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# Negotiating improved case management of childhood illness with formal and informal private practitioners in Uganda

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**Summary**

OBJECTIVE In Uganda, formal and informal private practitioners (PPs) provide most case management for childhood illness. This paper describes the impact of negotiation sessions, an intervention to improve the quality of PPs' case management of childhood diarrhoea, acute respiratory infection and malaria in a rural district in Uganda.

METHOD Negotiation sessions targeted PPs working at private clinics and drug shops. The aim was to improve key practices extracted from the national Integrated Management of Childhood Illness Guidelines, and to measure the PPs' performance before and after the intervention.

RESULTS Post-intervention the quality of case management for childhood diarrhoea, acute respiratory infection and malaria was generally better, although certain practices appeared resistant to change. We discovered various types of PPs who were mostly unregistered by the district authorities.

CONCLUSIONS Results suggest the importance of maintaining ongoing monitoring and support to PPs to understand barriers to change and to encourage more practice improvement. Modifications to the intervention are needed to take it to scale and render it more sustainable. Getting local organizations and professional associations more involved could make it easier to establish and maintain contact with PPs. The government needs to simplify registration procedures and reduce associated fees to encourage PPs to register and thus be included in a large-scale intervention. Future interventions need to measure the impact on improving childhood case management at the community/household level.

**keywords** child survival, private practitioners, diarrhoea, acute respiratory infection, malaria, quality, Uganda

## Introduction

In most developing countries, formal and informal private practitioners (PPs) are important sources for treating common childhood illness (Berman 1996; McCombie 1996). Qualified private practitioners such as pharmacists, doctors, nurses and midwives, as well as unqualified practitioners such as drug vendors, village doctors and traditional healers, are, for better or worse, popular sources of treatment for childhood diarrhoea, acute respiratory infection (ARI) and malaria (Berman 1996; McCombie 1996; Global Health Council 2003). It has also been documented that the clinical quality of care provided by PPs is generally sub-standard or even harmful (Bennett & McPake 1997; Bruga & Zwi 1998). While technical quality may be poor, the community's perception of the services offered by PPs is favourable. PPs are often described as more sensitive to patients' needs, more accessible, and their working hours are more convenient (Bruga & Zwi 1998; Tawfik *et al.* 2002). Families report that PPs typically spend more time with them than public sector providers. Given this favourable community attitude towards PPs' services coupled with some communities' lack of access to governmental health services, PPs will likely continue to play a prominent role in treating childhood illness. Thus, adopting interventions to improve the quality of their clinical services is important.

In Uganda, where governmental health services cover 50% of the population, PPs such as private clinics and drug shops, provide the majority of outside home care for childhood diarrhoea and fever. Realizing the PPs' prominent role, the Ministry of Health's Integrated Manage-

ment of Childhood Illness (IMCI) Unit worked with stakeholders to develop a national strategy, and then initiated an intervention to improve the quality of PPs' case management of childhood diarrhoea, ARI and malaria. This paper describes Uganda's experience in improving PPs' quality of case management of childhood illness in one district, Luwero, and discusses policy implications and modifications needed for large-scale implementation.

## Materials and methods

Luwero District, a predominantly rural district of 450 000 inhabitants located 50 km north of the capital Kampala, was selected to pilot the intervention. This district is included in the community component of the IMCI program, thus caretakers of children have been exposed to communication messages regarding correct management of childhood illness.

Due to the lack of reliable records/registry of PPs, an inventory of all formal and informal private health practitioners in the district was conducted. Twenty surveyors, each covering one of the district's 20 sub-counties, were selected from sub-district community development assistants and health assistants. These community members participate on a semi-voluntary basis in community development and health support activities. The surveyors received a full-day orientation and conducted the inventory in May and June 2002. Community informants helped these surveyors locate all PPs. Using a structured form, the surveyors interviewed each private practitioner to collect data on the type of practice, type of facility, location of facility, name of owner, qualification of owner and attendants of the practice, number of years in practice, registration at governmental or professional associations and child survival drugs stored.

As described later, the inventory revealed the presence of different types of private providers. The intervention focused on private clinics and drug shops because, according to a previous extensive household survey study conducted by the Ministry of Health in the year 2000, these two categories manage most of the childhood illness cases.

