

Utilizing the Potential of Formal and Informal Private Practitioners in Child Survival in Uganda

Situation Analysis and Outline for Developing a National Strategy

The Republic of Uganda, Ministry of Health, Integrated Management of
Childhood Illness (IMCI) Unit

August 2001



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Executive Summary

In Uganda, the infant mortality rate is 99 and the under-five mortality rate is 162, with malaria, acute respiratory infection (ARI), diarrhea, measles, and malnutrition causing most of mortality. Less than half of the 20 million population has access to governmental health services. The Integrated Management of Childhood Illness (IMCI) has been selected as the main strategy to reduce under-five mortality. IMCI, however, has focused on improving case management at public health facilities, while caretakers overwhelmingly prefer to seek care for their sick children from a range of formal and informal private practitioners.

This situation analysis revealed that the sources of outside home care for children with fever, acute respiratory illness (ARI), and diarrhea are mainly private clinics, drug shops, ordinary shopkeepers, and pharmacies. While laws to regulate private practitioners' exist, the capacity of the government regulating councils and authorities are limited. It is estimated that about 65 percent of private practitioners are not registered. Even when registered, drug shops and private clinics are often operated by unqualified staff. The quality of case management offered by private practitioners for childhood illness is poor, with major deviations from the national clinical standards for malaria, diarrhea and ARI. Despite this poor quality, the public's perception to private practitioner's services is favorable. Formal and informal private practitioners are accessible, courteous to their clients, have medicine, and will dispense it on credit.

Reaching private practitioners with messages and interventions is challenging, especially the informal practitioners in remote rural areas. Identified channels to contact private practitioners include: professional associations, non-governmental organizations (NGOs), community-based organizations (CBOs), district health teams, pharmaceutical companies, drug distribution networks and mass media.

In Uganda, a number of on-going or planned interventions attempt to improve the quality of care given by private practitioners; however, these attempts are limited and do not form a cohesive strategy. This situation analysis has identified important information gaps that need to be filled to help develop a national strategy. It is recommended that the national strategy have two components to improve the effectiveness of case management of childhood illness offered by formal and informal private practitioners: a policy component to review regulations, registration procedures, limitations to enforce regulations, and apply modifications to close the existing gap between regulations and practice; and a field intervention component to develop and test effective and sustainable interventions at a large scale. Adopted interventions need to consider other countries' experiences, particularly a focus on improving private practitioners' actual practices, not just knowledge and use of innovative techniques of persuasion and negotiation for behavior change.

Introduction

In Uganda, the integrated management of childhood illness (IMCI) strategy has focused on improving case management at the public health facilities, however, undeniable evidence shows that caretakers overwhelmingly prefer to seek care for their sick children in the private sector.

This paper documents a situational analysis conducted in Uganda on the role of formal and informal private practitioners in child health. This situation analysis looked at policies regulating the practices of formal and informal private practitioners, their role in child health, the extent of practice and distribution of these practitioners in Uganda, the channels for contacting formal and informal private providers, and various partners and their potential role.

The situation analysis reviewed relevant documents including policies, national health strategies and plans, and existing studies. Discussions were held with Ministry of Health (MOH) officials from different departments and projects such as professional councils, Roll Back Malaria, National Drug Authority, Public Private Partnership Unit (PPPU). Discussions were also held with WHO, UNICEF, USAID and its contractors, district health staff (Ntungamo and Kiboga districts), selected NGOs, such as Africare and Red Cross, and selected formal and informal private practitioners.

The purpose of this situation analysis was to discuss the results with stakeholders in Uganda and to draft an outline of a strategy for including private practitioners in child survival programs.

Background

Health status

Uganda, with a projected population of 20.4 million, the greatest majority of which live in rural areas, experiences an annual growth rate of 2.5 percent. Poverty remains high with an annual GNP per capita of US\$ 300; approximately 46 percent of people live in absolute poverty. Poverty is recognized to be the underlying cause of the poor health situation in the country. Associated factors are the low level of literacy and the high prevalence of communicable diseases. The country is divided into 45 districts. Districts are further divided into counties, sub-counties, parishes and villages. There are 40,000 villages. Geographic access to public health care has been limited to 49 percent of the population, i.e. those living within five kilometers of a health service unit. Rural communities are particularly affected because health facilities are mostly located in towns along main roads. There are marked variations in the access to health care both within and between districts, ranging from 9 to 99 percent. There is a national plan to expand governmental health facilities to improve access, yet this plan has not yet been implemented.

Other major problems in the health sector are related to health care organization, management and financing. In the past, the Uganda health sector was characterized by highly centralized management and authority. While this problem is now being addressed by devolving power to local governments, the sector is inadequately funded. Total per capita health expenditure ranges from \$7 to \$12, with only \$3.95 attributed to government and donor spending and the balance coming from individual out-of-pocket payments. Furthermore, available resources are currently inefficiently allocated within the sector since more than 63 percent of the recurring budget and 54 percent of trained staff are concentrated in hospitals. The inefficient distribution of human resources and low staff morale, arising out of poor remuneration, hinders the effective implementation of health programs (1). Table 1 presents selected health indicators in Uganda as compared to sub-Saharan Africa as a whole.

Table 1: Selected health indicators in Uganda compared to sub-Saharan Africa

Health Indicators	Uganda	Sub-Saharan Africa
Life expectancy at birth	42 years	51 years
Infant Mortality (per 1000 live births)	99	104
Under-five mortality (per 1000 live births)	162	169
Underweight prevalence in under 5	26%	30%
Maternal mortality (per 100,000 live births)	550	975
Total fertility rate	6.6	5.5
HIV prevalence (15-49 years old)	14.5%	8.8%

Source: Gabra M., December 2000, adapted from World Development Report 1999/2000, World Bank and HIV/AIDS Statistics and Features, 2000 (UNAIDS).

