

DEMONSTRATING THE POTENTIAL OF PRIVATE HEALTH PROVIDERS:

SUMMARY AND EVALUATION OF PRIVATISING A
REPRODUCTIVE HEALTH SERVICES PROJECT IN
UGANDA

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ABSTRACT

Private sector healthcare providers are often the provider of choice in many developing countries, among rich and poor alike. Public-sector oriented Ministries of Health, however, are skeptical of the private sector's motives and willingness to offer high quality care. Is the private sector able to provide high quality healthcare? Can private providers build on their comparative advantages — access, drug availability, and interpersonal skills — and improve their services? Conversely, can shortcomings such as poor recordkeeping or inadequate clinical practices be overcome? What is the potential of private providers to meet public health needs in developing countries? And can governments effectively work with the private sector to improve healthcare? This study addresses these questions by describing a series of three sets of interventions carried out in Uganda through USAID's Commercial Market Strategies project in collaboration with the Summa Foundation, a not-for-profit investment fund. All of the interventions were aimed at strengthening the private provision of healthcare services.

The first set of interventions were conducted with Uganda Private Midwives Association (UPMA) and focused on (1) increasing the organization's programmatic and financial sustainability, and (2) enhancing its ability to provide value-added services to its members — such as continuing medical education, group purchasing, newsletters, and participation in policy and planning. Assistance to the UPMA was designed to maximize the association's health impact at local and national levels. The second set of interventions focused directly on private providers, aiming to improve the quality and financial viability of private clinics through improved access to credit and enhanced business and clinical skills. The third component aimed to strengthen public-private partnerships through policy development.

The authors evaluate the effectiveness of these initiatives and present four case studies of private nurse-midwife clinics that participated, to varying degrees, in the interventions. Further, this study documents the experience and lessons learned from these interventions with the aim of informing similar projects.

KEY WORDS

USAID, Commercial Market Strategies, Summa Foundation, private sector, public-private partnerships, private midwives, microfinance, business skills, maternal and child health, NGO sustainability, Uganda.

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ACRONYMS

ACDI/VOCA:	Agriculture Cooperation Development International/Volunteers in Overseas Cooperation Assistance
AIM:	AIDS Integrated Model District Program
CMS:	Commercial Market Strategies
DISH:	Delivery of Improved Services for Health
DPMS:	Determined Private Midwives for Sustainability
FCI:	Family Care International
HMIS:	Health Management Information Systems
IEC:	Information, Education and Communication
IMCI:	Integrated Management of Childhood Illnesses
KCH:	Kansanga Health Centre
MVA:	Manual Vacuum Aspiration
MOH:	Ministry of Health
MUCH:	Mother Uplifting Child Project
NGO:	Non-Governmental Organization
NSBC:	National Smallholders Business Centre
PAC:	Postabortion Care
PNFP:	Private Not For Profit
PPPH:	Public Private Partnership in Health
PHR:	Partners in Health Reform
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
PSI:	Population Services International
PURSE:	Privatizing Uganda Reproductive Health Services Project
RR:	Regional Representatives
SEATS:	Service Expansion and Technical Support
SOMARC:	Social Marketing for Change
UCMB:	Uganda Catholic Medical Bureau
UDHS:	Uganda Demographic and Health Survey
UMA:	Uganda Medical Association
UMMB:	Uganda Muslim Medical Bureau
UMU:	Uganda Microfinance Union
UNANM:	Uganda National Association of Nurses and Midwives
UNFPA:	United Nations Fund for Population Activities
UPMA:	Uganda Private Midwives Association
UPMB:	Uganda Protestant Medical Bureau
UPMPA:	Uganda Private Medical Practitioners Association
USAID:	United States Agency for International Development
WHO:	World Health Organization

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EXECUTIVE SUMMARY

This report presents the evaluation of Privatizing Uganda Reproductive Health Services (PURSE) Project, an initiative implemented by Commercial Market Strategies in Uganda. The purpose of the evaluation is to document experience and lessons learned from the PURSE Project, with the aim of informing future projects in Uganda as well as contributing to the body of knowledge of private health provider interventions for other countries. The report summarizes the activities of the PURSE project and addresses the overall impact of the Project in meeting its objectives. In specific, the evaluation addresses the effectiveness of interventions in advancing private sector health care, strengthening the institutional capacity and sustainability of the NGOs, and improving the policy environment for private providers in health.

The findings and recommendations outlined in this report are based on information gathered from a variety of sources, including analysis of PURSE Project documents, interviews with USAID, CMS and PURSE Project staff and with key stakeholders, and case studies of four privately owned clinics.

The PURSE Project interventions covered three interrelated and complementary areas. The first group of activities relate to assisting indigenous NGOs, mainly Uganda Private Midwives Association (UPMA), to achieve greater financial and institutional sustainability. The second set of interventions was targeted to improve private sector clinics by assisting private providers to improve the quality and financial viability of their private practices. Finally, selective policy interventions were implemented to create a more favorable policy environment for private sector health care.

Accomplishments of the PURSE Project:

Assistance to UPMA: The PURSE Project provided extensive technical assistance to UPMA in a number of complementary areas, including development of income generating activities, enhancement of member communications and visibility, quality improvement, and institutional strengthening. Results of interventions are summarized below:

- UPMA improved its capacity to generate revenues to support the association from external and locally generated sources. The association was able to increase its local income as well as diversifying its external assistance base. The association implemented several interventions to increase income-generating activities. Examples include the establishment of group discount programs to help members to purchase commodities at reduced prices, while securing additional sources of income. Restructuring the management of its clinic, the Kansanga Health Centre, by renting the facility to a sub-group of member midwives significantly improved the clinic and the association's financial situation.
- UPMA initiated a quarterly newsletter to inform members about association activities and provide health updates. The newsletter, mailed to all members, generated income through advertisements and provided an excellent outlet for promoting CMS products. UPMA also developed a membership database and a directory to keep track of

members. The directory was sold to the members, which provided additional income for the association. UPMA monthly meetings were also restructured to deliver more value to its members. These sessions are used to provide continuing medical education for members.

- UPMA implemented a number of initiatives to enhance the visibility of its members, including use of signposts to announce their membership in the association, development and sales of health education brochures, and distribution of newspaper supplements.
- UPMA revitalized its Regional Representatives (RR) Program to provide peer support and to ensure quality and professionalism of member midwives. Findings from Regional Representatives database indicate that 25 out of the selected 37 indicators improved between 2002 and 2003. Positive changes were found mostly in indicators related to presence of essential drugs and supplies, infection prevention measures, and record keeping practices.
- UPMA members had access to integrated management of childhood diseases (IMCI) training; 186 private midwives, including 24 RRs were trained in IMCI skills. In addition, eight UPMA members were qualified to provide IMCI training, supervision and monitoring as trainer of trainers
- UPMA members had access to micro credit and training in basic business skills. To date, over 200 midwives received a total of 430 loans. The Uganda Private Health Providers Loan Program and the associated business skills training had a remarkable impact on improving the members' private practices.
- UPMA strengthened its management capacity by installing updated accounting software. In addition, the association was better able to produce association and project budgets and improve financial accountability.

Support for other NGOs: The PURSE Project kept close contact with other health care provider associations. The assistance provided to these professional associations included sponsoring meetings, presentations at conferences, provision of information on products, training opportunities and access to the Uganda Private Health Providers Loan Program.

Uganda Private Health Providers Loan Program and Business Skills Training: The PURSE Project played a critical role in the Uganda Private Health Providers Loan Program established by Summa Foundation, by coordinating among various partners, providing upfront expenses and extensive marketing support. Between January 2001 and June 2003, the Uganda Private Health Providers Loan Program provided a total of 970 loans to private providers, including midwives, nurses, doctors, clinical officers and pharmacists. In the meantime, the PURSE Project and Summa Foundation provided business skills training to 446 private providers to strengthen the success of the loan program. The follow up visits to trainees demonstrated that providers have greatly improved their record keeping practices and enhanced their ability to promote and expand their services.

Data from the Uganda Private Health Providers Loan Program confirm that the loans have helped expand reproductive health care services provided by the clinics while contributing to the financial sustainability of the facilities. There was a significant increase in the proportion of clients who received preventive maternal and child health services at the clinics. The findings also suggested that the loan program increased client perceptions of service quality and client loyalty.

IMCI Training: The PURSE project offered IMCI training to private providers with the purpose of improving practices for a number of common childhood illnesses using standard guidelines. Since 2001, 222 private providers received training in IMCI, mostly members of UPMA. Follow up visits to trainees indicated that the training program was very successful in improving the clinical practices of private practitioners.

Best Practices Bulletin: The PURSE Project initiated the publication of Best Practices Bulletin to update private providers in current best practices to improve the quality of services. The bulletin also enabled the project to stay connected with private providers. To date, the bulletin published 13 issues and approximately 450 copies were distributed bi-monthly.

Establishment of a Franchise Clinic Model: The PURSE Project facilitated the establishment of an AAR franchise clinic program. AAR is a major provider of prepaid healthcare in East Africa. The franchise clinic made significant improvements to its clinic and was “re-branded” as an AAR Health Centre to expand access to prepaid health care in Entebbe. The franchise agreement had only been in effect for less than three months at the time of the assessment thus it is too early to evaluate its impact on the operations of the clinic.

Support for Development of Private Health Providers Policies: The PURSE Project entered into policy discussions with key stakeholders, including the Public Private Partnership for Health Office within the MOH, with the aim of improving the environment in which the private health providers function. The Project helped draft a concept paper to identify areas of collaboration between the MOH and private health providers. Consequently, the project played a key role in development of the Policy Framework for Partnership with Private Health Practitioners. At the time of this assessment, the committees had begun drafting the implementation guidelines. The progress made towards the development of public and private partnership has been successful so far, however, the initiative is still in its early stages.

Reduction of User Fees in the Private-not-for-profit Sector: The PURSE Project worked with the leading faith based organizations to support them in reducing user fees to increase access to the poor. The Project provided extensive technical assistance to assess the effects of fee reductions on service utilization, revenues and recurrent costs. Assistance was provided to selected private-not-for-profit hospitals to help them plan, implement, and monitor the effects of fee reductions.

Conclusions and Recommendations:

Following are the key conclusions and recommendations based on the findings of the evaluation:

- Private sector providers, including the physicians, nurses and midwives operating private clinics have a critical role to perform in providing health care services in Uganda. Among other donors, USAID and projects funded by USAID have a comparative advantage in promoting the private sector due to their extensive technical expertise in this area. USAID/Uganda should continue supporting the private health sector.
- Overall, the PURSE Project has been effective in supporting private sector providers. The project maximized its impact by intervening in complementary areas in a holistic approach, to cover policy dialogue, access to credit, training, and institutional capacity development.
- The PURSE Project's greatest strength was the technical leadership of its staff, in particular, the Privatising Health Services Advisor. She was pivotal in identifying opportunities and implementing innovative approaches to support enhancement of private providers.
- The PURSE project interventions were closely integrated with the broader goals of the CMS Project in Uganda. The Project successfully linked its interventions with other programs implemented by the CMS Project, in particular with the Social Marketing Program and leveraged the effectiveness and impact of all interventions..
- Through all interventions, the Project used an approach to build on existing systems, which greatly increased the likelihood of sustaining project gains. In addition, the PURSE Project focused its interventions on institutional capacity building, policy dialogue, and training of providers. All accomplishments in these areas are sustainable, and if adequate resources are provided, replicable.
- Lack of a clear strategy and a monitoring plan to lead implementation was a challenge for the PURSE Project. Many of the interventions were designed during the course of implementation, rather than being led by a structured strategic approach. Nevertheless, the project was able to address obstacles limiting the growth of the private sector and designed interventions to address them effectively.
- The PURSE Project used an integrated approach to assist UPMA. Several of the interventions were effective, and the gains from these interventions are likely to sustain. However, the association needs continuing support in many areas to further the gains and achieve higher levels of sustainability.
- The PURSE Project's support to other NGOs and professional associations was minimal compared to its assistance to the UPMA. Many other NGOs merit

international assistance in Uganda. In particular, nurses and physicians in private practice should be given a higher priority through future projects and interventions.

- Provision of micro finance assistance through the Uganda Private Health Providers Loan Fund and the associated training courses in business skills have been effective. The results from these interventions are true success stories. It is highly recommended that the Uganda Private Health Providers Loan Program should be continued either through the Summa Foundation or through other mechanisms.
- Provision of IMCI training has also been a high impact intervention. The intervention has helped the participants to improve skills in managing common childhood diseases as well as other clinical practices, such as infection prevention.
- The PURSE Project has played a key role in facilitating the process of the Public Private Partnership in Health initiative. Despite the rapid progress over the last year, the initiative is still in its early stages. It is highly advisable that USAID/Uganda continues to assist the Government in moving on with the public private partnership agenda.

Key Lessons Learned:

- The private sector has a significant potential to contribute to improving the health of large populations, even in relatively less developed countries like Uganda. There are numerous opportunities to implement successful approaches to tap into the provision of private health care services.
- The process of public private dialogue is critical for building trust and understanding between the two sectors.
- Linking private providers is key for the growth and strengthening of private sector provision of health care services. In addition to organizing around professional associations, many other means of information sharing help private providers stay connected.
- Sustainability of NGOs can be maximized through a holistic approach that addresses elements of institutional development, high quality services and products, and a sound financial base.
- Professional associations of private providers are able to successfully leverage resources from multiple donors but require capacity building assistance to ensure that they can manage multiple programs effectively.
- Associations like UPMA grow and increase their likelihood of sustainability as they focus on the question of delivering more value to their members. UPMA has made progress in this regard, but it still has a long way to go.
- The case of the Kansanga Health Centre presents an exemplary lesson learned for international development efforts. It is not a sound strategy for international

organizations to fund establishment of clinical services especially within the context of a voluntary membership association without considering long-term financial consequences and sustainability aspects.

- Many private providers are committed to providing high quality services but are often constrained by lack of financing and training. Private providers welcome opportunities to update their skills and are willing to implement improved treatment practices.
- Access to micro credit makes a difference for private providers. Access to small amounts of financial assistance, supported by business skills training can help providers improve financial viability and service quality.

I. INTRODUCTION

Commercial Market Strategies (CMS) is a five-year global project whose aim is to promote private sector provision of family planning and other health care services. CMS has been active in Uganda since 1998 and will conclude in March 2004. CMS Uganda Program focuses on the social marketing of reproductive health products and services, increasing the capacity of private-sector providers to deliver affordable, quality services and encouraging the creation of innovative health financing mechanisms to increase access to health care.

Purpose of the Evaluation

The purpose of this review is to evaluate the effectiveness of CMS interventions specifically in the area of increasing the capacity of private health providers, referred to internally as Privatizing Uganda Reproductive Health Services (PURSE). The evaluation is conducted to document experience and lessons learned from the PURSE Project, with the aim of informing future projects in Uganda as well as contributing to body of knowledge of private health provider interventions for other countries.

The PURSE Project consists of three main activities:

- Strengthening Uganda Private Midwives Association (UPMA) and other associations;
- Improving private sector clinics; and,
- Creating a favorable policy environment for private sector health care.

This report addresses the overall effectiveness of the PURSE Project activities in meeting its objectives. In specific, the report addresses the following questions:

- Has the PURSE Project helped advance private sector health care in Uganda?
- Did the PURSE Project help private clinics?
- To what extent did the PURSE Project interventions help to strengthen the institutional capacity and sustainability of UPMA and other NGOs?
- How did the PURSE Project activities relate to broader CMS/Uganda goals?
- How did the PURSE Project contribute to improve the policy environment for public-private partnerships in health?
- What are the overall lessons learned about working with the private sector providers?
- Are the PURSE project interventions sustainable and replicable?

A detailed Scope of Work for this evaluation is found in Appendix A.

Evaluation Methodology

The Evaluation was conducted by two independent public health experts in January and February of 2004. Dr. Pinar Senlet is a consultant for international public health programs, with extensive experience in reproductive health and USAID programs. Dr. Paul Kiwanuka-Mukiibi is the Managing Consultant of one of the leading organizations for consultation in

health in Uganda, with experience in both reproductive health and public-private partnership programs.

The findings and recommendations outlined in this report are based on information and data gathered from a variety of sources:

- Analysis of CMS and PURSE Project documents, reports, and databases;
- Interviews with USAID, CMS and PURSE Project staff;
- Interviews with key stakeholders and partners;
- Interviews with other knowledgeable international and local individuals; and,
- Observations from clinical site visits.

In addition to the above, the evaluation conducted case studies of four privately owned clinics in order to collect additional data to assess the impact and effectiveness of PURSE Project activities.

Documents reviewed are listed in Appendix B and a list of key contacts interviewed is found in Appendix C. Clinical facilities visited during the evaluation are listed in Appendix D.

II. BACKGROUND

Country Profile

In Uganda, shortcomings in health care provision have contributed to a generally poor state of public health. Overall health indicators are poor; and they have not improved over the past decade. Life expectancy is 44 years while infant mortality remains 88 per 1,000 live births. The maternal mortality rate is estimated around 505 per 100,000 live births. Malaria and childbirth continue to be the main causes of death and disability. Malaria kills between 70,000 and 100,000 each year, mostly children under five. On the positive side, Uganda has been cited as Sub-Saharan Africa's success story to reduce HIV prevalence. Nonetheless, HIV/AIDS continues to be a major health problem with an estimated prevalence rate of 6.7 percent.

Underfunding and inefficiencies plague the current health system in Uganda. In addition, the current health system suffers from a weak logistical support and distribution of much needed supplies and commodities such as drugs, contraceptives and vaccines. Even with additional revenue from donor funds, the Ugandan government cannot satisfy its population's health needs. The Government of Uganda currently spends about \$6.40 per capita on health. This is well below the target established of \$9.60. The government predicts that health care needs will climb to \$12 per capita in 2005, resulting a wider gap between resources and needs. On the other hand, an average Ugandan spends about \$7 on health and medical services out of pocket. The majority of this is spent in the private for profit sector.

Since consumers of health care are not having their needs met by the government health system, the private sector consumes a large percentage of health expenditures. Ugandans are used to paying for health care and often prefer non-governmental services when they can afford to pay. Both the private for profit and non-profit sectors have been greatly instrumental in meeting the health care needs of the population for several decades. The Government of Uganda, already short of sufficient funds, recognizes the importance of the private sector in improving health outcomes and encourages its growth.

While private non-profit and for profit health care systems continue to be of great value to a large proportion of the Ugandan population, private health care remained largely unregulated until recently. Long years of war in Uganda devastated regulatory and supervision systems in the health care sector. In addition, many health care providers in the private sector suffer from outdated clinical and business skills and limited financial resources.

The private sector in Uganda is composed of not-for-profit organizations, traditional healers and private providers, including midwives, nurses, doctors, clinic officers and pharmacists. The not-for-profit sector is comprised of faith-based organizations and other NGOs that have an important role to play in delivery of health services. Traditional healers are able to reach a wide population but do not have the training and education that are necessary to significantly improve health outcomes. Accordingly, the modern, commercial health sector has an important role to play in achieving a sustainable impact on improving the health situation of large populations.

Among private providers, it is estimated that there are approximately 800 private midwives. Private midwives provide a wide range of services, including antenatal and postnatal care, deliveries, family planning, immunizations and well baby care, syndromic management of STIs, HIV counseling, health education and minor curative services on a fee for service basis. In addition, midwives sell over-the-counter drugs in their clinics. Unlike private doctors, which are primarily situated in urban areas, midwives serve in urban, peri-urban and rural areas. Frequently, midwives are considered trusted members of the community and are motivated to provide quality services in order to sustain their practices and local reputation.

The CMS Project in Uganda

Recognizing the importance of private health care providers, USAID/Uganda funded a number of projects to work with the private sector. Between 1991 and 1999, the Family Planning Service Expansion and Technical Assistance (SEATS) Project was charged with working with private midwives, through the Uganda Private Midwives Association (UPMA). The SEATS Project assistance to UPMA consisted of training the midwives in contraceptive technology and community mobilization and management, and establishment of a model clinic to be used as a training site.

The CMS Project launched its assistance program in Uganda in 1998 and will conclude in May 2004. CMS Project/Uganda implemented a broad program to improve the capacity of private providers to respond to the health needs of the country, as well as to increase access to affordable, quality products and services. To achieve these goals, CMS used three strategies:

- Social marketing, including behavior change strategies;
- Support for private providers; and,
- Identification and development of alternative sources of health financing.