Six interviewers who received 1-day training then conducted baseline-simulated visits (mystery client interviews) in all private clinics and drug shops in four randomly selected sub-counties within Luwero District. Using a list of private clinics and drug shops compiled during the inventory, the interviewers located and approached the private clinic/drug shop in the sample to seek treatment/advice for their supposedly sick children, who were supposedly left at home. Interviews were completed for those clinics/drug shops, which were open at the time of the interview. The attendant/PP in the clinic/drug shop at the time of the interview was the one interviewed. The interviews were conducted independently; multiple interviewers visited multiple PPs. The interviewers were trained to simulate a specific illness for a specific child and were prepared to answer specific questions that may be posed by the interviewee regarding the case. The PPs' treatment/advice for six specific predetermined cases was investigated:

- Simple diarrhoea: my child has diarrhoea, what can I give him?
- Severe diarrhoea (suspected dehydration): my child has diarrhoea, she passes many watery stools, what can I give her?
- Mild ARI: my child has runny nose and is not feeling well, what can I give him?
- Pneumonia: my child has a fever, has been coughing, and is breathing with difficulty, what can I give her?
- Simple malaria: my child has fever, and was sweating last night, what can I give him?
- Complicated malaria: my child has fever, sweats at night and he has convulsions sometimes, what can I give him?

Immediately after the simulated interview, the interviewer filled a simple checklist to register what the private practitioner asked, advised or gave/prescribed. The check list included questions such as: did the interviewee ask about the age of the child? Did he/she ask to see the child? Did he/she ask about the duration of illness? These check lists were collected and compared with the standard IMCI guidelines to determine the quality of the interviewee's care. This comparison was not performed by the interviewer; it was conducted by trained Negotiation Session Moderators.

Negotiation sessions were the intervention to improve the PPs' quality of management of childhood illness. Modified from the documented PRACTION (Private Practitioner Treatment Improvement) Model described by Chakraborty *et al.* (2000), negotiation sessions seek to satisfy both public health interest in improving clinical care quality and at the same time be sensitive to the complex factors influencing the practices of PPs, e.g. client expectations, profit and promotional activities by pharmaceutical companies (Bennett & McPake 1997; Bruga & Zwi 1998).

Negotiation sessions set a comfortable learning environment to encourage PPs to participate. Results from the baseline-simulated visits were used to stimulate participants to think critically about their own practices when compared with a list of desired (target) practices for managing childhood diarrhoea, ARI and malaria based on the National IMCI treatment guidelines, e.g. for every case

of diarrhoea, give or recommend oral rehydration salts (ORS) or increased fluid intake. Illustrative materials, e.g. posters explaining correct malaria treatment dose, developed by the Ministry of Health, were used to illustrate the discussion. The moderators of the sessions negotiated with participants, to see which desired practices they were able and willing to carry out. The approach was to improve a limited number of behaviours that would have an impact on child survival, and not to aim for optimal, but unrealistic, changes across the board. Eight public sector district health workers moderated the negotiation sessions. A 2-day training enabled them to be familiar with the clinical content and to run the negotiation sessions in a participatory way.

After completing the negotiation sessions, participants were asked to sign an individual contract agreeing that they would adopt the discussed desired practices. Participants were told that the contract served no legal purpose but included a summary/reminder of the specific practices they agreed to adopt during the negotiation sessions.

Four negotiation sessions were held in September and October 2003. They included 104 PPs from private clinics or drug shops. Participants included a mix of formal and informal practitioners including six physicians, 13 medical officers (assistant physicians), 33 nurses/midwives, 43 nurse assistants/aides and nine drug sellers. Each session lasted for 18 h over 3 days. Each participant received a certificate acknowledging his/her completion of the sessions.

One to two months after the negotiation sessions, moderators conducted monitoring/support visits to the participating PPs in their own private clinic/drug shop. During the visits, moderators discussed with each PP his or her progress in adopting the desired practices. The individual contract was used to review the list of practices and to discuss any difficulties PPs had in adopting the practices and ways to resolve them.

Post-intervention simulated visits were conducted using the same method as the baseline visits, 3 months after the negotiation sessions to measure change in PPs' practices. A comparison between the results of pre-negotiation (baseline) and post-negotiation simulated visits was conducted using two-sided *t*-test at 5% significance.

