

Decentralized Health Care Services Delivery in Selected Districts in Uganda



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**A Thesis Submitted in Partial Fulfilment of the Degree of Master
of Education, in Department of Education, University of the
Western Cape**

Date November 2005

ABSTRACT

Decentralization of health services in Uganda, driven by the structural adjustment programme of the World Bank, was embraced by government as a means to change the health institutional structure and process delivery of health services in the country. Arising from the decentralization process, the transfer of power concerning functions from the top administrative hierarchy in health service provision to lower levels constitutes a major shift in management, philosophy, infrastructure development, communication as well as other functional roles by actors at various levels of health care. This study focused its investigation on ways and levels to which the process of decentralization of health service delivery has attained efficient and effective provision of health services. The study also examined the extent to which the shift of health service provision has influenced the role of local jurisdictions and communities. Challenges faced by local government leaders in planning and raising funds in response to decentralized health service delivery were examined.

The study used a descriptive survey research design employing qualitative techniques, namely questionnaires, structured interviews, observation, and document analysis to establish the extent to which the decentralized approach to health service delivery has impacted on local governments and the vulnerable target groups such as the rural and urban poor, children, mothers, HIV/AIDS victims, orphans and refugees. Key respondents were government officials in health related management in the country at various levels. Health workers and beneficiaries of health services were interviewed to share their views and experiences of decentralized health care service provision.

Using a conceptual framework of *“Community as Client”*, the findings illustrate that while some local governments in the country have extended health units closer to some communities, the pursuit of a decentralized health service delivery system in Uganda over-assumed the benefits of decentralizing health care. The observations indicated that health care is not better organized; neither has decentralization provided greater involvement of local communities in mobilization and capacity building of community-based health workers. The acclaimed cost containment and reduction through duplication of services, reduction of inequities, integration of activities of different agencies and organizations involved in health care have not been achieved in concert with original expectations and assumptions of decentralization. These include: strengthened health policy and planning functions of the ministry of health, improved implementation of health programmes, greater community control and financing (ownership) and improved inter-sectoral coordination. From the findings, it would appear that the motivation for decentralizing health care was not intrinsically guided by how the decentralized health system can better serve the poor majorities in the country. The study concludes that the decentralization of health services in Uganda was not matched with commitment for provision of necessary health supplies, and delivery of health care services through a centrally coordinated national network of health facilities. The Ugandan Government in particular Ministry of Health and the government needs to evaluate the achievements and challenges faced by the health care system under decentralization within the broader perspective of health for all, as a means to establish appropriate refocusing of health care delivery for optimal benefit of the client communities.

DECLARATION

I declare that Decentralized Health Care Services Delivery in Selected Districts in Uganda is my own work, that it has not been submitted before for any degree or examination in any other university, and that the sources I have used or quoted have been indicated and acknowledged as complete references.



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ACKNOWLEDGEMENTS

I am heavily indebted to the following, who made it possible for me to accomplish this task. I sincerely express my gratitude to GRASSMATE Project for having taken me on board, the Norwegian Government through NUFU for the sponsorship, the Management of Public Health Nurses College and Mulago Hospital for granting me time off to attend a series of seminars/workshops.

I am very grateful to my supervisors Professor Dirk Meerkotter, Dr. Lorna Holtman, Dr. Silas Oluka for their constructive criticisms, guidance and encouragement, which kept me moving on.



My deep appreciation is extended to the supervisors in the GRASSMATE project and my colleagues for their valuable contributions towards this study.

I am very appreciative to Professor Marion Keim-Lees for editing this thesis and The Post Graduate Enrolment and Throughput (PET) project for the all the assistance rendered to me at the last stages of the production of this thesis.

I would like to extend my gratitude to Mr. Barugahare William from whom I gained my first background about research methodology, which helped me a great deal in this subsequent undertaking.

I thank members of my family for their support. I wish also to extend my sincere thanks to my husband Mr. Mohammed Mayanja for the moral support he accorded me.

Last but not least, I extend my appreciation to all the respondents in this study in their various capacities.



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LIST OF ACRONYMS

The following Acronyms have been used in the text of this thesis:

AIDS	-	Acquired Immune Deficiency Syndrome
AWI	-	African Women's Initiative
CAC	-	Community as Client
CBR	-	Crude Birth Rate
CDR	-	Crude Death Rate
CT	-	Computer Tomography
DDHS	-	Director District Health Services
DHC	-	District Health Committee
DHT	-	District Health Team
DRCs	-	District Resistance Councils
ECHO	-	Echo Cardiography
FGDs	-	Focus Group Discussions
GoU	-	Government of Uganda
HC	-	Health Center
HIV	-	Human Immuno Virus
HSD	-	Health Sub District
HSSP	-	Health Sector Strategic Plan
Labs	-	Laboratories
LC	-	Local Council Government
LJC	-	Local Jurisdiction Council
MHMC	-	Municipal Health Management Committee
MoH	-	Ministry of Health
NGOs	-	Non- Government Organizations
NRM	-	National Resistance Movement
NUFU	-	Norwegian Community for Development Education
NWSC	-	National Water and Sewage Corporation
P	-	Public
PHC	-	Primary Health Care
PHI	-	Principal Health Inspector
PHT	-	Phelophepa Health Train
PR	-	Private
PUIP	-	Peri Urban Infrastructure Development
STD	-	Sexually Transmitted Diseases
STI	-	Sexually Transmitted Infections
TB	-	Tuberculosis
TFR	-	Total Fertility Rate
UNFPA	-	Uganda National Family Planning Association
UNICEF	-	United Nations International Children Emergency Fund
USAID	-	United States Agency for International Development
US \$	-	United States Dollar
VIP	-	Ventilated Improved Pit Latrine
WHO	-	World Health Organization

CHAPTER ONE

1.1 Background

This study investigated the decentralization of health care services delivery. It focused on efficient and effective ways of providing health care services. Some of the key questions that guided the investigations were: How has the shift from a centrally managed to a decentralized structure of health care service provision impacted on the local institutions and benefited the local populations in particular the rural communities? How are the local government leaders coping with planning and raising funds in response to decentralized health care service delivery? To what extent has the decentralized approach to health care service delivery impacted on vulnerable target groups (e.g. the rural and urban poor, children, mothers, HIV/AIDS victims, orphans, refugees)? These interdependent questions guided the investigation in this study.

