health planning and collaborative working with the DHMTs. The challenges identified ranged from differing planning cycles to budgets and coordination.

Coordination and cooperation

Participants noted that while the DHMTs and HDPs want to be seen as one team, sometimes they act on their own without notifying the others, which can result in duplication of activities or wastage, as indicated in the quote below:

> They may do a baseline study of one or two sub-counties and assume that that's the real picture and use them to generalise the whole district, yet if we participated together, we could tell them case by case (Participant #3)

> Sometimes they pick the health workers without the in charge knowing and go with them and do mentorship in other districts, leaving a gap in service delivery in the lower health facility, and those are the things that we think should be corrected if we are to work together (Participant #10, DHMT)

Poor planning

Relatedly, participants observed that poor planning of operations hinders the ability to work together in delivering health services. This was mainly observed in HDPs who failed to align their work and plans with district timelines, ultimately rushing to complete everything at short notice, thereby creating unnecessary urgency for district leaders. Similarly, the failure of HDPs to share operational reports with the district at times also affects involvement. Improper planning causes delays and impromptu

responses, frustrating each party involved, as shared below:

> You come today, and tomorrow you want to have a meeting, then you rush us around that this meeting is going to be for half a day or 30 min. You put leaders under pressure, yet we have time frames and other engagements, and they don't ask us. We need to share vital reports in advance (Participant #3)

Differing interests

Participants often noted that the primary source of friction between HDPs and DHMTs is their differing interests. While HDPs have funders to report to who define the areas of specialisation, they find themselves in a compromised situation when the district wants to engage them in activities that fall outside their scope and interests, as indicated in the accompanying quotes:

> The partners aren't left out; they're the ones that opt out because they feel like some of their interests aren't going to be covered to help them achieve what they want (Participant #17, DHMT)

> There are other partners who may wish or who may have the will to work with us, but may be due to their level of operation, or interest, sometimes they don't engage (Participant #2)

Lack of transparency

Participants agreed that both parties struggle to work together due to their unwillingness to disclose financial information. The fear mainly came from the DHMTs, who accused the HDPs of intentionally hiding important information from them, which makes joint planning difficult, as typified in the quotes below:

> Others fear to expose their financial strength or financial sources or ability, so they end up hiding information and not turning up (Participant #3)

> They don't disclose, yet that is what we ask them, and we require that they share their work plans not necessarily because we have interest but also for us to understand that this organisation is supporting this area (Participant #17, DHMT)

Planning cycles

Furthermore, participants indicated that the government financial year is different from funders' planning cycles; thus, by the time the DHMTs bring the matter on board, the HDPs would have completed their annual plans, as shown in the quotes below:

> As much as we want, the planning periods of our partners don't tally with that of the government; that's the main reason. You may find that for them, they end in March, and for us, we end in July, so already there is a mismatch (Participant #3)

> Right now, you find that first, these people have two different planning years. Most of the partners, especially USAID, fund their planning years (financial years), which start in October or September, whereas the government of Uganda's fiscal year runs from June to July. In most cases, the parallel planning periods, cycles and activities cause issues (Participant #16, HDP)

Budget constraints

HDPs operate on tight budget lines, which are strictly monitored; therefore, they often do not reserve funds to accommodate district demands, yet the districts remain expectant. Most HDPs do not participate in district health planning because they feel like they have exhausted their budgets and do not see anything to contribute during such deliberations. In contrast, others think they are under donor restrictions to keep finance-related information private, as shown in the quotes below:

> Some of the partners are not very active in the district, and maybe when called on, they don't show up because they are usually overstretched, and when called on, they don't have enough resources to do extra work (Participant #1)

> We have donor restrictions, restrictions of financial information to share and budget, so you cannot participate in the district planning process with these restrictions (Participant #9, HDP)

Power dynamics

Similarly, participants noted that an element of power imbalance affects collaboration and participation. The district leaders intimated that because HDPs have considerable financial strength, they feel obliged to assert superiority and influence in the direction of district affairs. They further indicated that sometimes they do not even listen to the guidance of the DHMTs since they are dealing with higher authorities in government, as indicated in the quotes below:

> When they come here, they want to dominate. District health-led programming means that when the partners come into the district, they are not going to be leaders, but the district will lead and point to them that this is the area that we need your input, that these are the gaps (Participant #15, DHMT)