## Results

### The Inventory

The inventory revealed the presence of various types of private health providers in Luwero District: 386 traditional birth attendants (TBAs), 321 drug shops, 281 traditional healers, 74 private clinics, 19 maternity homes, 17 ordinary shops, and seven other categories mainly pharmacies and laboratories. Private health providers ranged from formal practitioners: 218 nurse/midwives, 90 medical officers, 43 physicians and three pharmacists, to informal practitioners: 268 nurse assistants/aides, 54 drug sellers and 27 ordinary shop keepers. Private clinics were owned or registered under a formal private provider's name, but managed on day-to-day basis either by the owner or, in most cases, by another formal or informal provider.

The inventory also revealed generally poor compliance with registration regulations. A large number of private practices were not registered at the district health authorities. Slightly over half the traditional healers (56%), private clinics (54%) and maternity homes (50%) were registered. Few drug shops (39%) and TBA practices (31%) were registered. In addition, numerous facilities were offering services that they were not authorized to provide. For instance, many drug shops provided clinical management services and clinics were selling drugs to clients.

Most private clinics and drug shops stocked essential child survival drug items including sulphadoxine pyremithamine, chloroquine, paracetamol, cotrimoxazole and ORS (Table 1).

### The intervention

Tables 2–4 compare the results of the simulated visits before and after the negotiation sessions. The data were aggregated for all PPs because of insufficient numbers in each category. They revealed that the intervention resulted in statistically significant improvement in several key child survival practices. For diarrhoeal diseases, an important improvement was achieved in the proportion of PPs who recommended continued feeding (from 4% to 20%; $P < 0.006$), and increased fluids intake or ORS (from 11% to 45%; $P < 0.001$). While the changes are statistically significant, a large proportion of PPs still did not adopt these two important practices: most did not recommend continued feeding (80%), and did not advise giving more

**Table 1** Proportion of private clinics and drug shops with stock of child survival drugs

| Drug item | % of private clinics that stocks the drug ($n = 74$) | % of drug shops that stocks the drug ($n = 321$) |
|---|---|---|
| Sulphadoxine pyremithamine | 70 | 86 |
| Chloroquine | 67 | 86 |
| Paracetamol | 63 | 82 |
| Cotrimoxazole | 58 | 76 |
| Oral rehydration salts | 49 | 58 |

**Table 2** Impact of intervention on Private Practitioners' practices for case management of childhood diarrhoea

| Practices | Baseline (%) | Post intervention (%) | *P*-value |
|---|---|---|---|
| Simple diarrhoea | $n = 57$ | $n = 71$ | |
| Asked about age of the child | 100 | 96 | 0.116* |
| Asked to see the child | 4 | 10 | 0.045* |
| Asked if there is blood/mucus in stool | 11 | 55 | <0.001 |
| Asked if the child appears weak/ does not play as usual | 7 | 28 | 0.002 |
| Asked about feeding during illness | 14 | 32 | 0.016 |
| Advised to continue feeding | 4 | 20 | 0.006 |
| Gave†/recommended ORS | 11 | 45 | <0.001 |
| Explained how to prepare ORS | 7 | 39 | <0.001 |
| Advised to give more fluids | 0 | 45 | <0.001 |
| Gave/recommended any other medicine† | 88 | 75 | 0.064* |
| Advised on danger signs needing immediate care | 0 | 32 | <0.001 |
| Severe diarrhoea/dehydration | $n = 53$ | $n = 73$ | |
| Asked about age of the child | 100 | 100 | |
| Asked to see the child | 32 | 84 | <0.001 |
| Asked about duration of illness | 79 | 95 | 0.009 |
| Asked if there is blood/mucus in stool | 36 | 52 | 0.072* |
| Asked about feeding during illness | 15 | 25 | 0.190* |
| Advised to continue feeding | 21 | 34 | 0.096* |
| Gave/recommended ORS | 62 | 70 | 0.226* |
| Explained how to prepare ORS | 60 | 56 | 0.226* |
| Advised to give more fluids | 62 | 70 | 0.226* |
| Gave/recommended any other medicine‡ | 77 | 22 | <0.001 |
| Advised to refer the child urgently | 21 | 51 | <0.001 |

*n*, number of private practitioners.
* Difference is not statistically significant.
† Gave, private practitioner gave to the interviewer (supposedly the parent of a sick child).
‡ Other medicine includes metronidazole (flagyl), Imodium, mebendazole, septrin and charcoal tablets. A decrease in this indicator is be an improvement.

fluids or ORS (55%). Similarly, for severe diarrhoea/dehydration, the proportion of those who discussed danger signs needing urgent referral improved significantly from 21% to 51% ($P < 0.001$), yet these remaining PPs failed to give this essential advice.