Infant and under-five mortality trends and causes

In Uganda, the infant mortality rate decreased, between 1991 and 1995, from 122 to 97 and the under-five mortality rate decreased from 203 to 147. The main causes of under-five mortality are summarized in Table 2.

Table 2: Main causes of under-five mortality in Uganda

Malaria	25%
Pneumonia	10%
Diarrhea	13%
Measles	6%
Malnutrition	54% (underlying malnutrition associated with other diseases)
Other causes	32%
HIV/AIDS*	6%

Source: UNICEF, Situation Analysis for Women and Children 1988; Pelletier, Bull WHO, 1995; 73.

* Source: Adome, Popular Pills, 1996.

Health policy and status of IMCI strategy in Uganda

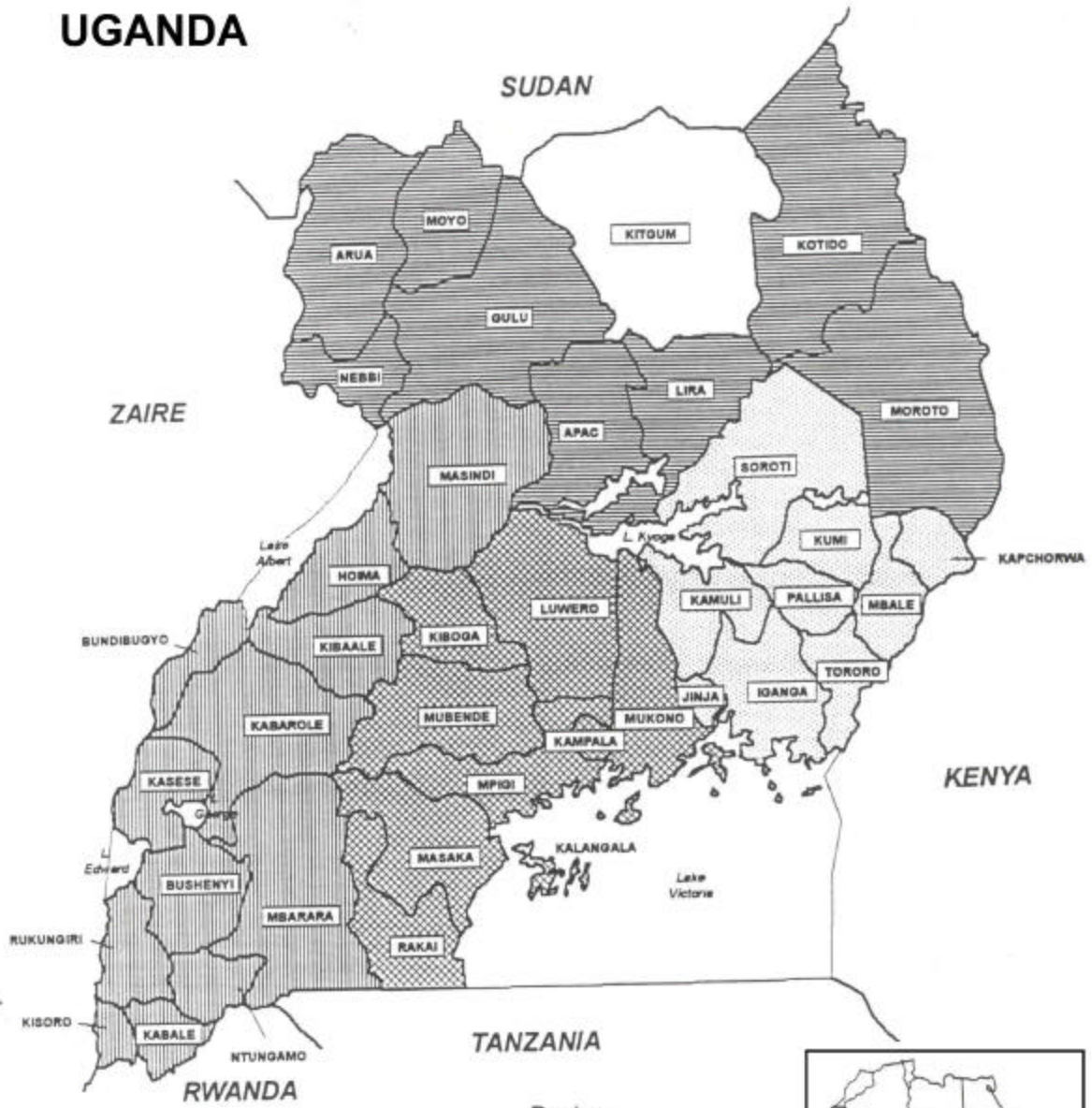
The Ugandan government's health policy focuses on health services that are demonstrably cost-effective and have the largest impact on reducing mortality and morbidity. The government also intends to encourage and support the private sector's participation in all

aspects of the National Health Policy. This includes assisting to private providers to become established in areas not effectively served by public facilities. In this manner, more people have access to health services and private providers are not competing with public services (1,2).





The IMCI strategy has been adopted to reduce infant and childhood mortality further and promote child health. Its introduction in 1995 was followed by early implementation in three districts: Kampala, Mukono, and Masaka. In 1997, after a WHO review, the expansion phase started gradually; expansion to all districts followed a second WHO review in 1999. Currently, all 45 districts are included in the IMCI strategy.