Decentralization as a concept is a change in the organization of government or other institution, involving the transfer of power and functions from the top of the hierarchy of power and service provision to peripheral levels. For a nation, the organizational shift involves transfer of decision-making, and other functional roles from national to various sub-national level(s). According to Conyers (1984) as quoted in Nsibambi, (1998:1), one of the key motivations for decentralization is its capacity to “empower the local institutions and people to make their own decisions and to introduce appropriate delivery of services.” However, decentralization is a term that comes with a range of assumptions and takes different perspectives depending on socio-economic as well as other factors.

In the last two decades, decentralization or devolution of roles and responsibilities such as planning, policy development and implementation to lower units and levels of government has been pursued in most African countries. In Uganda, decentralization was launched following a major presidential policy statement on 2 October 1992 (Nsibambi, 1998:1-2). According to Nsibambi “the quest for democratic decentralization and good governance countrywide started in 1986 when the National Resistance Movement (NRM) took power and started implementing its policies that had been conceived and developed during the war” (Nsibambi, 1998:1). The government subsequently produced the Constitution of 1995 following consultation with numerous stakeholders and individuals. In its National Objectives and Directive Principles of State Policy II (ii), it states that: “all the people shall have access to leadership positions at all levels, subject to the constitution.” (Government of Uganda, 1995: 2)



Following the promulgation of the 1995 Constitution of Uganda, the Local Government Act (1997) was drafted, discussed and passed by the Parliament, spelling out the relationship between the central government and the districts (Government of Uganda, 1997). This Act spelt out Uganda’s decentralization policy with the aim to:

Transfer of real power to the local governments and thus 'reduce' the workload of remote and under resourced central officials;

Transfer the delivery of services to the local communities in order to improve effectiveness and accountability and to promote a sense of peoples’ ownership (political, managerial and administration) of local government programmes and projects;

Free managers in local government from constraints of central authorities and to allow them to develop organizational structures that are tailored to local conditions;

Improvement of financial accountability and responsible use of resources by establishing a clear link between the payment of taxes and the provision of the services they finance; and

Improvement of the capacity of local councils to plan, finance and manage the delivery of services to their constituents.

It is clear from the above provisions that leeway for community involvement and networking between local governments and the central government were a possibility.

1.2 Health Care Service Delivery and Access

Preventable and treatable diseases take an enormous toll on the world. In Uganda, one of the poorest African countries, infections and parasitic diseases accounted for more than half of all deaths in 2001, compared to 2% in Europe (WHO, 2002). It is estimated that at least 300 people per 1000 people die from vaccine-preventable diseases annually (Global Alliance on Vaccines and Immunizations, 2003). Moreover, the gap between the poor and rich nations seems to be growing. For example, mortality of children under 5 declined by more than 70% in high-income countries between 1970 and 2000, compared with a reduction of 40% low income countries such as Uganda (Victoria, 2003:234). Nearly half of the people in sub-Saharan Africa live on less than US\$1 per day, adjusted for purchasing power – making people in poor nations like Uganda especially vulnerable to disease (World Bank, 2003). Those living in extreme poverty lack access to safe drinking water, decent housing, adequate sanitation, food, education, professional healthcare, transportation, safe and secure employment, and health information. In the health sector, differences in health care spending, investment in research, capacity building, and access to technology and information contribute to the high disparities in health status (WHO, 2000).

For Uganda, according to Baker and Gosh (1994), there are disparities in access to health services with the poorer regions and families being the most disadvantaged. Based on the known disparities in health care benefits among the communities in the country, a country like Uganda would have the central government playing a key role in financing and overseeing the delivery of health care services, and where possible, to use targeting strategies to direct more attention and the health care benefits towards the poor. Communities often focus on effectiveness, accessibility, equitability, interpersonal relations, continuity and availability of amenities as the most important dimensions for quality of a health delivery system. A common justification for public sector involvement is the need to provide affordable health care services to all citizens, especially the poorest and the most vulnerable groups. There was therefore an interest in this study, to establish how equity, fairness, affordability, and accessibility matters have been addressed by health care service delivery in a decentralized framework.



For the health care services provider, quality management implies that he or she has the skills, resources and the conducive conditions necessary to improve the health status of the communities according to current technical standards and available resources. Service providers tend to focus on technical competence, effectiveness and safety.

Health management must provide for the needs and demands of both service providers and beneficiaries. Also, they must be responsible stewards of the resources entrusted to them by the government, private sector and community (Government of Uganda, 1995). Health management must consider the need of multiple beneficiaries in addressing questions about resource allocation, fee schedules, staffing patterns and management practices. The multi-dimensional concept of quality is particularly helpful in a social service sector such as health,

where access, effectiveness, technical competence, equity and efficiency are the most important dimensions of quality in health care service provision (Government of Uganda, 1997).

The health care services delivery system in Uganda has undergone reorganization and restructuring to improve performance at all levels. The main aims are to create an efficient and effective system that will cope with the current reform that government is undertaking.