Regarding ARI, impressive improvements in the case management of mild ARI and pneumonia were documented. For example, most PPs advised continued feeding for pneumonia cases (81%), up from 24% ($P < 0.001$) and most advised urgent referral (70%), up from 24% ($P < 0.001$). Despite the statistically significant improvement, when compared with the baseline, for mild ARI cases, most PPs still did not ask if the child had difficult/rapid breathing (84%). Similarly, in recommending the correct medicine and referral, over half PPs still did not recommend the correct medicine (61%) and did not give advice on danger signs needing urgent clinical care (59%).

Regarding case management of malaria, an impressive improvement was achieved: most PPs (73%) gave the correct drugs (up from 2%), half gave the correct dose according to the national guidelines (up from 0), and almost half (49%) explained how to give the medicine (up from 8%). However, only one-third of PPs advised on danger signs requiring immediate medical care for simple or complicated malaria cases, while this was a statistically significant improvement over the baseline, there is room for further improvement.

Results show that some PPs' practices seem resistant to improvement. For example, in cases of simple diarrhoea and mild ARI, PPs continued to give/recommend unnecessary medicine. In severe diarrhoea the majority of PPs continued to ignore giving advice on feeding; and in malaria cases the majority of PPs did not advise making the child sleep under insecticide-treated nets to protect him/her from future attacks.

## Discussion

One important challenge facing the intervention was reaching the target PPs. As most are not registered with

**Table 3** Impact of intervention on Private Practitioners' practices for case management of childhood Acute Respiratory Infection (ARI)

| Practices | Baseline (%) | Post-intervention (%) | *P*-value |
|---|---|---|---|
| Mild ARI | $n = 50$ | $n = 69$ | |
| Asked about age of the child | 92 | 100 | 0.017 |
| Asked about the duration of illness | 42 | 96 | <0.001 |
| Asked if the child had difficult/rapid breathing | 4 | 16 | 0.044 |
| Asked about feeding during illness | 6 | 48 | <0.001 |
| Advised to continue feeding | 8 | 54 | <0.001 |
| Advised to give more fluids | 10 | 65 | <0.001 |
| Gave/recommended any medicine | 84 | 78 | >0.226* |
| Gave/recommended correct medicine | 0 | 39 | <0.001 |
| Advised on danger signs needing immediate care | 2 | 41 | <0.001 |
| Pneumonia | $n = 49$ | $n = 72$ | |
| Asked about age of the child | 100 | 100 | |
| Asked about duration of illness | 73 | 100 | <0.001 |
| Asked if the child had convulsions | 4 | 39 | <0.001 |
| Asked about feeding during illness | 22 | 90 | <0.001 |
| Advised to continue feeding | 24 | 81 | <0.001 |
| Advised to give more fluids | 27 | 86 | <0.001 |
| Advised to refer the child urgently | 24 | 70 | <0.001 |
| Gave/recommended any medicine | 63 | 90 | <0.001 |
| Gave/recommended correct medicine† | 0 | 85 | <0.001 |
| Gave/recommended correct dose | 0 | 68 | <0.001 |
| Explained how to give medicine | 32 | 85 | <0.001 |

*n*, number of private practitioners.
* Difference is not statistically significant.
† Cotrimoxazole, as described in the national IMCI guidelines.