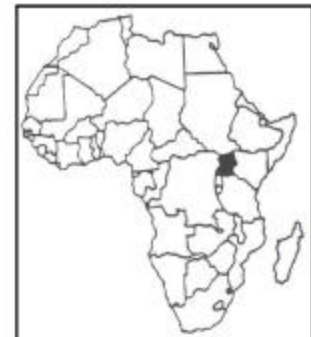
IMCI focuses on three components: training, systems, and community approaches. The target is to train a critical mass (60 %) of health workers. To date 6000 health workers (approximately 43%) have been trained in IMCI. To accelerate the training schedule, the IMCI unit is considering two innovative approaches: contracting the training to Makerere University, and testing a shorter (6-day) training course instead of the typical 11-day course. The Drug Management for Childhood Illness tool (DMCI) was selected to be the basis for investigating and improving the availability of essential drugs needed for the IMCI strategy. The community IMCI component was introduced in 1998 when guidelines and IEC materials were developed. Community IMCI was implemented in three districts: Kiboga, Mukono and Masaka and expansion is planned in 6 UNICEF-supported districts: Ntungamo, Mbarara, Kabarole, Bundibugyo, Kibaale, and Kasese.

UGANDA



TANZANIA

- Region
-  Central
 -  Eastern
 -  Western
 -  Northern
 -  Part of Northern not surveyed



Findings from Situation Analysis

Sources of care for common childhood diseases

In Uganda, 60 percent of caretakers sought care outside the home for childhood diarrhea and acute respiratory infection from the following sources: informal private provider (24%), NGO clinic (18%) and government clinic (18%) (3). A more recent extensive study involving 14,000 households revealed that the sources of care outside the home for sick children in Uganda were: public and NGO health facilities (17%); private clinic and pharmacies (41%); and shopkeepers (38%) (4).

A recent literature review of malaria treatment revealed that in peripheral Kampala, ordinary shops and drug shops are the source of drugs for 80 percent of cases. A study in Kabarole district revealed that in rural areas, 51 percent of households obtain malaria drugs from shop vendors and other informal practitioners and 20 percent from health centers. In urban areas, 41 percent of households obtained malaria drugs from health centers, 33 percent from private clinics, 21 percent from drug shops and drug vendors. Another study conducted in the districts of Mbarara, Tororo, and Arua observed that 37 percent of households obtained drugs from ordinary shops, 15 percent from drug shops, 15 percent from private clinics, 14 percent from health centers, 9 percent from hospitals. In particular, 60 percent of chloroquine used by households in this survey came from informal (unlicensed) sources (5).

A 1999 Delivery of Improved Services for Health (DISH) project survey conducted in 12 districts revealed that caretakers of sick children were more likely to seek treatment for their child's fever and cough from private sources. The study revealed that on average, the clients paid Shs 3,007 (\$ 1.88) for a child health visit (6).

Table 3: Sources of care sought for sick children

Source	Fever (% of sick children)	Cough (% of sick children)
Government	29	25
Private/NGO	47	52
Pharmacy	18	13
Other	13	16
No treatment	4	3

Source: DISH Project, 2001.

A household survey covering 450 households in three districts (Mbarara in the southwestern region, Arua, in the northwest, and Tororo, in the southeast) revealed the sources of drugs for fever, diarrhea, cough, and intestinal worms for all ages (7). See Table 4.

Table 4: Sources of medications obtained at household for fever, diarrhea, cough, and intestinal worms in Mbarara, Arua, and Tororo Districts

Source of medications	Percent
Public and non-profit:	
• Hospitals	9
• Health centers, dispensaries	14
Private, for-profit:	
• Clinics	15
• Drug shops	15
• Ordinary shops	37
• Markets	6
• Other	4

Source: Adome, Popular Pills, 1996

As the table shows, only 23 percent of pharmaceuticals were obtained from the public and non-profit sources; most drugs are obtained from the private sector. The largest suppliers of drugs are ordinary provision shops, the *dukas*, where people buy salt, sugar and tea. The next largest suppliers were the drug shops found in towns and larger trading centers, followed by private clinics. In many rural areas, differences between drug shops and clinics are minimal, since both offer diagnoses and sell drugs (7).

A more specific analysis was conducted to relate the type of medication with the source of medication. Results are presented in Table 5. It is interesting to note that public providers and NGOs provided most of the oral rehydration solution (ORS).

Table 5: Sources of selected child survival drugs by type of medicine obtained at household for fever, diarrhea, cough, and intestinal worms in Mbarara, Arua, and Tororo Districts

Child Survival Drug	% obtained from public & NGO sources	% obtained from private, for-profit sources	% obtained from other sources	n =
Analgesics: Paracetamol	21	76	4	193
Antimalarials: Chloroquine	26	71	3	448
Fansidar	37	63	0	24
Quinine	55	45		29
Antimicrobials: Septrin	18	74	8	96
Ampicillin	21	79	0	28
Penicillin V	37	63	0	71
Chloramphenicol	14	86	0	14
Anti-helminthics: Mebendazole	31	68	1	82
ORS	51	46	3	37

Source: Adome, Popular Pills, 1996

It is worth mentioning that the national cost recovery policy has recently been reversed. Governmental health facilities are going to dispense drugs for free. There is a need to monitor the influence of such change on the health care seeking pattern on the short and long terms.

Policies and regulations related to private providers' practice

The most relevant laws regulating private practice are the National Drug Policy and Authority Statute (1993), the National Medical Stores (NMS) Statute (1993), and the three professional bills of 1996. The National Drug Policy and Authority Statute and the NMS Statute established a national pharmaceutical policy body, the National Drug Authority, to oversee the compliance with and implementation of the drug policy in the country. This governing body controls and regulates importation, manufacture, export, quality, storage, and wholesale and retail sales of pharmaceutical products. A parastatal pharmaceutical supplies organization, the NMS, was created to work with the National Drug Authority to ensure efficient procurement, safe storage, distribution, and quality assurance of medicines and other medical supplies.

