THE ROLE OF NGO AND PRIVATE SECTOR IN HEALTH CARE PROVISION IN UGANDA

A qualitative study in Apac and Kabale Districts in Uganda

By

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EXECUTIVE SUMMARY

The role of Non Governmental Organisations and the private sector in health care provision has not been given due consideration by government and district officials. Decentralisation, Primary Health Care and reduced financing of the health sector have led us to the increased awareness of NGO and private sector activity in the health sector. NGOs are defined as non-profit making organisation, outside direct state control. Private sector is defined as profit-maximising, non-state organisations. As the NGOs and the private sector become prominent in the provision of health care, there is need for information about the range and nature of NGO and private sector work, their activities, and problems and needs. how they work and how they can be regulated in order to provide quality services.

The main objective of this study was to qualitatively assess the role of NGOs and the private sector in the provision of health care in two districts of Uganda. Specific objectives were : to identify the NGOs and private practitioners involved in health care operating in Kabale and Apac districts of Uganda; To describe the range and nature of health related services provided by the NGOs and private practitioners; to describe community perception on nature, range and quality of services provided by NGOs and private sector to qualitatively describe the role of NGOs/private sector in addressing existing health problems in the districts and to explore existing collaboration within the district and at community level.

Two districts of Uganda, Apac and Kabale were selected for the study. In both districts the municipalities purposively chosen to describe urban health service, Two subcounties, Aber in Apac and Hamurwa in Kabale, were selected to describe rural health service. Key informant interview and focus group discussions were the main methods of data collection. Data collected was entered using a word processing package and a text database programme (ASKSAM). The data was analysed using cut and paste method for main themes

This study shows that the nature of NGOs/private sector in the districts can be broadly categorised in four groups namely: international NGOs**,** religious organisations; locally based NGOs. and the private sector that has drug shops and the informal health sector (TBAs and traditional healers.

The range and nature of services that NGOs/private sector offer are in community health intervention, Preventive health services, and curative services. The key community health interventions mainly carried out by NGOs are: health education, nutrition education, AIDS education, environmental education and poverty reduction. Several international and local NGOs, operating in the two districts are addressing some environmental issues, especially access to safe water and sanitation. Private practitioners were said not to be involved in promoting the general environment and water and sanitation issues. Preventive health services carried out include immunisation activities in the districts. Immunisation is carried out at static units and outrech stattions. Family planning services were offered by some NGOs and private practitioners. Curative services are offered by mission hospitals or dispensaries. Private for profit healthcare providers were drug shops, private clinics, and trained TBAs. Private providers tend to establish themselves in curative activities. Other activities include developmental activities such as rehabilitation of health units, training of TBAs, Community health workers and AIDS educators and counsellors, promoting income generating activities, and protection of water sources.

Community perception of NGO/private sector services was sought on nature, quality, accessibility, relationships, problems and strengths of the NGOs and private sector .

Nature of services

Community members reported to have benefited from sensitisation done by NGOs on health issues. Counselling services to AIDS patients and other affected people appreciated by the community It was noted that the private sector did not do much on health education.

Various NGOs were said to have disunity among themselves. They operate in isolation, and have apparent competition. This leads to duplication of activities, uneven distribution of resources, competition for community support and may cause conflict within the community. Most of these NGOs are not aware of each others' activities.

Quality of services

Some NGOs are said to have a good relationship between health workers and patients, which contributes to the good quality of heath services offered in these units. The services of private practitioners were perceived by respondents to be better than those offered in public hospitals, e.g., many mothers deliver safely from private clinics, obtain adequate supplies of drugs, and the units are open for longer hours thus making services readily available to the clients. They also attended to patients promptly.

Communities recognise NGOs as providing cheaper and affordable health services. Curative services of mission clinics were said to be cheaper compared to private clinics.

Community concerns about quality include inadequate drugs dosages inadequate personnel, inadequately trained staff , high costs and poor facilities of private for profit practitioners. Private practitioners have their services limited by lack of availability of some needed facilities, including space and laboratories

Accessibility of services

Private practitioners are found in both urban and rural areas but are concentrated in the urban area. Private for profit sector extend credit facilities to users and this was an important benefit to the users of these services. However, private practitioner charge prices which are deemed by the community to be high and unstable.

Availability, accessibility and quality of the health services in both districts were found to be wanting. Participants compared government health services with NGO/Private sector services Some services and supplies reported to be unavailable in some places. Some community members felt that government health units are affordable but services not acceptable, because they are of low quality. Community Health Workers were not distributed equitably in all parts of the district. The health units and staff were said to be very few and there was reported lack of transport to take the sick to the health units. Government health units which are not functioning properly due to corruption, and inadequate funding Government health workers are not facilitated to provide these services.

The underdeveloped rural infrastructure also poses operational problems. The geographical terrain in Kabale, poorly developed communication and road network, was noted to de-motivate health educators in the CBHC programme.

Community Mobilisation.

NGOs have a different approaches to the community as they offer their services. The NGO programme designs and methods of work sometimes create community dependency. Some NGOs reportedly gave material benefits to the community
Sustainability of voluntarism was reported to make some of the NGOs operations difficult e.g., community health workers who were trained as volunteers, did not show adequate commitment to their work due to low/lack of adequate motivation.

Funding Problems
Local NGO reported inadequate funding and the lack of facilities as major problems. A good number of these NGOs depend on donor funding which may not be consistent or reliable.

High taxation and licensing fees of private practitioners and drug shops was noted as a major problem affecting their operations. The private sector has major financial constraints depends on the levels of income of the population they serve and may offer credit facilities, much to the detriment of their service.

Collaboration
NGOs and private practitioners were reported to collaborate among themselves and they also collaborate between themselves and government. In both districts, NGOs and government collaborated in supervision and training . Information gathering and its use is another area of collaboration between NGOs and government health units. However , there is little NGO/private sector collaboration.

Regulation
The regulatory process for the NGOs and the was inadequate and most cases not enforced. Thre was a lot of government bureaucracy involved in implementing NGO activities. Lack of political and community support led to poor implementation of NGO activities.

Community recommendations
A number of recommendations were made for inproving service provision
Recommendations to government were in the area of regulation of private sector through instituting bye-laws, enforcing minimum standards, supervision of the NGO/private sector by the DMO and the community, and recognition and training of the private sector staff. especially the informal sector. Private practitioners and community members suggested that government health workers should be allowed to run their private clinics in their free time as long as they respect both roles. Private practitioners also recommended that government should reduce taxation on health related activities and this would reduce the cost of health services.

Community members suggested that government should give direct funding support to private practitioners and NGOs in form of grants, loans or subsidies to improve the quality of services offered in the sector - specifically government should give support to see local NGOs that are undertaking major health preventive and promotional activities.

Measures also need to be considered by government to increase networking between NGOs, working in health and government health departments.

Recommendations to the NGOs and the private practitioners were in the areas of improvement and expansion of the services offered, reduced cost, co-ordinating their activities, ensuring transparency, encouraging community participation capacity building and

assisting in equipping local practitioners. The owners of private sector should recruit qualified staff, and should get bigger units where they have in-patients. NGOs should consider community priorities, by involving them (the community) in every stage of developing and implementing activities.

NGO staff recommended a policy which regulates the activities of politicians not to interfere with their activities. The political leaders should take an active role in health activities at community level and not block NGO activities. Community should increase their participation and interest in community programmes especially water and sanitation programmes. They should be able to accommodate changes and new developments in their areas.

We recommend that:

- Community recommendations should be reviewed and taken seriously by the community, government and the NGOs.
- All NGOs working in the Health Sector should be identified, classified and assisted by the DMO's office.
- Government should ensure that appropriate levels of care are provided. There should be quality assurance in hospitals, health centre, drug shops and the informal sector
- The informal sector should be recognised and trained to offer good quality and appropriate services.
- There should be effective use of registration rules and regulations for the private sector.
- Research in community financing of health care should be carried out. The use of community based NGOs in financing health care services should be explored.
- NGOs should explore other financing mechanisms so that the quality of service produces is improved.
- Government should honour its commitments to NGOs so that they can improve on the services they deliver.
- International NGO should allow flexibility in implementation of programmes
- An in-depth evaluation of the NGO and the private sector should be carried out form the NGO/private sector perspective. It should review the key issues of : efficiency in the organisations, equity of service in the different sectors, resource mobilisation, collaboration and referral systems between NGO and private sector, community mobilisation mechanisms, and quality of service issues.

LIST OF ABBREVIATIONS

ACP	AIDS Control Programme
AIDS	Acquired Immune Deficiency Syndrome
AMREF	African Medical and Research Foundation
CBHC	Community Based Health Care
CGR	Central Government Representative
CHW	Community Health Workers
CPAR	Canadian Physical Aides of Relief
DES	District Executive Secretary (Chief Administrative Officer)
DHT	District Health Team
DMO	District Medical Officer
EDF	European Development Fund
FGD	Focus Group Discussion
HI	Health Inspector
KDACIS	Kabale District AIDS Counselling and Information Services
KI	Key Informant
MOH	Ministry of Health
NGO	Non Government Organisation
NURP	Northern Uganda Reconstruction Programme
PHC	Primary Health Care
RC	Resistance Council
RDC	Resident District Commissioner (Central Government Representative)
SWIP	South West Integrated Project.
TB	Tuberculosis
UCOBAC	Uganda Community Based Association for Child Welfare
UEDMP	Uganda Essential Drugs Management Programme
UWESO	Uganda Women's Efforts to Save the Orphans
WATSAN	Water and Sanitation

1. BACKGROUND AND JUSTIFICATION

1.1 Introduction:

In most countries, there is increasing emphasis on the role of the private sector and the market in financing and provision of health care. Budget constrained government in sub-Saharan Africa have looked at the private sector as a possible means of supplementing their own health services (Bennett 1991). The term "private sector," includes all those organisations and individuals working outside the direct control of the state, that is both for-profit private companies and individuals, and not-for-profit organisations. The above definition includes providers such as Church or Mission Hospitals, traditional practitioners, and unlicensed practitioners. The private sector is not a homogenous group. The characteristics of the members differ considerably as well as their motives. The resources for the private sector also differ and this has an effect on the kind of services that the private sector renders to the community and the individual.