> Most of these partners come directly from the headquarters, the contract and whatever is done at the higher level, and for us, we only receive the MOU they have come with, but there is not any other negotiation there; even if we give our submission, it's hard for them to change (Participant #11, DHMT)

Corruption

Finally, participants agreed that corruption is another factor that hinders collaboration between the DHMTs and HDPs. Corruption is largely cited from the side of the district and often drives HDPs away, as shown in the quotes below:

If, for example, there is going to be a meeting and I ask you what you are going to give me, will you come back to me again? So the HDPs end up withdrawing because they may not have money to pay CAO, DHO, DPC, Chairman LCIV, etc. (Participant #3)

District officials are too expectant, and they believe that any organisation that comes and reports to them must have money. The district also wants their share (Participant #9, HDP)

Chances for improving involvement

Finally, participants shared insights that they believe can improve the relationship between the HDPs and DHMTs. The insights ranged from continued engagements to transparency, communication and mutual respect.

Regular engagement

Most of the study participants agreed that if the DHMTs can engage HDPs throughout the year and not only wait for the planning period, the relationship will also be strengthened and working together will become easier:

They need to involve us in everything from inception, not just inviting us because it's budget time, and they expect support (Participant #13, HDP)

Constant involvement in the work; then, we move together as a unit. You don't move alone as a district; then you come back to the HDPs (Participant #1)

Proper coordination

Relatedly, coordination needs to be streamlined. Participants shared that the DHMTs need to be intentional about how they interact with the HDPs, and where possible, a focal person responsible for coordinating HDPs should be assigned, as shown in the accompanying quotes:

They need to have a coordination focal person for each of the partners at the district; someone should be in charge of coordinating the partners' activities, other than the DHO himself or herself (Participant #16, HDP)

Districts should ensure that they have regular coordination meetings that'll be able to tap progress of the work the partners are doing (Participant #13, HDP)

Communication

Similarly, the role of communication in strengthening the relationship between HDPs and DHMTs was emphasised. Timely and adequate communication was deemed necessary, and everyone should be involved, as exemplified below:

I think sometimes communication does not go well; yes, a communication gap that needs to be addressed (Participant #18, HDP)

We need to inform them that we need to plan things together to avoid the confusion of implementation; we are doing the same things that they are also doing, and we are picking the same data that they are also collecting (Participant #11, DHMT)

Realistic expectations

Furthermore, the need for the DHMTs to have realistic expectations about HDPs was identified as necessary. Since expectations drive the relationship, the DHMTs should be a little more realistic and only ask HDPs to get involved in matters that align with their scope of operations, as shared in the quotes below:

The district would sometimes want you to do a lot more, which is out of what you have agreed on with the donor. This gets the relationship strained (Participant #1)

So sometimes they ask a partner to do everything like integration of all things (you know) and which is not possible, hence getting in the "bad books" of the district. They will want you to do this, finance that and yet you are unable to (Participant #16)

Mutual respect

The aspect of respect was also emphasised by the participants. This was deemed necessary, especially in areas of communication and conduct, as emphasised in the quotes below:

They say we are slow in almost everything; for them, they are very tough on timelines and deadlines, and the local government system is very bureaucratic, so that is how we are not matching, no need for insults (Participant #11)

When you invite them, they usually come towards the end to sign for their transport refund, and they assume to be too busy. When you want to meet them in their offices, they are not even there (Participant #9)

Equitable treatment of partners

Participants noted unfairness in the ways HDPs are treated and suggested that treating all partners equally regardless of their financial strength and contribution will result in meaningful engagements, as shared below:

Sometimes the district favours certain NGOs, basically because of what they can give the district and leave out the vital ones that may not be giving so much to the district in terms of finances, but when in terms of actual service delivery, they are doing so much (Participant #1)

Sticking to the memoranda of understanding

Related to respect, the idea of keeping to the promises that were signed in the form of memoranda of understanding (MOU) was identified as necessary in improving the working relationship between partners and the district:

The district itself should respect the scope of work of the NGOs and stick to what was signed for in the

memorandum with the district and not expecting much more (Participant #7, HDP)

The district also has to recognise that most of these implementing partners are donor funded, so their scope of work is very well defined and should be respected (Participant #1)

Transparency

Finally, addressing the challenge of lack of transparency from both ends was suggested as a good move towards improving the working relationship. The district needs to properly account for all the support received from the partners, while the HDPs also have a responsibility for disclosing their source of funding and sharing budgets, as typified in the quotes below:

Many of our NGOs don't want to be transparent; they don't want to come clean during the planning process, but you find them in the field, and sometimes, it attracts some reprimand. We need to work this out (Participant #15, DHMT)

We always ask if the district has a reputable experience in handling partner resources. Can they be trusted? Do they have a history of swindling partner resources? So all those factors are important (Participant #13).