The CMS project implemented a large and diverse social marketing program in Uganda. Products and activities were covered under three broad categories of family planning (oral and injectable contraceptives), maternal and child health (clean delivery kits and insecticide treated bed nets), and HIV/AIDS prevention (condoms, STI treatment kits and voluntary counseling and testing services). CMS/Uganda's social marketing efforts focus an emphasis on accessibility and distribution.

In the area of health financing, CMS/Uganda worked in collaboration with HealthPartners; a Minnesota based managed care organization, to improve access to affordable and quality health services. Together with HealthPartners' Uganda affiliate, the Uganda Health Cooperative, CMS provided support to assist in the development of community based prepaid health insurance plans. In addition, CMS supported the Mother Uplifting Child Health (MUCH) project in northern Uganda.

The third component of CMS/Uganda program was to support private providers. This component is referred to internally as Privatizing Uganda Reproductive Health Services (PURSE) and it is the subject of this review.

Privatizing Uganda Health Care Services (PURSE) Project

In June 2000, USAID/Uganda provided \$1.3 million to CMS in order to fund technical assistance to UPMA, assist in the development of nurse and midwife private practices, cover operating expenses for the Summa Foundation loan fund and identify other opportunities for nurse and midwives development of private practice. In preparation for these tasks, CMS undertook an initial assessment to develop plans of actions. As part of this assessment, CMS conducted several interviews with a variety of health organizations in Uganda, including the UPMA and the Uganda National Association of Nurses and Midwives (UNANM). From these meetings, CMS concluded that:

- Nurses and midwives are interested in improving their private practices but lack tools for market entry such as business skills, access to credit and incentives.
- The policy environment is not conducive to the entry of nurses and midwives into the private sector.
- Nurse and midwife associations support private provider activities but require technical assistance in organizational strengthening.

Based on the findings of this assessment, CMS designed the Privatizing Uganda's Reproductive Services (PURSE) Project in September 2000. As it was originally designed, the PURSE project offered a three-pronged approach to fulfill its mandate:

- Strengthening the UPMA;
- Creating opportunities for the development of private clinical ownership for nurses and midwives through the implementation of Provider Networks; and,
- Establishing the Uganda Private Providers Loan Fund through the Summa Foundation.

The Project concluded that there would be many alternatives that can be employed to ensure the sustainability of UPMA. However, at that time, USAID/Uganda believed that the UPMA had the best chance of sustainability if it is aligned with its clinic facility, Kansanga Health Center (KHC). (See Section III for information on KHC). Therefore, in addition to technical assistance in areas such as strengthening the management structure, membership recruiting and services, the project was designed to focus on improving the operational and financial position of KHC.

To respond to the need to foster nursing and midwifery in private health care provision and to minimize policy and other barriers for entry into private practice, the PURSE Project planned to support a Midwife and Nurse Initiative. This initiative would facilitate entry of young nurses and midwives who are committed to private provision of services and create a network of reproductive health providers. It would also provide showcase models of private clinics for other nurses and midwives to follow.

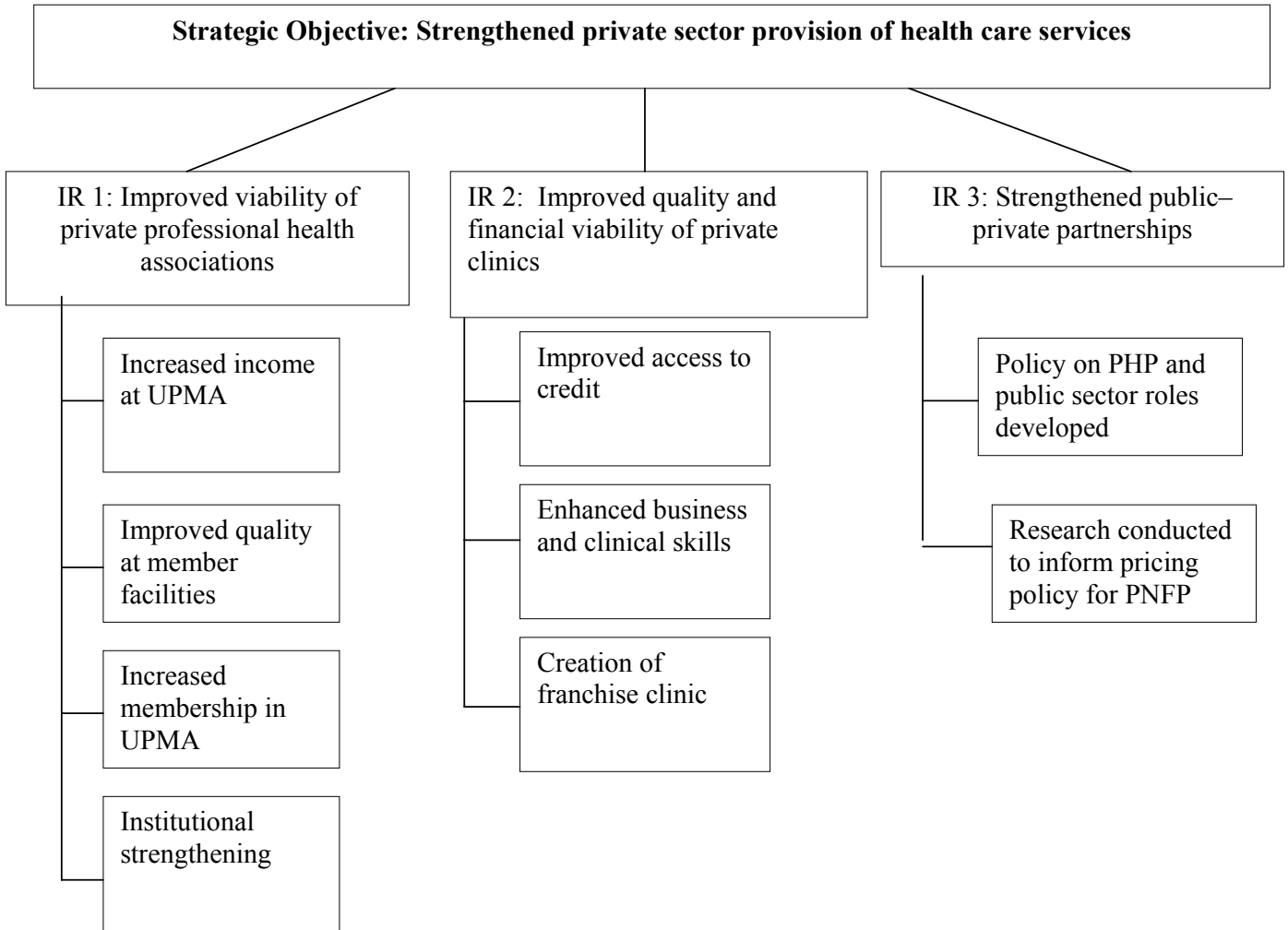
Finally, the PURSE Project envisioned supporting the activities of the Uganda Private Providers Loan Fund, a project funded by the Summa Foundation. (See Section III for details on the Summa Foundation and the Uganda Private Providers Loan Fund) The Summa Foundation had already designed a three-year project to provide a package of financing and technical assistance in order to meet the needs of private providers. The loan fund was

planned in two phases. First, the fund would provide loans to UPMA members to expand and improve their practices. During the latter phase, the Uganda Private Health Providers Loan Program would expand provision of loans to other private health providers.

The PURSE Project interventions were launched in early 2001. The overall directions of the original design were followed during implementation. However, it was necessary to revise many of the strategies since some planned interventions did not prove to be feasible or effective. In addition, there were many windows of opportunities, facilitated by requests from local stakeholders, which necessitated revising approaches during the course of implementation. In specific, assistance to UPMA focused on institutional capacity building in addition to restructuring KHC. Assistance to open new clinics and establish a network of private providers was replaced by wide-scale interventions to support existing clinics to improve the quality and financial viability of their private practices. Most importantly, the PURSE Project put a higher emphasis on policy dialogue and implemented specific interventions to strengthen public private partnerships in health care provision. The Uganda Private Health Providers Loan Program was implemented as it was originally designed.

The current PURSE Project Results Framework, as it has evolved over the years of implementation, is presented in Chart 1. As summarized in the framework, PURSE Project interventions covered three interrelated and complementary areas. The first group of activities relate to assisting indigenous NGOs, mainly UPMA, to achieve greater financial and institutional sustainability, and deliver value-added services and support to their membership. The second set of interventions was targeted to improve private sector clinics by assisting private providers to improve the quality and financial viability of their private practices. Finally, selective policy interventions were implemented to create a more favorable policy environment for private sector health care. Implementation of these interventions, findings on results, achievements and challenges will be discussed in the next section of this report.

Chart 1: PURSE Project Results Framework



III. FINDINGS: THE PURSE PROJECT ACHIEVEMENTS AND CHALLENGES

Support for UPMA

Background on UPMA

Established in 1948, UPMA is an NGO of midwives who offer primary health care services with an emphasis on maternal and child health care at individual private clinics nationwide. Currently UPMA represents approximately 540 midwives in private practice throughout the country. Membership is open to all self-employed midwives. To be eligible for membership in UPMA, members must be retired from public service and fully registered with the Uganda Nurses and Midwives Council. UPMA is a member of the International Confederation of Midwives.

UPMA members are organized into 11 branches covering 30 out of 56 districts of Uganda. The association conducts monthly national meetings in Kampala with representatives from branches. An elected executive committee, chaired by a chairperson, leads the association. Daily management responsibilities reside with the executive director. At present, the executive director is recruited by the CMS Project and is an employee of the project. She reports both to the executive committee and Privatising Health Services Advisor. UPMA maintains its headquarters in Kampala, staffed with a small group of salaried personnel. All other UPMA executive members work as volunteers.

UPMA plays a key role in promoting the professional development and socio-economic welfare of its members, through training, improving member communications, and access to credit. UPMA is the potential link for accessing, monitoring and assisting the midwives in private practice. During the civil war, the instability in Uganda caused UPMA to become virtually non-functional for almost two decades, as most members were severely incapacitated as service providers. It was not until early 1990s, that UPMA began reorganizing and had to reestablish itself through considerable efforts.

USAID, along with other international agencies, provided substantial support to UPMA over the last decade. USAID's support to the association began in 1991 through the SEATS Project. Between 1991 and 1999, the SEATS Project provided considerable assistance to UPMA to:

- Train midwives in reproductive health, management skills and community mobilization;
- Develop a system of Regional Representatives; and,
- Establish an association-owned model clinic in Kansanga district of Kampala, known as Family Nursing Home Kansanga.

In addition to the CMS Project, two other USAID-funded projects began providing assistance to the association in early 2000: The Futures Group International/Policy Project and the AIDS/HIV Integrated Model District Programme (AIM).

The Policy Project provides assistance in advocacy training, aimed at UPMA's Executive Committee. UPMA is currently working to develop an Advocacy Plan with assistance from

the Policy Project. The AIM Program has been assisting UPMA to develop a three-year strategic plan since last year. The strategic plan is still in a draft form. In addition, the Executive Committee members, the Executive Director and Accountant have participated in various management workshops and information technology training funded by the AIM Program. UPMA has recently submitted a grant proposal to AIM Program for expanded capacity building interventions. In addition to these current activities supported by USAID, UPMA has submitted a comprehensive grant proposal to the recently launched UPHOLD Project, again, funded by USAID.

UPMA implements a number of other projects with support from other organizations: These include UNFPA, The Global Fund for Women, IPAS and Family Care International (FCI). UNFPA has been supporting UPMA for several years. Currently UNFPA supports training of member midwives in life saving skills and donates bicycles for midwives. The Global Fund provides IT training for member midwives and helps in the establishment of outreach radio programs. IPAS assisted UPMA in training of midwives in Manual Vacuum Aspiration (MVA) to be used for post abortion care (PAC) in 2001 and 2002. FCI helped UPMA to provide training in adolescent reproductive health. International assistance to UPMA since 2000 and areas of focus are summarized in Table 1.

Table 1: International Support for UPMA 1999-2004

International Organization/Project	Timeframe	Description
USAID/CMS Project (PURSE)	2000-2004	Will be discussed in this section.
USAID/Policy Project	2002-Ongoing	Advocacy training Development of advocacy plan
USAID/AIM Program	2003-Ongoing	Management training for EC and staff Strategic planning
UNFPA	1999-Ongoing	Life saving skills training Donation of bicycles for midwives
Global Fund for Women	2001-Ongoing	IT training for members Outreach radio programs
Family Care Int'l (Private foundation)	2002-Ongoing	Adolescent reproductive health training
IPAS (Private foundation)	2001-2002	PAC Training

Source: UPMA financial and administrative records

Aside from these international organizations, UPMA was able to secure funding from the Ministry of Health for the first time in 2003. The support was used for training of UPMA

Regional Representatives in Integrated Management of Childhood Illnesses (IMCI), in collaboration with the CMS Project. (IMCI training will be discussed later in this section).

The CMS Project, through the PURSE Initiative, has been providing technical assistance to the UPMA since 2000. The PURSE Project interventions are focused in the following complementary areas:

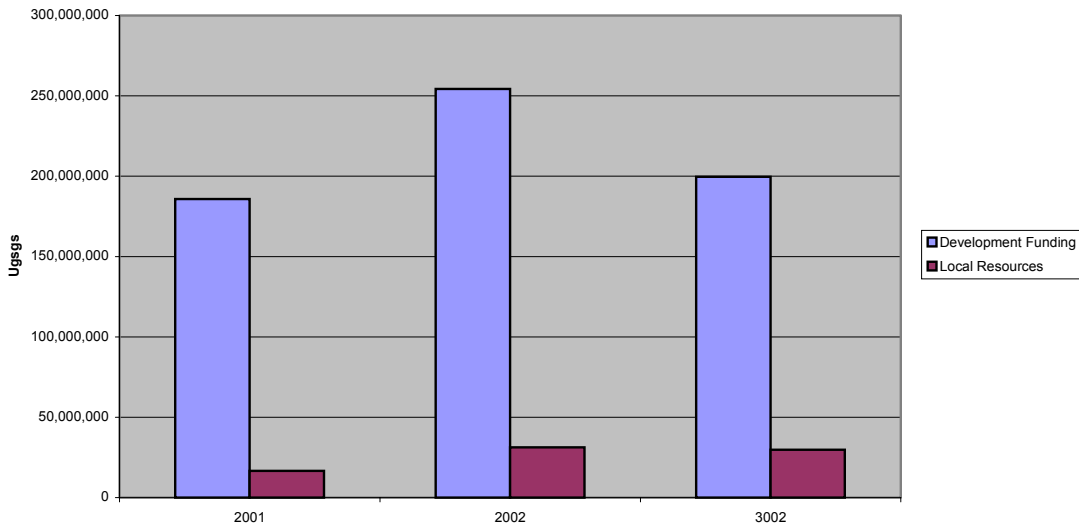
- Development of income generating activities;
- Enhancement of UPMA member communications;
- Enhancement of UPMA Visibility;
- Quality improvement; and,
- Institutional strengthening.

Development of Income Generating Activities

Reducing its dependency on donor support and improving its financial self-sufficiency has been a priority objective for UPMA for several years. Although the association had made much progress in increasing its income generating activities over the previous decade, it was still financially weak in 2000. With the ending of the SEATS Project support in 1999, the association’s income reduced dramatically in 2000. (See Table 2).

Since 2001, the PURSE Project supported UPMA through a variety of interventions to increase the association’s income generating activities as well as diversifying its external assistance base. Chart 3 summarizes the changes in UPMA income levels since 2001. The association still relies heavily on donor contributions although local and foreign income resources have grown and diversified over the years. As of 2003, 13% of UPMA’s budget came from locally generated income up from 8% in 2001 and just 2% in 1999.

Chart 2. UPMA Revenues from Development and Local Resources



* *Figures do not include miscellaneous items such as auto insurance, newsletter development, printing and postage, signpost purchasing, and subsidies for the directory.*

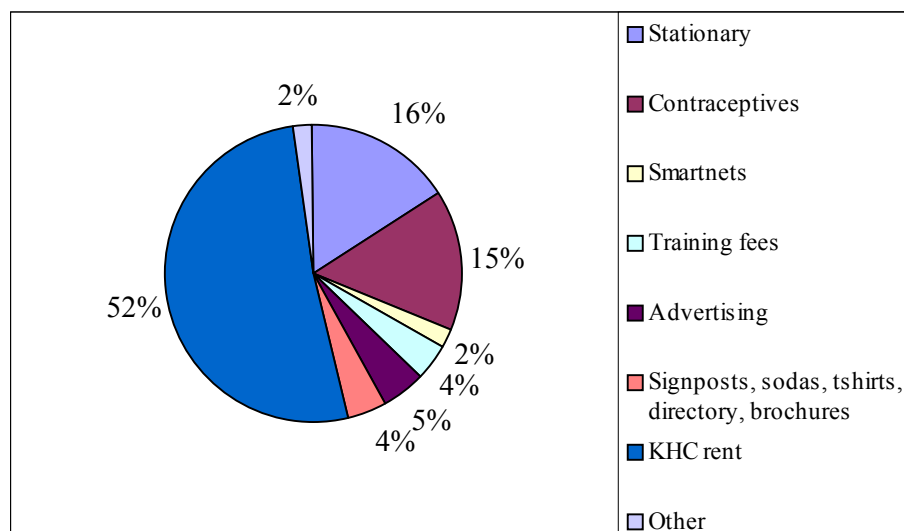
Table 2. UPMA External and Local Revenues 1999–2003 (in Ugshs)

Revenues	1999	2000	2001	2002	2003
<i>External (Development) Resources</i>					
SEATS Project	658,180,160				
CMS Project*		83,275,000	89,908,233	79,497,000	70,775,000
POLICY Project				5,092,598	1,637,402
AIM Program					14,081,600
UNFPA	36,650,000		61,041,000	69,800,000	90,923,585
Global Fund			8,900,000	9,345,000	10,237,500
IPAS			25,841,375	44,125,000	
Family Care International	18,591,120			46,415,700	7,661,023
Ministry of Health					4,348,000
Total External Revenue	713,421,280	83,275,000	185,690,608	254,275,298	199,664,110
<i>Local Resources</i>					
Membership Fees	3,806,000	5,257,000	3,952,200	4,379,500	2,943,000
Sale of Stationary and Commodities	7,241,135	11,851,930	12,775,850	15,525,950	12,495,200
Rental income from KHC				10,000,000	13,200,000
Training Fees	521,500			1,433,000	1,085,000
Total Local Revenue	11,568,635	17,108,930	16,728,050	31,338,450	29,723,200
Grand Total	724,989,915	100,383,930	202,418,666	285,613,748	229,387,310

Source: UPMA Financial Records.

Between 2000 and 2003, UPMA used many means to generate income and diversify its local income sources. Chart 3 shows the distribution of UPMA local income sources as of 2003. Although UPMA was able to diversify its income generating activities substantially, its capacity to generate large sums of income is still limited.

Chart 3: Distribution of UPMA Local Income Sources, 2003.



Source: UPMA financial records

UPMA implemented the following interventions to reduce its dependence on international support and move towards financial sustainability. (Note: While many efforts were directed at increasing local and external revenues of UPMA and controlling its expenses particularly those associated with Kansanga Health Centre, a detailed analysis of the impact of these efforts on the long-term financial sustainability of UPMA is beyond the scope of this evaluation.)

- *Diversification of International Resources and Support:*

The PURSE Project helped UPMA to seek and secure support from other international agencies and projects to lessen its reliance on a few projects. The Project was helped link UPMA with other USAID-funded projects such as the AIM Program to position the association to continue to receive needed support. The PURSE Project also played an important role in helping UPMA to receive funding from the MOH for training of its regional representatives in IMCI. More recently, the Project was instrumental in facilitating discussions between UPMA and the newly launched UPHOLD Project to ensure that the association continues to receive additional financial and technical assistance once the CMS/Uganda program ends.