The terms “NGO” and “private” need to be defined prior to analysing the roles the NGOs and

the private sector in health care. The definition shall depend on two criteria: whether the organisation is directly managed by or accountable to the state, and whether its stated aims are for profit maximisation. Using such criteria, NGOs are defined as non- profit making organisation, outside direct state control. Private sector is defined as profit-maximising, non-state organisations.

It is useful to draw a distinction between the financing and provision components of health care (Figure 1). Services may be publicly financed and publicly provided (e.g., national health services in many countries), or privately financed and provided (e.g., private health care funded by private insurance). Governments are increasingly experimenting with health care systems mixing public and private elements. The private sector has, in the recent past, delivered some of these services to the populations they serve.

Figure 1: Conceptual Approach to the Public/Private Mix

		PROVISION	
		Public	**Private**
FINANCING	Public	National Health Services	Services contracted to providers
	Private	Supplementary Direct users Charges Private beds in public hospitals	Private health care funded by private insurance Health Maintenance organisations.

Source: [Bennett, S., The Mystique of Markets: Pubic and Private Health Care in Developing Countries 1991: PHP Departmental; Publication 4, 1991 London school of Hygiene and Tropical Medicine .

In Uganda, private expenditures outweigh government expenditures on health. This is a natural reflection of the manner in which most health services are produced and consumed.

1.2 Classification of Health Systems

Health systems can also be broadly categorised into two:

1. Public Health System. The Public Health Programmes work in three ways:
   - (i) Delivers specific health services to populations, e.g., immunisations.
   - (ii) Promotes health behaviour
   - (iii) Promotes health environments.

2. Clinical/Curative health services can be organised into:
   - (i) Private (non-profit)
   - (ii) Private (for profit)
   - (iii) Public. (World Bank 1993)

A framework for classifying health sector intervention was developed by the World Bank to help in developing programme budget categories for analysis of efficiency and equity of

government spending (Table 1).

Table 1: Framework for classifying Health Sector Intervention

Category 1:	**Community Health Interventions.**
	Epidemiological data collection
	Health System Planning
	Health Education
	Regulation; Licensing
	Environmental Health , Water, Sanitation
	Prevention of Communicable Diseases.
Category 2:	**Personal Health Services - Preventive**
	Maternal and Child Health and Family Planning
	Infant Nutrition
	Immunisation
	Treatment of Communicable Diseases.
Category 3:	**Personal Health Services - Curative**
	Acute Care : Hospital/ Hotel services
	In-patient and Out-patient services
	Laboratory Services

Source: Uganda Social Sectors Study - 1993

The health care system can also broadly be classified into three groups according to: ownership styles (public, not for profit, for profit) systems of medicine (allopathic, homeopathic, traditional) and types of organisations (hospitals, clinics, etc.). Using the ownership criterion, the health care system can be divided into four broad sectors:

1) Public sector that includes government run hospitals, dispensaries and clinics.
2) Not for profit sector that includes voluntary health programmes, missions, churches.
3) Organised private sector that includes the general practitioners, private hospitals and dispensaries.
4) Private informal sectors that include herbalists, drug shops, diviners, etc.

Overall, the private health sector consists of organisations practising in allopathic, homeopathic and traditional systems of medicine, providing health care services privately through organised or informal channels or through voluntary agencies.

Green (1987) distinguishes seven broad groupings of non-governmental organisations/private organisations involved in the health sector as ;

1. Religious Organisations: Church-related health services are often multi-dimensional, and involve hospital-based services with outreach services, vertical programmes relating to specific diseases, training of staff (usually for their needs and sometimes for the government).
2. International (social welfare) NGOs such as Save the Children Fund (SCF), International Planned Parenthood Federation (IPPF). The scope of their work varies. In most cases, they start out with explicit and well defined targets but sometimes broaden out depending on some of the needs found in the area.
3. Locally based (social welfare) NGOs . These are groups that usually operate in the social welfare field. These either address broad community development issues (e.g., women groups) or specific issues (e.g., ***engozi*** groups)

4. Unions and professional associations: The primary motive of these groups is protection and promotion of their constituents. There contribution in the health field is currently limited. Examples in Uganda include The Uganda Medical Association (UMA) and Uganda Private Midwives Association.
5. Other non-profit making organisations: These are organisations that have access limited to only a small group of individuals on non-financial grounds. Occupational health services is one example that has a substantive input in the overall health sector but may be regarded as non profit making in themselves.
6. Non Profit making but (pre-paid) healthcare. Organisations are modelled on the American group health care such as the Health Maintenance Organisations
7. Private Sector. These are for-profit organisations, which may be locally based or international. This is perhaps the biggest sector in developing countries.

1.3 The Ugandan Situation

During the 1950s and 1960s, Uganda established one of the finest public health systems in Africa, combining preventive disease control programs with an expanding network of clinics and hospitals. Together with the modest parallel efforts by NGO facilities, mainly mission hospitals, this resulted in a steady improvement in Uganda's health sector (Dodge and Wiebe 1985). This progress was dramatically interrupted by the disruption of the economy and the collapse of social services during the late 1970s and early 1980s. In the districts, the health care provision is characterised by the presence of hospitals, health units (health centres, dispensaries, dispensary maternity units, sub-dispensaries and aid posts), health inspectors and other public health staff. Following government's commitment to Primary Health Care (PHC), village health committees, and village health workers are present where the PHC/ CBHC strategy has taken root.

Since independence, Uganda, like other African countries, has channelled a substantial proportion of public funds to the health sector, providing services free of charge at the point of delivery. This was partly done to reduce the inequalities in access to health care and partly due to the view that health care was a right. There exists a funding gap between health care needs and resources available. Faced with the recent fiscal pressure characterised by international recess and structural adjustment programs, and recommendations from the World Bank (to reduce spending on social services), the health budgets have declined. Donor funding has become essential in most of these countries. In Mozambique for example, over 50%; and in Benin, Burundi, Chad, Tanzania and Uganda, over 40% of total funding comes from donors (Bennet,1995).

The private sector reportedly finances about 63% of the total health care expenditure; it is the major provider of health in Uganda. The government, financing 32% of the total health expenditure is the second major provider of care (The Three Year Health Plan, 1993/1996).

NGOs in Uganda, especially religious organisations, have played an important role in financing and provision of health services. Their work alone is estimated at 30% of all the health care services in Uganda. Both NGOs and the private practitioners provide both curative and preventive services like immunisation and health education to the community (Asiimwe et al., 1994).

While both government and NGO health facilities deteriorated during the years of disruption,

the NGOs have largely rebuilt and expanded, particularly due to external assistance and through maintaining higher staff morale both of which are important for preventive and curative services. Most government units remain in a state of severe disrepair, with relatively unmotivated staff who are very poorly paid, as elsewhere in the public sector (Bennett 1994). Available literature indicates that people utilise NGO facilities more than government units. For example, 17-35% of people seek care at government facilities compared to 30-57 % at NGOs and private ones; the remainder going to traditional healers (White, et al., 1995). The private facilities ranging from small paramedical clinics to commercial pharmacies, have mushroomed all over Uganda, delivering care of highly variable quality. This has created a culture in which good care has come to be associated by patients with availability of injections and drugs, regardless of their medical appropriateness (Bennett, 1994).

1.4 Regulation of NGOs

Part of the difficulty with regulating the NGOs and private sector is its diversity. The differing motivations, scale and areas of operation, mean that it is quite difficult to arrive at meaningful standard guidelines for regulation.

The mission sector is relatively cohesive and organised. In Uganda, mission institutions are organised under the Uganda Catholic Medical Bureau (UCMB)for the catholic-founded institutions, Uganda Protestant Medical Bureau (UPMB) for the Protestant-founded institutions. Muslim-founded institutions fall under the Uganda Muslim Medical Bureau(UMMB) and Islamic Medical Association of Uganda (IMAU).

Private clinics, drug shops, traditional healers are less cohesive than the mission sector. Some of the reasons for this are the operational time scale for these types of providers (often shorter than that of the religious missions), and frequently, the weak resource base. These problems, where local NGOs lack funds, lack personnel and thus have short life span have been noted (DeJong 1991). Simukonda (1992) further attributes the lack of heterogeneity of NGOs and the heroic approach of some that make them reluctant to concede any degree of autonomy.

As the NGOs become prominent in the provision of health care, there is need to understand how they work and how they can be regulated in order to provide quality services. The mechanism of regulations may include; registration, inspection, and incentives from the government. There is limited information on regulatory practices and this suggests that this is an area which has received inadequate emphasis. Registration of private facilities with the Ministry of Health is one of the regulatory measures common to both developed and developing countries. It is potentially a strong mechanism for ensuring adequate standards of care. However, Bennett (1994) noted it is not often used effectively and registration rules are used as a means of getting revenue. In Uganda, private clinics are licensed by the Uganda Medical and Dental Practitioners Council while midwifery and domicillary clinics are licensed by the Uganda Nurses and Midwifery Council. Drug shops are licensed and controlled by the National Drug Authority. Traditional healers and birth attendants currently do not have a licensing body.