Under the new Constitution (1995), and Local Government Act, (1997), responsibilities have been defined for Central Government and Local Government, in terms of local jurisdictions (Government of Uganda, 1997).



As for the case of health, the apex of the structure is the Ministry of Health, whose core functions (MoH, 2000) consist of policy formulation, standard-setting and quality assurance, resource mobilization, capacity development and training support, provision of nationally co-coordinated health services (such as epidemic control), co-ordination of health services, monitoring and evaluation of the overall sector performance and training. In a decentralized framework, the responsibilities of the local Government have been spelt out to include:

Implementation of national health policies;

Planning, management and monitoring of local health care services and health units;

Provision of disease prevention services, health promotion, curative and rehabilitative services with emphasis on the minimum health care services package and related national priorities such as vector control, health education;

Provision of safe water, environment and sanitation;

Health data collection; and
Interpretation and dissemination of health messages to communities in
local languages; (MoH, 2003:13)

In Uganda, health care services delivery has been decentralized to the district and sub-district levels. Districts and sub-districts (local jurisdictions) are, under a decentralized framework, preparing their own annual work plans, human resource recruitment and management of personnel for health care service, passing by-laws related to health, planning and resource mobilization and allocation for health care services.

The local jurisdiction council through the local jurisdiction health committee heads the structure for the management of health services in the local jurisdictions. The Principal Health Inspector heads the local jurisdiction health management team. This team is composed of the health inspectors and section heads.

Figure 1.1 below shows the structure for local jurisdiction health services delivery.

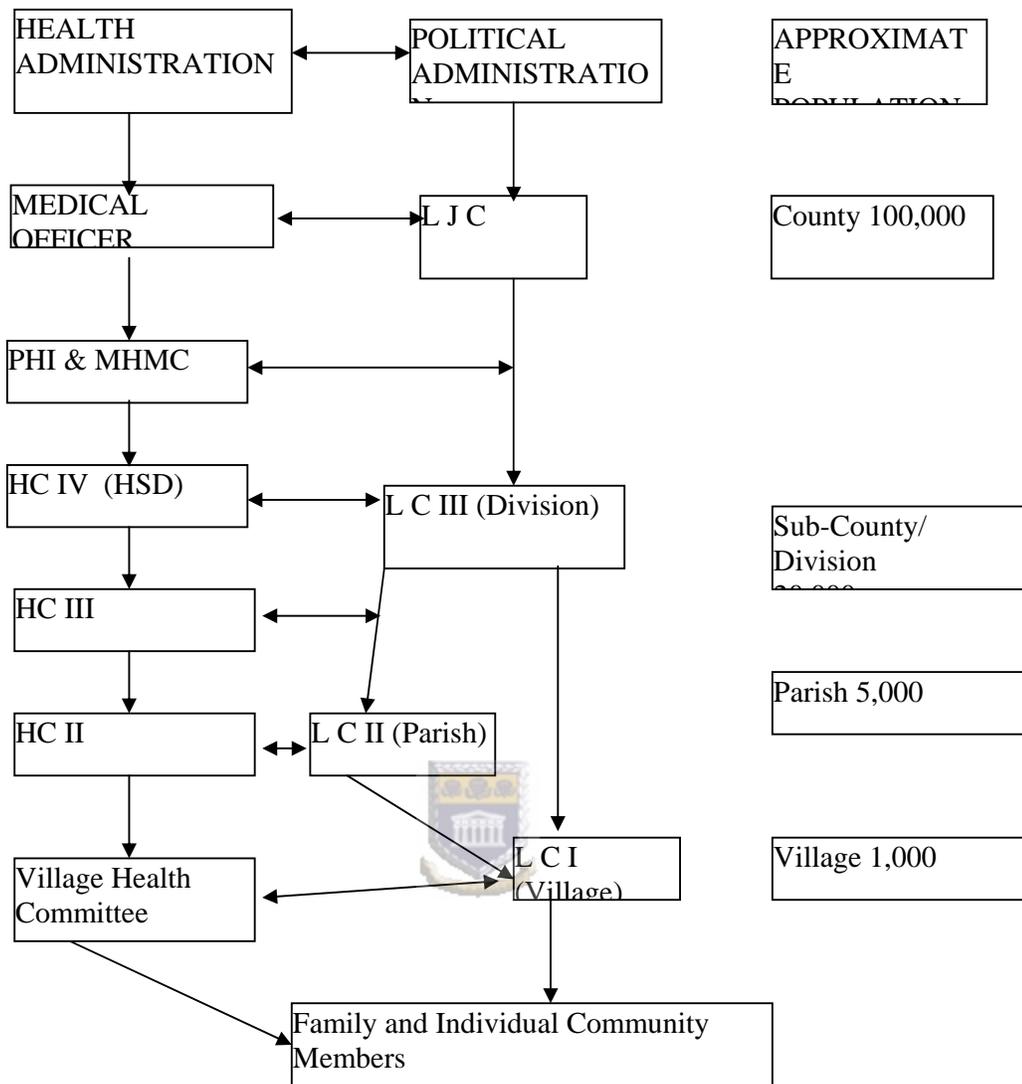


Figure 1.1 Local Jurisdiction Structure for Health Service

Source (Adopted from MoH – HSSP 2000/01 – 2004/05: 56)

Key to Figure 1.1

- HC IV Health Center
- HSD Health Sub-District
- LC Local Council Government
- LJC Local Jurisdiction Council
- MHMC Local Jurisdiction Health Management Committee
- PHI Principal Health Inspector

Figure 1.1 above shows the linkages between the political, administrative and technical arms of the various levels of the services delivery system and the related communities whose roles and responsibilities are vital.