Three professional bills were adopted in 1996: the Uganda Medical and Dental Practitioners' bill, the Uganda Nurses' and Midwives' bill, and the Allied Health Professionals' bill. These bills establish a supervisory council for the three main categories of professional health workers. The councils regulate the professionals and discipline, maintain educational standards and professional ethics, keep registers, and supervise practice at all levels, including those in private sector. In addition, the Pharmacists Council evolved to register pharmacies and drug shops and supervises their practices. See MOH organogram in Annex 1.

The bills require all health professionals to register with their respective council and to be members of their respective professional associations. The bills established registration requirements and empowered the councils, under specific conditions, to remove persons from the registry. Similarly, the councils oversee the requirements and licensing procedures for private practice. Private health facilities/consulting rooms must meet certain standards to be licensed. Provisions for revoking a private practice license and for disciplining health professionals are included.

The bills allow different cadres of health professionals to operate freely in private practice, where once participation was limited. The laws also ensure that private practitioners regularly report the diseases and conditions they handle.

It is known that private health care in Uganda has grown considerably and that the government lacks the resources to enforce regulations. Many unlicensed drug shops and private clinics sell antibiotics and other prescription only-drugs quite openly. A wide gap between policy and practice is a general characteristic of drug use in Uganda (7). A survey conducted in Kampala in 1996 indicated that only 190 of over 400 private clinics in the city were registered. Ninety-five percent of the surveyed clinics had their own stock of drugs and were dispensing drugs directly, defying the laws that do not allow private clinics to stock or sell drugs. In addition, although many clinics outside the main town centers were registered under the name of a doctor, they were, run by very junior staff. In some cases a doctor registered multiple clinics under his/her name and only visited each of them briefly while the junior staff did all the clinic's work with virtually no supervision (8).

Private practitioners complain that the registration procedures are complex and expensive. The annual fees and taxes required from different private practitioners in Kampala city is presented in Table 6.

Table 6: Annual registration fees and taxes levied by different authorities*

Type of Private facility	Registration fees		Uganda Revenue Authority Tax		Kampala City Council Tax		Total	
	Sh.	\$	Sh.	\$	Sh.	\$	Sh.	\$
Maternity	30,000	18.75	100,000	62.50	50,000	31.25	180,000	112.50
Clinic	70,000	43.75	100,000	62.50	50,000	31.25	220,000	137.50
Pharmacy	250,000	156.25	100,000	62.50	105,000	65.63	455,000	284.38
Drug shop	125,000	78.13	50,000	31.25	50,000	31.25	225,000	140.63
Religious (EESABO, DUWA)	1,700	1.06	0	0	15,000	9.38	16,700	10.44

Source: Asimwe D., MISR, 1999

*\$ 1 = Ugandan Shilling (Sh) 1600, (1999)

A qualitative assessment of a few selected private providers working in clinics and drug shops revealed an average daily income of Sh. 20,000 and 35,000 respectively. These providers are required to pay fees and taxes estimated to be equivalent to about 11 days of work for a health worker in a clinic and about 6 days for a drug shop keeper. If these average income figures are true, then the cost for registration fees and taxes seem reasonable.

Nonetheless, compliance with registration is weak; 274 (65%) of the 420 facilities identified in the study were unregistered (9).

Number and geographical distribution of formal and informal private providers

In general, an information gap exists regarding the numbers and distribution of unregistered drug shops, which constitute the majority operating drug shops, particularly in rural areas (9).

The informal private practitioners in this report are defined as those who offer health advice or treatment but are not either licensed or trained/qualified to do so. In Uganda, a close relationship exists between the formal and informal sectors in the health care system. Unauthorized drug retailers often obtain their medicine and drug supplies from the formal sector—mainly from registered pharmacies. In return, many government health units, faced with drug shortages, buy drugs from these informal sources with their cost sharing money.

A study in Rubaga Division in Kampala District showed that most drug shops are owned by nurses and midwives. Doctors may also own drug shops and clinics but they do not usually operate them (10). See Table 7.

Table 7: Profession of owners and attendants of drug shops and clinics, Rubaga Division, Kampala

Profession	Drug Shop n = 88		Clinic n = 61	
	Owners (%)	Attendants (%)	Owners (%)	Attendants (%)
Midwives & Nurses	61	77	45	84
Medical	23	3	49	13
Paramedical	7	5	5	2
Non medical	9	15	2	2

Source: Dan Twebaze, 1994

The same study revealed that a high proportion of clinics and drug shops had been operating for less than one year. This suggests that private clinics and shops have recently become a “booming” business. See Table 8.

Table 8: Length of time drug shops and private clinics have been operating, Rubaga Division, Kampala

Duration in Years	Drug Shops n = 86	Clinics n = 59
< 1	43%	47%
1-3	29%	31%
> 3	28%	22%

Source: Dan Twebaze, 1994

An inventory of private health facilities was carried out in 11 parishes (sub-district administrative units) covering 15 percent (116,136) of the total population (774,241) of Kampala District. The study identified the following private providers: 1 hospital, 2 health centers, 1 dispensary, 22 maternity/nursing homes, 130 clinics, 15 pharmacies, 103 drug shops, 134 religious providers and 41 traditional birth attendants/herbalists. There were 1037

private health workers (including support staff) in the 40 recorded private health facilities with 96 based at the hospital. The private health facilities were evenly spread throughout the divisions; 52 percent were small one-room shops or clinics run by one person practicing and supplying western medicine, and 38 percent were traditional healing facilities. The study concluded that there is an over supply of private health services in the divisions included in the study. On average, one private health facility existed for every 260 people. See Table 9.