Quality regulations also tend to be weak. In Uganda, the process includes: initial self-assessment through annual reports; then unit inspection by local, district, and central level teams; and lastly a form of accreditation is issued. In order to qualify for the free supply of essential drugs, health units must pass an inspection. In general however, there is surprisingly

little quality regulations given the level of government support to NGO providers and the private practitioners (Gilson et al 1994). NGOs are more regulated than private sector in respect to the information they provide to government. In Uganda, such reports should include financial reports but they commonly do not provide them. In particular returns for publicly supported activities (e.g., immunisation) are mandatory. Bennett (1994) argues that this is not satisfactory because these reports tend to go directly to the central level, by-passing the district health teams and local authorities thus by-passing their local managers.

Recent developments place greater emphasis on both private provision and the private financing of health care. These developments have followed a long period of mistrust and lack of confidence in relations between the public and private sectors. In Uganda, for example, apart from providing grants-in-aid, seconding staff and providing a few guidelines, the government has never defined the role of NGOs. In addition, there is no defined role of private for profit in the provision of health services. There is a shortage of information about NGOs and the private sector and the information which exists is dispersed and inaccessible (Asiimwe and Lule 1992). It is hard to find out who is doing what and where. What are their objectives and how far have they achieved these objectives? This lack of information leads to lack of understanding and possible misunderstanding in some cases.

The NGO/private sector can be used as intermediaries between government and local groups and the community. But before this collaboration could be started there is need for information about the range and nature of NGO and private sector work, their activities, and problems and needs.

2 OBJECTIVES

2.1 Overall objective

To qualitatively assess the role of NGOs and the private sector in the provision of health care in two districts of Uganda.

2.2 Specific Objectives

a) To identify the NGOs and private practitioners involved in health care operating in Kabale and Apac districts of Uganda.
b) To describe the range and nature of health related services provided by the NGOs and private practitioners.
c) To describe community perception on nature, range and quality of services provided by NGOs and private sector.
d) To qualitatively describe the role of NGOs/private sector in addressing existing health problems in the districts.
e) To explore existing collaboration within the district and at community level.

3 METHODOLOGY

3.1 Operational Definitions

For this study an NGO includes all those organisations and individuals working out of the direct control of the state and not for profit organisations.
Private sector is organisations and individuals that work outside direct control of the state and work for a profit. In reality, some of the organisations do not strictly conform to these definitions. Their activities and relationships with the state and work ethics may overlap.

3.2 Area Of Study

Two districts of Uganda were studied; Apac to represent the North and Kabale the south-western part of Uganda. To compare rural-urban provision of service, the municipalities in the two districts (Kabale Municipality and Apac municipality) were sampled. Aber subcounty in Oyam county, Apac district and Hamurwa subcounty in Rubanda county, Kabale district, were identified with the District Medical Officers (DMO) in the respective districts to represent the rural areas.

3.2. Sources Of Information

Information was obtained from the district level personnel, including the District Medical Officer, District Health Visitor, District Agricultural Officer, and the District Community Development Officer. The community members included Local Council executive members, in particular the chairpersons. Health providers interviewed were NGO practitioners, religious institution health workers, private practitioners and trained TBAs.

3.3 Method Of Data Collection

Key informant interview and focus group discussions were the main methods of data collection. Six research assistants , four of whom were from the study districts, were recruited and trained for four days by the Principal Investigator and Co-Investigator in the data collection techniques.

Key informant interviews

A minimum of fifteen key informant interviews were conducted in each district, with district level personnel knowledgeable about the topic, supervisors of the health units in the area of study and some community members.

Focus group discussions

At least six focus groups discussions (FGD) were carried out in each district. These included two FGDs for the community leaders, two for the practitioners and two for program heads. FGD were moderated by a facilitator while a recorder took detailed notes. The sessions were also recorded on tape where permission was granted by the members of the group.

3.4 Data Analysis

Recorded notes were reviewed at the end of each session by the recorder and facilitator. These were also supplemented by listening to the tape recordings. The recorded tapes were transcribed and translated. The transcripts were edited to ensure completeness. Data from the focus group discussions was entered using a word processing package (WordPerfect 6.0). Key informant interviews was entered and analysed using a text database programme (Ask-Sam). Data was then analysed by extracting recurrent themes using the cut and paste method.

3.5. Limitations Of The Study

Due to resource constraints, it was possible only to study two districts which represents two of the five regions in the country. However, the study provides an overview of what is going on in the country within a district setting.

There was limited documentation on NGOs and the private sector in the districts that were sampled.

There was limited access to traditional healers and trained traditional birth attendants.

4. FINDINGS OF THE STUDY

4.1 District health service profile

The two districts have health facilities shown in Table 2.

Table 2. Health Facilities Distribution by Type and Ownership

Type of health facility	Apac		Kabale	
	Government	NGO	Government	NGO
Hospital	1	1	1	0
Health Centre	3	0	6	3
Unit (DMU):	0	5	1	0
Dispensary	2	2	2	0
Sub-dispensary	9	2	25	5
Aid Post	10	0	1	0
Total	25	10	36	8
Total Hospital beds	100	200	200	0
Other Unit Beds	88	44	560	52
Total number of beds	412		612	
Population per Unit	13,080 (22,725)*		9,457 (11,920)*	
Access to Health Unit (Population within 5 km. Radius)	21.4%		71.1%	

Source: MOH Health Facility Inventory 1993. (*Population excluding AID Posts)

Apac district has 36 health units of which ten are NGO institutions while Kabale has 44 health units of which only eight are NGO units. The quality and range of services offered depend on the type of health institution (Owor, et al, 1987). Health centres offer curative inpatient and outpatient services By definition and type health unit , NGOs in both districts have developed larger curative institutions than government institutions. Government has developed more Aid Posts and Sub-Dispensaries than NGOs. In Kabale most Sub-dispensaries have at least two beds while only two Sub-dispensaries in Apac have beds (MoH,1993). This suggests that government services in Kabale are trying to improve the services they offer even at Sub-dispensary level. The few bed in NGO units also implies that NGOs have not expanded their curative services.

In Aber subcounty, there is a 200 bed, NGO hospital and a government sub-dispensary and Dispensary Maternity Unit. These health units were all supplied with Uganda Essential Drug Management Programme (UEDMP) drug kits from the Ministry of Health.

In Kabale Municipality, there is one Government hospital with 200 beds, two government sub-dispensaries one Aid Post and three NGO health centres. The NGO health units are not supplied with drug kits. In Hamurwa, there is one Government sub-dispensary, which, unfortunately is not supplied with an UEMDP drug kit. Most health units are located in urban area of the districts. The is duplication of services in the urban area and in the rural area that was studied in Apac .

Some health service indicators are shown in Table 4.

Table 4. Selected health service indicators

Health Service Indicators	Apac	Kabale
Population per Curative staff	11,085	4,392
Population per Health Inspector.	28,281	20,327
No. of CHW's	2,553	1,216
No. of Village Health Committee	229	186
No. Reproductive Age Women per trained Maternity staff.	37,875	10,176
No. of Reproductive age Women per TBA	532.23	1,848.91
BCG Immunisation	87%	96%
Measles as %	53%	82%
Immunisation Dropout (as a percentage)	39%	15%

Source: Barton, T and Wamai, G. Equity and Vulnerability: A Situation Analysis of Women, Adolescents and Children in Uganda 1994.

The health-related projects that have been reported to the Ministry of Finance and Economic Planning are found in the PIP document are shown in appendix 1. Some of these projects are carried out by NGOs.

4.2 NGOs/Private Sector Involved in Health Care Provision in Apac and Kabale Districts

NGOs and the private sector have a variety of providers with different motivations and varying degrees of access to resources. The nature of NGOs/private sector in the districts can be broadly categorised in four groups:

4.2.1 International NGOs. These are mainly social welfare NGOs. Examples from the districts include; Canadian Physicians Aide of Relief (CPAR), CUAAM and ACTIONAID in Apac. In Kabale, CARE, EDF and AMREF were found operating there. UNICEF operates in both districts. These NGOs have been carrying out both general developmental activities and specific health activities (See Appendix 1).

4.2.2 Religious organisations; Religious organisations have had a major role to play in health care in the districts. They are found in both the rural and urban areas. Although they were initially strengthening the curative service, they have expanded their role in personal preventive health care and some areas of community health intervention.

4.2.3 Locally based NGOs. These are national NGOs (e.g., Uganda Red Cross (URC),

African Development Fund (ADF), Uganda women's Effort to Save Orphans (UWESO), Uganda Community Based Association for Child Care (UCOBAC), Kabale handicapped society). The above mentioned categories are all non profit making organisations that have provided health services. "***Engozi groups"*** are local community groups in Kabale that have been organised to offer health transport for the sick

4.2.4 Private Sector. These include drug shops, Traditional Birth attendants (TBAs), traditional healers, and private clinics. All of them sell their service to the users and may make a profit.

4.3 Community Definition of NGOs

During discussions, the community defined an NGO as 'a body or group of people that cares, has specific objectives targeted to certain groups of people, with the aim of improving their condition. They usually have no assistance from the government.' Many community members agreed that people working in NGOs are good people who come to help the needy. However, some members expressed concern that some of their activities may not be known or may not be in the best interest of the community.