DISCUSSION

The purpose of this study was to understand the challenges to involvement and the opportunities to improve the engagement of HDPs in district health planning in Northern Uganda. The study's findings aim to drive discussions on collaborative partnerships between DHMTs and HDPs as a means of improving the delivery of healthcare services in a decentralised system of operation, where health service planning occurs at the district level.

The study revealed that HDPs play a crucial role in delivering healthcare services, and their involvement in district health planning is essential, as they are engaged in activities ranging from data collection to monitoring the provision of specialised healthcare, infrastructure development and planning, and the delivery of healthcare services. HDPs cover areas that the government may not fund due to budget constraints and competing demands. Thus, attempts to streamline the intricate relationship between DHMTs and HDPs serve the public interest.

Beyond identifying areas of participation, challenges to the involvement of HDPs in planning healthcare services at a sub-national level were identified. Factors such as corruption, differences in planning cycles, differing interests, a lack of transparency and power dynamics were highlighted. These challenges were identified as sources of misunderstandings between the DHMTs and HDPs that can affect collaborative planning. Several studies conducted in Uganda have documented challenges to the provision of health services in the country.[5 16 17] Solutions to some of the challenges were identified, including regular engagement between both parties, fostering mutual respect, setting realistic expectations and adhering to the provisions of the MOU signed between the parties. To the best of our knowledge, this is the first study to explore the perspectives of both DHMTs and HDPs regarding the challenges to collaborative planning for health services and opportunities for strengthening collaboration.

Issues of financial mismanagement and a lack of transparency have long impacted the delivery of health services in developing economies, often deterring well-intentioned development partners and compromising service delivery. The evidence from the study highlighted financial management, including differing funding priorities, transparency and corruption as key barriers to joint planning and collaborative engagement between the HDPs and DHMTs. The current findings align with a related study conducted in Tanzania, which identified resource mismanagement, differing planning cycles and misalignment between recipient needs and the partner's priorities as some of the reasons for the low engagement of HDPs in healthcare planning.[3]

Relatedly, coordinating partner activities while integrating district priorities seemed to be a point of departure when attempting to conduct integrated planning. Unfortunately, the lack of clear direction limits the ability to address the most pressing community needs. This study's findings are supported by the literature, which indicates that poor coordination and selective interests between HDPs and district leadership disrupt the delivery of services, deny the target community the needed benefits and encourage the duplication of services, resulting in wastage.[11] Any form of collaboration that drives service delivery thrives on proper coordination. Thus, efforts to streamline coordination must take centre stage in any partnership. Designing a function allocation chart is one approach that has frequently been mentioned in the literature as a tool for mapping collaborations and activities.[18] This chart is a visual representation of all activities available in the district. On consultation and continuous engagement with the HDPs, the DHMTs can allocate activities on the chart to the HDPs, and the parties retain responsibility for monitoring the chart throughout the operational cycle. This approach can help streamline inconsistencies that arise from back-and-forth communication.

Another significant challenge that makes joint planning difficult, as identified by the study, is the difference in the planning cycles. District local governments follow the government financial year, which ends in June and starts in July. In contrast, most HDPs run cycles that either end in March or September, and these cycles are determined by the parent funder, making adjustments difficult. Thus, collaborative planning will require innovative participation, which is cognisant of this reality. Since aligning the planning period is not within the control of stakeholders, using internet-powered

platforms or systems that facilitate access to information from both sides can enhance planning outcomes. Several participants highlighted the lack of timely information as a significant obstacle to the planning process. Working with an information support system that is jointly updated and accessed can help address this problem. In a related study conducted in Tanzania, using web-based aids in planning was appraised as a solution that accelerated knowledge sharing in planning sub-national healthcare.[3]

Future initiatives that prioritise flexibility as a means of creating an enabling environment for collaborative engagement, while respecting operating realities, are also encouraged.[19] The study findings, however, do not align with the literature, which indicates that in some regions of the world, the planning of health services can occur smoothly even when collaborating partners have differing planning cycles. The authors suggest that the DHMTs need to develop competencies to manage and integrate the differing planning cycles into the broader district health planning.[20] Nevertheless, each context is unique, and what works in one region may not necessarily work in another.