Table 9: Population per private health facility in selected divisions and parishes in Kampala District

Division: Parish	Population	Number of private health facilities	Population/ private facility
Nakawa:			
Banda	8,952	39	230
Luzira	11,273	47	240
Rubaga:			
Nateete	14,008	80	175
Mutundwe	12,279	33	372
Makindye:			
Katwe I	7,589	30	253
Kibuli	14,498	42	345
Makindye I	8,352	24	348
Central:			
Kamwokya	12,079	46	263
Nakasero II	6,478	6	1,080
Kawempe:			
Wandegeya	5,091	33	154
Kawempe I	16,102	69	233
Total	116,701	449	260

Source: Asimwe D., MISR, 1999.

The same study identified 941 private providers from all the facilities other than the hospital. Seventy-two (7.6%) were reported to have ownership status, 355 (51.2%) as employees at the facilities. In total, 914 providers reported on their qualifications; 376 (41%) were reported being nurses and midwives, 186 (20%) traditional healers, 157 (17%) physicians, 83 (9%) paramedics and 20 (2%) pharmacists (9). The study also concluded that the number of health workers practicing privately has increased dramatically during the period 1990 – 1998. Forty-seven percent of identified providers had been working in private practice for 5 years or less, and only 40 percent had been in private practice for over 10 years. Nurses, midwives and nursing aides showed the most significant increase. This could have been encouraged by the recent policy change that allowed nurses to prescribe certain drugs. See table 10.

Table 10: Type of private health provider and number of years in private practice

Type of private health provider	Number of years in private practice		
	Up to 5 years	6- 10 years	Over 10 years
Pharmacist	10	0	10
Paramedic	38	7	37
Physician	47	19	90
Nurse/midwife	217	48	105
Nurse Aide	61	13	17
Traditional Healer	37	29	119
None of the above	66	11	34
Total (1015)	476	127	412
%	46.5	12.5	40.6

Source: Asiimwe D., MISR, 1999

Effectiveness of private practitioners' case management for common childhood diseases

A recent study conducted in Kampala district investigating childhood ARI case management revealed that pharmacists' and drug sellers' assessment of the severity of the disease was very weak. Important symptoms such as state of breathing received little attention from both pharmacy attendants and shopkeepers. Both categories of providers over-dispensed antibiotics; in 52 percent of pharmacies and 49 percent of drug shops antibiotics were dispensed for mild ARI. Advice on monitoring the child's condition was not given in 93 percent of pharmacies and 86 percent of drug shops (11).

A study investigating knowledge of private drug shop and clinic attendants regarding correct dose for stocked antimalarial drugs revealed generally good knowledge for chloroquine and Fansidar (SP) and particularly poor knowledge for quinine (10). See Table 11.

Table 11: Knowledge about and possession of antimalarial drugs among private drug shops and clinics

Drug	Correct knowledge of Dose		Possession of Drug	
	Drug Shop n= 86	Clinic n= 59	Drug Shop n= 86	Clinic n=59
Chloroquine	89%	89%	97%	98%
Amodiaquine	28%	26%	90%	87%
Fansidar	72%	89%	65%	72%
Metakelfin	63%	80%	34%	48%
Quinine	23%	23%	53%	64%

Source: Dan Twebaze, 1994

The majority of drugs sold at drug shops and clinics were based on clients demand (71%) not on a prescription. Drug shops and clinics obtain their drug stock from pharmacies (95%), the open market (23%), and other sources (23%).

Ordinary shops, a major source of medicine particularly in rural areas, are operated by people without medical training or experience, some of whom are illiterate. Customers do not expect advice or instructions from these providers. They do not inquire about symptoms or suggest alternatives to the drugs requested by customers (7).

A study conducted in five districts (Jinja, Kabarole, Lira, Mbale, and Mbarara), and in Kampala, investigated the quality of case management of selected private health facilities by reviewing the facilities records. In the 164 health facilities where records were available, a total of 31,160 patients were seen in the month preceding the study, of which 6,731 (21.6%) were children under 5 years. Table 12 summarizes the study findings.

Table 12: Proportion of cases managed by private health facilities according to the National Guidelines

Case (all ages)	Managed correctly	Not managed correctly	Total
Simple malaria (uncomplicated)	93 (18.9%)	399 (81.1%)	492 (100%)
Simple diarrhea (with no blood)	16 (5.7%)	268 (94.3%)	284 (100%)
Pneumonia	114 (36.4%)	198 (63.6%)	312 (100%)

Source: Omaswa F., Quality of care in private medical practice, 1999.

Most cases of simple malaria were treated with chloroquine or quinine injections as first line treatment. Often chloroquine was combined with Fansidar or quinine tablets as first line treatment. Pneumonia was commonly treated with penicillin gentamycin injections in combination with antibiotic capsules or septrin (cotrimoxazole) tablets. Almost all diarrhea cases were treated with an antimicrobial, sometimes in combination with ORS, as first line treatment. The most common antimicrobials prescribed were chlormaphenicol, flagyl (metronidazole), and septrin (cotrimoxazole). Most of the required first-line drugs for malaria, ARI, and diarrhea were generally available in health facilities surveyed (12).

A study conducted in Kampala city concluded that drug shop and pharmacy attendants do not ask important questions to parents coming for advice on their sick children. The study used “parent simulated interviews” for two types of childhood acute respiratory infections (ARI): uncomplicated and severe (13). Results are summarized in Table 13.