> ***"I do not know about the Food for the Hungry because although the officer is smartly dressed there is nothing on the ground. This can be a briefcase programme. (Apac KI)***

Some NGOs were noted to be developmental and working with groups of people. Examples given were EDF, CUAMM, in Apac district and CARE, Uganda Red Cross in Kabale district. Community based organisations such as ***Engozi groups*** in Kabale, women's organisations and Village Health Committees were regarded as NGOs by some respondents.
Some government projects such as the Northern Uganda Reconstruction Project (NURRP) and the Programme for Alleviation of Poverty and Social Costs of Adjustments (PAPSCA) are viewed as NGOs by the community because, they bring into communities' resources and work toward general development of the community.

4.4 Existing health problems in the two districts

Health service provision of the NGO/private sector is largely dependent on the kinds of health problems that exist in the area. NGOs and the private sector tend to develop their services addressing key health problems in their areas of operation. Respondents noted that communities in Kabale and Apac districts have health problems that fall into several categories namely:

- Specific health/disease conditions,
- Environmental problems
- Poor knowledge of health practices
- Poor access to health services.

4.4.1 Specific health conditions

A range of specific diseases was noted to be prevalent in both districts. Malaria, Respiratory Tract Infections (RTI) including TB, diarrhoeal disease, AIDS and poor nutrition among children were mentioned in both districts. Syphilis, measles, and meningitis were specifically mentioned in Apac. Some causes of these specific problems discussed included: Poverty, lack of community involvement in preventive measures to control the diseases and lack of

knowledge about disease.

> ***Tuberculosis is rampant in Kabale municipality because many patients discharged from hospital continue to drink with healthy people (sharing drinking pots, cups and straws), thus spreading the disease.*)(Kabale Focus group)**

Poverty was considered to be a significant factor leading to ill health, because without money people cannot afford to pay for health services, have a good diet or improve their conditions.

> ***For me, I see poverty as one of the health problems because people do not have enough money for digging latrines in their places.*** (Apac KI)

4.4.2 Environmental factors

Environmental problems were among major determinants of health in the districts. Lack of safe water, poor sanitation facilities were major problems in both districts. There was poor access to safe water and sanitation in both districts. It was reported that there was general lack of water in some places and the little water that was available, was said to be dirty.

> **"The water that is fetched is multipurpose. It is used to wash sweet potatoes, the same water is used to make porridge or even cooking the same potatoes. (Kabale FGD)**

Contaminated (surface) water was noted to flow into the lake which is the main source of water for domestic use. This water is not treated before use and the water for drinking is not boiled.

> **"People dig ditches on top of the hills and water collects there, they use it for some time. This is running water that gathers many bad things, people do not use latrines and these Bakiga people do not have time to boil water except the few educated ones. (Kabale KI)**

The few protected water sources available, e.g., boreholes, were not well looked after by the community. Boreholes in Apac were drilled primarily along main roads because of the "poor ability of drilling and the heavyweight of the machinery". Apac's geographical terrain does not favour the formation of springs, and the water table is low. In some areas, people use shallow wells while others use swamps for water collection.

> ***"There are no safe drinking water where I come from, people drink water from swamps and the same water is where people wash and animals drink."*** **(Apac FGD)**

Health personnel reported that there is a general lack of latrines in the area, while those who have them do not actually use them. This problem was attributed to the culture and beliefs of the people in Kabale. Land was said to be abundant and the bush would be used for toilet purposes. Digging latrines was said to be of little value in both districts. In Apac, some people were said to be too poor to dig latrines, while rebels burnt down some others. Where latrines exist they were noted to be shared by many households.

> ***"You find in a home of twenty people there is no single latrine, the people***

help themselves in the bush and when it rains the dung is washed into the swamp from which some people wash and drink together with their animals." **(Apac FGD).**

The broken down sewage system, negligence of landlords and the municipal councils has contributed to poor sanitation in the municipality. Water sources are contaminated by the sewage and hence dysentery and typhoid are frequent.

"The drainage system is very poor. The town council takes nearly eight months without cleaning the drainage and mosquitoes get better breeding places." **(Kabale FGD)**

"Within our town here most people stay in unfinished buildings and most occupants use paper bags and "kavera" (Polythene bags) for toilets and throw these anywhere." **(Apac FGD)**

The swampy nature of some areas in Kabale is another factor that constrains the availability of sanitary facilities in the municipality.

"Bugongi is swampy even you cannot dig a pit latrine with more than six feet deep, beyond that it will be filled with water." **(Kabale FGD)**

4.4.3 Inadequate Knowledge on health and health related aspects.

Community members in both districts were said to lack adequate knowledge on health and other health related aspects. Low literacy of the population and poor sensitisation about health related programs were cited as reasons for low knowledge on health and prevention in both districts.

"Lack of basic education which leads to poor implementation of health programs because some people do not know the concepts and health education is inadequate. Those who know have the 'I don't care attitude.' **(Kabale FGD)**

It was reported that some people think that when they take children for immunisation, they are taking them to be killed.

"Where I come from, people believe that AIDS is transmitted through immunisation thus people do not take their children for immunisation **(Apac FGD)**

Community members in both districts attributed this lack of knowledge to a number of factors that included:

- Health inspectors were no longer making outreach visits to educate the public.
- Families lack guidance on how to care for themselves.
- Community beliefs about the need for clinical care.
- Lack of seriousness of community members.

The community also regarded LCs as people who should educate them about health matters, but they were not doing it.

4.4.4 Poor access to health services

Health services were not being utilised because of:

- Geographical location- the health units were far and people lacked transport for the service.
- Corruption in the service.

Doctors are corrupt, nor dedicated; they embezzle some hospital drugs and take them to village shops and private clinics **(Kabale KI)**

- Financial constraints or poverty

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4.5 Range of services offered by NGOs/Private sector.

Participants in both districts reported a number of services rendered by NGOs to the community (Appendix 1). Services rendered were specific and addressing some health problems in the area. These have been grouped using the framework developed for classifying health sector interventions.

4.5.1 Community Health Interventions

The key community health interventions mainly carried out by NGOs are: health education, nutrition education, AIDS education, environmental education and poverty reduction.

Health education mainly centred on the Primary Health Care (PHC). Health education and preventive health services operate at grassroots level, and these are, in most cases complimenting government efforts where there is little or no service. Some religious organisations (the Catholic church in Kabale) reportedly combined health education with economic activities and spiritual education. The Community Based Health Care Association is also operating in both districts and provides health education to the communities where they operate.

As an attempt to address the increasing AIDS problem in the districts, many (NGO, Private or community groups) counselling units have been established in the districts to offer counselling support to those affected.

Several international and local NGOs, operating in the two districts are addressing some environmental issues, especially access to safe water and sanitation. Both districts have Water and Environmental Sanitation (WES) projects supported by UNICEF that deal with protection of springs, sinking and rehabilitation of boreholes. In Kabale, CARE was reportedly carrying out seminars that encourage tree planting and soil conservation as well as water and sanitation education. CPAR, and Food for the Hungry in Apac were also reported to support spring protection.

Private practitioners were said not to be involved in promoting the general environment and water and sanitation issues. Community respondents noted that private practitioners especially in private clinics provide education to those who visit their unit, e.g., about prevention of diarrhoea and the importance of boiling drinking water and child nutrition.

4.5.2 Preventive health services.

NGOs and some private sector organisations (especially doctors clinics) carry out immunisation activities in the districts. CUAMM in Apac has immunisation programme in Amati Centre and Kamdin. The PHC programmes mainly to educate communities on components of PHC and ensure implementation of immunisation; mothers are mobilised to immunise and check immunisation cards to see that they are complete. The Catholic Church in Kabale reportedly request for the immunisation card before baptism of children as a way of

encouraging immunisation of children. Some private clinics also provide ANC services and TT immunisation for pregnant mothers who visit them.

Family planning services were offered by some NGOs and private practitioners. CARE Kabale is training government health staff and some private practitioners in offering family planning services.

4.5.3 Curative Services.

NGOs were reported to provide curative services to the community. This is mainly done by religious hospitals or dispensaries. In Kabale, Rubanda, Rugarama and Rushoroza health centres are health units run by religious organisations and offer curative services to the members of the community. In Apac, the mission hospital at Aber also offered curative services.

Private for profit healthcare providers were drug shops, private clinics, and trained TBAs. Private providers tend to establish themselves in curative activities that require little capital. Private clinics were offering out patient services, nearer to the people and are easily accessible. Referral is another service facilitated by private practitioners. Complicated cases are referred to hospitals. They also refer clients to laboratories for investigation. Private clinics tend to collaborate with other units, e.g., drug shops where they send their patients with prescriptions if the drug is not available in that particular clinic. They sometimes transport patients to hospitals. Some private practitioners' liase with hospitals for the follow-up of patients who need close supervision or who may need admission.

TBAs specifically collaborate with hospitals and refer difficult cases to the hospital. In Apac TBAs sometimes they also go to the hospital to follow up their clients and help to deliver them there. Consultation amongst TBAs themselves may take place when necessary.

4.5.4 Other health services

Developmental activities were perceived as another form of promoting health. Some of NGO activities include:

- Rehabilitation of health units
- Training of TBAs
- Training of CHWs
- Training of AIDS educators
- Promoting income generating activities
- Protection of water sources

4.5.5 Community Mobilisation for Health action

NGO and local community-based organisations were considered significant in mobilising community resources (mainly personnel and finance) for health. The ***Engozi*** groups in Kabale were noted to be very important in transporting patients to health units. They were also said to help in resource mobilisation through setting up revolving funds that assist people in need, especially those who need to be taken to hospital and at burial.

> ***In some communities, members organise themselves into collective efforts to alleviate the problem of transport (Engozi groups) to carry the sick to the hospital. (Kabale FGD).***

Volunteers at community level in both districts were reported to be participating in different programs.