UPMA has been able to diversify its international donor base. In 1999, the association relied on assistance from three international agencies while as of 2003, there were six projects contributing to the mission of UPMA. However, uncertainties in levels of funding and continuity of donor assistance remain an issue for UPMA. There is room for

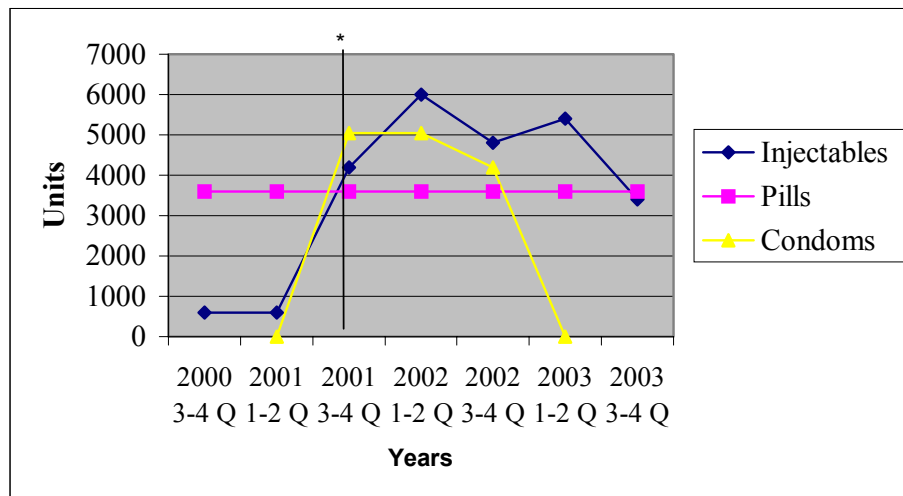
UPMA to further diversify its international assistance base and develop strategies to ensure continuity. (See Table 2)

- *Group Discount Program for Commodities:*

Sales of stationary and commodities to member midwives is one of the top local income sources for UPMA. The PURSE Project helped UPMA to develop a group discount program for CMS social marketing products to encourage members to buy products from UPMA at favorable prices. In addition, the Project assisted UPMA to negotiate a discount-buying program with Rene Pharmaceutical Company. These two programs helped UPMA members to purchase commodities and supplies at reduced prices and also helped the association to secure additional sources of income.

The CMS discount program was initiated in mid-2001 through which CMS social marketing products were provided to UPMA at wholesalers' prices. The program improved the pricing structure and significantly increased CMS product sales, particularly contraceptive sales, to UPMA in 2001 and 2002 (See Chart 4). Injectable sales increased four-fold between 2001 and 2003. Pill sales remained at the same levels over the years. In addition to contraceptives, CMS provided preferred pricing to UPMA for its mosquito nets and clean delivery kits.

Chart 4: UPMA Discount Buying Program for CMS Social Marketing Contraceptives



Source: CMS Project Social Marketing Products Sales Records

* Introduction of discount buying program.

In late 2002, the social marketing program was turned over to PSI from CMS and the commodity prices were increased. The price increase caused a reduction in UPMA purchase of commodities. At the same time, the MOH began providing free contraceptives to private midwives, which accelerated further reduction in UPMA purchases. UPMA also ceased purchasing CMS condoms, as a result of client preferences. UPMA members found out that the majority of their clients preferred

another socially marketed condom brand and that MOH also provided private clinics with free condoms.

Group discount program for CMS social marketing products to UPMA is an innovative approach to benefit all players. CMS social marketing sales increased while UPMA was able to secure additional income. The recent increase in commodity prices seems to have a negative effect on UPMA commodity purchases, which deserves further analysis. At the time of the review, UPMA had just begun re-establishing a group discount program with PSI Uganda.

- *Increasing membership and dues collection.*

CMS worked to both increase overall membership in UPMA, and increasing the percentage of members that pay the annual dues. Currently 540 privately practicing midwives are registered members of UPMA. However only about 1/3 of the members pay regular membership dues and this proportion has not changed much over the recent years. As of 2003, 207 members have paid dues. The annual membership fee is 20,000 Ugshs. and it is an important income source for UPMA.

The PURSE Project helped UPMA to expand its membership and place an increased emphasis on dues payments through various approaches. For example, the association established policies that only enable members to access training and purchasing discounts if they paid dues. The association's newsletter (will be discussed later) included articles to provide information on UPMA, and advantages of being a member. The regional representatives also provided information to both member and non-member midwives about the association, encouraged midwives to become members and pay dues on time. The association also began introducing new members at each monthly general meeting for recognition.

Despite these efforts, the number of UPMA dues paying members seems to have plateaued over the years. There appears to be various reasons for low rate of dues payment. First, the majority of the private midwives income levels are low and a proportion of the midwives may not afford the annual fee. Second, some midwives may not be fully aware of the advantages of being a UPMA member. Finally, lack of banking services might be a factor for many midwives, in particular in rural areas, for not paying dues. Member midwives are expected to pay their annual fees at the headquarters or branches in cash. It also requires a sustained effort from the association leadership and management to encourage payment.

- *Restructuring of Kansanga Health Centre:*

A key area in which the PURSE Project was instrumental in helping UPMA to increase its income was the restructuring of Kansanga Health Centre (formerly Family Nursing Home Kansanga). KHC was built, equipped, and staffed by funds provided through the SEATS Project in late 1990s. The facility is located in Kansanga, a neighborhood on the edge of Kampala city center. The neighborhood is a residential area, mainly comprised of middle-to-higher socioeconomic tier families. KHC is a three-story facility, with 15 beds and a fully equipped surgery theater. It serves as a small general hospital.

KHC was originally intended as a model clinic that would generate income for the association. However, the facility was unable to generate profit, mainly because of its location and low client volume. The residents of Kansanga tend to prefer health services provided by doctors rather than midwives (except for maternity services) and have easy access to hospitals in Kampala. With the conclusion of the SEATS Project in 1999, UPMA was unable to subsidize the operations of the hospital. Unpaid expenses increased each month and the clinic was threatening the overall financial standing of the association and became a drain on management and resources.

The PURSE Project assisted UPMA to consider options for turning the facility into an income-generating asset. UPMA evaluated several alternatives and ultimately in 2002, decided to rent the facility to a sub-group of member midwives who were highly committed to the clinic. This group of about 30 midwives formed Determined Private Midwives for Sustainability (DPMS) and rented the clinic from UPMA to generate income for the association. The new management was able to lower the costs of KHC by reducing staff and diversifying services. Since this change, the clinic's financial situation has been significantly improved, however it is still not financially stable. Over the last two years DPMS had difficulty in paying the negotiated rent and the amount was revised. Although the facility is financially self sufficient now, it is barely making its ends meet.

From a sustainability standpoint, KHC has little value for UPMA. KHC also poses as a management burden for the members of the DPMS, since all DPMS members have their own private practices and have to devote time for the management of KHC. Despite these negative consequences, UPMA management and members are proud of the facility and have a very high sense of ownership. As the UPMA Chairperson stated, "KHC is our pride. Even the best doctors in Uganda do not have such a nice facility". Nevertheless, KHC continues to be a concern for UPMA and the future sustainability of the facility remains uncertain.

Enhancement of UPMA Member Communications

UPMA members are spread throughout the country but the communication channels between the members and the association are very limited. In an effort to better inform member midwives about activities of UPMA and to encourage members to actively participate in those activities, the PURSE Project helped the association to launch several communication initiatives.

- *Creation of a quarterly newsletter:*

UPMA established a quarterly newsletter that informs members about association activities and provides health updates to members and other stakeholders. Given the widespread distribution of members and the inability of all midwives to attend either branch or general meetings, this newsletter provides an important channel for communication. The newsletter, mailed to all members, also generates income through the advertisements and provides an excellent outlet for promoting CMS products.

- *Development of membership database and directory*

The PURSE project also helped UPMA to develop a membership database and a directory to keep track of members. An improved software application enables the association to routinely update information and produce an association directory. The directory is sold to the members, which provides additional income for the association.

- *Monthly General Meetings*

UPMA restructured its monthly general meetings to deliver more value to its members. These sessions are now used to provide continuing medical education for members. Each month, a guest speaker is invited to speak at the meeting on relevant topics. Sessions cover a variety of topics such as management of malaria, family planning, infertility, and PMTCT. Upcoming meetings are announced through the newsletter. Attendance at monthly meetings grew significantly with the introduction of the guest speaker program. In 2001, attendance averaged 30-40 members per month but often reached over 90 members in 2003 before the association moved the venue of the monthly meeting to its head office.

Enhancement of UPMA Visibility

Since Ugandan laws prohibit advertising and promotion of private health care services, UPMA members cannot directly market their clinics and services. One of the value added services that UPMA began offering its membership, with assistance from the PURSE Project, is indirect promotion to help build clinic clientele.

- *Development of sign-posts*

The PURSE Project helped UPMA develop clinic signposts for sale to its members as an income generating activity and member visibility initiative. Members use signposts to announce their membership in the association, on the premise that clients associate UPMA membership with higher quality services.

- *Development of Health Brochures*

The association also developed and sold health education brochures called “Health Tips”. These are customized client education brochures on six different health topics. The brochures help to educate the communities in health care while providing information on UPMA and its members. In addition, sale of these brochures to members generates income for UPMA.

- *Development and Distribution of Newspaper supplements*

UPMA developed and distributed more than 40,000 newspaper supplements promoting the association and listing clinics with UPMA members’ locations throughout the country.

Quality Improvement

UPMA is committed to assist its members in updating their clinical skills and promoting quality health care services. To assist the association with this goal, the PURSE Project implemented various interventions:

- *Regional Representatives Program:*

To support the UPMA goals in quality improvement, the PURSE Project provided funding and technical assistance to the association's Regional Representative (RR) program, a peer education and support program that uses UPMA members as trained volunteers. The rationale for the program is to improve the quality of services provided by private midwives and to strengthen UPMA as an organization. The system was created to provide service support and supervision of members and communicate with the head office. The RR program was initially launched in 1993 with assistance from the SEATS Project. Until 1996, UPMA trained 30 RRs in management supervision, including skills development and use of facility checklists. The program discontinued after 1996, mainly due to lack of donor funding. In particular, the association was not able to pay for the transportation of the RRs.

UPMA sees the RR program as an important vehicle to ensure quality and professionalism of member midwives and requested assistance from the PURSE Project to continue the initiative. In 2002, with assistance from the project, the association was able to revitalize the program.

The regional representatives are elected based on their qualifications and experiences. UPMA provides one day training and reorientation for the representatives and provides transport reimbursement. The RRs are requested to conduct site visits to assigned clinics once every four months. On average, a representative is expected to conduct 3 or 4 clinics visits per month and is also expected to visit at least 3 non-member midwives each quarter although the number of actual visits reported has been less than expected.

The RRs carry out a variety of tasks during visits by using facility checklists as a key tool. The facility checklist is a comprehensive questionnaire, and includes over 70 entries. It is patterned after the Yellow Star quality program within the Ministry of Health. The topics cover infrastructure, equipment, supplies, record keeping, infection prevention practices, and quality of services. The list also covers several other questions regarding member-UPMA relations. During visits, the RRs provide clinical support to the peer midwives, help members to identify clinical problems and offer practical ways to solve them, and assess the members' training needs. The RRs are also intended to act as liaisons between the association and the midwives. They inform members about UPMA activities and events, promote UPMA products and services and support members to become active in UPMA. In addition, they encourage non-members to join UPMA.

Currently there are 42 RRs, and since 2002, the representatives have completed 757 visits to member midwives. Originally, the RRs were expected to report to the branches. However, since the coordination and communication between the branches and the headquarters is not optimal, they currently report directly to the head office. The

reporting is accomplished by using the facility checklist. Through PURSE, UPMA head office established a computerized database to enter the reports from the RRs to enable the association to analyze the information obtained through the program. Unfortunately, at the time of the assessment, there were problems with the software and it was not working. Nevertheless, the consultants were able to convert the data into another program and attempted to analyze the data to assess the impact of RR visits.

The findings from all clinics were entered into the database; however, it was not designed to track the changes in individual clinics. Thus the consultants grouped the data from 2002 and 2003 to examine if there were changes in indicators over time. The findings are presented in Table 3. Results indicate that 25 out of the selected 37 indicators improved between 2002 and 2003. Positive changes were found mostly in indicators related to presence of essential drugs and supplies, infection prevention measures, and record keeping practices. For example, presence of debtors books in clinics improved by 10 percentage points and correct use of aseptic techniques improved by nine percentage points in 2003, compared to the findings in 2002. This could be attributable to providers access to business skills and infection control training in this period. In contrast, indicators related to some infrastructure criteria and presence of essential equipment either did not change or worsened between 2002 and 2003

Although RR program data was being routinely collected since 2002, UPMA has not yet conducted a thorough analysis of the data. The staff created some tables and charts using the software, but they were not helpful to monitor the program. It would have been more useful if data were analyzed to help UPMA board and staff to monitor and improve the program. Nevertheless, UPMA members and RRs interviewed through this assessment were satisfied with the program.

The RR program is a potentially effective approach in providing support to private midwives however, additional efforts are needed to streamline and increase its impact. First, the program needs closer and stronger coordination, which is not currently being adequately handled by the limited staffing. A more structured follow up is needed to increase the effectiveness of the efforts. Most importantly, the program needs a user-friendly database to be used as a “management tool”. Data needs to be routinely examined to guide monitoring and evaluation of the program.

Transportation of RRs continues to be a concern for some representatives. UPMA provides support for transportation but midwives contend it is not enough to cover the entire costs especially if they factor in lost time. Another challenge is related to the clinical knowledge base and skills of the RRs. The representatives are selected by their peers. Many of them have already undergone a variety of clinical skills training supported by international agencies or the MOH, but their skills are not standardized. Therefore it is questionable whether all representatives possess updated and standard clinical knowledge and skills to assist the peer midwives.

- *Provision of IMCI training:*

Building on prior successes of private provider training in Integrated Management of Childhood Illnesses (IMCI) initiative, the PURSE Project assisted UPMA to provide the same type of training to its membership. In addition, UPMA was able to secure funds

from the MOH to provide IMCI training to its regional representatives. To date, 5 workshops exclusively for UPMA members, were conducted to train 186 midwives, including 24 RRs in IMCI skills. The PURSE Project also helped the UPMA through training of eight trainers of trainers (TOTs) qualified to provide IMCI training, supervision and monitoring. This is a noteworthy capacity building contribution. IMCI training is highly appreciated by all UPMA members interviewed through this assessment. The methodology of IMCI training and results are discussed under the next section.

- *Provision of Business Skills Training and Improved Access to Credit*

As part of the Summa Foundation's Uganda Private Health Providers Loan Fund, and with assistance from the PURSE Project, UPMA members had access to micro credit and training in basic business skills. To date, over 200 midwives received a total of 430 loans. The Uganda Private Health Providers Loan Program and the associated business skills training had a remarkable impact on improving the members' private practices. These interventions are discussed in detail in the next section of this report.

In addition to these interventions specifically designed to improve the quality of services by the private midwives, many of the other activities mentioned in this section helped to enhance the quality at the member facilities. Examples are clinical articles published in the quarterly newsletter and the continuing medical education sessions held during the monthly meetings.

Table 3: RR Program Data: Change in Indicators between 2002 and 2003

Indicator	2002 Percentage Yes N=277	2003 Percentage Yes N=442	Percent Change
Presence of clean water supply	92	96	+4
Presence of clean toilets	95	95	0
Presence of an examination couch	89	85	-4
Presence of a delivery couch	100	100	0
Presence of a thermometer	95	96	+1
Presence of a fetoscope	95	95	0
Presence of a BP/cuff machine	93	93	0
Presence of a stethoscope	93	94	+1
Presence of an adult weighing scale	79	76	-3
Presence of equipment for boiling	95	95	0
Presence of a speculum	80	76	-4
Presence of baby weighing scale	52	56	+4
Presence of ORT corner	47	53	+6
Submission of monthly reports	61	64	+3
Are stock cards updated regularly?	39	48	+9
Availability of Chloroquin	91	95	+4
Availability of Fansidar	89	95	+6
Availability of Cotrimoxazole	89	95	+6
Availability of Ergometrin	91	95	+4
Availability of Vitamin A	79	79	0
Availability of Folic Acid	86	94	+8
Availability of Depo-Provera	82	90	+8
Availability of condoms	82	89	+7
Presence of cash analysis book	39	43	+4
Presence of delivery book	87	89	+2
Presence of family planning book	72	75	+3
Presence of treatment book	86	90	+4
Presence of receipts book	61	64	+3
Presence of debtors book	53	63	+10
Presence of profit/loss statement	95	95	0
Hand-washing practices	78	79	+1
Presence of disinfection equipment	78	80	+2
Proper disposal of sharps	71	73	+2
Correct aseptic techniques	74	93	+9
Client privacy	93	91	-2
Presence of referral systems	81	75	-6
Does the owner pay annual dues?	43	47	+4

Source: Regional Representatives Program Database, UPMA.

Institutional Strengthening

The PURSE project placed a higher emphasis to assist UPMA in institutional strengthening over recent years. Specific interventions included improving the accounting systems, training of the executive director and the staff in management skills, and development of UPMA service statistics database.

- *Improving accounting systems*

Although UPMA had received assistance in financial management through the former SEATS Project, the association's capacity to monitor and control costs needed further strengthening. The PURSE project continued to provide technical assistance on institutional and financial responsibility. The project helped UPMA to install the QuickBooks accounting software and train staff in its utilization. Through assistance from the PURSE Project, UPMA was able to establish a budget, which it had not done for many years.

- *Training in management skills and information technology*

To improve UPMA's management capacity, the PURSE Project supported the Executive Director to receive additional management training. The Executive Director received management training through a local NGO; Private Sector Foundation. The Executive Director was also trained on publishing software to enable the association to produce the newsletter internally. In addition, UPMA and the board members received limited computer and information technology training through CMS.

- *Development of service statistics database*

With support from the PURSE Project, UPMA also started compiling monthly service statistics data from members. The purpose of this initiative was to have a better understanding of the magnitude of member services. This was often a question UPMA received from donors and others who are interested in working with the association.

All private midwives are also requested to fill out and return Health Management Information System (HMIS) forms to MOH. HMIS forms are difficult to fill in so there is a high level of non-compliance. Thus, UPMA's intent was to create a simple form that midwives could fill out easily. An analysis of monthly services statistics reveals that, although these forms are more user friendly compared to MOH HMIS forms, only a fraction of the midwives fill in and return monthly statistics. The number of reporting midwives had increased to 64 in January 2003, which reduced to only 21 in December 2003. Since such a small proportion of the practicing midwives report on service statistics, the compiled data is not meaningful. Given these facts, UPMA should reconsider continuing to collect service statistics from member midwives.

Support for other NGOs

In addition to support of UPMA, the PURSE project kept close contact with other health care provider associations including the Uganda National Association of Nurses and Midwives

(UNANM), the Uganda Medical Association and the Uganda Private Medical Practitioners Association (UPMPA). The assistance provided to these professional associations included sponsoring meetings, presentations at conferences, provision of information on products, participation in branch meetings, training opportunities and the Uganda Private Health Providers Loan Program. Despite the limited scope of support, the NGOs, in particular UNANM significantly benefited from the project interventions. Members of these organizations were able to participate in training courses and several members had access to credit through the Uganda Private Health Providers Loan Program. CMS was also able to establish strong relationships with these associations that aided in policy efforts discussed later.

Private Provider Initiatives

The second broad component of the PURSE Project relates to improving the quality and financial viability of private clinics. Professional associations like UPMA are valuable partners in enhancing quality health care service delivery and access yet these associations reach only a portion of health providers in the private sector. Thus the PURSE Project designed a set of interventions to reach segments of health care providers to improve the effectiveness of private clinics in meeting health care needs. The project's approach was to focus on existing private provider clinics that require further technical and financial support to enable them to succeed. The interventions under the Private Provider Initiative included the following:

- Private Health Providers Loan Fund and Business Skills Training;
- IMCI Training;
- Best Practices Bulletin; and,
- Health Plan Franchise Clinics.

Private Health Providers Loan Fund and Business Skills Training

In 2000, the Summa Foundation¹ conducted a comprehensive assessment in Uganda to assess the needs of private midwives and other private providers. This research revealed that there was a significant demand for credit to expand and improve practices and there was a capacity to repay. The assessment also examined the private providers' business skills and knowledge of credit and found that most providers were not keeping adequate service statistics and financial records and were not able to use these records as a management tool. It was also determined that most private providers did not have experience in accessing credit or managing it and concluded that this should be included in a package of technical assistance. Based on these findings, Summa Foundation established the Uganda Private Health Providers Loan Fund.

The objective of the Uganda Private Health Providers Loan Fund Project is to provide access to credit and technical assistance to private providers, thereby increasing the viability of their practices and improving and expanding their services. The project was implemented in two phases: In phase one, the fund targeted UPMA member midwives. During the latter phase, the fund expanded to include other private providers.

The PURSE Project played a valuable role in implementation of Summa Foundation's loan fund. The project provided upfront expenses for the program including computers, vehicles, and loan officer's salary for two years. The project also provided extensive marketing support for the loan project throughout the initial years. PURSE also expanded business skills training to more providers than Summa's original workplan provided. Since the loan program became fully self-sustaining in two years, the project ceased direct support for the Uganda Private Health Providers Loan Program.