Table 13: Proportion of drug shop and pharmacy attendants who inquired about breathing and drug intake

Shop/pharmacy attendants who:	Uncomplicated ARI		Severe ARI	
	Drug Shop n = 169	Pharmacy n = 27	Drug Shop n = 163	Pharmacy n = 28
Inquired about difficulty in breathing or rapid breathing	4%	3%	6%	17%
Asked whether the child has been given any drugs	46%	33%	59%	57%

Source: Tumwikirze, INRUD, 2000

Although private providers’ practices deviated from the national guidelines, the public has a favorable perception of these providers. An exit interview conducted with 160 clients at private clinics in Mbarara district revealed that availability of private providers, their proximity, their respect to clients’ time, their courteous reception to their clients and their

willingness to dispense medicine on credit are among the important reasons that attract clients (14). See Table 14.

Table 14: Reasons mentioned by clients for selecting private clinics*

Reason	Number and (%)
Provider available at clinic	148 (93)
Courteous reception (friendly)	146 (91)
Little waiting time	142 (89)
Provision of medicine on credit	117 (73)
Privacy	108 (68)
Proximity	91 (57)
Total	160

Source: Mwesigwa Robert, Characteristics of private clinics in Uganda – A case study of Mbarara District, 1999

*Visits were not specific to childhood illness.

Channels for contacting formal and informal private practitioners

To develop a sustainable strategy, interventions to improve private providers' practices will need to be carried out through existing channels that have natural access to formal and informal practitioners. The following potential channels have been identified:

- MOH councils: The presence of councils outside Kampala is limited. Councils only have access to registered practitioners. They represent the authority and could be threatening to private practitioners.
- District health staff: They have limited capacity and are over-committed to many projects. These staff may not consider working with private practitioners related to their work. They also represent the authority and may be threatening to private practitioners.
- Local government structures such as Local Councils (LC), Parish Development Committees (PDC), and Village Health Committees (VHC).
- Professional associations such as Uganda Medical Association and Uganda Private Midwives Association: These associations have access only to registered members.
- NGOs and CBOs: These organizations are close to the community. Their presence varies from one district to another (15).
- Donor-supported projects such as DISH, BASICS, CMS: These projects can facilitate initial strategy development, fill information gaps, and test interventions.
- Pharmaceutical companies: This group may have access to private practitioners in big cities but is unlikely to have contact with informal practitioners in rural areas.

- Drug distribution networks: they are the source of drugs to various formal and informal providers
- Mass media

Interventions to improve the private practitioners' quality of services in Uganda

The following is a brief summary of important attempts to improve the quality of private practitioners services in Uganda:

- Minnesota International Health Volunteers (MIHV) supported an intervention in Ssembabule District, in 1997 included training 25 traditional healers and 50 drug sellers on case management of childhood diseases. The training lasted for three days with one day refresher training every six months. The District Health Team conducted the training course and the training modules were developed based on the MOH's curriculum for traditional birth attendants. The impact on improving quality of care to children by traditional healers or drug sellers was not described (16).
- Commercial Marketing Strategies (CMS) project is working with Uganda Private Midwifery Association (UPMA) to train selected midwives who are UPMA members. The training is focused on family planning issues, but could potentially include child survival topics.
- Makerere Institute for Social Research (MISR) developed training modules for community providers to improve drug use for malaria. The one-week training, conducted in Tororo and Arua districts, was followed by support supervisory visits by the district health team. Evidence shows that private practitioners improved their practices after training (17).
- Applied Research for Child Health (ARCH) project and International Network for the Rational Use of Drugs (INRUD) project are planning to conduct operations research and a situation analysis on private providers' drug dispensing practices for ARI. This research will be followed by face-to-face persuasion visits to improve private practitioners' treatment of childhood ARI cases.
- The National Drug Authority (NDA) is broadcasting radio messages to improve the use of antimalarial drugs.
- Delivery of Improved Services for Health (DISH) and CMS projects plan to support the distribution of prepackaged antimalarial drugs to improve compliance with the drug dose.
- AFRICARE conducted an inventory of private providers in Ntungamo district and is planning a training intervention.

Current relevant activities of potential partners

The following lists the activities of other projects related to studying the pattern of private practitioner's activities or supporting the public-private partnership in Uganda. The IMCI unit at the Ministry of Health should explore the possibility of forming partnerships with these projects. Annex 2 shows organizations and projects with field activities by district.

- Private Public Partnership Unit (PPPU) supports public-private partnerships in health with the goal to facilitate and institutionalize a greater role for NGOs and private providers in providing the population with access to essential health services. PPPU sponsors different policy working groups at the national level. This unit plans to develop a database that will include all registered private practitioners. It will also support selected operations research.
- Roll Back Malaria (RBM) plus includes pharmacists, drug sellers and shopkeepers in its strategy.
- WHO supports including private practitioners in child survival programs.
- UNICEF supports community-based activities particularly in 26 districts.
- DISH project is planning a study related to the quality of care in the private sector.
- BASICS is supporting a coordination network of national-level NGOs and studying the distributions and capacities of NGOs and community-based organizations (CBOs) in six districts (15).
- MISR/ Makerere University, INRUD, and ARCH support operations research including the testing of interventions to improve private providers' practices.
- Agency for Accelerated Regional Development (AFARD) is planning a study on private practitioners' profile in Nebbi district.