4.6 Community Perception Of NGO/Private Sector Services

Community perception of NGO/private sector services was sought on nature, quality, accessibility, relationships, problems and strengths of the NGOs and private sector .

4.6.1 Nature of service

Health education

Community members reported to have benefited from sensitisation done by NGOs on health issues. NGOs were noted to have taught people good health practices through outreach programs, Areas of sensitisation covered included, better feeding methods, environmental sanitation especially how to use latrines and rubbish pits in their homes. Sometimes an NGO sponsored some people to attend health course such as Child Health Care.

In Apac, counselling services to AIDS patients and other affected people appreciated by the community . The youths were informed about the usefulness of education, the dangers of AIDS, the consequences immorality, early sex and early marriages. Many youths were reported to have positively responded to these messages. Other behaviours like drinking boiled water and protecting springs were reported to have been influenced by the education. It was noted that the private sector did not do much on health education.

Whereas community members appreciated the good work done by NGOs in the area of health care activities, community members expressed some problems which result from NGO activities.

Various NGOs were said to have disunity among themselves. They operate in isolation, and have apparent competition. This leads to duplication of activities, uneven distribution of resources, competition for community support and may cause conflict within the community. Most of these NGOs are not aware of each others' activities.

> ***The PHC programme, most of the activities are voluntary, there is a problem getting dedicated personnel…. Religious differences, most people think that it is a catholic affair so they do not participate. Even politicians, divert peoples attention at times.*** (Apac KI)

This lack of transparency, co-ordination and collaboration minimises community participation especially when not involved in planning of the programme.

Despite the contribution toward increased access in the rural areas, inequity in distribution of the health units is still apparent. Most private clinics are located in urban settings. This is possibly because the private practitioners are mainly profit oriented and they expect a better market in the urban setting where the population is dense and incomes relatively high. There were also reports of some NGOs concentrating in one area leaving out others under-served. Some NGO's did not involve the community in the planning and decision making process.

> ***Most of the implementation is left to us and originally we were not involved in planning and evaluating. When the Bazungu left, they went with everything and we are beginning at zero. The RC and administrators in some areas are not interested in the programme.*** (Apac KI)

Preventive Health service

Private clinic and drug shop owners were blamed for not carrying out health education to the community which would help prevention of some diseases.

"The owners of clinics do not bother to go out and health educate, the community end up buying some drugs for diseases which could be prevented." (Apac FGD)

Being mainly profit oriented may be a reason why private practitioners are not involved in promotive and preventive activities.

Curative health service

Community respondents were concerned with some NGOs which do not give drugs in the required dosages. Some health centres belonging to NGOs, and drug shops were said to lack adequately trained personnel. Community members reported that the inadequate personnel, inadequately trained staff , high costs and poor facilities of private for profit practitioners affects the quality of services they render. Unqualified personnel in private units sometimes may fail to diagnose diseases, sometimes sell expired drugs, or give wrong doses of drugs to patients. As a result, diseases may re-occur after treatment or patients may die after these conditions.

"Clinics are employing unqualified people who at times give wrong dosage or even may give wrong drugs that can kill people especially children." (Apac FGD)

Private clinics owners and their staff were stated to treat patients with conditions which are beyond their technical abilities. Some tend to treat any disease condition which are presented to them for they often do not want to miss the money from patients.

"Some of the private clinic staff may know only simple drugs such as aspirin and panadol but may not have knowledge about medicine for injections" (Apac Community FGD).

"Sometimes treatment given by private sector causes swellings that turn into pus and removing the pus needs more money". (Apac FGD).

4.6.2 Quality of services

Communities recognise NGOs as providing cheaper and affordable health services. Participants reported that curative services of mission clinics are cheaper compared to private clinics. The quality services offered by some NGOs and private sector were rated better than those in the public sector. Drugs and equipment were noted to be generally cheaper at the NGO units.

NGOs subsidise their drugs e.g. a pair of spectacles at Rugarama health centre costs 4,000/= only as compared to other private clinics. Even other general costs are low in the NGOs than in other sectors" (Kabale KI)

The good quality services of NGOs were attributed to good funding and foreign influence, arguing that since NGOs had external funding, they could afford to provide better services, which are different from those offered by government units and private clinics. Private clinic funding is usually and individual's effort, locally mobilised and most of the time inadequate.

"We have financial constraints. We cannot buy most of the drugs." **(Apac**

KI)

However, Some of the NGO and private sector were said to use untrained staff, did not have adequate staff or did not have adequate equipment and supplies which made them offer low quality of service.

> ***" I lack adequate equipment, especially in the field of dentistry and surgery. The instruments are quite expensive. We are understaffed, we don't have someone to operate here full time; we are only here only when we are off duty."***(Apac KI)

Another aspect of NGO health care is the good relationship between health workers and patients, which contributes to the good quality of heath services offered in these units.

> ***People are not so much concerned with the drugs, but the relationship, it is psychological healing*** (Kabale KI)

Inadequate facilities

Private practitioners have their services limited by lack of availability of some needed facilities, including space. Sometimes, the nature of these clinics do not allow them to have facilities. Many of them are too small for they are started with little capital. Facilities needed for diagnosis and treatment of particular diseases e.g., laboratories are at times not available in many private practitioners' units. A syndromic approach to treat disease conditions is used. Clinics were noted to lack transport facilities which may be essential to refer patients, to hospital especially those in critical conditions.

> **"Some Clinics lack equipment for doing certain services say for removing teeth, and they use poor tools that can cause more problems to the patients". (Apac FGD).**

Drug shops and private clinics were also noted to have poor storage facilities for drugs, and as such the drugs get spoilt, but the owners continue to sell them because their primary interest is to get money.

4.6.3 Accessibility of services

The services of private practitioners were perceived by respondents to be better than those offered in public hospitals, e.g., many mothers deliver safely from private clinics, obtain adequate supplies of drugs, and the units are open for longer hours thus making services readily available to the clients. They also attended to patients promptly.

> ***"We are happy with clinics, the owners are friendly and they work at any time."*** (Apac FGD).

While patient-practitioners relationship was said to be generally good, poor patient-staff relationship was also noted by the community members in some private clinics.

Private for profit sector extend credit facilities to users and this was an important benefit to the users of these services. Private practitioners acknowledged giving credit to those they had served before or they know. In some cases community members abused this facility.

> ***Patients take long to seek medical attention, they come with serious***

problems yet they do not have money. [I treat]They benefit and I lose (Apac KI)

Interestingly, in Apac, trained TBAs lowered their charges following a discussion with the trainers as to what the communities can afford and do rather than what TBAs would like to earn. This increased access to reproductive services, while at the same time it improved the quality of these private providers .

Facilities run by private practitioners were reported to have better drug availability compared to government health units. However, private practitioners as noted earlier are mainly concentrated in urban settings, leaving the rural majority not catered for and hence maintaining distribution inequalities

Costs of services

Private practitioner charge prices which are deemed by the community to be high. Prices of drugs in drug shops and clinics were noted to be not only high, but also differ from unit to unit and in the same unit over time.

"In clinics, the prices of drugs are not constant, so you are forced to keep roaming from clinic to clinic in search of cheaper drugs yet the disease is increasing." (Apac FGD).

Private practitioners were compared to witch doctors in some instances for charging high and non-uniform prices for their services. The drive to get profits affects the quality of service they offer to the community and reduces the access these providers.

Improving financial accessibility

From the developmental services offered by NGOs, community members reported to have been able to increase their income. Some members expanded their agricultural activities, increased incomes and have increased accessibility to health care.

The revolving funds by the different community based projects helps poor members of the community to pool together resources which helps them in times of emergency like deaths or sickness.

4.7 Constraints in health service provision

4.7.1 Overview of constraints

Availability, accessibility and quality of the health services in both districts were found to be wanting. Participants compared government health services with NGO/Private sector services Some services and supplies reported to be unavailable in some places. Some community members felt that government health units are affordable but services not acceptable, because they are of low quality. In Kabale district participants reported lack of essential supplies such as clinical forms (Form 5) in government health facilities. Physical access to health facilities was also limited in both districts. Government health facilities were said to be few in number. NGO units are not evenly distributed while private enterprises are mainly located in urban centres and along main roads. Many people, therefore, live far from health units and the main hospitals. Transport was noted to be a big problem in Kabale, the common means of transport to the health units was a stretcher which is labour intensive, and can also be expensive sometimes.

"For us in our village people demand for drinks before taking the patient to the health unit." (Kabale Focus Group).

Participants noted that the government health units and NGOs that have outreach programmes, e.g., immunisation outreach to alleviate the problems of access in terms of distances. However, these are hindered by inadequate funding. In both districts immunisation staff were said to lack transport to take them to rural outreaches.

Community Health Workers were not distributed equitably in all parts of the district. The health units and staff were said to be very few and there was reported lack of transport to take the sick to the health units.

Another contributing factor to poor quality health services was noted to be the Government health units which are not functioning properly due to corruption, and many had almost completely collapsed. For example, in Kabale, health workers noted that drug kits (in government units) were adequate. All this attributes to provision of poor quality health services.

"Essential drug kits are too small to cover the catchment areas, chloroquine meant to serve for about three months can be used up within about two weeks and the rest of the months people are left to suffer." (Kabale FGD)

Inadequate funding also hindered the proper functioning of outreach programs, e.g. immunisation, etc. Health workers are not facilitated to provide these services. Therefore, most of the time, communities in the far rural areas are not reached.
In preventive and developmental activities, some NGOs require community contributions in cash, which was perceived by the community members to be a considerable cost to the already poor families. For example, an NGO that helps in construction of schools only provide materials such as iron sheets and cement while payment for skilled labour is provided by the community. The community was reluctant to make contribution towards such programmes when they do not have adequate resources, and the money is not accounted for.