¹ The Summa Foundation is a not-for-profit organization created in 1992 with USAID funding to provide financing and technical assistance to private organizations engaged in health care activities in developing countries. The Summa Foundation is currently operating under the CMS Project and employs a variety of financing mechanisms such as direct loans and revolving funds.

The PURSE Project was responsible for the daily oversight of coordination among various partners, and monitoring and evaluation of program activities. The PURSE Project worked with several partners in order to maximize the Uganda Private Health Providers Loan Program's impact and future sustainability. Each partner had a specific role:

- Uganda Microfinance Union (UMU): UMU is a non-governmental organization with the mission of providing financial services to low income people in Uganda. UMU had the overall responsibility of administering the loan fund, including marketing of loans, processing applications, approving or rejecting loan requests, collecting repayments and monitoring outstanding loans. UMU's received the corpus of the loan fund through a \$175,000 loan from Summa Foundation later increased to \$350,000.
- UPMA: The primary role of UPMA toward the Uganda Private Health Providers Loan Program was marketing and promoting it to its members, so that the loan fund would target high quality private providers. The UPMA also had an important outreach function in helping to organize the midwives who were interested in attending training.
- National Smallholder Business Center (NSBC): NSBC is a Ugandan Company, formerly operating as a locally implemented project of ACDI/VOCA. NSBC provides a comprehensive range of technical services, including training, consultancies and research, to cooperatives and small-scale enterprises. NSBC's role was to train providers in basic business skills.

Between January 2001 and June 2003, the Uganda Private Health Providers Loan Program provided a total of 970 loans to private providers, including midwives, nurses, doctors, clinical officers and pharmacists. There were 482 one-time borrowers while 488 were repeat borrowers, with many providers on their third and fourth loan. Loans were extended for 6 to 12 months and ranged from roughly \$200 to more than \$7,000, while the average loan size was around \$900. Providers who successfully repaid their first loans took additional loans for larger amounts. Loans applied an interest rate of 3.5% per month on a declining basis. Repayment rate was 99 percent. As of December 2003, the loan program had disbursed over \$960,000 in loans to private providers.

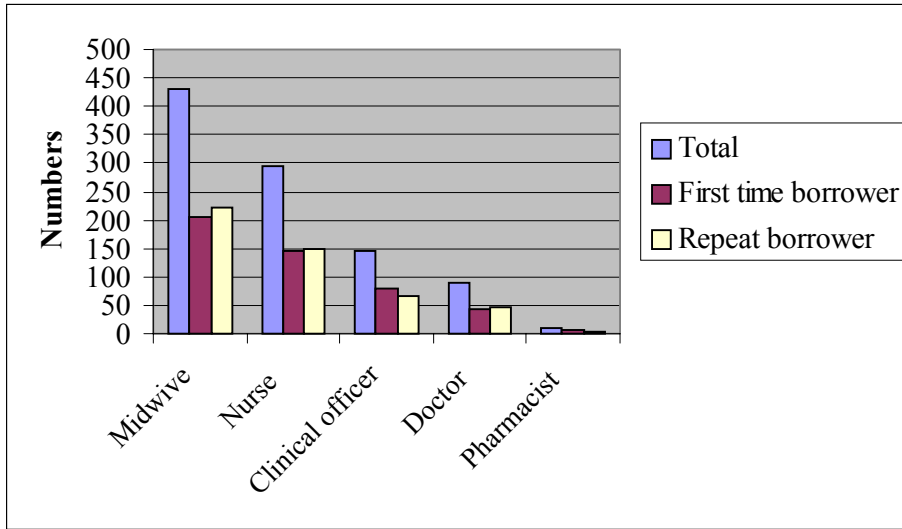
The majority of the borrowers were midwives (44%), followed by nurses (30%) and clinical officers (15%). Doctors comprised 9% of the borrowers. Chart 5 shows numbers of first-time and repeat borrowers by their professional background.

An overwhelming proportion of borrowers (56%) defined their clinics as being in peri urban areas in comparison to rural (18%). Half of the borrowers described the majority of their clients as lower middle income, followed by middle income (38%) and poor (10%). All borrowers provide family planning services, including injectables, condoms and pills.

Data from the Uganda Private Health Providers Loan Program suggests that providers typically took loans to purchase drugs and equipment, and to renovate and/or to expand their clinics. (See Chart 6). Over 70 % of first time borrowers and more than 60% of repeat borrowers purchased drugs. Approximately 1/3 of all borrowers used loans to purchase

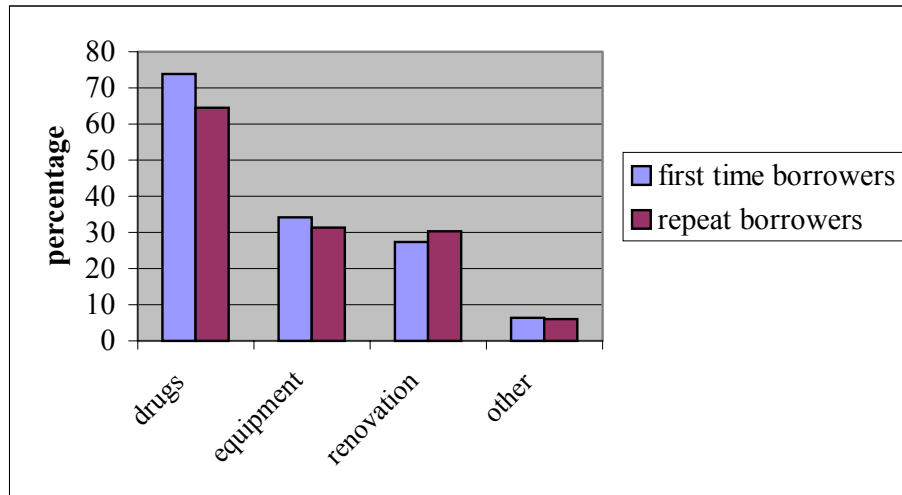
equipment. Thirty percent of the private providers used loans to renovate and/or expand their clinics. The proportion of private providers using loans for renovation was slightly higher among repeat borrowers, compared to first time borrowers.

Chart 5: Distribution of Loans by Provider Type



Source: Summa Foundation Semi-annual Reports

Chart 6: Percentage distribution of loans by planned use of the loan



Source: Summa Foundation Semi-annual Reports

In addition to financing, an important dimension of the Uganda Private Health Providers Loan Program was provision of basic business skills training to private providers and would-

be loan applicants.² The PURSE Project provided business skills and loan management training to 446 private providers between January 2001 and January 2004. (An inventory of 18 training courses conducted in this period is found in Appendix F). The purpose of this training program was to impart basic business and credit management skills to private providers in order to strengthen the success of the Uganda Private Health Providers Loan Program and to support the on-going development and viability of their practices.

The training curriculum was designed in a number of modules that could be conducted one day a week over five weeks. This arrangement best suited the needs of private providers. Providers were trained in business planning and management, record keeping, financial reporting, credit management and marketing. The training program was conducted through a contract with National Smallholder Business Centre. Through the course, modules were strengthened to focus attention on approaches for improving quality of care, including client provider interactions, availability of drugs and supplies, hygiene and sanitation, patient confidentiality, and affordability. An innovative approach was homework assignments given to the participants that included applying data from their own clinic in order to determine whether they grasped the concepts covered. Cash incentives were provided for top performers.

The PURSE Project staff actively participated in training sessions from the beginning. First, PURSE Project staff conducted sessions on social marketing products. In 2002 and 2003, PURSE project staff shared the overall responsibility of conducting the courses with NSBC. Realizing that trained providers need the opportunity to exercise their new skills on the ground and discover where there may be gaps in understanding, the project conducted follow-up visits to the clinics two months after the training sessions. Since 2001, 371 trainees received follow up visits. The purpose of the follow-up visits was to determine whether trainees were applying their new skills and to offer continuing support. The follow up visits demonstrated that providers have improved their record keeping skills and enhanced their ability to promote and expand their services. The visits revealed that 84% of the trainees successfully kept records of numbers of clients by type of service, and 70% recorded their income and expenditures by maintaining cashbooks. In addition, 63% of the trained providers were maintaining debtors books, while 50% were able to compute profit and loss statements periodically.

Data from the Uganda Private Health Providers Loan Program provides valuable insights regarding the program's impact. For example, the loans have helped expand reproductive health care services provided by the clinics while contributing to the financial sustainability of the facilities. According to the data, the number of total family planning visits reported by the second time loan applicants increased 55% over what had been reported at their first loan application. Another interesting finding is about the savings of loan applicants. Savings are an important safety net for small businesses. Only 19% of percent of the first time borrowers had savings of more than \$337. By the time of the second and third time applications, this proportion increased to 33% and to 46% respectively.

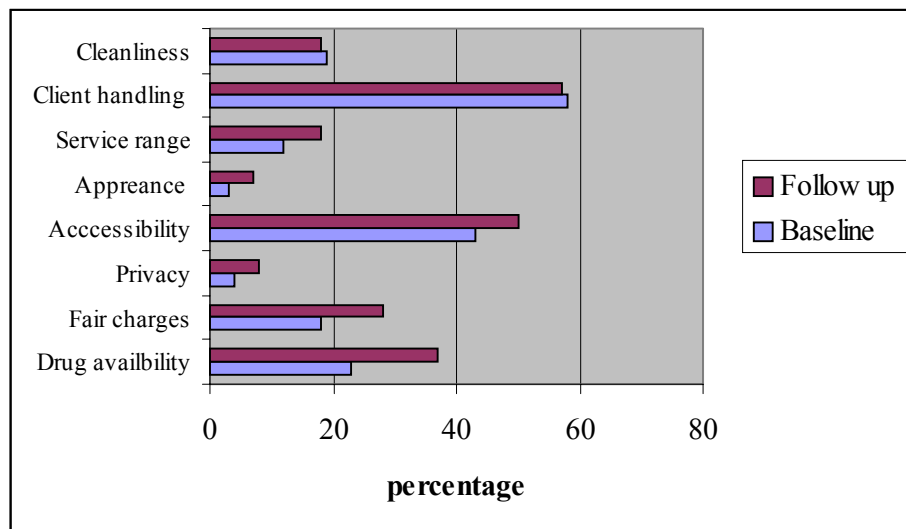
² It is worth mentioning that while these programs were highly complementary they were mutually exclusive. A clinic did not have to go through training to get a loan nor did a clinic that went through training have to get a loan.

In 2002, the CMS Project conducted a study to evaluate the impact of the Uganda Private Health Providers Loan Program on services expansion and quality of care entitled, *The Impact of a Microfinance Program on Client Perceptions of the Quality of Care provided by Private Sector Midwives in Uganda*. By S. Agha, A. Balal and F. Okello The methodology consisted of interviewing clinic clients before and after the intervention and using a comparison group to assess the impact of the loans. About 1,200 clients were interviewed in each survey at 15 intervention and seven control group clinics. The study found that there was a significant increase in the proportion of clients who received preventive maternal and child health (MCH) services at the intervention clinics. Clients at intervention clinics were 1.6 times more likely to report MCH services as the reason for their visit over baseline, but there was no similar trend in this indicator at control clinics.

The study also suggested that the loan program had increased client perceptions of service quality and client loyalty. There were significant changes at intervention clinics in perceived quality in six of the eight selected indicators, including drug availability, fair charges, client privacy, accessibility, physical outlook of the clinic, and range of services offered. There were no comparable increases at control clinics except for a significant improvement in the range of services. Chart 7 depicts changes in perceived quality of services between the baseline and follow-up surveys.

These findings, coupled with information collected from numerous interviews with key stakeholders and borrowers who benefited from the program confirm the program’s impact. The loan program, together with the business management training, has been very effective in improving private providers access to credit and thus expansion of private provider practices.

Chart 7: Changes in perceived quality of services at intervention clinics



Source: *The Impact of a Microfinance Program on Client Perceptions of the Quality of Care provided by Private Sector Midwives in Uganda*. S. Agha, A. Balal and F. Okello

Integrated Management of Childhood Illnesses (IMCI) Training

Concerned with high infant and under-five mortality rates, the Ugandan Ministry of Health (MOH) developed a training program to reduce morbidity and mortality rates due to common childhood illnesses. IMCI training integrates control of diarrhoeal diseases, acute respiratory infections, immunization, malaria case management and nutrition. Since these diseases and conditions constitute approximately 70% of all childhood illnesses, training health care providers in IMCI was expected to contribute significantly to the reduction of childhood morbidity and mortality.

The MOH recognizes the level of contribution of the private sector in delivery of health care, and in specific, the role of private providers play in the care of children. A study conducted by the MOH, for example, reveals that 80% of children with fever seek for care in private health facilities. Data also showed that private providers incorrectly manage most of the common illnesses, in specific, 81% of malaria cases, 64% of acute respiratory infections and 94 % of diarrhea cases.

Thus IMCI training for private providers was intended to change malpractices of providers for a number of common childhood illnesses using standard guidelines. In 2001, the PURSE Project, in coordination with the MOH and DISH II Project, began offering IMCI training to private providers. To date, 10 three-day IMCI training workshops were conducted to train 222 private sector providers. The majority of trainees were midwives as PURSE expanded the program through UPMA. The training program also helped build capacity within UPMA through training of a group of trainers within the association. It is also worth mentioning that the business skills training program provided a foundation for IMCI intervention to be effective, by helping the providers to gain a solid understanding of record-keeping and marketing. IMCI training program would not have been as successful, if the providers had not participated in business skills training first.

As of February 2004, 153 trained providers were followed up about 4 weeks after the training to assess whether they were using the skills acquired during training and assist them to solve any outstanding problems. The follow-up methodology included specific tools to guide the intervention. The first tool is a verbal case review to analyze diagnosis of cases, treatment, caretakers' knowledge about the prescribed drugs and counseling given. The second one is a facility support tool to analyze the availability of essential drugs and equipment in the facility. A final tool assesses the provider's overall performance by analyzing availability of recorded and individual performance. Finally, the supervisors make a general impression of the provider and rate them as excellent, satisfactory or poor. A key finding from the follow up visits is that private providers were willing to change their behavior and prescribing patterns to comply with the guidelines even though some of the recommended treatments would ultimately be less profitable for the provider. According to observations made during the follow up visits, 83% of the trained providers were able to administer or prescribe the correct course of treatment.

IMCI training for private providers is highly valued by all trainees interviewed by the assessment team. The trainings address an important need by updating the knowledge base and clinical practices of private providers in management of common childhood diseases.

The results from follow up visits confirm that the trainings were successful in changing malpractices of private providers. In addition, the assessment team has observed during site visits, that common childhood diseases were successfully treated using internationally accepted treatment standards.

Best Practices Bulletin and the Special Report

The PURSE Project initiated the publication of the Best Practices Bulletin in 2002 with the purpose of updating the private providers in current best practices to improve the quality of services provided by private providers. The effort also enabled CMS to stay connected with these private providers once they had completed training. The Bulletin is prepared by the PURSE Project staff and published bi-monthly. As of January 2004, the Bulletin had published its 13th issue. The PURSE Project distributes the Bulletin to a wide array of private providers by using its trainee and loan database. On average, the project distributes approximately 450 copies bi-monthly to private providers who have received a loan or participated in business skills training. Private providers interviewed during this assessment found the Best Practices Bulletin to be a helpful communication initiative.

The project also prepared and published a special report, titled “How Successful is Your Clinic?” in 2002. This publication was prepared using information collected from approximately 250 private clinics, which had applied for loans. The document provides basic financial information to help private providers to assess how they manage their businesses and what they can do to improve their practices. It also served as a marketing tool for the Uganda Private Health Providers Loan Program by providing information on how to access the loan program.

Health Plan Franchise Clinics

A final activity designed by the PURSE Project under the Private Provider Initiatives was the development of a model franchise clinic in Uganda that would extend health care coverage through pre-paid health plans to new markets. AAR Health Services Ltd. approached the Project as a disinterested third party with a commitment to private sector health care, to help implement a franchise program in Uganda. AAR is a private company involved in providing pre-paid health care services in the East African Region largely through its own health centres. It is the largest health maintenance organization in East Africa and has been a presence in Uganda since the early 1990's. The company had established a successful model franchise program in Kenya that enabled it to reach more people through improved access at lower cost since AAR did not have to build and own facilities but rather franchised private clinics to become AAR health centres. The Kenya project had received financial support from Dfid. AAR was interested in finding partners to replicate this model in Uganda and CMS was interested in exploring the ability to extend pre-paid health care coverage to a larger portion of the population. The purpose of the franchise model is to extend the high quality services of AAR to other areas in a manner that is less capital intensive than AAR building its own clinics and that brings prepaid health care to new markets and to new market segments. Finding lower cost alternatives to delivering prepaid health care will enable more employers and consumers to access this type of coverage.

The PURSE Project and AAR developed an MOU in 2003 to collaborate on establishment of an AAR franchise program in Uganda. According to the MOU, the PURSE Project provided support to AAR by assisting in establishment of criteria for potential medical centers. The project also helped to identify potential clinics as franchise partners, and helped negotiate the terms of the franchise agreement with the chosen facility, Victoria Medical Centre in Entebbe.

In October 2003, the first franchise agreement with AAR was signed with Victoria Medical Centre in Entebbe. The center made significant improvements to its clinic and was “re-branded” as an AAR Health Centre. The owner of the clinic is so far optimistic about the future of the franchise agreement. He told the assessment team that he thought the fee charged by AAR was high, but he wanted to be a franchisee because AAR helped with marketing of the clinic and training of the clinic staff. The franchise agreement had only been in effect for less than three months at the time of the assessment. It is too early to assess its impact on the operations of the clinic.

Public Private Partnerships

Support for Development of Private Health Providers Policies

Resources devoted to private providers promote sound business practices, enhance access to services and improve clinical practices. However, scaling up successful interventions requires policy changes at the national and district levels. Toward this end, the PURSE Project entered into policy discussions with key stakeholders in the country, including the Public Private Partnership for Health Office within the MOH. The Project's policy efforts aimed to improve the environment in which the private health providers function, and to help providers to adapt to evolving priorities and regulatory issues.

Over the last decade, the Government of Uganda has spent considerable efforts to put in place policies and plans to address the health sector development in the medium and long term. One of the areas the government has emphasized is to address “partnerships “ among the public and private sector stakeholders and providers. For the past several years, the MOH has been formulating a partnership initiative with private health care providers including private-not-for-profit providers (PNFPs), private health providers and traditional healers. In 2000, a Public Private Partnerships for Health (PPPH) Office was established within the MOH to lead and facilitate coordination of the partnership efforts. The Italian Cooperation Agency supported the establishment of the office and provided a long-term consultant to assist in implementation of the partnership initiative. The PPPH office concentrated its work on developing policy frameworks and implementation guidelines for the private sub-sectors in health: PNFPs, private health care providers and traditional healers. Since 2001, the PURSE Project staff worked closely with the PPPH office and was actively involved in the initiative, by serving on working groups and providing technical assistance as needed.

In early 2003, the PPPH undertook a mid-term review of the progress of the public private partnership initiative. The review concluded that considerable progress had been made in the areas of partnership with the PNFP sector; however, limited progress was reported to further the partnership between the government and private health providers. The study cited many reasons for this slow progress including inadequate organized structure for collaboration with private health providers and unfavorable attitudes of the MOH toward private health providers.

After working with private sector health providers, developing an understanding of their issues and cultivating a sense of trust, the PURSE Project was uniquely positioned to help shape the policy environment that affects private health providers. The MOH requested increased involvement of the PURSE Project to provide assistance to private sector providers as they adapt to evolving national priorities and legal and regulatory settings. As a first step, the PURSE Project helped draft a concept paper to identify areas of collaboration between the MOH and private health providers. This document elaborated on several areas for establishing a closer working relationship between the MOH health services and private health providers. These areas included health promotion, policy and planning, training, service provision, referral systems and regulatory environment.

Throughout 2003, the PURSE Project worked closely with the PPPH to develop the National Policies regarding the private health providers. The project's assistance included sponsorship

of stakeholders workshops, support for a local consultant to work with the drafting committee to prepare policies and guidelines, as well as active participation on the committee. The draft Policy Framework for Partnership with Private Health Practitioners was finalized in 2003. Soon after, the committee began drafting the implementation guidelines.

The MOH officials in charge of the PPPH are extremely committed to this initiative and optimistic about the future impact of the policy work. The officers believe in the rationale of the partnership and are committed to move it forward. Some interviewees voiced their concern over the long years that they have struggled to develop national policies for public private partnership initiative. However, senior MOH officials are very satisfied with the progress made over the recent years. They acknowledge, and highly praise the role the PURSE Project played in facilitating the process. In specific, the officers appreciate the depth of technical assistance provided by the PURSE Project. “This kind of work does not require a lot of financial resources,” commented one senior officer, “what we need is the know-how and experienced people to help us walk through the process. This is what we received from the PURSE Project”.