Quality health management services in a localized (decentralized) arrangement are intended to provide comprehensive preventative and promotional health care services to school-going children and youth (5-24 years) estimated at 45% (8,055,459) of the national population 1991 Census (MoH, 2000:35). It focuses on: the improvement of the health of the school children; the reduction of the dropout rates and enhancement of performance in schools; it also augments the government programme on education, including 'Universal Primary Education'. In response to decentralization of health care services, districts and municipal councils are expected to plan and raise funds required to support the population as well as to monitor the performance of workers in their jurisdictions.



1.3 Statement of the Problem

Worldwide, sweeping changes in public health have transformed life in the last century. This is indicated by increased average lifespan, and healthier lives than ever before. Even so, the revolution witnessed in health and well-being is incomplete. For people living in abject poverty¹, health services and modern medicines are out of reach. Preventable and treatable diseases take an enormous toll among the poor, particularly in the rural and peri-urban communities, which constitute 89% of the population of the country.

The government of Uganda, working in concert with development partners in health, has recognized the need to improve the health of the majority poor population. Prior to 1995, the Ministry of Health managed

¹ World Bank (2001) World Development Report 2000/2001: Attacking Poverty has examined the connection between poverty and health, pointing out that people living less than 1 US\$ are in abject poverty, and are estimated to be 1 billion.

post-independence health services centrally. Decentralization of services has meant that the mind-set and culture of work, management, organisational setup following the transfer of powers and functions to lower levels. It raises concerns about the responsiveness and efficacy of the whole health services delivery system to the demands and expectations of decentralization. At management level therefore, the organizational shift has involved the transfer of decision-making, and other functional roles from national to sub-national levels.

Despite the 1995 National Constitution of Uganda and the Local Governments' Act of 1997, both of which apportion responsibilities to central and local authorities, health care service delivery access is so far limited to only 49% of the households (MoH, 2000:11). Even at locations where the facilities exist, access to basic elements of the health care package is far from communities in need.



As a result of many years of civil strife and neglect, there is a massive backlog on public health services, such as personal hygiene, health education, medical and dental care, the onslaught of HIV/AIDS with its opportunistic infections and the restructuring of family roles and responsibilities. These health maladies in various communities raise a series of demands and expectations in a decentralized health care system in terms of quality and range of services provided at existing health facilities.

1.4 Overall Study Objective

The overall aim of the study was to investigate the challenges faced by health professionals in the provision of a decentralized health care services delivery system in Uganda.

1.5 Specific Study Objectives

The following specific objectives guided the study:

To find out what was understood by the meaning of decentralization by local government officials, health officials at the headquarters, districts and sub-county, the nurses and other personnel concerned with health and patients in the districts of Wakiso, Kampala, Pallisa, Soroti, Lira and Gulu in Uganda.

To identify and assess how the health care facilities and resources had changed from decentralization initiatives in Uganda.

To examine major successes and impediments in the implementation of the decentralization initiative in health services delivery in Uganda.

To establish what the implications of the decentralization of health services delivery are for the education of health professionals.



1.6 Research Questions

Guided by the above objectives, the study sought to answer the following questions:

- 1) What is understood by decentralization in the context of health care service delivery in Uganda?
- 2) What changes in health care service delivery resulted from the decentralization with regard to initiatives, management and process, facilities and information flow in Uganda?
- 3) What were the challenges on implementation of decentralization in the health care service delivery in Uganda?

What implications might decentralization of health care service delivery have on the education of health professionals in Uganda?

1.7 Scope of Study

The study was conducted in selected districts (Wakiso, Kampala, Pallisa, Soroti Lira and Gulu) in Uganda health care service provision units at district headquarters, divisional centers, and health units.

The study focused its inquiry on the ways health care services are being implemented and identified constraints in service delivery under the decentralized National Health Service.

1.8 Significance of the Study

This study might be important in many respects. For policy makers, the findings may help in the formulation of health policies. The findings might assist planners and implementers of health policies with regard to aspects of relevance and contextual demands made on health services delivery. Health professionals and other stakeholders might benefit from the study's findings especially in terms of clarifying unquestioned assumptions and beliefs about health care delivery in a decentralized framework to offset the continued death rate in Uganda from preventable diseases such as diarrhoea, malaria, and measles.

The key objective of the study centred on the establishment of the status of health services of decentralized health service provision units, and on the constraints hindering service delivery to local communities. The study's findings are a source of baseline data and information, providing details and important valuable references on efforts to enhance future planning and implementation strategies in health care in Uganda.

The findings may also provide vital baseline information concerning community health services in decentralized health service provision units to all interested parties including academicians, researchers, and public

libraries. The findings may assist the policy makers in formulating strategies to resource utilization, which favour “Community as Client” oriented ways to improving health care provision for the target communities. The study may also trigger a concerted interest among the local government centres in the respective districts, non-governmental organizations and other stakeholders for appropriate and cost-effective but equitable health service implementation and management.