Poor leadership, mismanagement and competition are a major difficulties in the developing of good health services.

4.7.2 NGO/ Private sector Constraints in Health service provision

Community Mobilisation.

NGOs have a different approaches to the community as they offer their services. The NGO programme designs and methods of work sometimes create community dependency. Some NGOs reportedly gave material benefits to the community. NGOs which did not give handouts were said to find problems in getting people to participate in community programmes, e.g., attending seminars and community meetings. These approaches may differ even within the same NGO. The Aber Hospital AIDS programme carries food when it goes to the community while the PHC/CBHC programme in the same hospital instead tells the people to contribute. The community was reported to be more active in the AIDS programmes than the PHC programme.

Church leaders in Kabale expressed concern about the difficulty of combining pastoral work with community work, which lead to heavy workload. Some people may not

appreciate the services offered while others would not put the assistance given by the church to proper use.

> ***When money is given to educate children it may be used to buy alcohol, with the hope that the church will give more.***(Kabale KI)

Sustainability of voluntarism was reported to make some of the NGOs operations difficult e.g., community health workers who were trained as volunteers, did not show adequate commitment to their work due to low/lack of adequate motivation.

> ***After training, the trainees expect some allowance, if not given they are frustrated.*** (Apac KI)

These expectations might develop out of the nature of work which may turn out to be more demanding leaving little time for the health worker carry out their own economic activities.

> ***" The work of AIDS counselling is so demanding, e.g., a volunteer may go to a family with an AIDS patient, he may have to continue with that family even after death of the patient. The work interferes with their own time and they are not paid."*** (Apac KI)

Conflicting messages to the communities between NGOs and other collaborators was another perceived problem by NGOs workers. For example, NGOs emphasise preventive health action, e.g., PHC, while hospital staff were reported to stress curative services. NGO workers felt that this was possibly because PHC does not earn money to the hospitals in form of cost-sharing.

Rural Infrastructure

The underdeveloped rural infrastructure causes operational problems. The geographical terrain in Kabale, poorly developed communication and road network, was noted to de-motivate health educators in the CBHC programme.

> **One may want to get information on immunisation, you make appointments and the people are not there, yet you have climbed mountains and crossed swamps with difficulty" (CBHC Staff Kabale)**.

An NGO in Apac could not easily communicate with their head office in Kampala.

Collaboration between NGOs , government and local administrative systems.

Activities which are jointly funded by international NGOs and Government were reported to delay because of the bureaucracy in government departments. This affects release of government counterpart funds which in most cases is a pre-requisite for release of funds from some NGOs.

Lack of political will at the local level was reported to affect participation in NGO activities. For example, if LCs and local chiefs lack interest in some of the NGOs activities, they do not

give adequate support in terms of community mobilisation to such activities. Some TBAs in Apac were not being supported in their activities by the political leaders in the area.

Funding Problems

"The biggest problem is the uncertainty of the future funding of this hospital." (Apac KI)

Local NGO reported inadequate funding and the lack of facilities as major problems. A good number of these NGOs depend on donor funding which may not be consistent or reliable. This lack of funds affects the NGO activities because they fail to maintain equipment, and are unable to carry out supervision due to lack of transport.

High taxation and licensing fees of private practitioners and drug shops was noted as a major problem.

The revenue collectors are overtaxing us. To establish a drug shop, you need 120,000/= when revenue authority is here we also pay a lot. They just approximate the amount with no criteria (Apac KI)

The private sector has major financial constraints depends on the levels of income of the population they serve and may offer credit facilities, much to the detriment of their service.

Financial constraints most people are poor and prefer to go to hospital; sometimes we extend credit facilities to these people and some do not pay back. The population is low and this leads to poor attendance.(Apac KI)

Some of the NGOs activities are intended to promote health through improving income of the family, e.g., by providing capital for income generating projects. However, some respondents noted that when application are made to such NGOs, they are turned down due to lack of funds. This often frustrates their efforts and failure to continue with such activities demoralises the community members. In some cases, NGOs fail to account for funds received, fail to perform adequately thus leading to donor discontinuing their funding.

4.8. Collaboration

NGOs and private practitioners were reported to collaborate among themselves and they also collaborate between themselves and government.

4.8.1. Collaboration with government

In both districts, NGOs and government collaborated in supervision and training . The District Health Visitor supervises in some NGO units. In turn, NGO staff who are technically able to supervise, did so in government units. This supervisory collaboration enables NGOs and government to share experience and responsibilities for improved care. This is encouraged and facilitated by a World Bank funded project- District Health Service Project- (DHSP) . The DHSP aims at improving services through strengthening collaboration between government and NGO units at district level. At the time of the study, districts were trying to establish mechanisms for setting up effective NGO supervision . Supervision was carried out by Rugarama Health Unit , in Kabale and Aber Hospital in Apac supervise units in their catchment areas.

The district medical officers also used facilitators from NGOs in the district during training of various cadre of staff. CARE Kabale trained heath workers in government institutions to become trainers in family planning.

Some NGOs also collaborate with different government departments at district level in planning and implementation of activities. CPAR in Apac co-operates with heads of departments (Veterinary Department, Agriculture, DES office and CGR office), in community mobilisation toward income generating activities. They also worked closely with the LC officials, during this mobilisation.

Information gathering and its use is another area of collaboration between NGOs and government health units. For example, CBHC in both districts reported gathering information on epidemics through, the in-charge of health units and forwards it to the DMO to take appropriate action. Private practitioners also provide information about the health status of the people in the area where they operate to the Ministry of Health.

> ***"The Private Practitioners give information to the DMO's office on epidemics, e.g., meningitis, measles, etc."*** **(Kabale KI)**

4.8.2 NGO / NGO Collaboration

There is little NGO/private sector collaboration. NGOs collaborate with the private sector in training and exchange of information. For example, CPAR in Apac is training CHWs, TBAs, PHC counsellors. DMOs UNEPI activities and sharing of information. Community Based Organisations, e.g. Women groups from different sub-counties visits and learn from each other.

They share funding assistance, manpower and technical services. UNICEF , for example provides funding and some training materials to local NGOs and Government/public officers in provision of safe water. The officers provide expertise to community activities, and the community contributes in terms of labour. Girl guides give support to CBHC programs, e.g. labour and education.

4.8.3 Problems of Collaboration

Non-collaboration is the main problem faced by NGOs. In some cases participants reported areas where collaboration does not exist.. The NGOs in both districts are collaborating with the DMO but not the Private clinics. Private clinics are rivals and competitors so they do not collaborate amongst themselves. There is no clear way in which the private sector collaborate with the community or government institutions around . In addition, Kabale government hospital does not co-operate with the local clinics around It was reported that TBAs in Apac district are doing their work individually. Most NGOs have no time to meet local people.

4.9 Recommendations for improvement in service provision

Respondents made a number of recommendations for improving health service provision.

4.9.1 Recommendations to government

Community members recommended that government should improve on the policies and regulating measures to control private practitioners. Government should strengthen the certification and licensing of all private practitioners DMO should have more authority to enforce the regulations. Local Councils and VHCs or sub-county health committees should also be involved in enforcing regulatory measures by government on the private practitioners

and NGOs by giving the required information to the authorities. Since Uganda is already implementing the decentralisation policy, districts can pass their by-laws, and district specific policies to regulate, supervise and control activities of NGOs and private practitioners to suite the specific district needs.

Government should institute regulatory mechanisms make sure that some minimum standards are in place before one is allowed to start a private clinic. These may include ; storage facility for the drugs; minimum qualification for the personnel working in the clinic; maximum number of clinics a private doctor can operate; and the maximum number of private clinics and drug shops in a given area, e.g., sub-county or parish to avoid overcrowding in one location. The regulation should also look at the operation of NGOs and their area of operation to reduce inequity in access to services, and duplication of activities.

All clinics operated by unqualified staff and lacking equipment should be closed. Regular supervision of private clinics' physical facilities and training of staff should be carried out by the DMO. Government may have to put more resources to train the personnel in private sector, e.g., nurses, etc. in some basics to improve on their quality of work.

Private practitioners and community members suggested that government health workers should be allowed to run their private clinics in their free time as long as they respect both roles. Although this is illegal, the recommendation was made recognising the fact that many private practitioners are also government health workers.

Traditional birth attendants and community members suggested that government and community leaders should recognise the TBAs and the role they play in providing maternity and other health services. They should assist and equip these local practitioners.

Private practitioners recommended that government should reduce taxation on health related activities and this would reduce the cost of health services.

Community members recommended that government should give direct funding support to private practitioners and NGOs in form of grants, loans or subsidies to improve the quality of services offered in the sector - specifically government should give support to see local NGOs that are undertaking major health preventive and promotional activities.

Respondents suggested that government should have a centralised pharmacy to handle drugs and ensure quality. A ban on the sell of drugs in the in market places should be put in place .

Collaboration was noted to be inadequate. Measures also need to be considered by government to increase networking between NGOs, working in health and government health departments. This could be done through regular meetings, or monthly returns to the Ministry of Health or other kind of reports. There is need for regular information sharing and use by the three sectors, i.e., government, NGOs and private practitioners.

4.9.2 Recommendations to the NGO/Private sector

Recommendations to the NGOs and the private practitioners were in the areas of improvement and expansion of the services offered, reduced cost, co-ordinating their activities, ensuring transparency, encouraging community participation capacity building and

assisting in equipping local practitioners.

The owners of private sector should recruit qualified staff, and should get bigger units where they have in-patients.