The progress made towards the development of public and private partnership has been successful so far, however, the initiative is still in its early stages. Development of implementation guidelines had just begun at the time of this review. The MOH will need, and deserves continuing assistance contributing to this initiative.

Reduction of User Fees in the PNFP Sector

PNFP providers, in particular, faith based organizations play a significant role in Uganda’s health care system by serving the poor and less privileged. Currently 44 hospitals and 525 health units operate nationwide. These units belong to one of three faith-based umbrella organizations: These include Uganda Catholic Medical Bureau (UCMB), Uganda Protestant Medical Bureau (UPMB), and the Uganda Muslim Medical Bureau (UMMB). These umbrella organizations represent this sector with the government at national levels and provide technical support and training to their members. In recognition of the sector’s contribution in serving the most needy, the Ugandan Government provides financial support to the PNFPs through delegated Primary Health Care Grants. In return, the Government expects PNFP facilities and providers to reduce client fees in line with its own policy of eliminating user fees in the public health facilities.

Owing largely to economic decline and sustainability challenges, the PNFP sector gradually increased its dependency on user fees during the 1990s and the user fees were substantially increased by early 2000s. This rise is not matched by increased ability of the people to pay, thus the PNFP sector relied on Government subsidies to ensure access of the poor to their services. Some facilities were able to maintain low fees with support from Government grants but many others did not reduce their fees although they continued to receive Government support. In early 2003, the three medical bureaus decided to take actions and requested all facilities to examine their fee structures and reduce their fees to ensure that they remain true to their mission and strive to serve the most vulnerable, defined as women, mothers and children.

The bureaus launched a user fee reduction initiative under the name of "Faithfulness to the Mission" with the goal of reducing user fees through a careful process to increase access to the poor. Soon after, the PURSE Project was requested to support the initiative by examining opportunities to reduce user fees in PNFP facilities. As a first step, the Project provided technical assistance to assess the extent of implementation of the initiative so far and collected data on current fee restructuring activities. This study also looked into the effects of fee reductions on service utilization, revenues and recurrent costs in three hospitals. Based on the findings, a dissemination workshop was held to share the results and lessons learned with a broad audience including hospital managers, representatives of the Bureaus and the MOH.

The PURSE project provided hands-on technical assistance to nine selected PNFP hospitals to help them plan, implement, and monitor the effects of fee reductions. The assistance included a broad range of technical areas such as the appropriate selection of services for fee reduction, establishing final prices, estimating the effects of fee reductions on service utilization, revenues and expenditures. In addition, advice and assistance was provided in areas not directly related to fee reduction such as information dissemination, management practices and increased attention on quality of care. PURSE also provided financial support for two regional board of governor meetings with representatives from PNFP hospitals to communicate the importance of user fee reduction initiatives. This was the first time board members from the three different bureau hospitals had come together.

PURSE also provided support to UPMB members hospitals in acquiring communication equipment to facilitate communication and data-sharing among hospitals and UPMA. Related to this, PURSE funded the training of 13 UPMB hospital IT representatives in HMIS data collection and management in conjunction with UCMB and Uganda Management Institute.

The assessment team interviewed UCMB and UPMB, the two leading Bureaus involved in the fee reduction initiative. Representatives of both Bureaus highly appreciate the technical assistance received from the PURSE project. The Bureaus recognize that this initiative is a high priority for all PNFP partners, and they felt lucky that finally they were able to address the issue in a definite way. The Bureaus admit that this is a long process and they need to do a lot more to ensure that PNFP facilities establish reasonable and efficient fee payment structures. However, they are thankful to the PURSE Project for assisting in a good start. As the representative of the UPMB stated: "Our challenge is to be faithful to the mission while remaining sustainable. User fees alone cannot sustain PNFP services but we learned the importance of basing our decisions on data and we are grateful to the PURSE Project for that."

IV. FINDINGS FROM CASE STUDIES

Design of this review included case studies of four private provider clinics, which received different levels of assistance through the PURSE Project. The purpose of conducting these case studies was to collect additional information to assess the effectiveness and impact of the project's interventions.

The PURSE Project staff, with the assistance of UPMA, selected four clinics based on the following criteria:

- The owner's UPMA membership status,
- Level of assistance the owner received from PURSE Project interventions,
- Location of the clinic (peri-urban vs. rural)

Four clinics were selected as sites for case studies:

- **Clinic A** is a peri-urban clinic. The owner is a member of the UPMA and has benefited from the full range of interventions implemented by the project.
- **Clinic B** is a rural clinic. The owner is also a member of UPMA and has received assistance from all of the project interventions.
- **Clinic C** is another peri-urban clinic. The owner is not a UPMA member. She has received some assistance from the project, but not the full range of interventions.
- **Clinic D** is also a peri-urban clinic. The owner is not a member of UPMA and she has not benefited from any of the PURSE Project interventions.

The consultants developed and used an interview guide, including a facility check list, to collect data from the clinics. The interview guide is found in Appendix E.

Clinic A:

Clinic A is located in a peri-urban area at the outskirts of Kampala, in a low socio-economic neighborhood. It is owned and managed by Ms. R, a dynamic middle-aged midwife. Ms. R has been in private practice since 1981, when she opened a small two-room clinic in another peri-urban area of Kampala. Ten years ago, she moved to this neighborhood and opened her new clinic.

Ms. R. has been a dedicated member of UPMA for several years and she served as the chairperson between 1999 and 2001. Through UPMA, she has been closely involved with the activities of PURSE project, as well as other USAID-funded projects and programs supported by other international organizations.

Ms. R. was able to benefit from all PURSE Project activities. She took four loans from the Uganda Private Health Providers Loan Program and received business skills training. She also received IMCI training offered by the project. She routinely receives the UPMA

newsletter and the Best Practices Bulletin and finds both publications very useful to advance her practice.

In addition to participating in various trainings and activities through the PURSE Project, Ms. R. also benefited from other training programs supported by other projects and international organizations. Back in the 1980s, she was trained through the SOMARC Project in provision of injectable contraceptives and was certified as a trainer. Through IPAS, she was trained in manual vacuum aspiration (MVA) technique to treat incomplete abortions and was certified as one of the few MVA trainers in Uganda. She also received training in various topics supported by UNFPA such as safe motherhood, life saving skills and community mobilization. Her knowledge and skills in reproductive health was strengthened through training she received from the former USAID-funded DISH Project. Finally she participated in advocacy training, offered by the POLICY II Project.

Ms R. was among the first borrowers from the Uganda Private Health Providers Loan Program. She took her first loan of 1.5 million Ugshs. in 2001, which she used to increase drug stocks at the clinic. Her next loan was 4 million Ugshs and she purchased more drugs and some medical equipment and also did minor renovations at the clinic. With the third loan of 15 million, she was able to expand the clinic to twice its original space, and refurbish the entire clinic. Finally, she took a fourth loan about six months ago. She spent the loan to open a second clinic in another neighborhood. The new clinic was opened only three months ago and it is already profitable. Ms. R. remembers that she was quite nervous when she took her first loan three years ago. She was not sure whether she would be able to repay the loan. However, she very much wanted to expand her business so she had decided to take the risk. “Now I am confident,” she says, after taking four loans with increasing amounts. “If you know what you are doing with your private practice, the Uganda Private Health Providers Loan Program is an excellent opportunity.” She highly appreciates the business skills and loan management training she participated in, prior to taking loans.

Clinic A has both outpatient and inpatient services and it is open 24 hours a day, seven days a week. The clinic’s outlook is not much different from the surrounding buildings. It is a one-story building on a street lined with small shops and privately owned workplaces. The facility is spacious, clean and orderly; it has running water and clean toilets. There are waiting areas in front of the building and also in the clinic with several benches. The clinic is divided into several small rooms and partitions. Ms. R. has a small office, which she uses to examine clients. There are 3 inpatient wards, each with two beds. There is a labor room, and a separate PAC room where patients with complications of incomplete abortions are treated. There is a small laboratory at the back of the facility, equipped with a microscope and other basic laboratory supplies. Finally there is a storage room. Client privacy is adequately provided throughout the clinic.

The drug store is located in the front of the clinic, next to the storage room, facing the street. This is a small dispensary; various over-the-counter drugs and other hygienic supplies are displayed on the shelves. The dispensary has all the essential drugs as listed in the Case Study Interview Guide, plus several other remedies to treat common conditions, such as painkillers, vitamins, cough medicines and the like.

Ms. R. divides her time between Clinic A and the new clinic she has just started. Excluding her, the clinic has 5 full time staff. There are three enrolled midwives, one clinical officer, and one nursing aide. In addition, she has hired a guard for night and a part-time laboratory technician. The laboratory technician visits the clinic twice daily.

The clinic provides a wide range of services:

- Curative services
- Antenatal and postnatal services
- Deliveries
- Counseling services
- Family planning
- Immunizations
- Post abortion care
- Drug sales
- Home visits

The clinic offers all kinds of contraceptives and the vaccines that are available in the country. Contraceptive methods include Norplant, oral contraceptives, condoms, Depo-Provera, and IUDs. Ms. R. purchases CMS social marketing contraceptives at discount prices through UPMA and also receives free contraceptives from the MOH. Vaccines include DPT, BCG, measles and polio for children and tetanus for pregnant women. The clinic offers vaccinations free of charge since the vaccines are donated by the MOH, and the MOH calls for free delivery of immunization services.

The facility is fully equipped with basic but essential medical equipment and supplies to provide quality primary health care at the community level. There is a fridge for vaccines and vaccine carriers to maintain the cold chain and sterilization equipment, including a steam sterilizer. The labor and PAC rooms are adequately equipped with all the necessary medical equipment to manage deliveries and perform MVA procedures. Both rooms have supplies and equipment to ensure infection control. Ms. R. puts an emphasis on infection prevention measures in her clinic. At the entrance hall, there is a hand-written poster on the wall, titled “infection control prayer”, which is worth mentioning. It reads:

“Almighty God; help me to gain strength to understand all available knowledge in the world that I may undertake to control hospital infections, help me to assist my patients to avoid hospital infections; help me to regard my patients as intelligent human beings, that I may be free to them, that I may be open to them, that I may be fair to them, That I may treat them in the same way I would myself like to be treated if I were in their position. Amen.”

The clinic does not have informational materials such as brochures or pamphlets to educate the clients. Instead, Ms. R and her staff have made hand-written posters, which are displayed at the clinic waiting area. The posters are about high-risk pregnancies, people at risk of STDS, including HIV/AIDS, and prevention and control of STDs. In addition, several posters about family planning methods are seen on the walls.

The shelves in Ms. R.’s office are full with professional publications. “Standards of Midwifery in Private Practice”, “Midwives Handbook and the “National Guidelines on Management of Common Conditions” are among the reference documents Ms. R. and the staff refer to most frequently. Ms. R. is very prudent with record-keeping. The clinic keeps registries for all types of services offered. Clients are first recorded in a general registry, and then the information is entered into service specific registries such as the antenatal register, maternity register, referral registry and the like. The clinic is very thorough with financial record keeping as well. Ms R. maintains all financial records required of loan borrowers. She periodically calculates profits and losses and prepares an income statement every six months. “I am very careful with financial records” she says “not only because it is required by the Uganda Private Health Providers Loan Program, knowing my finances helps me to better manage my clinic”.

Ms. R. readily provides some basic service statistics. When asked to compare average number of clients seen monthly, now and prior to PURSE assistance and interventions, she came up with the following figures:

Table 4: Clinic A Service Statistics

Type of clients	Average # of clients/month pre-intervention	Average # of clients/month post-intervention
General outpatient	150	250
Deliveries	40	15
Antenatal	60	30
Family planning	30	45
Immunizations	150	250
PAC	0	4-5

Source: Clinic A Service Statistics

She believes that the reduction in number of antenatal clients and deliveries is due to vigorous family planning efforts within the clinic’s catchment area. There are fewer pregnant women amongst her clientele. On the other hand, the clinic receives increasing numbers of general outpatient clients, and family planning clients.

The clinic has established a modest fee schedule in order to serve the community. A consultation is charged 1,000 Ugshs unless no additional treatment is required, while an antenatal booking is 5,000 Ugshs., to cover all antenatal consultations unless there is a complication. Deliveries cost around 15,000 to 30,000 Ugshs., depending on the need for interventions. A family planning visit for condoms, pills or injectables would cost a flat rate of 1,000 Ugshs., including the cost of the contraceptive, while Norplant and IUD insertions would cost 10,000 Ugshs. MVA to treat the complications of an incomplete abortion is charged between 10,000 to 30,000 Ugshs., depending on the severity of the condition and treatment needed. Immunizations are provided free of charge. Ms. R. is flexible with her fee schedule—“I cannot deny treating a sick woman or a child because they don’t have the money” she says. The majority of the clients treated without paying at the time of the visit come back to pay their debt. There are some clients, who can never afford to pay, as Ms. R. admits. “I think its O. K.,” she says, “as long as I know my finances. After all, I am not here

only to make a profit. I do take care of some members of the community although I know they will never be able to pay back. What else can I do?”

Ms. R. is satisfied with the profitability of the clinic. On average, the clinic’s revenues are around 3 to 4 million Ugshs. per month. Her expenses range between 1-2 million Ugshs. monthly, thus her monthly income is roughly around 1.5 million Ugshs. She states that while she was not making a meager profit prior to the interventions, she cannot recall the figures. At that time, she was not keeping regular financial records and was drawing money as she needed. However, there is definitely a substantial increase in her profits now, compared to 4-5 years ago.

Ms. R. reiterates that she is not here only to make money. She feels that it is her responsibility to serve this poor community. In fact, she is a genuine community leader. In 2001, she led the efforts to found a grass roots organization, the Women Development Association, with the goal of supporting the poor and underprivileged women in the area. Over the last several years, she had seen so many women bringing their sick children to the clinic and asking for free services, Ms. R decided to start this association. The association raises money, which is given to the needy women as seed money to start up their small businesses. The association was able to generate 3 million Ugshs. in 2003.

Among various interventions supported by the PURSE project, Ms. R. thinks that business skills training was the most helpful. There was so much learned that she did not know or did not do prior to business skills training. “My understanding of the whole concept of business, such as what profit is as opposed to revenue, has completely changed,” she said. “As a result, I have completely changed the way I run my clinic”.

Ms. R provided a long list of practices that she is doing differently as a result of the PURSE Project interventions:

- She started giving herself a salary, instead of drawing money when she felt like it.
- She started making savings from her income for the business, instead of using everything that was made.
- She began keeping proper stock records.
- She now makes annual plans, something unknown prior to the training.
- Her clinic is now adequately staffed. She realizes that the clinic was seriously understaffed before she received training.
- Based on her business and management skills, and supported with the Uganda Private Health Providers Loan Program, she started a new clinic. The choice of location was based on a market survey, something she would not have been able to do prior to the business skills training.
- Her record keeping, which was nominal before, is now at a level that can no longer be faulted, as far as national standards are concerned.
- She learned how to market her clinic. Now she knows that marketing does not mean TV or radio advertising only. She appreciates the fact and uses her community mobilization network as a marketing tool.

“It is difficult to express how much UPMA has helped” she emphasizes. Had she not been a member, she would be “isolated”; there is no way she would have achieved all that she has

done. As a member, she has received trainings that have added immeasurably to her abilities and skills. She also believes that her clients have benefited from her services in a way that would have been impossible, if she had not stayed “professionally current” through her close involvement in UPMA activities.

When asked what could have been done differently by the PURSE Project, Ms. R points out that family planning training could have been stressed more than was done. She admits that there is a lot of confusion in the health sector regarding contraceptive technology. Many times there are inconsistent views and practices among different schools of thought of doctors and midwives on the indications of use of various contraceptives. She also thinks that PAC could have been emphasized more by the PURSE Project. Complications of unsafe abortions continue to be a major public health issue in Uganda. She believes PAC is a powerful approach through which maternal morbidity and mortality can be addressed effectively. In her own clinic she treats at least one post abortion patient each week, and saves the life of the woman.

When asked to compare her clinic with others in the area, Ms. R. does not hesitate. Her clinic is definitely the best in the area, particularly since she implemented all that she learned recently. She proudly explains that her clinic receives clients not only from the surrounding neighborhoods, but also from faraway towns.

Ms. R. is highly satisfied with her clinic but she is also looking into ways to improve her practice further. Her plan for the future is to buy an ambulance and improve the referral system of the clinic. She points out that since there are no functional referral systems in place, sending clients to other facilities when needed is a challenge. In particular, it is a problem to transfer clients with serious conditions to other facilities where they can get emergency care. She gives the example of a woman whom she found lying at the doorstep of the clinic at 3 am, a few weeks ago. The woman’s uterus had already ruptured due to prolonged obstructed labor. Ms. R. took her to the hospital in Kampala, and luckily, was able to find a doctor to operate on her that night, and the woman’s life was saved. “We are not always so lucky” she points out. “Each year we lose many patients, mostly women and children because we can’t refer them to other facilities where they can receive emergency care”. Ms. R’s big dream is to eventually build “a health center,” someday. The health center would be a model facility providing integrated primary health care services to the community.

Finally, Ms. R shares her views on the future of UPMA. She thinks that UPMA should be more active in improving the clinical practices of member midwives. Monthly CME meetings are very useful but she believes the association should expand this program and do more to update the clinical knowledge base and practices of private midwives. Another recommendation she has for UPMA is to initiate an exchange program with other countries in the region to help midwives to learn from each other. For example, she has heard that home deliveries are much more common in some other countries, whereas in Uganda providers usually have clients deliver at their clinics.

Ms. R. is seriously concerned about the current structure of the Kansanga Health Centre and its future. She does not think that renting out the facility to a subgroup of UPMA members was a good strategy. “KHC belongs to UPMA; it is supposed to serve the entire

membership,” she comments, “with its current structure, it does not”. Furthermore, she believes that the facility creates conflict among the membership and some members have dropped out because of it. “UPMA should urgently reconsider this issue and has to come up with solutions to satisfy its members”, she concludes.

Clinic B:

Clinic B is located in a rural community about 54 km. away from Kampala, and it is owned by Midwife J. Ms. J. has been in private practice for 10 years; she opened her first clinic in Kampala, then opened this one in 1996. Although she sees the Kampala Clinic as successful, she says she felt the need ‘to give back to the community’ that she and her husband come from. “Besides life is easier here. Food is free, because we own the land and here we are somebody”. Not only does she run this clinic, as well as supervising the one in Kampala, but she and her husband started a vocational and secondary school in 2001, that now has about 300 students.

Ms. J. joined UPMA in 1997 and since then she has been an active member. Currently, she is the vice-president of the UPMA branch covering two districts, and also serves as a UPMA regional representative for her district. Over the years, her clinic and Ms. J benefited from all types of assistance supported by the PURSE Project through UPMA. She received three loans from the Uganda Private Health Providers Loan Program between 2001 and 2003. She attended the business skills training course in 2001 and the IMCI training course in 2002. In addition, she receives the UPMA newsletter and Best Practices Bulletin.

As well as benefiting from interventions supported by the PURSE Project, Ms. J has also been closely involved in activities supported by other USAID-funded projects and international agencies. She received life savings skills training supported by UNFPA in 2000. In 2001, she was trained in PAC through IPAS. In 1998 she was trained in provision of oral contraceptives and injectables, an initiative supported by the SOMARC Project. Finally she was trained in Norplant insertions and IUD insertions by the MOH in 2002 and 2003, respectively.

Ms. J. took her first loan from the Uganda Private Health Providers Loan Program in 2001, an amount of 200,000 Ugshs. She used the entire loan to purchase drugs because her drug stocks were depleted. The second loan of 1 million Ugshs. helped her to purchase equipment (she bought a microscope) and patient beds. Her final loan was 1.5 million Ugshs. in 2003 and she used the money to purchase equipment and furniture for the labor room and bought some more drugs.

Ms. J’s clinic has both outpatient and inpatient services, including 4 beds. It is open 24 hours a day, seven days a week. In addition to Ms. J. herself, the clinic is staffed with a full-time nursing assistant, a part-time midwife, a cleaner and a maid. Ms J does not provide on the job training to her staff, believing that they are already well trained when they come from school. However, in the past, when she has had someone who seemed very inexperienced, she would do on-the-job training.