1.9 Conceptual Framework

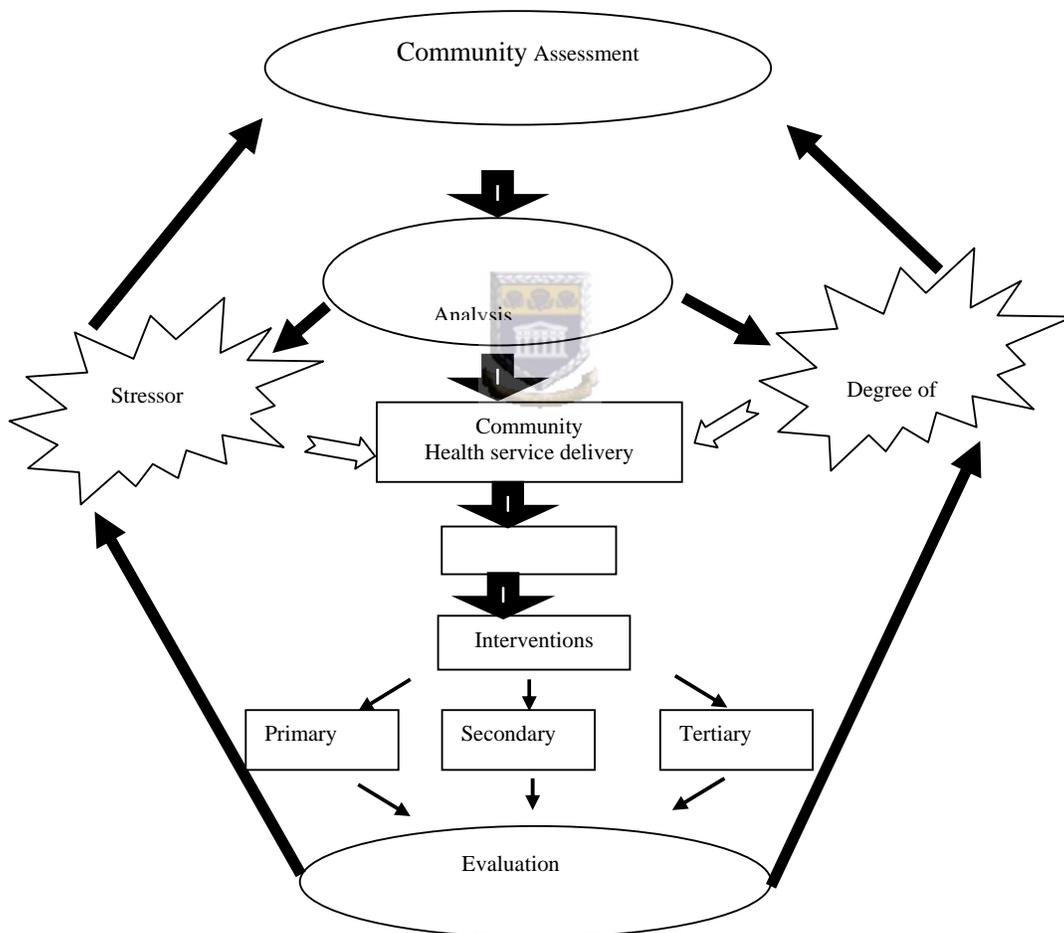


Figure 1.2 “Community as Client” (CAC) Model²

² Adopted from Neuman (1982: 21-23).

The “Community as Client” model is based on Betty Neuman’s model “A total-person approach to viewing patient problems” (Neuman, 1982: 21-23). The model is modified in this study to illustrate the definition of community-oriented health care service delivery, where community replaces the *person* and health care service delivery replacing the *nursing process* in the original Neuman model. Table 1.1 below provides foundational definitions for the more specific description of the “Community as Client” (CAC) model. Considering the “Community as Client” model in Figure 2, there are two central factors in the model: a focus on the “Community as Client” (represented by the community assessment wheel at the top of the model) and the use of the health care service delivery process.

Table 1.1 Definitions of Concepts Central to the Community-as-Client Model

Community/People	This epitomizes the community: all persons residing within a defined geographical boundary or sharing a common characteristic
Environment	All the conditions, circumstances and, influences surrounding and affecting the development of the community, which is, in and of itself, also a part of the environment
Health	Competence to function; a definable state of equilibrium in which sub-systems are in harmony so that the <i>whole</i> can perform as its maximum potential
Health care service provision	A professional practice that brings a unique, holistic view of the community and contributes to the health of the community by participating in the assessment; identifying and diagnosing problems amenable to nursing intervention; planning for the alleviation of community health problems; carrying out interventions in conjunction with others; and evaluating the effect of those interventions on the health of the community

Source: Neuman, B.N. 1982: 23

The focus of the Community-as-Client Model is the community (presented in Figure 1.2, section 1.9). The core element of the model is the people that make up the community. The central core to the community is the demographics of the population as well as the values, beliefs and history of the people. In the context of Ugandan communities, demographics would include aspects such as rural-urban divide in which 89% are rural, proportions of people by sex, age groups, people's livelihood activities, to state a few (World Bank, 2001).

Below is a description of the key features of the "Community as Client" model guided by the analysis of Clark (1992: 130-133). According to Clark, residents of the community are affected by, and in turn influence their whole fabric of life. He further argues that in matters of health, the community is expected to have its normal line of defense or the level of health the community has reached over time, and may include characteristics such as a high rate of immunity, low infant mortality, or community income level. The normal line of defense includes the usual patterns of coping, along with the problem-solving capabilities: it represents the *health* of the community (Neuman, 1982).

Freire (1995:107), in his arguments on democracy and conscientisation, provides a further dimension to the conception and role of community in the "Community as Client" model as central to

“... a dialectical ...relationship between world and awareness, between economic production and cultural production, ...[drawing] attention to the contradictory movement between culture's "negativities" and "positivities".”

Based on these explanations, it would imply that the community's response to matters of health when need arises may include strategies such as neighbourhood mobilization against an environmental stressor such as flooding or social stressor such as activities aimed at prohibiting divergent pop culture among youth which potentially exposes them to

sexually transmitted diseases, including HIV/AIDS. The communities are thus multi-system entities whose operations are consistent with an ecological viewpoint that everything is connected to everything else (Orr, 1994). In health care services delivery, this model raises need for a systemic understanding of this complexity of the communities, and calls for community assessment as a pre-requisite for defining means for providing health services.