Key information gaps

This situation analysis has identified a number of studies conducted in Uganda related to the profile of private practitioners, most of which were conducted in or near Kampala. Few studies have dealt with unregistered providers. Even fewer studies describe the impact of interventions on improving private providers' practices. Thus, for the purpose of developing a national strategy to include formal and informal private practitioners in child survival programs, the following information gaps have been identified:

1. The number, distribution, and quality of practice unregistered practitioners
2. Specific problems with quality of case management (deviation from the standard IMCI clinical guidelines) for diarrhea, ARI, and malaria, particularly among informal providers
3. Sources of care for childhood illness by severity of illness

Conclusions

1. Formal and informal private practitioners provide the majority of case management for childhood diarrhea, ARI, and malaria. Shopkeepers and drug sellers are particularly important in rural areas.
2. Laws regulating the registration and practice of private practitioners and the authorization of the sale of drugs exist, yet the MOH, the National Drug Authority, and the district health staff have limited capacity to enforce them.
3. Many private practitioners, particularly drug sellers, are not registered. Many shopkeepers, particularly in rural areas, store and sell commonly demanded drugs.
4. The private practitioners' case management practices deviate greatly from the standard clinical guidelines (IMCI).
5. The quality of care for childhood illness provided by the registered and the unregistered facilities is not noticeably different.
6. Inadequate information exists about the number, distribution and quality of care provided by the unregistered practitioners, particularly in rural areas. Most of the available studies have addressed registered private practitioners in Kampala or other urban areas.
7. Channels for contacting private practitioners include: MOH councils, which are limited in capacity and include only registered practitioners; professional associations, such as UMPPA and UPMA, which conduct some training activities for its members as part of continuing medical education (CME); NGOs, CBOs, and CSOs with differing levels of presence and activities in different districts; and donor supported projects such as DISH, CMS, and BASICS.
8. Documented interventions to improve private practice for childhood illness are limited in Uganda. The few that exist have only been tested on a small scale and little evidence exists of lasting improvement on the actual case management practices.
9. The MOH (IMCI, RBM, and PPPU) knows that including private practitioners in child survival efforts is important. The MOH is interested and willing to collaborate with partners.

Recommendations for developing a strategy to utilize the potential of formal and informal private practitioners in child survival

1. Child survival programs in Uganda, particularly IMCI and RBM, need to consider the important role of private practitioners, formal and informal, in the case management of childhood illness. Suitable interventions need to be developed and tested to improve the ability of private practitioners to provide effective case management for childhood diarrhea, ARI, and malaria.
2. The national strategy needs to have two components: **A policy component** to review policies and regulations, registration procedures, limitations to enforce regulations and to apply modifications to close the existing gap between regulations and practice; and a **field intervention component** to develop and test effective and sustainable interventions to improve the practices of formal and informal private practitioners at a large scale.
3. The MOH should lead a national forum led that includes relevant partners and representative of private practitioner associations and individuals to develop this national strategy. Rather than create a separate structure, the existing Public Private Partnership Group, particularly its sub-Working Group 2—partnership with medical practitioners, pharmacists, nurses and midwives, allied professional and informal sector—could be modified to host this forum. This national forum will need to be supported by a smaller, less formal, support group.
4. Because human resources available at the MOH headquarters are very limited, the strategy should, to the extent possible, build on existing structures and programs at national and district levels, and benefit from the capacities and experience of NGOs and CBOs.
5. Working with private practitioners seems to be a suitable point of collaboration between the national IMCI and RBM programs, especially at the community level. Community IMCI mapping needs to include marking formal and informal practitioners and shopkeepers. RBM community activities that involve private practitioners should expand to include ARI and diarrhea.
6. Interventions to improve the quality of private providers' practices should consider experiences from other countries (21), hence adopted interventions need to:
 - Focus on practice and not just knowledge
 - Be realistic, consider the private practitioners' interests and motives, and be limited to key practices
 - Use simple clear tools and benefit from the tools already developed e.g. MISR.
 - Be conducted in a non-threatening manner
 - Respect the time limitation of private practitioners
 - Use innovative techniques of persuasion and negotiation and avoid traditional lecturing-style training
 - Be evaluated based on impact on actual private providers' practice.

7. Including informal practitioners in a national program is a sensitive issue. Therefore, it is recommended that formal private practitioners be considered as partner health providers, while informal practitioners be considered as special community members who are conveniently available to the community. (In this way, informal practitioners are not recognized as partner providers.)
8. The strategy should have a specific monitoring and evaluation component that includes ongoing monitoring of providers' practices by a suitable local entity (District Health Team, NGO, CBO, etc.).
9. The results of the household baseline study conducted as part of the IMCI impact evaluation should be further analyzed to get more specific information on the household seeking behavior for childhood illness in rural versus urban areas as well as by severity of disease for malaria, diarrhea, and ARI.
10. To fill the information gap without adding a significant burden on the MOH, the IMCI Unit should coordinate with partners who are planning some research in this area e.g. DISH, ARCH, AFARD, MISR.

Next Steps

May – August 2001

1. Complete situation analysis report.
2. Discuss situation analysis results and recommendations with the working group (to be identified).
3. Present situation analysis & recommendations through individual consultations and meetings with partners.
4. Analyze the baseline household survey (IMCI Impact) to obtain specific information on health care seeking in rural versus urban areas and by severity for childhood diarrhea, ARI, and malaria.
5. Contact and coordinate with MISR, AFARD, ARCH, DISH, BASICS to fill the information gap regarding the profile and quality of care in rural areas.

August – September 2001

6. Continue discussions with MOH.
7. Develop broad lines of a strategy for developing and testing interventions with the working group.

October- November 2001

8. Collect additional information, if needed, identify consultants and field visits.
9. Draft preliminary 5-year strategy with priority interventions including who, what, where, budget, etc.
10. Conduct a workshop for consensus on strategy. This will include NGOs, donors, private association groups.