**Table 4** Impact of intervention on Private Practitioners' practices for case management of childhood Malaria

| Practices | Baseline (%) | Post intervention (%) | *P*-value |
|---|---|---|---|
| Simple malaria | $n = 57$ | $n = 66$ | |
| Asked about age of the child | 100 | 97 | 0.187* |
| Asked if child had convulsions | 21 | 23 | 0.823* |
| Asked if child had cough or cold | 82 | 86 | 0.55* |
| Asked to see the child | 28 | 38 | 0.25* |
| Gave/recommended any medicine | 98 | 73 | <0.001 |
| Gave/recommended correct medicine† | 2 | 73 | <0.001 |
| Gave/recommended correct dose | 0 | 50 | <0.001 |
| Explained how to give medicine | 8 | 49 | <0.001 |
| Advised on danger signs needing immediate care | 0 | 34 | <0.001 |
| Advised to make child sleep under bed net | 0 | 5 | 0.105* |
| Complicated malaria | $n = 61$ | $n = 72$ | |
| Asked about age of the child | 98 | 99 | |
| Asked about duration of illness | 13 | 99 | <0.001 |
| Asked if the child has cough/cold | 21 | 35 | 0.087* |
| Asked about previous medication | 54 | 82 | <0.001 |
| Advised to refer the child urgently | 16 | 33 | 0.026 |
| Advised to make child sleep under insecticide treated net | 0 | 24 | <0.001 |

*n*, number of private practitioners.
* Difference is not statistically significant.
† A combination of Chloroquine and sulphadoxime pyremithamine, as described in the national malaria treatment guidelines.

district authorities, a survey (inventory) was necessary to find them. The inventory revealed several different types of PPs who are actively practising in the community. Drug shops and private clinics were particularly important sources of care for childhood illness. Both categories were similar, places that store drugs with an attendant. Perhaps the only difference was the private clinics had a bench or a bed. Yet, both facilities provided case management counselling and sold drugs. The attendants were often not the owners. Private clinics are frequently registered under a physician's name, yet the attendants are nursing aides. This points to the need for detailed inventories and for the interventions to address both owners and attendants.

The results of the negotiation sessions revealed that despite the important improvements in some practices, some other practices only changed slightly or were resistant to change. This observation suggests that changing PPs' practices may require more than one round of negotiation and follow-up. Keeping close contact with PPs is required through ongoing support visits to continue the process of behavioural change and to help them continue to practice in the desired way. Further dialogue with participating PPs on why certain practices did not change could be valuable in shaping the content of future negotiation sessions.

Modifications to the pilot intervention are needed to make it more suitable for a large-scale implementation. Involving local organizations, such as community-based organizations and non-governmental organizations can be important in maintaining ongoing communication with PPs. Strengthening the presence of professional associations, e.g. Uganda Medical Association and Uganda Private Midwifery Association, may be a worthwhile investment to provide a long-term vehicle to reach out to and work with PPs. In this study results were aggregated for all PPs in the sample. Yet, large-scale implementation can allow measuring the impact of the intervention on improving the quality of care for specific groups of PPs. In addition, large-scale implementation will need to include measuring the impact of the intervention on the community/household management of childhood illness.

In addition, national authorities must endorse scaling up the intervention. This may be difficult at the present time as most PPs are not registered. PPs' status included three main categories: qualified and registered (easiest to endorse); qualified but not registered (can be endorsed if registered); and non-qualified and non-registered (hardest to accept by national authorities). The Uganda National Strategy for Utilizing the Potential of Private Practitioners in Child Survival has a component to simplify registration procedures and reduce the associated fees and taxes to encourage qualified PPs to register. However, the strategy does not consider unqualified practitioners as partners. Rather, they are considered as special community members, conveniently available to the community, who can deliver health messages but not clinical services.

The annual cost for this intervention to cover all private clinics and drug shops in one Ugandan district was estimated at $8600. The components are: Inventory (suggested frequency is once every 5 years) $440; simulated visits (twice per year for a 20% sample of PPs for six childhood conditions) $2880; negotiation sessions (once every 5 years for all target groups in the district) $1280; ongoing visits to PPs (twice per PP per year) $4000. No cost is calculated for developing communication materials or for communicating with clients as this was performed as part of the district's ongoing community IMCI programme. Thus, in total, the intervention costs $21 per PP working in private clinics or drug shops per year not including the cost of communicating with clients. These costs need to be examined against the intervention steps and suggestions for practical cost reduction measures need be tried. Furthermore, the suggested frequency for conducting inventory, negotiation sessions and ongoing visits could be modified based on the programme evaluation results.