The private practitioners should charge lower fees which are affordable by the community who are the users.

NGOs were urged to co-operate with each other to avoid duplication of efforts. They should also discourage raising high hopes in the community they serve. NGOs should clearly define guidelines for their co-operation so that their activities can effectively benefit the communities they serve.

NGOs should consider community priorities, by involving them (the community) in every stage of developing and implementing activities.

In terms of capacity building, community members suggested training of local people e.g., S.4 leavers in medical knowledge so that they can assist in health services delivery programs.

Health education of the community should include drugs and drug use, their side effects and dosages This is important because a lot of self medication was being carried out and many people reportedly did not know that drugs can be poisonous.

Community respondents recommended that NGOs should assist TBAs with proper facilities e.g. gloves and clear razor blades when delivering mothers. They suggested bringing dispensing services near the TBAs so that users of TBA facilities do not have to travel long distances to get drugs and supplies. TBAs expressed the need for transport to help them with referral of cases to hospitals.

4.9.3 Recommendations to the Community

NGO staff recommended a policy which regulates the activities of politicians not to interfere with their activities. The political leaders should take an active role in health activities at community level and not block NGO activities. The RCs for example, were suggested to be directly involved in CBHC activities as a policy not as volunteers. They should further co-ordinate all activities, and work together to educate the community.

Community should increase their participation and interest in community programmes especially water and sanitation programmes. They should be able to accommodate changes and new developments in their areas.

5. DISCUSSION.

The role (in terms of the size and nature) of NGOs in health care provision has not been given due consideration by government and district officials. Of recent, three things have led us to the increased awareness of NGO activity in the health sector:

1. Decentralisation: The trend towards a more decentralised political system and in health sector, with the districts doing the planning management and co-ordinating of health activities should give due consideration for the role of the NGO activities.
2. Primary Health Care (PHC). PHC has forced government and international NGOs to realise the need to critically study the working of all health providers . It also stresses interagency collaboration, appropriate health care and equity.
3. Reduced Finance. Financial crises have forced government to look at means of expanding/ maintaining health care provision with minimum implications for government expenditure.

5.1 Nature of services

The nature of services offered by NGOs/private sector are diverse. NGOs and private sector are involved in the promotive, preventive and curative health services. Their involvement ranges from advocacy (e.g., for child rights) to water and to clinical service.

NGO/private sector services are seen to complement government efforts in offering health care to the community. The NGO/private sector is sometimes seen as competitive with government heath services and terms of provision. This has led to duplication of services in some instances- especially in the urban areas.

5.2 Cost of services

The cost of services offered in the private for profit sector is perceived as higher than that in the NGO - mission units. Interestingly though, Barton and Bagenda (1993) found that the cost at NGO hospitals were the highest among the NGO private sector. However, mission units have had financial problems in sustaining the services offered at the low cost.

Private-for profit units are usually small; with little capitalisation and often owned by individuals. It is very difficult, in the health care context to unravel the trade off between cost of care and quality of care. This is especially so at the smaller health units.

The smallest units (drug shops) may unscrupulously trade quality of service for cost of service. It is perceived that the work ethics of the small drug shop owners seemed to be eroded by the value placed on profit over service provided.

5.3 Financing of the NGO/private sector

One key limitation to the NGO/private sector is the finance. Most of the mission units have external funding but also charge a fee for service. The fees charged are often inadequate to run the institutions.
Private practitioners cannot expand as they would like because of the low capital that they

usually have or are willing to place on developing their units. Private practitioners also offer credit facilities which are often abused by some community members.

Preventive interventions (e.g., Immunisation) are seen as expensive to some NGO institutions for they do not charge for these services.

Donors have specific objectives and are not usually flexible in funding other activities that implementers feel should be carried out.

5.4 Quality of Services

Key determinants of the quality of service are staff, availability of supplies and equipment, cost of services, and client-provider relationship.
Perceptions of quality of service offered by NGO/Private sector varies from "good" to "poor." The NGO/private sector was said to use unqualified staff (especially drug shops) in their units. Some units were understaffed. Part-timing is common and this does not offer full time good quality services. Private clinic and drug shops did not have laboratory equipment and would refer patients to hospital or bigger unit for diagnosis.
The lack of a referral system from the private informal sector to the formal sector also lowers the quality of service that is being provided by the private informal sector.

In an earlier study, access or use of health units is influenced by the distance to the health unit, the level of education, and the person seeking treatment. Private clinics were used more in trading centres and villages. Government units were used in towns while NGO and government health centres were used more in the isolated villages. Herbalists were less used in towns and trading centres (Barton and Bagenda 1993).
Information sharing is inadequate among the NGO/Private sector. Only the prescribed routine information is collected and given to the DMO's office. There is no information flow from the NGO/ private sector to government and back to the NGO for use to improve their services.

5.5 Regulation

While regulatory frameworks exist in Uganda, they are seen as prohibitive to the private sector. There is no regulatory framework for the informal private sector. Execution of the policies has had a negative impact on some institutions. Communities are unaware or can enforce some regulations laid down for the private sector, especially the drug shops. Government too, does not have the capacity to effectively regulate the private sector. Law enforcement officers are sometimes the private sector players causing a conflict of interests. (One of the drug shop owners interviewed was the district assistant drug inspector!!)

Government bureaucracy or failure on government commitments has been seen as an impediment in implementing NGO activities in the communities and the district. Political commitment to the programmes has not been obtained because political ,leaders' suspicious attitude to NGO and Private sector activities.

5.6 Collaboration

Factors that influence relationships include; historical antecedents- Complementality not competition; motivational considerations; consideration of trust as a result of information sharing ; Legal and bureaucratic barriers; existing service patterns in the districts and the degree of funding (Green 1987).

While there is a place for different organisational types to network in the districts, the ability of such a network is currently constrained by:

- Lack of clear open relationships within the network of various actors.
- Lack of a co-ordinating mechanism outside government and within government.
- Lack of a legal framework that binds the NGO in the district
- Inadequate information sharing among the various types.
- diverse nature of services being offered by the NGOs.

6.0 CONCLUSIONS

Communities recognise that NGO and private sector are playing a significant role in the provision of health care in the two districts of Uganda. The findings could be applied to other districts in the country. Their services seem to tackle on every aspect of the problems existing in the districts, namely curative promotive/preventive and developmental activities. Curative services are offered at hospitals health centre, clinics, and drug shops. The informal health sector, (traditional birth attendants, traditional healers) should be recognised a strong component of the private health sector. NGOs were noted to have a good geographical coverage, offered relatively cheap services, and some NGO were good at mobilising resources and could have a strong pressure group role to play. Some private clinics and the informal private sector offer credit facilities or services perceived as being cheap by the community.

Some limitations in service delivery identified include: lack funding , lack of community support and community mobilisation, inadequate staff or using untrained staff, duplication of services in an area, and lack of flexibility in implementation of some programmes, and poor quality services.

7 RECOMMENDATIONS

NGOs have a significant contribution in health care provision, given the current shortage of government resources, the thrust towards PHC, and the policy of decentralisation.

- Community recommendations should be reviewed and taken seriously by the community, government and the NGOs.
- All NGOs working in the Health Sector should be identified, classified and assisted by the DMO's office.
- Government should ensure that appropriate levels of care are provided. There should be quality assurance in hospitals, health centre, drug shops and the informal sector
- The Informal sector should be recognised and trained to offer good quality and appropriate services
- There should be effective use of registration rules and regulations for the private sector.
- Research in community financing of health care should be carried out. The use of community based NGOs in financing health care services should be explored.

- NGOs should explore other financing mechanisms so that the quality of service produces is improved.
- Government should honour its commitments to NGOs so that they can improve

on the services they deliver.

- International NGO should allow flexibility in implementation of programmes
- An in-depth evaluation of the NGO and the private sector should be carried out form the NGO/private sector perspective. It should review the key issues of : efficiency in the organisations, equity of service in the different sectors, resource mobilisation, collaboration and referral systems between NGO and private sector, community mobilisation mechanisms, and quality of service issues.

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APPENDIX 1 NGOs in the districts

Apac District	**PIP**	**Title**	**Sub-sector**
Large Project	H115	Health services Rehabilitation	Curative
	H117	District Health Services Project	PHC
	H123	Hospital/CBHC Support (CUAMM)	PHC
		PHC/CBHC (CPAR)	
		Guinea Worm Eradication	
CBHC/PHC Projects	**Funder**	**RC3**	**RC2**
	CPAR		
	Aber Hospital (CUAMM)		
	Misereor		
	Lira Catholic Diocese		
	Uganda Red Cross		
AIDS Projects	**Title**	**Funder**	
	CHUSA	USAID/ WLI	
	CUAMM	Italy, World food Programme	
	PAPSCA/ADF	World Bank	
	SYFA	URC, UNICEF	
	Sentinel Sites	ACP/ WHO	
		Christian Children Fund	
		Int. Islamic Charitable Fund	
		Soroptimist International	

Kabale District	**PIP**	**Title**	**Sub-sector**
Large Project	H109	rehabilitation district Health units	
	H109	Safe Motherhood	
	H110	SWIP	
	H116	STI (pilot)	
	H117	DHSP (Pilot Phase)	
	H125	Rural Health Programme (EDF)	
	S105	National population Programme	
	S110	Community Based Rehabilitation	
CBHC/PHC Projects	**Funder**	**RC3**	**RC2**
	Kabale Catholic Diocese		
	Uganda Red Cross		
	Kigezi Diocese		
	SWIP		
	"Local"		
	"Self"		
	AICM		
	Kiziwama		
	Rubanda Sisters CBHC		
AIDS Projects	**Title**	**Funder**	
	AIDS Prevention	AMREF	
	CHUSA	USAID	
	DACC, Caring	UNDP	
	SYFA	UNICEF	
Disability /Mental Health Project	**Title**	**Funder**	
	FPD	OXFAM	
	Sheltered Workshop		