Within the community are also internal mechanisms that act to defend against stressors. An evening recreational, counselling, or church programme for youth implemented to decrease vandalism, and a free-standing no-fee health clinic, to diagnose and treat sexually transmitted diseases are examples of lines of resistance that a community could have to strengthen its defenses on matters of health, and represent the community's strengths.



Stressors are tension-producing stimuli that have the potential of causing disequilibrium in the system, constituting what Freire (1995) would refer to as sources of oppression, because stressors may originate outside of the community (e.g., air pollution from a nearby industry) or inside the community (e.g. lack of a health services unit in the community, unavailability of medical supplies in the local health unit, poor or lack of proper planning, or closure of the clinic). Stressors penetrate the flexible and normal lines of defense, resulting in disruption of the community. Inadequate, inaccessible, or unaffordable services are stressors for a community.

The degree of reaction is the amount of disequilibrium or disruption that results from stressors impinging upon the community's lines of defense. The degree of reaction may be reflected in mortality and morbidity rates, unemployment, or crime statistics, to name a few examples. It is, however, observed by Neuman (1982) that the outcome of a stressor

impinging on a community is not always negative, for it can also be positive. For example, in the face of a crisis people may band together, and develop a community group to deal with the crisis. Freire (1995: 106), referred to this as “the *intervention of the intellectual as an indispensable condition of his or her task.*” The intellectual observed here by Freire is a reflective member of the community, who undertakes the “reading of the world and reading of the word.” (1995: 105). Such individuals in a community may continue to function after the crisis is over, strengthening the community and continuing to contribute to its “health”. In Uganda, a good example relates to the spontaneous family nursing care offered to an HIV/AIDS patient at family level. As a country that had a very high incidence of the AIDS scourge, the health care system alone in Uganda was unable to meet all the patients’ care needs, and family input made a significant and an invaluable contribution to patient care.



The community’s inherent subsystems, its lines of defense and resistance, stressors, and degree of reaction comprise assessment parameters for the community health care unit that views the “Community as Client”. *Analysis* is a process that synthesizes the assessment information and derives from it appropriate diagnoses specific to the community. Analyzing data on the assessment parameters “leads to the community health care provision decision-making or diagnosis” (Stewart, 1982:39). Table 2 below presents a comparison between individual and community health service (care) decision-making.

The community health care service delivery gives direction to both health care goals and interventions. Its goals, Freire (1995); Stewart, (1982); Tien and Chee, (2002) would argue, should be derived from analysis of the stressors, and may include the elimination or alleviation of the stressor strengthening the community’s resistance through strengthening

the existing lines of defense in the community. By a critical analysis of the community's degree of reaction, the decentralized health care unit can plan interventions to strengthen the lines of resistance through one of the prevention modes.

Primary prevention is a health care service implementation that aims at strengthening the lines of defense in the community so that stressors cannot penetrate to cause a reaction, or at interfering with a stressor by taking action against it. An example of primary prevention in Uganda is the immunization of infants to increase the percentage of immunized youngsters in the community. Secondary prevention on the other hand is applied after a stressor has penetrated the community, like the National Community Outreach Programme on HIV/AIDS on community awareness creation initiative, which educates communities about the dangers of HIV/AIDS, and on safe sex (Uganda AIDS Commission, 2002). Any form of health care intervention contributes to supporting the lines of defense and resistance, hence minimizing the degree of reaction to the stressor. Conducting a blood pressure screening, ante natal/post natal support for mothers, and referral programmes in an identified high-risk community, are examples of secondary prevention. Such programmes are aimed at early case-finding to reduce the degree of reaction (e.g., the incidence of strokes, proper nutrition or supplementation of expectant or young mothers). Tertiary prevention is what is applied after the stressor penetration and a degree of reaction have occurred (Neuman, 1982). The implication here is that there has been system disequilibrium, and the tertiary prevention is aimed at preventing additional disequilibrium and at promoting equilibrium in the health status of the community. As an example, an epidemic such as Ebola virus infection has occurred and a number of individuals are infected (and have physical and psychological presentations). A team of specialists (including support from community health care units) would be required to carry-out an assessment of

medical and social intervention as a means to re-establish equilibrium in the community (Tien and Chee, 2002).

Table 1.2 Nursing diagnoses: comparison of individual and community focus

Response	System/Function	Source of Situation	Manifestation of Problem
Individual Patient behavior Example: Alteration in status	Bio-psycho-social spiritual Oral integrity	Aetiology Loose fitting dentures	Symptoms from head to toe assessment Oral pain; redness in mucosa; open sore, etc.
Community Degree of reaction Example: Increased Respiratory disease	Community sub-system	Stressor Air pollution	Systems assessment (e.g., rates) Increased hospital admissions for respiratory problems; higher rate of chronic obstructive pulmonary disease readmissions

Feedback from the community provides the basis for evaluation of the community health service unit's interventions and level of operation. Often the parameters that are used for assessment are also used for evaluation (Stewart, 1982). For example, after the immunization programme, did the morbidity rate for the target disease among children significantly decrease? How many persons with hypertension were identified and referred for medical care? Were additional precautions instituted in the community? Concerns over these questions in provision of health care services at central as well as local government levels, as Victoria (2003) argues, would reflect the process of working with the "Community as Client". Interconnections overlap, and interdisciplinary considerations must be the rule rather than the exception.

Considering the "Community-as-Client" Model (Figure 1.2) once more, the goal represented by the model is system equilibrium, a healthy community, and includes the preservation and promotion of community

health. The model target or “patient” is the total community system, the aggregate, and as such includes individuals and families. The *actor’s role* (i.e., the decentralized health care unit’s role) is to help the community to attain, regain, maintain, and promote health. In this context that Pariyo (1999), in his analysis of the decision making process on allocation of resources in decentralized care in Uganda advocates that a decentralized health care unit should, in this respect, contribute to the regulation and control of system responses to stressors that are the source of difficulty.