Clinic B is a well-constructed permanent structure, owned by Ms. J and her husband. It is clean and well aerated and has a well lit reception area, with a bench and adequate space for

clients. The examination room just next to the reception is fairly small, with one desk and a resting bed; there is no examination couch. Client privacy is relatively poor; there is only a net-curtain dividing the examination room from the wardroom with the beds. Lighting in the examination room is also quite dim. The ward is a fairly large room with two beds and is well lit. There is a storage room, which is also used for washing/cleaning. The labor room has a delivery couch and a bed for postnatal patients. It is clean, but lighting is relatively poor. Although PAC services are provided, there is no space specifically set up for the MVA procedures. There is a separate dispensing room, in which drugs, supplies, and records are kept. Outside the facility, there is a pit latrine, which is used exclusively by the clinic patients. There is also a well-constructed placenta pit, with a cement top and removable cement cover. Clean supply of water is available, through a nearby borehole.

Clinic B provides a variety of services except for laboratory tests. The services include:

- Curative services
- Antenatal and post-natal services,
- Deliveries
- Family planning
- Immunizations
- PAC
- Drug sales
- Home visits.

The clinic has all the essential medical equipment to provide the services listed above, and as specified in the interview guide. The only exception is that there is no fridge for vaccines. Vaccines are not stored at the clinic: they are collected (using vaccine carriers) from a nearby government Health Center and administered at the clinic on designated immunization days. The vaccines available include BCG, Oral Polio, DPT, Measles as well as Vitamin A. The clinic also has all the essential drugs as specified in the interview guide. Available contraceptives include oral contraceptives, condoms, injectables and Norplant. The clinic does not offer IUDs although she was trained for IUD insertion at the main government hospital last year. Staff has not been trained for IUD insertions.

Ms. J. keeps copies of all of the essential guidelines and standards for her practice. She frequently refers to Standards of Midwifery Practice, Midwife Handbook and the latest version of the National Clinical Guidelines. She finds these publications vital to keep up with professional standards.

Infection prevention is an area in which Ms. J. puts a special emphasis in her clinic. She candidly admits that her practices in the past were far from the international standards. Now she is certain that her clinic complies with the principles of infection prevention measures.

Client fees at Clinic B are lower compared to those in peri-urban Kampala, to accommodate with the affordability level of the rural community. Consultations cost 500 Ugshs., and deliveries usually cost about 10,000 Ugshs. Antenatal bookings are charged at 1,500 Ugshs. and follow-up antenatal visits would cost an additional 1,000 Ugshs. each. For family planning visits, 300 Ugshs. is charged for oral contraceptives, 1,000 Ugshs. for injectables,

and 200 Ugshs. for condoms. Immunizations are free, as the vaccines are provided by the MOH. Ms. J. charges about 10,000 Ugshs. for MVA procedures.

Record keeping practices at Clinic B seem adequate. There is a general registry book in which clients, by type of services, are recorded. Records of drug sales and contraceptive sales are kept in the same book, and there is a separate book for stock control purposes. In terms of financial record keeping, the clinic maintains a cashbook and debtors' book and receipts are routinely provided. Ms J. calculates the clinic's revenues, expenses and profits on a monthly basis.

Ms. J. is glad to see that the clinic's client load has increased substantially over the last couple of years. She attributes the change to the impact of her trainings and her "new ways of doing business." All types of clients have increased several times over the years. She thinks that introducing immunizations services has helped to boost her client load.

Table 5: Clinic B Service Statistics

Type of clients	Average # of clients/month pre-intervention	Average # of clients/month post-intervention
General outpatient	10	60
Deliveries	2	8
Antenatal	6	13
Family planning	7	17
Immunizations	0	30
PAC	0	1

Source: Clinic B Service Statistics

Ms. J. also confirms that her profits have increased significantly as a result of increased client load.

Table 6: Clinic B Revenues and Profits

	Pre-intervention	Post-intervention
Ave.revenues/month (Ugshs)	125,000	450,000
Ave.expenses/month (Ugshs)	60,000	60,000
Ave. profits/month (Ugshs)	65,000	390,000

Source: Clinic B Financial Records

Of all assistance she received from the PURSE project through UPMA, Ms. J. believes that she benefited most from the IMCI training. She now thinks of her old practices as having been "illegal", especially with regards to infection control. "My whole outlook to service delivery has changed as a result of PURSE project interventions and assistance" she says and gives several examples:

- She is more confident with her clinical skills and practices now.
- She has significantly improved infection prevention practices.
- She considers her clinic to be a business and runs it as such, making use of what was taught her in business skills training.

- She learned how to promote and market her clinic through innovative ways
- She routinely visits the members of the community and also other midwives in the district, including non-UPMA members. These visits are now part of her outreach and marketing efforts.
- Her clinic is now a good example of how things should be done. Her clinic has become kind of a “referral center” by other midwives, especially non-UPMA member midwives in the area.
- Her clinic successfully competes with other facilities, which are run by non-medical personnel (but they have more money to invest), while midwives who have not received assistance are struggling to survive against the competition.

Ms. J., as a result of all she has learned, puts a special emphasis on marketing of her clinic and she promotes her clinic through a number of ways. For example, her clinic now has visible signs, something she lacked a few years ago. Her community outreach activities are also an important means of promoting the clinic. She gives out the “Health Tips” brochures to promote the clinic when she visits the community. Her visits to the other midwives as a UPMA regional representative also help to promote her clinic.

Being an active member of UPMA has helped her tremendously, she states. She would not have had the access to the various trainings she received, if she was not a UPMA member. The assistance she received through the UPMA has helped her to improve the clinic’s service delivery, as evidenced by the increase in the clinic’s service statistics and the substantial increase in profits. Overall, Ms. J. thinks that her clinic was doing “poorly” before the interventions. She did not know what the members of the community really needed and expected from her services. She now realizes that she was not “doing properly” in several areas of her practice. She was not providing some basic public health services, such as immunizations, prior to her training.

With all that said, Ms. J thinks that the PURSE project could have been more effective if there was more emphasis on improving “support supervision” among the midwives, not necessarily limited to UPMA members, in rural areas. She believes that a stronger support supervision system would encourage non-UPMA member midwives to join the association. She feels that, although the RR programme has done a great deal and is achieving its goals, this district has the disadvantage of being a new district and thus a new UPMA branch. “There are many midwives here operating illegally. They do not have licenses, they carry out out-dated practices and, in particular, their infection control is very poor. As a Regional Representative I need more direct support to help them and convince them that UPMA will be of benefit to them, rather than just taking membership fees and exposing them to the authorities”, she comments.

Ms. J. thinks that UPMA should start an aggressive member recruitment effort. “At present, the majority of the midwives in this area are not UPMA members” she points out. Out of the 15 midwives she regularly visits, only three are UPMA members. Strengthening the regional representatives program and improving feedback for the RRs would be effective to recruit new members. “Every time I visit non-UPMA member midwives, they ask me if I have something new to give or tell them, which I don’t. Without encouragement, they are unlikely to join”, she explains. She says that the greatest fear is ‘exposure’. By becoming members

they will be ‘traceable’ and thus have to pay taxes, registration fees apart from the UPMA membership fess, spend money to improve their facilities, which they cannot afford to do.

Ms. J. also believes that UPMA can do a lot more to help member midwives. She gives an example about the level and range of subsidies. At the moment, she often finds herself having to buy from the open market, which is expensive. Although the midwives are supposed to have access to drugs, sundries and supplies through the district store, the store is invariably out-of-stock. Ms. J is very satisfied with UPMA’s assistance to subsidize contraceptives so she thinks that the association can encourage the district offices to be more organized. She also points out that the midwives are not invited to district CME training programs although “we are the ones who look after poor people”.

Ms. J. is highly satisfied with the improvements in her clinic over the recent years, but she has a lot more to do. She plans to create a PAC-specific room to treat the patients with incomplete abortions. Next, she needs to design two more rooms for HIV/AIDS patients. In addition, she realizes that client privacy is not very good at the clinic so she will need to improve the partitions.

Ms. J provides valuable insights on the needs of the rural community and the needs of the midwives serving in this area. She believes additional help is needed to increase drug supplies, especially because of the increasing numbers of HIV/AIDS cases. An increased and improved supply of essential drugs from the MOH is also a necessity. She thinks UPMA should advocate for these issues, with assistance from international organizations. She also thinks that all UPMA members need training in PMTCT. Finally, she points to the inadequate supply of informational and educational (IEC) materials for clients. MOH has distributes posters on family planning, HIV/AIDS and STD prevention, and malaria. Although she does have some posters on her walls, she feels more is needed.

Clinic C:

Clinic C is located in one of the peri-urban settlements of Kampala city. It is managed and owned by Nurse G. She has been in private practice for about 8 years now, since she established this clinic in 1996.

Ms. G is not an UPMA member, but has benefited from some PURSE Project activities. She received ‘Clear Seven training’ in 2001 from CMS’ social marketing program, participated in the business skills training and has received loans from the Uganda Private Health Providers Loan Program in, 2002 and 2003. Ms. G. did not benefit from any other intervention supported by the PURSE Project. She was able to expand the clinic by adding laboratory services, and improved her finances to be able to pay her staff more regularly. She took out her first loan of 500,000 Ugshs. in 2002, and purchased drugs. With the second loan, which was 1.5 million Ugshs. in 2003, she purchased clinic stationary and drugs and paid out the outstanding salaries. In addition, she was able to start a drug shop in a nearby town.

Clinic C is a well-constructed building. It is relatively clean, with a well-aerated and well-lit reception area. The reception has adequate space, with a bench for clients to sit and wait. Within the reception there is a partitioned space, which serves as the dispensary. Records are

also kept here. The examination room is very poorly lit. There is a desk but no examination couch. There is a treatment room next to the examination room, with a bed. The bed is probably also used for examinations.

Clinic C's water is supplied from an external tap, and the pit latrines are located some 15 meters away from the clinic. Incineration of waste is done in an open pit, also about 15 meters from where the tap is located. Sharps and other waste are burned there. Although it was said that the pit is regularly cleaned, at the time of the interview there was a pile of unburned material. It is possible that other people in the area use the open pit for the same purpose.

The clinic offers only outpatient services. The working hours are from 9.00 am to 9.00 pm. It is staffed by Nurse G. herself, and a nursing aide. In addition, there is a part-time laboratory technician. The staff receives on the job training, which has been provided in the past by Nurse G., by sharing material she has received from trainings she herself has participated in.

The range of service provided by the clinic is relatively limited to drug sales, curative services, counseling and family planning. As a result, the clinic has only some basic medical equipment including a thermometer, sterilization equipment (large saucepan, with which she boils water on a charcoal stove) a BP cuff/machine, a stethoscope and gloves. There is a fridge but it is not working. Availability of essential drugs is also limited to anti-malarial drugs, painkillers, fever reducers and eye ointments. Although the clinic does not provide antenatal or delivery services, it stocks ergometrine, folic acid and iron supplements. This is because they have in the past received patients bleeding, who prefer to receive treatment "near home, from someone they know". For family planning clients, the clinic offers pills, condoms and injectables. No vaccines are available.

Although the clinic has been recently equipped to carry out laboratory services, the laboratory is not fully operational yet. Ms. G. assures that she will be able to provide a wide range of services including urine, blood slide and stool analysis, and hemoglobin, VDRL and pregnancy tests soon. On a different note, infection prevention practices seem to be inadequate at the clinic. Sharps and needles are deposited in a specific sharps container; however, there is no use of disinfectants.

The clinic has a copy of the National Standard Treatment Guidelines. In addition, there are copies of the MOH publications including, "Immunization Practice in Uganda", "Field Guide for Measles Vaccine and Vitamin A", and "Vitamin A Facts". There are various educational posters on the walls (family planning, STDs and HIV/AIDS prevention) of which some are handwritten. There are no brochures or pamphlets for client education.

Clinic C has a simple fee schedule for clients. Consultations cost 2,000 Ugshs. while family planning clients pay 300 Ugshs. for pills and condoms, and 1,000 Ugshs for injectables. The clinic keeps a general registry for all clients by type of service. Records of drug sales and contraceptive sales are kept separately. In addition, stock control records are kept. Ms. G. keeps a cashbook and calculates revenues, expenses and profits on a monthly basis. She does not keep a separate debtors book; debts are recorded with the service statistics. The clinic

does not routinely issue receipts. Receipts are provided only to clients who receive reimbursement from their employers.

On average, the clinic receives about 120 clients a month. Half of the total clientele are general outpatient cases while the rest visit the clinic for family planning purposes. In addition, the clinic has lots of clients who walk in to purchase over-the-counter drugs in small quantities. These clients are not recorded in the service statistics and are considered to be a separate category. Ms. G. is not sure how her client load has changed over the years, since she did not keep records prior to receiving business skills training. However, she is definite that previously she had more clients, as she knows her profits have been declining. She attributes the decline to the recent proliferation of other clinics in the area. There is considerable competition from the new clinics, of which some are larger and better equipped.

Ms. G. estimates that her profits have been declining over recent years. Her overall expenses have not changed, but since she has fewer clients, her profits have declined.

Table 7: Clinic C Revenues and Profits

	Pre-intervention	Post-intervention
Ave.revenues/month (Ugshs)	550,000	450,000
Ave.expenses/month (Ugshs)	260,000	260,000
Ave. profits/month (Ugshs)	290,000	190,000

Source: Clinic C Financial Records

Although both her client-load and income have reduced, Ms. G. believes that without the loan and the business skills training, she would not have survived the current competition. She also thinks that the quality of the clinic’s services is definitely better now. Although laboratory services are not yet fully operational, she is optimistic that these services will make a difference. Ms. G. predicts that availability of laboratory services will help to regain the market share she has lost. Her future plans are based on expanding the clinic by adding a few beds and initiating in-patient services. She is also determined to introduce immunization services.

There are several things that Ms. G. does differently as a result of business skills training and the Uganda Private Health Providers Loan Program. As a result of the training, she is now “tracking her money properly”. For the first time, she started balancing her books as well as financial planning, ahead of time. Overall, the loan, combined with business skills training has helped her to become a better businesswoman and an employer. She realized the need for laboratory services and expanded the clinic to include laboratory services. Although she did not purchase laboratory equipment directly with resources from the loan (the equipment belongs to the laboratory technician, with whom she has an understanding), she would have been unable to consider entering such an arrangement, had it not been for the loan and training.

Ms. G. considers her clinic as the first “good quality” clinic in the area she is serving. Since then, however, there has been influx of new clinics and competition has increased. This has made things more difficult for her, because the community she serves has not grown at the same pace. In spite of increasing competition, she has been able to hold her own, and she

believes that her clinic is “still the best clinic in the area, one of the cleanest and the one people trust. People don’t like moving around and it’s not good to take your children to strangers. The community also knows they can see me at anytime; it is as if I have become a mother.” She believes that this is in part due to the business skills training and the loans she has received and also due to the fact that she has been a member of that community for a long time now. “They trust me”.

Ms. G. fully appreciates the assistance through the PURSE Project; however, she believes more could have been done to help health workers like her. Her specific comments include:

- There should have been greater facilitation of immunization services. Facilities such as hers would have liked to offer full immunization services to their clients; however, they need support from governments to do so. She believes that projects like the PURSE project are well positioned to advocate for much needed assistance to private sector health workers. She says that for some reason, the MoH stopped supplying some facilities with vaccines; no particular reason was given. Despite her and some other colleagues pointing out that they are willing and would very much like to offer immunization services, they are yet to receive a positive response. This, she thinks, may be due to the fact that they also required support for transport, syringes, etc., in order to participate cost-effectively.
- She thinks that the Project could have done better follow-up with trainees/ borrowers like her. “I appreciate the help I have been given”, she comments. “But it is difficult to continue if help is not always there because we are still very small and weak”
- Although not a UPMA member, she is aware of the fact that she can participate in training activities, such as the IMCI training; she fully intends to benefit from as much as possible in the future, if the opportunities still remain open for health workers like her. However, Ms. G also thinks that information about various trainings could have been shared more timely. She heard about some of the other training opportunities after they had taken place and regrets that she was not able to benefit from them. The only other training program she was able to participate in was an immunization training course offered by the MOH in 2002.
- Ms. G. is a member of the UNANM and she feels that UNANM deserves the same level of support provided to the UPMA by the PURSE Project.

As her final comments, Ms. G. reiterates her frustration about the inadequate support from the Government. Immunization is an area in which the Government does not fully appreciate the potential of the private practitioners, in providing preventive care to their communities. Many private providers are not willing to introduce immunization services when they are not sure who will pay for the needles, syringes and other expenses associated with providing vaccines. Most of the private providers cannot afford to cover these expenses, but the Government expects them to do so.

Ms. G intends to expand her clinic by introducing an inpatient service, as well as introducing immunization facilities. Although she has noticed a decline in her income, she believes that with beds, she will be able to boost her client base.

Clinic D:

Clinic D is also located in one of the peri-urban settlements of Kampala. The clinic is owned and managed by nurse-midwife, Ms. D. It is a one-storey building that she owns, next to some shops she rents out. It is about 15 kilometers away from the Kampala city center, situated on the main road. Ms. D. has been in private practice since 1995, when she opened this clinic. Ms. D. is not a member of UPMA and she did not receive any assistance provided by the PURSE Project.

In addition to her private practice, Ms. D. works at Mulago Hospital in Kampala, the nation's largest referral hospital, as a senior night superintendent. As part of her duties, she has received training in various areas, all through training programs supported by the MOH. She has received comprehensive training in provision of family planning services, including Norplant and IUD insertions. She is also trained in IMCI and provision of PAC services and MVA procedures.

Clinic D is a well-constructed building; it is clean, well ventilated and well lit. It has a reception area, with adequate room for clients and a bench. The reception area is also used as a drugs dispensary. The examination room is well equipped with a desk and an examination couch. Client privacy is good throughout the clinic. There is neither separate storage area nor a labor room. The clinic has running water and a well-constructed toilet.

In addition to herself, the clinic is staffed with one nurse. The Clinic provides outpatient services only. The clinic hours are flexible. Usually, the clinic is open for about 5 hours a day, although the 'official hours' are supposed to be from 7.30 am to 11.30 pm. Ms. D. arrives at the clinic about 3 pm and is available through 8 pm most days. Although a member of the staff is supposed to be present the rest of the day to receive patients, Ms. D. admits that there is no guarantee that the clinic is open during the day. At the weekends the working-hours situation is much the same. The staff member however, is the one responsible for running it, Mrs. D. not necessarily attending to the clinic.

The range of services offered at Clinic D is limited to drug sales, curative services, counseling and family planning. The clinic possesses all the necessary equipment to carry out these services. Infection prevention practices are reasonable. Sharps and needles are kept in a specific box and disinfection practices are in place. The choice of drugs available at the clinic includes a wide range of remedies to treat common illnesses such as anti-malaria treatment, IV fluids, painkillers, fever reducers, eye ointments and vitamins. Choice of contraceptives includes oral contraceptives, condoms and injectables. No vaccines are available.

The clinic possesses two of the MOH publications to guide clinical practices: "Standards of Midwifery Practice" and the "Midwife Handbook" There are a few educational posters on the walls; some are hand-written. It was interesting to note that apart from immunization material, education material was limited to 'general' services. Posters included information on elephantiasis and hydrocele, as well as skin infections. There were no posters concerned with family planning, HIV/AIDS and STDs.

There isn't a set fee schedule for services at Clinic D. Charges are made according to the severity of the diagnosed condition and required treatment. Calculation of costs is made according to the materials/drugs used. Although somewhat arbitrary, Ms. D. believes that this arrangement has proved to work over the years.

Record keeping at the clinic is limited to records of drug sales, contraceptive sales, and a cashbook. Ms. D. cannot provide the average number of clients seen per month. Client load is seasonal and very low. She admits that she has not looked at the numbers for quite a long time. However, she would estimate it to be a total of 10 clients per day. On average, Ms. D. estimates that the clinics revenues are around 200,000 Ugshs. per month while the expenses total to 150,000 Ugshs. This leaves a profit margin of about 50,000 Ugshs. per month.

Ms. D. has been extremely disappointed with the clinic over the years and feels discouraged about its future. She believes that her clinic has much the same experience as those in the immediate area; it is very difficult to make the clinic's ends meet. The community is relatively well to do, but illiterate, thus they do not appreciate the need for health care. Ms. D. is thinking seriously of leaving the private health sector altogether. If she decides to stay in private practice, she admits that she has to find out about the weaknesses of her business. Meanwhile, she is looking into other business opportunities. For example, she is constructing a double story building just behind the clinic, which she plans to turn into a guesthouse. Another alternative she has been considering is to start a nursing care home for the elderly.

In response to the question as to why she has never joined the UPMA and why she did not participate in the business skills training she had been invited to, Ms. D. explains that timing is the most critical factor. If the training sessions were conducted over the weekends, instead of weekdays, she would have considered participating in them. Besides, "UPMA is the preserve of the fully private midwives only".