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**Négociation avec les praticiens privées formels et informels en Ouganda pour une prise en charge améliorée des maladies infantiles**

OBJECTIF En Ouganda, la plupart des prises en charge de cas de maladies infantiles sont administrées par des praticiens privés formels et informels. Cet article décrit l'impacte de sessions de négociations et d'interventions chez les praticiens privés pour obtenir l'amélioration de la qualité de la prise en charge des diarrhées, des infections respiratoires aigues et de la malaria infantile, dans un district rural de l'Ouganda.

MÉTHODE Des sessions de négociation ont ciblé les praticiens privés exerçant dans les cliniques privées et dans les postes pharmaceutiques avec pour but d'améliorer les pratiques clés tirées des directives nationales de prise en charge intégrée des maladies infantiles, et afin de mesurer la performance des praticiens privés avant et après l'intervention.

RÉSULTATS La qualité de la prise en charge des diarrhées, des infections respiratoires aigues et de la malaria infantile était généralement améliorée à la suite de l'intervention, quoique certaines pratiques se soient avérées résistantes au changement. Nous avons découvert plusieurs types de praticiens privés dont la plupart n'étaient pas enregistrès par les autorités du district.

CONCLUSIONS Nos résultats suggèrent qu'il est important de maintenir un suivi et un support continu des praticiens privés, ce qui permettra de comprendre les barrières au changement et encouragera plus l'amélioration des pratiques. Des modifications de l'intervention sont nécessaires afin de la rendre plus mesurable sur une échelle et pour la rendre plus durable. L'obtention de implication plus poussée des organisations locales et des associations professionnelles pourrait rendre plus facile l'instauration et le maintien des contacts avec les praticiens privés. Une simplification, par le gouvernement, des procédures d'enregistrement et une réduction des frais requis, est nécessaire pour encourager les praticiens privés à s'enregistrer et ainsi, pouvoir les inclure dans une intervention à grande échelle. Les futures interventions devraient mesurer leur impacte sur l'amélioration de la prise en charge des maladies infantiles au niveau de la communauté et de la famille.

**mots clés** survie de l'enfant, praticiens prives, diarrhée, infection respiratoire aigue, malaria, qualité, Uganda

**Negociando una mejora del manejo de casos de enfermedades infantiles con médicos privados formales e informales en Uganda.**

OBJETIVO En Uganda, los médicos privados (MP) formales e informales proveen la mayor parte del manejo de casos de enfermedades infantiles. Este artículo describe el impacto de las sesiones de negociación, una intervención para mejorar la calidad en el manejo de los casos de diarrea, la enfermedad respiratoria aguda y la malaria, que realizan los MP en un distrito rural de Uganda.

MÉTODO Las sesiones de negociación estaban dirigidas a los MP que trabajaban en clínicas privadas y farmacias. El objetivo era mejorar las prácticas claves, sacadas del las Guías Nacionales para el Manejo Integrado de las Enfermedades Infantiles, y medir el desempeño de los MP antes y después de la intervención.

RESULTADOS En general, la calidad del manejo de los casos de diarrea, las infecciones respiratorias agudas y la malaria en niños, mejoró después de la intervención, aunque algunas prácticas parecieron resistirse al cambio. Descubrimos varios tipos de MP, que en su mayoría no estaban registrados por las autoridades del distrito.

CONCLUSIONES Los resultados sugieren la importancia de mantener constantemente una monitorización y apoyo a los MP con el fin de entender las barreras que impiden el cambio y promover la mejora de la práctica clínica. Se requieren modificaciones en la intervención, para poder ampliarla y hacerla más sostenible. El lograr una mayor participación de las organizaciones locales y las asociaciones profesionales, podría hacer que fuese más fácil el establecer y mantener el contacto con los MP. El gobierno necesita simplificar los procedimientos de registro y reducir las tasas de asociación, con el fin de promover el registro de los MP y por lo tanto incluirlos en una intervención a gran escala. Las intervenciones futuras necesitarán medir el impacto sobre el manejo de casos en niños a un nivel comunitario y de hogares.

**palabras clave** supervivencia infantil, private practitioners, diarrhea, acute respiratory infection, malaria, quality, Uganda

 