The interventions in the model relate to initiatives directed at actual or potential triggers of disequilibrium that otherwise would lead to inability of the community to function. The intervention mode is comprised of the three levels of prevention: primary, secondary, and tertiary (Neuman, 1982). The consequences intended in this model include a strengthened normal line of defense, an increased resistance to stressors and a diminished degree of reaction to stressors in the community. A summary of this analysis is provided in Table 1.3 below.

Table 1.3 "Community as Client Model: Application of Essential Units of Health Care Provision

ESSENTIAL UNIT	COMMUNITY-AS-CLIENT MODEL
Goal	System equilibrium
Target	Total community system
Actor’s role	Assist to attain, regain maintain and promote health stressors.
Source of difficulty	Stressors
Intervention focus	Inability of community to function.
Intervention mode	Prevention (primary, secondary, and tertiary levels).
Consequences intended	Strengthened normal line of defense: increase resistance to stressors, decrease degree of reaction.

1.9.1 Relationship of Model to Theory and Practice

The primary emphasis in this section has been placed on the use of a conceptual model in community health practice (Clark, 1992). Model development comprises the identification of key concepts, and their placement in a logical order with clear definitions and defined relationships.

Besides meeting criteria of clarity and logic, the “Community as Client” model possesses social congruence, social significance and social utility in what would bring about equity and effectiveness in healthcare delivery (Mills et al. 1990). As will be presented later in the results, chapter and discussion sections, society’s expectations of health care service delivery and its action based on the model parameters make a useful premise in the analysis and explanation of a decentralized health care system as practiced in Uganda.



The “Community as Client” model as presented here provided this study with a theoretical framework for health care service delivery. The relationships and assumptions of the model adopted from its original applications to nursing practice are herein used to explore and explain health care service delivery in the decentralized setup in Uganda.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Prior to the upheavals that beset northern Uganda for two decades during the 1970s and 1980s the country had the best health indices in the sub-region (Dodge and Wiebe, 1985:69-70). The period of decline led to the collapse of the health sector and to a reversal of progress made so that the Ugandan health indices (in particular northern Uganda) at present are probably the worst in the sub-region.

While interventions, which have been made over the last 15 years have resulted in some tangible progress; there remains much to be accomplished in the development of the health care system to reach acceptable levels of health care. Accessibility to basic health care services, measured in terms of the population living within five kilometres of a health care facility, is estimated to be 49% country wide with only 42.7% of the parishes having any type of health facility, with a wide variation between rural and urban areas and between different districts according to the Ministry of Health (MoH, 2000:8).

Under the current Government Policy on decentralization and liberalization, roles of health practitioners both at the centre and at local government level have changed. In addition, the role of the private sector and the interaction of the private with the public sector, have become more prominent. This chapter presents an analysis of writings from different sources on health care services delivery and its impact on communities.

2.2 Concept of Decentralization of Health Care Services

The MoH in Uganda has developed a National Health Policy, which is cognizant of a decentralized health service system in the country. As noted by the MoH (1999b, 1999c and 1999d), each year millions of vulnerable people, especially children, die unnecessarily of disease and malnutrition, because they lack access to basic health care and nutrition (MoH, 1999). Uganda is focusing its health response to this crisis in three areas: Emerging and Re-emerging Diseases (HIV/AIDS and Tuberculosis), Maternal and Child Health and Emergency Health. Ongoing efforts are analyzed where the MoH trains local health promoters, volunteers and caregivers to advocate and teach proper health practices concerning as breast-feeding, sanitation and the detection of early signs of disease in children. This network of health promoters, including youth/peer educators, is the critical community link between national and local health prevention programmes such as vaccine campaigns, distribution of bed nets against malaria and HIV/AIDS awareness.

Decentralization is viewed as the transfer of power from the central government to regional and local levels. In the case of Uganda, this would translate to the districts, municipalities, town councils and sub-counties, which then, in theory, would be made responsible to the management of their services and the use of their resources. According to the Government of Ugandan Constitution (1995) the policy framework provides for four aspects of decentralization. These are: delegation, deconcentration, devolution and privatization. The type of decentralization practiced in the past in Uganda and other developing countries could be described as deconcentration, for example: decentralization to the office of the District Medical Officer was a means to provide a satellite MOH office at district level (Bukonya and Ziegler, 1997:5).

The current national policy on decentralization refers to devolution, which is, the transfer of power to sub-national units of government (local authorities and local government) whose activities largely fall outside the central government's direct control with respect to a defined set of functions. The local authorities usually have a clear legal status, recognized geographical and administrative boundaries (Nsibambi, 1996). They also have the statutory authority to raise revenue and budget for expenditures. Local authorities in Uganda include all district administrations, municipal councils and the Kampala City Council. According to article 189 of the Ugandan Constitution (1995:75), these local authorities are, although not completely autonomous, largely independent of central government in their areas of responsibility. The centre usually retains significant influence, especially over policies and resources.



The World Health Organization's concept of district health system as a basis for primary health care is being implemented in Uganda (Ndie, 1988). It includes all institutions and individuals providing health care in the district namely (governmental, social security, non-governmental, private and traditional).

According to the Government of Uganda Local Government Act 1997, the Resistance Council Statute of 1984 created standing committees of the District Resistance Councils (DRCs), which are policy-making organs. One of these committees is the District Health Committee (DHC) made up of seven councillors appointed by the DRC and the District Health Team. This committee reviews all aspects of health services in the district and makes health bylaws where appropriate.