Ms. D. admits that she has not gone out of her way to get more information about the UPMA even though she personally knows a number of members. Her impression of UPMA is that it is "an exclusive affair, only for a certain category of private-sector midwives." The impression received during the interview however, was less so of this being the reason and more of a seeming lack of interest in both membership and the profession of private practice.

Discussion on Case Studies

The four clinics studied have received different levels of support from the PURSE Project. The owners also vary in their backgrounds, their interests and aspirations. The case studies are conducted in a limited number of facilities, however, in-depth observation of the clinic sites and thorough interviews with the owners provided valuable insights into the provision of health care services in Uganda.

Regardless of their level of involvement in UPMA and the PURSE Project interventions, the respondents provided much information on the challenges of serving the poor in their private practices. One of the most often cited difficulties relates to the inability of patients to afford treatment. Generally, the communities are poor and people want to have treatment and drugs for free. It is common for poor paying patients to request credit services; for many it takes

too long to pay back, and some do not pay at all. Respondents were also concerned about the patients' reluctance to seek health services until their conditions had worsened, mostly attributed to poverty.

Competition among private providers is common in most areas. Respondents in peri urban areas cited that some areas are over saturated with clinics. In rural areas, the presence of too many unqualified people running clinics posed a different form of competition. Some respondents cited inadequate recognition of private providers' services and support from the Government. The support for immunization services was given as an example. The MOH provides free vaccines to the private health care providers to expand immunization coverage. While this is a sound strategy, the Government is reluctant to reimburse the expenses of providing vaccination services born by the private providers.

The challenges summarized above are more or less relevant to all providers interviewed through the case studies. Those who had access to interventions implemented by the PURSE Project, however, were better equipped to deal with the results of these challenges.

There was ample evidence that those clinics that received assistance from the project, significantly benefited from the interventions. The impact of the Uganda Private Health Providers Loan Program was apparent at all sites. The clinics were able to expand their services and improve operations. All respondents recognized the value of business skills training. Similarly, the providers who participated appreciated trainings provided in IMCI.

Two of the respondents were involved in UPMA activities, while the other two were not. Those who were active members of UPMA benefited from all PURSE Project interventions and stated that their involvement in UPMA has been a "tremendous help over the years". Both respondents gave many examples on how they are doing things differently as a result of interventions they received through the project and UPMA. These changes can be summarized as:

- *Improved clinic management, as evidenced by proper record keeping, budgeting and planning:* The respondents gave several examples on how they have improved management of their clinics. In specific, they cited that they are now able to run their clinics "as businesses" in contrast to what they did in the past. Proper record keeping, both for service statistics and financial recording to track business performance, development of annual plans and income statements, improved staffing, were among improved practices.
- *Improved quality of clinical services, particularly in infection control and better management of common curative services:* The respondents were able to improve their infection prevention knowledge and practices. One respondent acknowledged that she did not really know what infection prevention was all about prior to her involvement with the Project activities. Another respondent showed the assessment team specific practices that she has changed as a result of her trainings.
- *Expansion of preventive services such as immunizations and family planning.* The respondents were able to either initiate or expand preventive services offered by their clinics. One respondent, who did not provide immunization services prior to the

interventions, initiated immunization services as a result of her trainings. Providing immunization services boosted her overall clientele.

- *Increased emphasis on community outreach:* Respondents acknowledge that they became aware of the importance of community outreach activities through the interventions. They placed more emphasis on reaching out to the community, were able to have a better understanding of the needs of the communities and thus change the way they did business.
- *Increased efforts to promote clinics and services:* The respondents acknowledged the importance of promoting their practices and learned how to do it. As one of the respondents stated, “I thought marketing was all about radio and TV advertising” They learned, and used many approaches to promote their services and clinics.

On the other hand, respondents pointed to many areas through which the PURSE Project, or projects alike, could have been more effective in furthering the practices of private providers. Most important comments included:

- *Increased emphasis on standardization and upgrading of clinical knowledge and practices:* Two of the respondents had extensive clinical training, not only through the PURSE Project but also through other USAID-funded programs. These respondents voiced their concern about inconsistencies in clinical practices among the private providers and commented that additional efforts to upgrade the clinical skills would be very helpful.
- *Increased support for professional associations such as the UNANM for strengthening of private practices.* The only nurse practitioner among the respondents (all others were midwives) emphasized the need for more support to UNANM. She pointed out that the UNANM merits more support from international organizations.
- *Inadequacy of client IEC materials.* A common observation made at all sites was the inadequacy of client IEC materials. This was also an issue brought up by some respondents. Three of the clinics displayed educational materials on the walls, many of them were hand written by the staff. Only one clinic carried the Health Tips brochures developed by the UPMA and used the brochure to promote the clinic as well as educating clients.
- *More support supervision.* Respondents appreciated the follow-up visits received after the training but pointed out that a continuous process for support supervision is needed especially for those not part of UPMA and its regional representative program.

There were many recommendations specific to UPMA. While all UPMA member respondents highly appreciated the work of UPMA and acknowledged the assistance received, they provided useful tips to further the effectiveness of UPMA:

- *Strengthening and supporting branches:* There is a great need to support the UPMA branches to improve the effectiveness of the association activities.
- *More aggressive strategies for member recruitment:* The respondents voiced their concern about high numbers of midwives in private practice who are not members of the UPMA. Although the interviewees were not able to make specific recommendations to increase UPMA membership, they thought that this is an area for UPMA to consider.
- *Increased support for the Regional Representatives Program:* The respondent who was also a regional representative provided useful comments on how to improve the regional representatives program. In specific, she commented on the need for stronger coordination and feedback.

Finally, it is worth mentioning that clinic A, which has benefited from all interventions supported by the PURSE Project, excelled among others. This facility is a model clinic managed by a private midwife. On the other hand, the performance of clinic D, which did not receive any assistance from the project, was relatively poor. It is interesting to note that both clinics have comparable locations and the owners have similar backgrounds. They are both midwives with several years of experience in private practice. The owner of Clinic D had more or less the same level of access to the services of UPMA and the PURSE Project. One can conclude that the individual provider's interest and commitment to private practice determines her attitude to reach out for support and achieve in private practice. The fact that the owner of Clinic D is only at the clinic part-time and continues to work in the public sector reduces her level of motivation to be a successful private provider.

V. CONCLUSIONS AND RECOMMENDATIONS

General Conclusions and Recommendations:

- Private health providers, including physicians, nurses and midwives operating private clinics and private not for profit providers have a critical role in providing health care services in Uganda. This is in part due to the inadequate provision of services by the public sector. In particular, the private midwives and nurses are major providers of health care to the less privileged populations. The international community should continue to support the development of the private sector providers. Among other donors, USAID and projects funded by USAID have a comparative advantage in promoting private sector health care services, due to their extensive technical expertise in private sector. USAID/Uganda should continue supporting the private health sector.
- Overall, the PURSE Project has been very effective in supporting private sector providers. The project maximized its impact by intervening in complementary areas in a holistic approach, including policy dialogue, access to credit, training, and institutional capacity development. In addition, the project was successful in building on the lessons learned and the gains accomplished by prior projects to support the development of private health providers.
- The PURSE Project's greatest strength was the technical leadership of its staff, in particular, the Privatising Health Services Advisor. She was particularly pivotal in identifying opportunities and implementing innovative approaches to support enhancement of private providers. She also played a key role in facilitating policy dialogue between the public and private sectors, in coordinating project activities among various stakeholders, and mentoring local project staff.
- The PURSE project interventions were closely integrated with the broader goals of the CMS Project in Uganda. The Project successfully linked its interventions with other programs implemented by the CMS Project. In particular, linkages among the PURSE Project, the Social Marketing Program and the Uganda Private Health Providers Loan Program leveraged the effectiveness and impact of all interventions.
- While many aspects of financial sustainability in the Ugandan setting is beyond the PURSE Project's control, the Project has been highly concerned with issues of sustainability and replicability. Through all of its interventions, the Project used an approach to build on existing systems, which greatly increased the likelihood of sustaining project gains. In addition, the PURSE Project focused its interventions on institutional capacity building, policy dialogue, and training of providers. All accomplishments in these areas are sustainable, and if adequate resources are provided, replicable.
- Lack of a clear strategy and a monitoring plan to lead implementation was a challenge for the PURSE Project. Many of the interventions were designed during the course of implementation, rather than being led by a structured strategic approach.

Nevertheless, the project was able to address many of the obstacles limiting the growth of the private sector and designed interventions to address them effectively. In specific, the Project was very successful in identifying windows of opportunities that emerged during project implementation and in responding by well-designed interventions.

Activity Specific Conclusions and Recommendations

Assistance to UPMA:

- The PURSE Project focused on UPMA to help strengthen the association. UPMA is a valuable partner in reaching private midwives, who are highly motivated to provide quality services. The private midwives provide affordable alternatives for clients who can afford to pay a reasonable fee, thus relieving some of the burden on public facilities. In addition, the private midwives are the only service providers in many underprivileged rural areas.
- The PURSE Project used a holistic approach to assist UPMA. Interventions focused on a number of closely related and complementary areas, including income-generating activities, enhancement of member communications and visibility, quality improvement, and institutional strengthening. Several interventions have proven to be effective, and the gains from these interventions are likely to sustain. However, the association needs continuing support in many areas to further the gains and achieve higher levels of sustainability.
- The PURSE Project assisted in helping UPMA to improve and broaden its donor base. The association received funding from various donors and was able to considerably diversify its donor base since 2000. However, its needs further assistance to continue diversifying and strengthening its financial base.
- With assistance from the PURSE Project, UPMA expanded its capacity to generate its own sources of income by selling advertising, stationery, commodities, signposts, and other items. In spite of this progress, the association's capacity to generate large sums of income is still limited. The association needs further support to increase its local resources.
- The PURSE Project implemented a number of interventions to assist the association to strengthen member communications and enhance the visibility of the association and members. These interventions have been very effective, and by nature, these efforts can be sustained by UPMA since they do not require substantial financial resources.
- Despite various efforts to increase UPMA dues paying membership, the proportion is still low. UPMA should analyze the causes contributing to this issue. While it is understandable that many members cannot afford to pay the fees, there seem to be other factors contributing to low payment of membership dues. UPMA should be assisted to uncover the reasons leading to non-payment and design strategies to resolve the issue.

- UPMA and its members have greatly benefited from the IMCI and business skills trainings and the Uganda Private Providers Loan Program supported by Summat Foundation and the PURSE Project. There is ample evidence that these interventions have been successful in expanding and improving the practices of member midwives. There is a continued need, however, to strengthen the clinical skills of UPMA members. It was assumed that the UPMA members did not need comprehensive training in clinical skills since many of the previous programs offered such training courses. However, it is possible that a considerable proportion of the midwives did not have access to clinical training opportunities. It is recommended that future projects support clinical skills trainings in priority areas to upgrade and standardize the clinical practices of the midwives.
- The regional representatives program is a valuable approach to improve the practices and the skills of the UPMA membership. UPMA was able to revitalize the program through PURSE support for two years. UPMA, however, needs further support to improve and expand the program. Further, the continuation of the program will require external resources as this is an activity that cannot readily be supported by locally generated income. In specific, the regional representatives program should be strengthened through:
 - Closer coordination among the representatives, the headquarters and the branches;
 - More systematic follow-up and feedback;
 - Development of user friendly database to track progress; and,
 - Upgrading clinical knowledge and skills of regional representatives
- One area of support not adequately addressed through the PURSE Project is strengthening UPMA branches. The next phase of capacity building for UPMA should include a focus on the branches, which are the primary contact points between the association and the members. Strengthening leadership, management and communications at this level will improve the effectiveness of the association. It is also vital to have strong branches to interact with District Health Services under Uganda's increasingly decentralized provision of health care.
- UPMA needs to restructure how it is collecting data from members or should discontinue the efforts to collect service statistics from midwives as the current level of underreporting renders the data meaningless. The association might consider integrating the data reporting function into the role of the regional representatives. Having data on the members and their service statistics is very important in advocacy and fund raising efforts.
- The PURSE Project provided substantial management assistance to UPMA; as did the former SEATS project. However, management assistance was not a core intervention for either project. While the staff and board participated in various workshops to strengthen their management capabilities, and benefited from the mentorship of the PURSE Privatising Health Services Advisor, many of the skills are complex and new. In addition, the fact that the board members are elected

volunteers and are subject to turnover has made it difficult to sustain the gains from management assistance. In spite of these challenges, UPMA has grown greatly in its organizational capability, but it needs more structured support, specifically in:

- Leadership development;
 - Organizational development and management,
 - Development of management information systems; and
 - Logistics management.
- The PURSE Project assisted in linking the UPMA with other international programs and other USAID-funded projects. UPMA submitted a grant proposal to the UPHOLD Project to continue receiving support in priority areas, which had just been approved at the time of this assessment. The proposal includes support in many of the key areas mentioned above, however, it does not cover areas of institutional capacity building and management assistance. It is recommended that assistance in these areas should also be provided, either through the UPHOLD Project, or through other resources.
 - The PURSE Project played a critical role in helping UPMA to resolve the issues related to management and financial sustainability of KHC. Through restructuring, KHC was able to lower costs and significantly improve its financial situation, however, the clinic is still not financially stable. UPMA needs additional support to help resolve the issues related to KHC.

Support to other NGOs

- The PURSE Project's support to other NGOs and professional associations was minimal compared to its assistance to UPMA. While not underestimating the importance of supporting UPMA, many of the other NGOs merit international assistance. In particular, the UNANM deserves more attention from international agencies. Nurses should be given a higher priority through future projects and interventions. The potential of nurses in expanding private sector health care services is evidenced by the high percentage of the profession receiving loans from the Uganda Private Health Providers Loan Program. Uganda Private Medical Practitioners Association also needs support to enable its members to play a larger role in health care delivery.

Private Provider Initiatives

- Provision of micro finance assistance through the Uganda Private Health Providers Loan Fund and the associated training courses in business skills have been very effective. The results from these interventions are true success stories. It is highly recommended that the Uganda Private Health Providers Loan Program should be continued either through the Summa Foundation or through other mechanisms. Provision of business skills training have contributed significantly to the success of the Uganda Private Health Providers Loan Program, as well improving the overall management of private clinics. Although a significant number of private providers

have already participated in business skills trainings, it is recommended that this type of training should be provided to loan applicants in the future.

- Provision of IMCI training has also been a high impact intervention. The intervention has helped the participants to improve skills in managing common childhood diseases as well as other clinical practices, such as infection prevention. It is encouraging that the UPHOLD Project Integrated Health Strategy includes continuing training in IMCI for private providers.
- A final activity implemented by the PURSE Project under the Private Provider Initiatives was the development of a franchise clinic model in Uganda. The intervention had only been in effect in one clinic for less than three months at the time of the assessment, thus it is too early to assess its impact. It is recommended that future projects follow up on the results of this pilot case. Health plan franchise clinics might prove to be a viable approach to expand and strengthen private sector health services in Uganda.
- Like the midwives, other private providers need to upgrade and strengthen their clinical skills in a number of areas. Training programs need to respond to the unique circumstances and motivations of private providers to be effective however the PURSE project has demonstrated the willingness of private providers to update their skills. Potential topics for training include reproductive health, especially family planning and PAC, infection control, immunization, and infectious diseases, including malaria, STIs, HIV/AIDS including PMTCT.
- A serious public health issue in Uganda, which has not received adequate attention from either the PURSE Project or other assistance programs, is PAC. Unsafe abortions continue to be a major issue in the country; it is estimated that about 1/3 of all maternal deaths are due to complications of unsafe abortions. Provision of PAC training to a broader proportion of private providers could help improve maternal health in the country.

Public Private Partnerships:

- The PURSE Project has played a key role in facilitating and moving forward the process of the Public Private Partnership in Health initiative. In specific, all stakeholders appreciate the technical assistance provided by the project. Despite the rapid progress over the last year, the initiative is still in its early stages. The MOH needs continuing assistance to further its efforts in developing strategies to encourage private sector's growth in health. It is highly advisable that another USAID funded project, such as the Partnerships in Health Reforms (PHR) continues to assist Uganda in moving on with the public private partnership agenda.

VI. LESSONS LEARNED

- The private sector has a high potential to contribute to improving the health of large populations, even in relatively less developed countries like Uganda. There are numerous opportunities to implement successful approaches to tap into the provision of private health care services.
- Health care providers, especially the midwives and nurses in Uganda, are valuable resources in reaching clients and communities because they already work in communities, and they are dispersed widely throughout the country. Private providers provide affordable alternatives for clients who can pay a reasonable fee for services, thus relieving some of the burden on public facilities.
- The process of public private dialogue is critical for building trust and understanding between the two sectors. Active participation of private sector providers in policy dialogue ensures realistic outcomes and policy changes that lead to successful interventions.
- Linking private providers is key for the growth and strengthening of private sector provision of health care services. In addition to organizing around professional associations, many other means of information sharing, such as development of databases and distribution of bulletins help connect private providers.
- Sustainability of NGOs can be maximized through a holistic approach that addresses elements of institutional development, high quality services and products, and a sound financial base.
- Professional associations of private providers are able to successfully leverage resources from multiple donors but require capacity building assistance to ensure that they can manage multiple programs effectively.
- Associations like UPMA grow and increase their likelihood of sustainability as they focus on the question of delivering more value to their members. UPMA has made much progress in this regard, but it still has a long way to go.
- The case of the Kansanga Health Centre presents an exemplary lesson learned for international development efforts. The clinic was established through donor funding, as a model center to contribute financially to the association. Unfortunately, the clinic has become a burden for UPMA. It is not a sound strategy for international organizations to fund establishment of clinical services especially within the context of a voluntary membership association without considering long-term financial consequences and sustainability aspects.
- Many private providers are committed to providing high quality services but are often constrained by lack of financing and training. Private providers welcome opportunities to update their skills and are willing to implement improved treatment practices. Further, they are willing to invest in their practices to upgrade their

services. This is especially true for those providers engaged in private practice on a full-time basis like members of UPMA.

- Private providers can play a significant role in public health efforts such as immunizations and family planning services.
- Access to micro credit makes a difference for private providers. Access to small amounts of financial assistance, supported by business skills training can help providers improve financial viability and service quality.
- Training programs increase their effectiveness by establishing structured follow up systems. Follow up visits to trainees in their own work environment strengthen the gains of the training programs, as well as providing valuable information on the effectiveness of training efforts.
- The accomplishments of the PURSE Project provide models for successful interventions to increase the capacity of private health providers in developing country settings. Projects designed to strengthen the institutional capacity and sustainability of private sector health care organizations have a high potential to advance private sector health care. Activities targeted to improve service quality, financial sustainability and the policy environment increase the effectiveness and impact of interventions.

APPENDICES

APPENDIX A: SCOPE OF WORK FOR COMMERCIAL MARKET STRATEGIES CONSULTANCY FOR EVALUATION OF PRIVATIZING REPRODUCTIVE HEALTH SERVICES PROJECT IN UGANDA

Background

Commercial Market Strategies is a five-year global project whose aim is to promote private sector provision of family planning and other health care services. CMS has been active in Uganda since 1998 and will conclude in March 2004. The Uganda program focuses on the social marketing of reproductive health products and services, increasing the capacity of private-sector providers to deliver affordable, quality services and encouraging the creation of innovative health financing mechanisms to increase access to health care.

The CMS project seeks a consultant to evaluate the effectiveness of its interventions specifically in the area of increasing the capacity of private health providers. This portion of the project is referred to internally as PURSE –Privatizing Uganda Reproductive Health Services. The PURSE project consists of three main activities – Strengthening Uganda Private Midwives Association and other associations, improving private sector clinics and creating a favorable policy environment for private sector health care.

The major project objectives within PURSE and the key interventions designed to achieve these objectives are presented in Exhibit 1. Refer to attached results framework.

A more detailed description of PURSE project activities appears in the workplan that is available upon request.

Evaluation objectives

The evaluation should address the overall effectiveness of the project in meeting its objectives. Other questions to address include:

- Has PURSE helped advance private sector health care in Uganda? What interventions proved most effective?
- Did PURSE interventions help private clinics? Are private clinics that benefited from PURSE interventions performing better than non-intervention clinics?
- To what extent did PURSE interventions strengthen the capacity and sustainability of UPMA?
- How did PURSE project activities relate to broader CMS goals? What does this imply for social marketing programs?
- How has the PURSE project advanced the policy environment for public private partnerships in health including Private not for profit and private health provider segments?

- What has been learned about working with private sector providers?
- Are interventions likely to be replicable in other settings?
- Did the project work well with MOH, USAID and other donor programs?