December 2001

9. Develop a two-year workplan for intervention/s and integrate with other workplans e.g. RBM plus, DISH, BASICS, WHO, etc.

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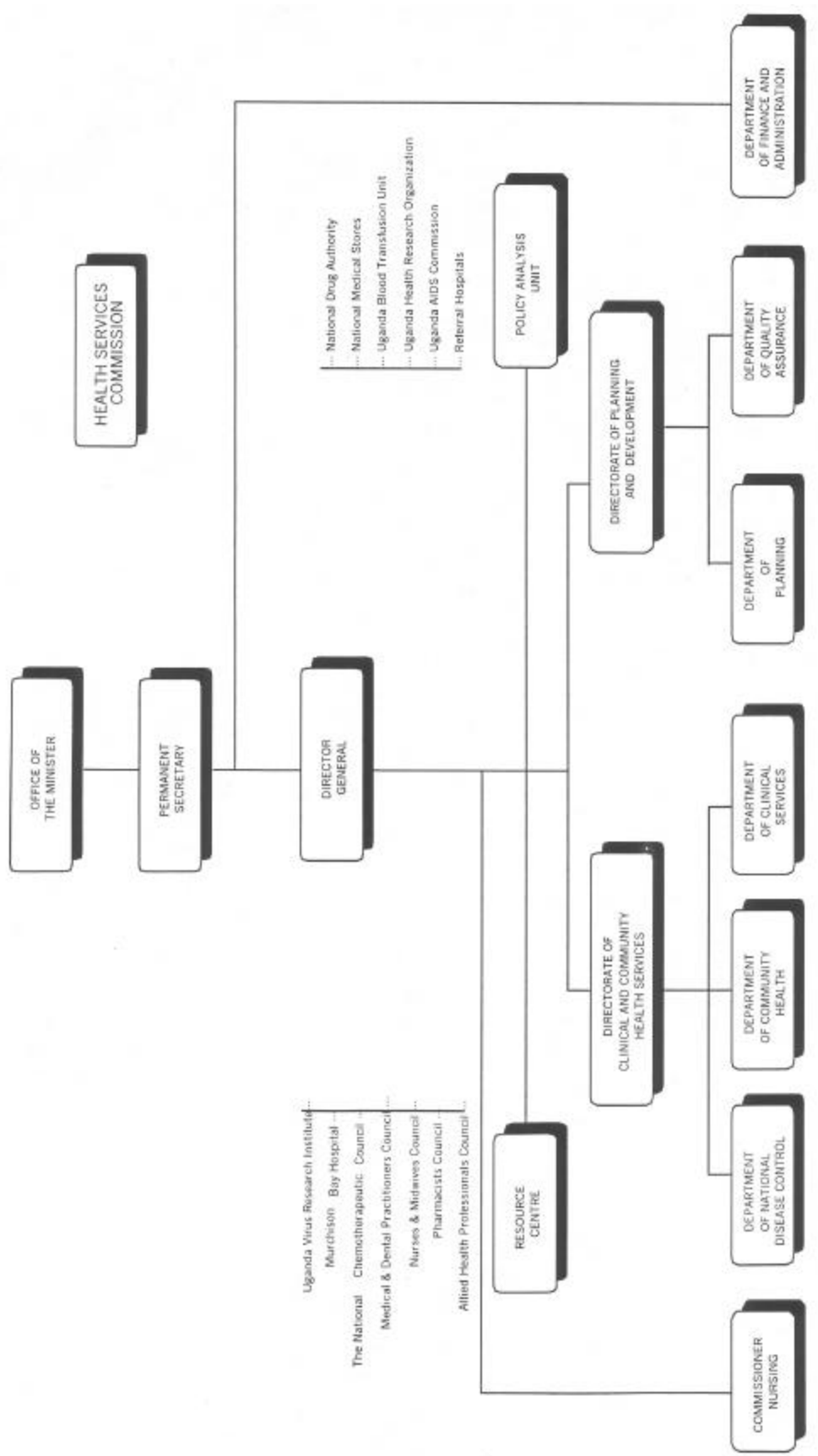
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Annex 1: Ministry of Health Organogram



Annex 2: Organizations and projects with field activities by district

Districts	Organizations/ Projects with field Activities
1. Adjumani	UNICEF
2. Apac	UNICEF
3. Arua	UNICEF
4. Bugiri	UNICEF
5. Bundibugyo	UNICEF
6. Bushenyi	
7. Busia	UNICEF
8. Gulu	UNICEF
9. Hoima	
10. Iganga	
11. Jinja	DISH
12. Kabale	
13. Kabarole	UNICEF
14. Kalangala	UNICEF
15. Kampala	DISH, UNICEF
16. Kamuli	DISH
17. Kapchorwa	
18. Kasese	DISH, UNICEF
19. Katakwi	
20. Kibaale	UNICEF
21. Kiboga	BASICS, UNICEF
22. Kisoro	
23. Kitgum	UNICEF
24. Kotido	UNICEF
25. Kumi	BASICS
26. Lira	UNICEF
27. Luwero	DISH, BASICS
28. Masaka	DISH, BASICS, UNICEF
29. Masindi	DISH, BASICS
30. Mbale	UNICEF
31. Mbarara	DISH, UNICEF
32. Moroto	UNICEF
33. Moyo	UNICEF
34. Mpigi	
35. Mubende	UNICEF
36. Mukono	
37. Nakasongola	
38. Nebbi	UNICEF
39. Ntungamo	Africare, DISH, BASICS
40. Paliisa	
41. Rakai	DISH, UNICEF
42. Rukungiri	
43. Ssembabule	DISH, UNICEF
44. Soroti	
45. Tororo	UNICEF



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