(Source: T. Barton OXFAM Health Sector Review 1995)

Table Showing some of the NGOs in Apac and Kabale Districts with their Activities and the

Population served

APAC

Organisation	Population served	Activities
CPAR (Canadian Physical Aides of Relief.	Sub-counties	Health Education Train Vaccinators Protect Springs Well Train Aids Educators Opened Many Health Centres.
Aber Hospital		Train TBAs Curative And Preventive Services
WATSAN (Water and Sanitation)	General community	Protect Water Sources. Dig Shallow Water Sources Rehabilitate Boreholes.
RTIs CDO/ARI	All age groups	Assist UNEPI By Providing Bicycles. Topping Up Allowances For Vaccinators. Rehabilitation Of Health Units.
UCOBAC	Children	Advocacy
Safe motherhood	Expectant mothers	
UWESO	Orphans women	
Action Aid	All age groups of people	builds health units, Schools
CBHC	Women and children	- Immunisation
ADF	Mainly women	
Arach veterans	group of veterans	
Moterokimo Women Group.	Women	Educate people on AIDS
ATOPI drama group	Rural population	Educate people on AIDS

KABALE

Organisation	Location/Population served	Activities
Rugarama	General	
Rushoroza	General	
Rubanda Health Centre	Rubanda General	• It is just like a hospital, offers most of the services.
AMREF	Primary and Schools in Kabale	• Treating AIDS education in schools • Health environment in schools
Safe Motherhood	Mothers	• Educating Mothers on safe delivery. • Antenatal, postnatal care. • TBA training.
CARE	General	• Community outreach programmes. • Family planning/ reproductive health. • AIDS and health education. • Safe water programmes • Supervise government health units.
Church of Uganda Organisation based in London	General	• Protecting wells. • Building water tanks.
Kabale handicapped society	Disabled	• Community based rehabilitation of the disabled. • Workshop for disabled. • Workshop for disabled.
World Vision	General	• Not well defined, today they build schools, tomorrow health unit.
KDACIS (Kabale District AIDS Counselling Services.)	AIDS affected families	• Counselling.
ACSO	General	• Counselling • Family support
Women groups	Women	• Help in health education. • Nutrition
Kabale Network organisation		

Organisation	Location/Population served	Activities
Rushoroza CBHC	General	• Inter-county activities. • Health education, etc.
UNICEF	General	• Clean safe water
SWIP	General	• Provides boreholes
Local women groups	Women	• Growing potatoes, tailoring to generate income.
LCS	General	• Community work "bulungi bwansi." • Support women groups by protecting their gardens from thieves.
Rugarama Foster Care	Orphans	• Pays school fees • Looks at their welfare
Church of Uganda based in London	Orphans	• Pays fees for orphans • Gives fuel, clothes
Rubanda PHC programme	General	• Health education

APPENDIX 2 Interview schedule guide

THE ROLE OF NGO/PRIVATE SECTOR IN HEALTH CARE PROVISION

KEY INFORMANT TOPIC GUIDE Form
No._____
Date of Interview_____

Name of
Interviewer:_____
Introduction

We are a team of researchers from Child Health and Development Center, and we are doing a study on the role of NGO and the private sector in health care provision. You have been identified as one of the people in this community to discuss issues related to this topic. The purpose of this information is to give a picture of what is going on, in your area/district the aim is better integration of health sectors for improved health and well-being of the people.

We are doing this study in two districts, Apac and Kabale. There is no promise of resources, but the information will come back to you for local planning.

Please discuss freely, and do not hesitate to raise issues about NGO and private sector practitioners. The views you will give will be taken generally as community views. You are free to participate in the interview and you may stop the discussion if you feel you cannot continue. However, we hope that you are willing to contribute ideas for the good of the district. Thank you.

District_____

Subcounty_____

Name (respondent)_____

Occupation (Title)_____

Name and type of organization (for respondent)_____

1(a) What are the objectives of your organization?

_____
_____
_____
_____

(b) What are the various activities that you (or your organization) you currently doing in this area?

_____
_____
_____
_____

2.(a) What population do you mainly serve (probe children, men, women, disabled, etc)?_

_____
_____
_____
_____
___

(b What are the specific services rendered to each category of population you have mentioned?

_____
_____
_____

3.(a) What are the main sources of funding for your activities?

_____
_____
_____

4. What are the specific health issues/roles you (your organization) deal with?

_____
_____
_____

5. In your opinion how has the community benefited from your organization/unit?

_____
_____
_____

6.(a) What kind of constraints does your organization face in implementing its activities? (probes - from the community; within the organization, other actors, etc.)

_____

_____

_____

(b) In meeting your goals?

_____

_____

_____

(c) In your opinion, what do you see as the shortcomings of your organization to the community? Probes: (increased demand on their time; costs, change in social structures, relationships, etc)

_____

_____

_____

7. What measures would you suggest to address the above problems you have mentioned?
(From your organization, from the community, etc)

_____

_____

_____

8. What other organizations/individuals, etc. in this area or elsewhere do you collaborate/co-operate with in carrying out your activities?

_____

_____

_____

And in which way?

_____

_____

_____

9. What policy measures/suggestion do you think can help you improve the activities you are doing now?

_____

_____

_____

(Probe collaboration/co-operation)

10. What other comments/suggestions/questions do you have about NGO/private roles in health care provision?

_____

_____

_____

INTERVIEWER THANK THE RESPONDENT

Appendix 3: Focus Group Topic Guide

THE ROLE OF NGO AND PRIVATE SECTOR IN HEALTH CARE PROVISION: A STUDY OF KABALE AND APAC DISTRICTS

FOCUS GROUP TOPIC GUIDE
Introduction

We are a team of researchers from Child Health and Development Center, and we are doing a study on the role of NGO and the private sector in health care provision. You have been identified as one of the people in this community to discuss issues related to this topic. The purpose of this information is to give a picture of what is going on, the aim is better integration of sectors for improved health for the public.

We are doing this study in two districts, Apac and Kabale. There is no promise of resources, but the information will come back to you for local planning.

Please discuss freely, and do not hesitate to raise issues about NGO and private sector practitioners. The views you will give will be taken generally as community views. You are free to participate in the interview and you may leave the discussion if you feel you cannot continue. However, we hope that you are willing to contribute ideas for the good of the district. Thank you.

1. Community perception of major health problems.

Communities everywhere may be afflicted with a number of health problems. Some of them may be minor and can be dealt with in the homes, while others are major and they require specialized knowledge to solve.

a) What do you consider to be the major health problems in this sub-county? (e.g., diseases, environmental conditions, etc..)

b) What do you think to be the causes of these problems in this area?
(please indicate the problem and reason)

2. Management by NGO/Private practitioners

There are many health providers that help communities to deal with their health problems. Some of these may be employed by the government on non-governmental organizations. Others working privately, such as healers and private clinics.

a) What are the major types of providers who are not employed by government, that help communities in this area to deal with these health problems you mentioned? (Please indicate the problem together with the type of practitioner)

Probe:- Curative

- Preventive (PHC)

i) What specific groups of people are served by each category?

Probes: children of certain age
older men
out of school children
disabled etc.

b) Communities sometimes organize themselves into collective or competitive efforts to solve their own problems. They may pool resources together, or be funded by external sources and form what is commonly known as NGOs.

i) What do you understand by NGOs.

ii) What are the different NGOs that exist in this sub-county?

Probe: **community initiatives to solve health problems directly**
- Indirectly related to health e.g., income generating and how it relates to health in their own view.

iii) What specific groups of people are served by each category?

Probes: children of certain age
older men
out of school children
disabled etc.

3. Contributions by NGO/Private sector

As these organizations/private practitioners work with the people, there are some benefits that the community gain from them

What benefits does the community get from these providers/organizations? (ask NGO and private separately).

Probe: treating diseases, immunization, health education, incomes, etc..

How satisfactory are they?

Probe: what do you think about the service, how good, how bad, etc.

4. Problems

Communities sometimes may face problems with private practitioners or organizations working with them.

What problems do you encounter with these providers/organizations
that work in yor community.

Probe: For practitioners; costs of care, type and mode of payment, type and quality of treatment, relationship etc

For organizations; accessibility to other members of the community, level of participation, sharing benefits etc.

5. Possible solutions

In order to solve some of the problems communities face with these providers/organizations, so as to provide better service, there may be a number of actions that can be done, e.g., by the organizations themselves, the community and the government.

a) What is being done to solve these problems?

b) What more do you think can be done to:

i) improve on what they are doing right?

ii) Discourage them from doing what they are doing poorly?

Probe: what organizations/providers can do, community and government, for both NGO and private sector.

6. Collaboration/ Co-operation

As part of the efforts to provide better services to the people, the different sectors of health may need to collaborate/co-operation or work together.

What are the existing areas of collaboration/co-operation between the different sectors.

Probe: relationships between providers and community, the RCs, district administration and other organizations e.g., for referrals, sharing knowledge, instruments etc,

What other forms of collaboration/co-operation do you recommend between the different sectors in order to improve their services?

Probe: NGO/private and public
NGO/private and NGO/private
NGO/private and the community.

7. What other comments/suggestion/ questions do you have regading our discussion?

THANK YOU VERY MUCH FOR YOUR PARTICIPATION, TIME AND INFORMATION