Scope of Work

The scope of work for the consultant in this evaluation is described below:

1. Review the objectives and activities of the PURSE project through a review of project documents and interviews with project staff. Data sources that will be available to the consultant are detailed in Appendix A.
2. Develop interview guide and data collections tools as needed to carry out subsequent tasks.
3. Interview key stakeholders about their perception of the effectiveness of the PURSE project in meeting its objectives. Up to 20 to 30 interviews are expected. Consultant should audio tape the interviews and provide tapes to CMS. A list of individuals that might be interviewed for this evaluation appears in Appendix B.
4. Synthesize information from project documents, training reports, follow-up reports, databases, and other sources to present a comprehensive description and assessment of the key program interventions including quantitative and qualitative data.
5. Visit selected clinics to develop four mini case studies including three clinics that clinics have benefited from CMS interventions and three comparable clinics that did not participate in any CMS interventions. Describe impact of CMS interventions, relative effectiveness and lessons learned. Compare and contrast with intervention clinics with non-intervention clinics on key dimensions of accessibility, financial sustainability, community outreach, quality, and other factors.
6. Prepare a report outlining the accomplishments and shortcomings of the PURSE initiatives, the level of effectiveness of these initiatives in meeting overall project objectives, lessons learned and recommendations for further strengthening private health care. Comment also on the replicability of these interventions in other settings and any modifications that would be advised.
7. Prepare PowerPoint presentation summarizing major findings from the evaluation and present findings to client and USAID representatives at a meeting to be organized by CMS.

Deliverables

- A work plan for carrying out the evaluation including a list of key tasks and timelines.

- An interview guide and other data collection tools to carry out the evaluation including mini case study evaluation tools.
- A draft outline of the final report including anticipated appendices, etc by February 13, 2004.
- A draft report of the evaluation by March 15, 2004 to be finalized after client review.
- Final report and PowerPoint presentation due by March 22, 2004.

Duration

The consultant will provide up to 30 days including all fieldwork, report preparation and presentations. The period of work will begin on or about January 13, 2004 and continue through March 15, 2004 unless otherwise extended. An estimated two trips to Uganda are anticipated to complete the evaluation.

Sources of Data for PURSE Evaluation

Source of Data	Type of data available
CMS Workplan	Annual Summary of intended PURSE activities
PURSE monitoring plan	Brief table of key indicators, 2001-2003
PURSE monthly reports	Brief summary of monthly activity by major PURSE area
Training reports for each business skills training	Number of participants, basic demographics of participants, training performance scores
Follow up site visit reports for business skills training	Statistics on record keeping and quality indicators
Business skills applications	Uncompiled data on provider demographics and key challenges in running a clinic
IMCI training reports	Number of participants, basic demographics of participants
IMCI followup reports	Statistics on compliance with treatment guidelines, record keeping
UPMA IGA records	Data on UPMA income from multiple sources – monthly for three years
UPMA membership records	Data on number of members and paid members incl. mailing addresses
UPMA monthly service statistics	Data on service utilization for 2002; incomplete
Regional representative database	Data on indicators from RR visits since program inception incl. infection control, equipment, record keeping, activity levels in UPMA

Clinic profiles	Data on provider demographics, clinic location, range of services, revenue and expense categories
Loan application database	Data on provider demographics, amount and use of loans, gross revenue and expense data, savings
Summa semi annual reports	Analysis of data drawn from loan application database
Summa client exit interview reports	Client satisfaction survey from control and intervention clinics baseline and followup
Clinic visits reports	Data from onsite clinic visits to control and intervention clinics
Outlook database	Names and mailing addresses of providers trained in BST or receiving loan
AAR franchise agreement	Franchise agreement with VMC that spells out terms of relationship
PNFP workshop report	Proceedings from CMS workshop on reducing user fees
PHP concept paper	Concept paper on collaboration between PHPs and MOH
PHP draft policy	Policy drafted from concept paper
Internally generated publications	Best Practices Bulletin, UPMA newsletters, UPMA directory, Health education brochures, Special Report on financial characteristics, Reports on challenges in running a clinic

Potential Individuals/organizations to contact

Commercial Market Strategies Staff

Dr. Peter Cowley
Harriet Nakanyike
Paul Akera
Nina Shalita
CMS detailers

Project Partners

Rodney Schuster, Uganda Microfinance Union
Andrew Luzze, Uganda Microfinance Union
Irene Ntanda, National Smallholders Business Centre
Timothy Bwiiso, National Smallholders Business Centre
Dr. John Odaga, consultant to PNFP project
Dr. Godfrey Magumba, UPHOLD and IMCI training developer

Uganda Private Midwives Association

Executive committee
Members
Branch chairs
Determined Private Midwives for Sustainability
Staff

Ministry of Health

Dr. Bagambisa, Public Private Partnership Office
Dr. Nsungwa, IMCI coordinator
Dr. Filippo Curtale, technical advisor to PPPH
Dr. Francis Rnumi Mwesigye, Planning Commissioner MOH

Uganda Private Medical Practitioners Association

Dr. Eva Kajjumba, Secretary
Dr Kanyerezzi, President
Dr. Harold Bisaase, representative to PHP drafting committee

Uganda Medical Association

Dr. Margaret Mungherera, President
Dr. Lugemba Myers

Uganda National Association of Nurses and Midwives

Janet Obuni, President
Patrick Souleymane Bateganya, Secretary

Uganda Catholic Medical Bureau

Dr. Daniele Giusit, Executive Director
Dr. Peter Lochoro, Asst. ED
Andrea Mandelli, IT coordinator

Uganda Protestant Medical Bureau

Steven Mutyaba, executive director

USAID

Rob Cunnane
Suzzane McQueen

AAR

Maryjka Beckmann

Victoria Medical Centre

Dr. George Mayanja

Others

Dr. Paul Kiwanuka, consultant to UPMA
Marie Stopes International
UPHOLD

APPENDIX B: LIST OF DOCUMENTS REVIEWED

Uganda Country Profile, Commercial Market Strategies, October 2003.

Commercial Market Strategies/Uganda Workplans for FY 2001, 2002, 2003.

Privatizing Uganda's Reproductive Services (PURSE); September 2000.

PURSE Workplan 2002 – 2003.

CMS Six-Month Extension Workplan.

CMS/Uganda Quarterly Reports from April 2001.

The 2000-2001 Uganda Demographic and Health Survey

Business Handbook for Private Health Providers, Summa Foundation.

The Summa Foundation Investment Proposal: Uganda Private Provider Loan Fund. September 2000.

The Uganda Private Providers Loan Fund, Summa Foundation, May 2001.

Summa Loan Monitoring and Evaluation: A Study of Exit Clients and Clinic Visits at Second Group of Health Providers Clinics in the Districts of Kampala, Mukono, Mpigi and Wakiso; October 2001.

Year to Date (Semi-annual) Summa Reports; June 2001- June 2003.

Investment Brief: Summa and the Uganda Private Providers Loan Fund. (Undated)

The Uganda Private Providers Loan Fund: A Combined Report on the Baseline and Follow-on Survey of Exit Clients at Private Health Providers Clinics, CMS, October 2002.

Uganda Microfinance Union Private Health Providers Loan Fund Activity Reports; 2001-2003.

The Impact of a Microfinance Program on Client Perceptions of the Quality of Care Provided by Private Sector Midwives in Uganda, CMS, October 2002.

Business Skills and Loan Management Training Workshops Reports.

Business Skills and Loan Management Training Follow-up Reports.

Annual Report, UPMA, December 2003.

Regional Representatives Program, Uganda Private Midwives Association. (Undated)

Regional Representative Training Report; April 2002, UPMA.

Profile of Uganda National Association for Nurse and Midwives, UNANM. (Undated)

Findings from Clinic Visits, CMS, (Undated).

Special Report: How Successful is Your Clinic, CMS, 2002.

Challenges in Running a Private Clinic: Summary of Provider Perceptions; CMS, August 2001.

Quality Care from the Clients' Eyes, CMS, 2003.

Integrated Management of Childhood Illnesses Training Reports.

Integrated Management of Childhood Illnesses Training Follow-up Reports.

Health Sector Strategic Plan 2000/02 - 2004/05 Midterm Review Report, MOH.

Faithfulness to the Mission: Accelerated reduction of user fees to increase access by the poor to our facilities'. Report of the Second Workshop, UCMB, UPMB, UMMB, September 2003.

User-fee Reduction Initiative, UCMB, UPMB, UMMB, January 2004.

Manual on Drug Logistics and Stores Management Procedures for Districts and Health Units.

National Policy on Public Private Partnerships in Health, Implementation Guidelines for Private Not For Profit Health Providers, Final Draft, September 2003.

National Policy on Public Private Partnership in Health, Final Editorial Draft, October 2003.

Draft Principles of the Proposed Private Health Sector Bill 2003.

Concept Paper on Areas of Collaboration between Ministry of Health and Private Health Providers, (Draft); April 2003.

Policy Framework for Partnership with Private Health Practitioners; Part Three, The Republic of Uganda. (Undated)

Policy Framework for Partnership with Private Health Practitioners; 10th September 2003. (First Draft)

National Policy on Public Private Partnership in Health, Final Editorial Draft, October 2003.

Best Practices Bulletins; CMS, Issues 1-13.

Uganda Private Midwives Association Member Directory. (Undated)

National Smallholder Business Centre, Profile. (Undated)

Annual Health Sector Performance Report: Financial Year 2002/2003; October 2003.

Memorandum of Understanding Between AAR Health Services LTD and Commercial Market Strategies Project. (Undated)

UPHOLD's Integrated Health Strategy: Uganda Programme for Human and Holistic Development, Draft Document, November 2003.

Uganda Final Country Report, SEATS Project, 2000.

APPENDIX C: LIST OF PERSONS CONTACTED

Commercial Market Strategies/Uganda

Peter Cowley, Director CMS
Elizabeth Fischer, Privatizing Health Services Advisor
Harriet Nakanyike, Privatizing Health Services Specialist
Paul Akera, Privatizing Health Services Assistant
Karen Bulsara, Social Marketing Manager
Nina Shalita, Executive Director, UPMA

USAID/Kampala

Suzzane McQueen, Deputy Health, HIV/AIDS and Education Office

Ministry of Health

Francis Runumi, Commissioner of Planning
George Bagambisa, Assistant Commissioner of Planning
Filippo Curtale, Technical Advisor, PPPH Office

Uganda Private Midwives Association

Mary Namusisi, Chairperson
Kato Ahmed, Accounts Assistant
Sarah Kikomeko, Member, Regional Representative
Jane Mpanga, Member, Regional Representative
Robinah Kato, Member, Former Chairperson

Kansanga Health Center

Moses Ssemenda, Administrator
Sarah Nabembezi, Member, Determined Private Midwives Association

Uganda National Association of Nurse and Midwives

Patrick Souleymane Bateganya, General Secretary

Uganda Medical Association

Dr. Myers Lugemwa, General Secretary

Uganda Private Medical Practitioners Association

Professor Kanyerezi, President

National Small Holders Business Center

Irene Ntanda, Business Development Manager and Board Member
Sam Zinunula, Training and Operations Coordinator and Board Member

Uganda Microfinance Union

Rodney Schuster, Executive Director

Uganda Protestant Medical Bureau

Stephen Mutyaba, Executive Secretary

Uganda Catholic Medical Bureau

Daniele Giusti, Executive Director

UPHOLD Project

Dr. Godfrey Magumba, Private Sector Specialist

Victoria Medical Center

George Mayanja, Director

Others

Diana Kyomuhangi, Midwife in private practice
Gorreti Arinaitwe, Nurse in private practice

APPENDIX D: LIST OF CLINIC VISITED

Embabasi Clinic, Busega

Gold Cross Clinic and Laboratory Services, Nsambya

Kansanga Health Center, Kansanga, Kampala

Kugumikiriza Clinic, Matuga

Martyrs Clinic, Luzira, Kampala

Mujjanjabi Clinic, Namasuba, Kampala

Victoria Medical Center, Kampala

Womeraka Domiciliary Clinic

APPENDIX E: CLINIC CASE STUDY INTERVIEW GUIDE

(Explain the purpose of the visit and provide information re UPMA and CMS/PURSE as needed)

1. Name of the clinic
2. Name of the owner
3. Clinic Type

Clinic A	Full intervention, peri-urban
Clinic B	Full intervention, rural
Clinic C	Partial intervention, peri-urban
Clinic D	Non intervention, peri-urban
4. Facility services

Outpatient only
Outpatient and inpatient
of beds
Hours of service
5. Years in private practice (owner)
6. When did the clinic establish?
7. Types of assistance/training received through CMS

Loans
BS training
IMCI training
Newsletter
Best Practices Bulletin
Involvement in PPP
Other
8. Which of the above assistance/interventions was most helpful? Why?
9. What would she recommend done differently by CMS? Why?
10. What has she done differently as a result of CMS intervention?
11. How does she compare her work and her clinic with others in the area that did not have any interventions?
12. Owner's level of involvement in UPMA activities
13. To what extent has involvement in UPMA been a help to herself and her clinic? How?

14. Assistance/training received through other local or international agencies/projects
- UNFPA
 - IPAS
 - SOMARC
 - SEATS
 - POLICY
 - DISH
 - MOH
 - Other
15. If the clinic received loans, specify amounts
1. loan
 2. loan
 3. loan
 4. loan
16. What did she do with each loan? (Purchase of drugs, renovation/expansion of the clinic, purchase of equipment, etc)
1. loan
 2. loan
 3. loan
 4. loan
17. Staffing of the clinic (Write down each staff and qualifications)
18. Does the staff receive on the job training?
19. Range of services
- Drug sales
 - Curative services
 - Antenatal care
 - Deliveries
 - Counseling
 - Family planning
 - Well baby (includes immunizations)
 - Post-abortion care
 - Lab services
 - Home visits
 - Others (specify)
20. Cleanliness /hygiene
- Clean supply of water
 - Presence of toilets
21. Physical outlook
- Comfort and adequacy of examination rooms, wards and waiting areas
 - Number and designation of rooms (wards, labor room, PAC room, storage, lab, etc.)

22. Presence of essential equipment

- Adult and children weighing scales
- Thermometer
- Light source
- Sterilization equipment
- Examination couches
- Fetoscope
- BP cuff/machine
- Stethoscope
- Speculum, tenaculum
- Fridge and vaccine carriers
- Gloves
- MVR equipment
- Others(specify)

23. Availability of essential drugs

- Cotrimoxazole
- Chloroquin
- ORS
- Fansidar
- Paracetamol
- Tetracycline eye ointment
- Mebendazole
- Vitamin A
- Cotrimoxazole
- Ergometrine
- Oxitocine
- Folic Acid
- Aspirin
- Iron supplement
- IV fluids

24. Availability of lab equipment and services

- Microscope Urine analysis
- Blood slide
- Stool analysis
- Hemoglobin
- VDRL
- Pregnancy test
- Other

25. Availability of contraceptives

- Pills
- Condoms
- Injectables
- IUDs
- Norplant

26. Availability of vaccines
 - BCG
 - DPT
 - Measles
 - Polio
 - Tetanus
27. Presence of Guidelines and Standards
 - Standards of Midwifery Practice
 - Midwife Handbook
 - National Standard Treatment Guidelines or Clinical Guidelines 2003
 - Others
28. Presence of client education materials (specify)
29. Infection Prevention Measures
 - Disposal of sharps and needles
 - Disinfection practices
30. Adequacy of client privacy (describe)
31. Fees for services (specify fees for each category of services)
 - Consultations
 - Deliveries
 - Antenatal
 - Family planning
 - Immunization
 - MVA
 - Other
32. Record Keeping
 - Service statistics (Number of clients by type of service)
 - Records of drug sales
 - Contraceptive sales
 - Stock control records
33. Financial records
 - Cashbook
 - Periodic calculation of profits and loss
 - Debtor's book
 - Issuance of receipts
34. Average number of clients seen per month (by type)
 - General outpatient cases
 - Deliveries
 - Antenatal
 - Family Planning
 - Immunizations
 - MVA

Other

35. What were the average numbers of clients seen monthly prior to the assistance/interventions?

General outpatient cases

Deliveries

Antenatal

Family Planning

Immunizations

MVA

Other

36. Average monthly revenues, expenses and profits

Revenue (including loans)

Expense (including loan payments)

Profits

37. What were the average monthly revenues, expenses and profits prior to the assistance/interventions?

Revenues

Expenses

Profits

38. Marketing of the clinic

Visibility of clinic signs

Community outreach

Brochures

Other marketing efforts

39. Overall, could she describe what her clinic was like before CMS interventions?

40. What would she like UPMA to help her to do better in her clinic?

41. What plans does she have to improve her business in the future?

42. Any other comments/observations

APPENDIX F: INVENTORY OF BUSINESS SKILLS TRAINING AND FOLLOW UP VISITS

Location	Funded by	Facilitators	Trainees	# Trained	Training Date	Follow-up Date	No Followed	Follow-up By
Masaka	CMS/Summa	ACDI-VOCA	UPMA	21	1/2001	4/2001	20	ACDI-VOCA
Kampala	CMS/Summa	ACDI-VOCA/UMU/CMS	UPMA	26	1/2001	4/2001	20	ACDI-VOCA
Mukono	CMS/Summa	ACDI-VOCA	UPMA	27	2/2001	4/2001	17	ACDI-VOCA
Mpigi	CMS/Summa	ACDI-VOCA	UPMA	21	2/2001	4/2001	18	ACDI-VOCA
Kampala	CMS	ACDI-VOCA/CMS	PHPs	26	8/2001	10/2001	26	CMS
Kampala	CMS	ACDI-VOCA/CMS	PHPs	24	10/2001	11/2001	24	CMS
Jinja, Kamuli, Iganga, Mayuge	CMS	NSBC/CMS	PHPs	36	1/2002	4/2002	36	CMS
Mbarara & Bushenyi	CMS	NSBC/CMS	PHPs	22	4/2002	7/2002	22	CMS
Kampala	CMS	NSBC/CMS	PHPs	22	7/2002	10/2002	22	CMS
Mbale	CMS	NSBC/CMS	PHPs	20	9/2002	2/2003	20	CMS
Mbale	CMS	NSBC/CMS	PHPs	29	10/2002	2/2003	29	CMS
Mbarara, Bushenyi	CMS	NSBC/CMS	PHPs	27	1/2003	4/2003	25	CMS

Location	Funded by	Facilitators	Trainees	# Trained	Training Date	Follow-up Date	No Followed	Follow-up By
Hoima, Kibaale, Masindi	CMS	NSBC/CMA	PHPs	20	2/2003	5/2003	19	CMS
Mityana-Mubende	CMS	NSBC/CMS	PHPs	23	4/2003	6/2003	23	CMS
Kabarole	CMS	NSBC/CMS	PHPs	24	5/2003	8/2003	24	CMS
Masaka	CMS	NSBC/CMS	PHPs	26	9/2003	12/2003	26	CMS
Mayuge	CMS	NSBC/CMS	PHPs	29	11/2003	Not yet followed up		
Kampala	CMS	NSBC/CMS	PHPs	23	1/2004	Not yet followed up		
Total				446			371	

APPENDIX G: INVENTORY OF IMCI TRAINING WORKSHOPS AND FOLLOW UP VISITS

Location	Funded by	Facilitators	Trainees	# Trained	Training Date	Follow-up Date	# Followed	Follow-up By
Kampala	CMS	DISH/CMS	UPMA	20	11/2001	12/2001	20	MoH/UPMA/CMS
Kampala	CMS	DISH/CMS	UPMA	20	2/2002	3/2002	20	MoH/UPMA/CMS
Mbale	CMS	MOH/CMS	PHPs	19	2/2003	3/2003	19	MoH/UPMA/CMS
Kampala	MoH	CMS	UPMA (RR)	24	6/2003	9/2003	24	MoH/UPMA/CMS
Mbarara	CMS/MoH	MoH/UPMA/CMS	PHPs	20	8/2003	9/2003	20	MoH/UPMA/CMS
Mukono	CMS	MoH/UPMA/CMS	UPMA	20	10/2003	11/2003	16	MoH/UPMA/CMS
Kampala	CMS	MoH/UPMA/CMS	PHPs	20	11/2003	12/2003	18	MoH/UPMA/CMS
Kabarole	CMS	MoH/UPMA/CMS	UPMA	18	12/2003	1/2004	16	MoH/UPMA/CMS
Kampala	CMS	MoH/UPMA/CMS	PHPs	19	1/2004	Not yet followed up		
Masaka	CMS	MoH/UPMA/CMS	PHPs	21	2/2004	Not yet followed up		
Total				222			153	