The findings suggest that to improve collaborative planning, mutual respect between the HDPs and district health teams is necessary. Respect encompasses a commitment to the interests outlined in the MOU, being accountable for both resources and time, communicating properly and listening to one another. The DHMTs are responsible for guiding operations in the district as representatives of the government in a decentralised system. At the same time, the HDPs bring in resources and expertise to fund areas where the government is falling short or complement available care services. While this relationship may appear straightforward and suggest balanced power relations, the findings revealed that aspects of disrespect often emerge. First, the DHMTs occasionally exceed their powers and attempt to force HDPs to operate outside the scope of the MOUs signed. The HDPs also use their financial strength and try to dictate the direction of operations at the district level.

Collaborations thrive on mutual respect; thus, if district health planning is to be improved, both parties involved should be intentional and committed to respecting one another. One intervention that can improve communication and respect is organising stakeholder forums where accusations and blame can be openly discussed and misunderstandings can be resolved. From the findings, it was evident that DMHTs and HDPs were not meeting often until the planning cycle was due. In a Tanzanian study, stakeholder forums enhanced collaboration between development partners and local district governments and were viewed as avenues for resolving differences.[3] The study findings are further supported by a systematic review of the literature, which identified mutual respect and continued dialogue as opportunities for improving collaborations between government and non-government actors in planning health services.[9]

Strengths and limitations of the study

A key strength of this study is its generalisability. Recruitment of participants from 12 districts in Northern Uganda, in a region with a considerable concentration of HDPs, allowed us to tap into varied voices and capture the unique experiences of different DHMTs, resulting in a broad range of perspectives and a representative dataset. Thus, the study's findings can be applied beyond the study area. Second, collecting data from both sets of stakeholders (HDPs and DHMTs) resulted in more balanced findings. Studies that focus on a single group of stakeholders often yield results that are biased. Therefore, being able to triangulate enhances the credibility and validity of our findings.

Notwithstanding these strengths, this study had limitations. Foremost, being a qualitative study that relied on the subjective experiences of people interviewed, it was susceptible to response bias. Participants could have shared information that gave a positive image of the sides they represented or shifted blame. Nevertheless, given that both sets of stakeholders were involved, we assume we made a balanced representation. Relatedly, although we aimed to have equal representation from both sets of participants, in the end, more HDPs were interviewed compared with DHMTs, which could potentially influence the results by leading to biased findings. However, according to Morse, a minimum of six participants in a targeted population is adequate to give a representative voice in a qualitative study.[21] Thus, since the DHMTs that participated were more than six, our results can generate valid and unbiased conclusions. Although the study has some limitations, it offers a starting point for meaningful engagements between HDPs and DMHTs.

CONCLUSION

Engaging HDPs in planning health service delivery at the district level is at the heart of improving access to and the quality of services for end-users. While HDPs have their priorities, working with the DHMTs in planning services will result in a more intentional and rational use of the limited available resources, reduce duplication of services and extend service provision to those most in need. Addressing the challenges that hinder joint planning through a focus on open communication, mutual respect and adherence to the terms of the MOU can enhance working relationships.

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Contributors KM conceived the study, reviewed the literature, participated in designing the data collection tool, led the data analysis and drafted the manuscript. EBN led data collection, participated in data analysis and coordinated the study. RFM wrote parts of the manuscript and contributed to data collection and transcription. JN collected data and contributed to the drafting of the manuscript. GCR identified funding for the study, coordinated research activities and participated in drafting the manuscript. KM is the guarantor.

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Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by The study received ethics clearance from the Makerere University School of Social Science Research and Ethics Committee (MAKSSREC-03-2022-535 and the Uganda National Council for Science and Technology (HS2314ES). The study also obtained administrative approval from all 12 participating districts. We also explained the study's objectives to all participants and obtained their written informed consent before collecting data. Participants were compensated US $13 for their participation, equivalent to 50,000 Ugandan shillings. To protect their privacy, they were assigned study numbers to replace their names and any other personal identifying information during the analysis and reporting of results. Participants gave informed consent to participate in the study before taking part.

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