The Government of Uganda in its Constitution of 1995:117, interpreted in the context of decentralization of health services in Uganda anticipated to achieve the following:

- Organization of more rational and unified health services.
- Greater involvement of local communities.
- Cost containment and reduction in the duplication of services.
- Reduction of inequalities.
- Integration of activities of different agencies and organizations involved in health care.
- Strengthened health policy and planning functions of the Ministry of Health.
- Improved implementation of health programmes.
- Greater community control and financing to enhance ownership.
- Improved intersectoral co-ordination.

With these lofty provisions of decentralization in health care services, this study aims to explore the congruency between the objectives of decentralization of health care services and society's expectations of health care services' delivery. It was necessary to determine the extent to which decentralized health care services in practice were articulated by the "Community as Client" (CAC) model presented.

2.3 Central Government Involvement in Health Care Provision

The legal basis for the central government's involvement in health care is enshrined in the Constitution of Uganda (Government of Uganda, 1995), which gives the Parliament power to promote the general welfare, the effective planning and implementation of which is seen as accruing from decentralization. The question arises as to how the general society should define and determine general welfare and decentralization, and how the two concepts are linked in practice to health care. Both before and after the drafting of the 1995 Constitution, there have been debates about the question of decentralization and the role and responsibility of the central government.

The unique feature in Uganda's decentralization policy, as it relates to health care service provision, continues to be the total disregard to inequity among the different regions in terms of availability of health units, personnel and local government's potential to harness resources needed to develop functional health care service provision units. Decentralization and the establishment of self-sustaining units of governance under which all members of the society have equal access to certain basic commodities, namely, education, food, shelter and health care under equal opportunity legislation are held as overriding values to which the actual status and needs of an individual are subordinate. This approach has inadvertently led to the unequal evolution of a health care delivery system in which relatively richer locations have better resourced health units accessible to their communities than in other locations. As Moccia (1984:485) has observed, such policies suggest a willingness to sacrifice a nation's health in the cause of decentralization. Moccia states "...[in order] to sustain a valid social contract, it is clear that in matters of health care we must develop alternatives to the status quo that take into

account the interdependent relationship between liberty and equality” (1984:481).

This demands a critical consciousness of the dilemmas alongside rights of individuals and communities, and to have these appropriately addressed and monitored in various commitments at the central, as well as at local government levels.

2.4 Decentralization and Changes in Health Care Service Delivery

The Ugandan Ministry of Health’s Health Sector Strategic Plan (HSSP, 2003), in its overview of health care and development from 1991/92 notes that most district development plans in Uganda for 1993 and thereafter, indicate the peak period of the social services decline as being between 1986 and 1990, when cattle rustling and rebellion destroyed the quality of the health management services system. The system was affected to the extent that the entire infrastructure was destroyed, health workers like other civil and private sector workers were displaced and resources like drugs were very scarce with the whole system coming to a standstill in most places. From the 1990s there are efforts by the government to renovate and re equip some of the facilities that were damaged during the war with the assistance from the donor community.

Whereas, in view of the power and authority wielded by government to make decisions and establish law and order in society, the MoH (2003) acknowledges the central role of government as: best placed to undertake and play certain roles in the broad political economy, as well as in the individual social service sectors, including health care. These roles are never static, as they shift in accordance with changes in political, economic and social situations. The need to re-examine the

traditional roles of government is not unique to Uganda. Many other countries have recently begun to re-define the roles of government in health.

The World Bank Development Report (World Bank, 1997) has a comprehensive analysis on the changing roles of government, not just in health issues, but in other sectors as well. The report emphasizes the need for government to focus its attention on the provision of public goods, protection of the poor and in regulating the private sector. Yet up-to-date, decentralized health care service provision units in some areas in Uganda have only one health care service structure that has not been completed; it is situated at the headquarters and the working conditions have not improved since the 1960s despite the relative peace prevailing and implementation of decentralization policies that started in 1993 in a few districts. All the districts are by now involved.



According to the MoH Draft Health Policy Paper for 1999-2004, equitable distribution of health services should be assured throughout the country. Priority should be given to all further decentralization of health care delivery systems so as to ensure effective access by all sections of the population to the national minimum health care package.

The district health situational analysis in the MoH-HSSP (2003) reveals that the health status of the people of urban and rural communities in Uganda is poor. Poverty, illiteracy (mainly of females (68.2%) are rampant. High fertility with Crude Birth Rates (CBR) of 5.6% and a Total Fertility Rate (TFR) of 6.62% respectively. Corresponding with this, a low contraceptive prevalence rate of 4.7% are associated with high morbidity and mortality rates. A national average for Crude Death Rate (CDR) is 20.8 per 1000, while life expectancy at birth is 50 years for females and

44 for males. These population indicators place Uganda among the poorest nations of the world, with a significant need for quality health provision.

The critical view of the MoH-HSSP (2003) draws attention to the state in which the national (public) health system components exist in the local jurisdictions. Of concern are the principles guiding and driving health care provision in practice; how health care is practiced in a decentralized mode helps communities respond to health needs. The “Community as Client” model earlier presented advances the ability of health systems, communities and individuals to effectively respond to health needs through the application of primary health care principles. The principles applied to advance health include consumer and community participation, self-management and reliance, intersectoral collaboration and partnerships, prevention, health promotion and integrated care. The principles require the search for a balance between macro and local needs and between short and longer-term gains in health, recognition of the inequalities in health between groups and in access to policy development and resource allocation processes.

Private providers are on their own and, save certification for operating private practice units, have virtually no link to the urban local government or NGO services particularly in monitoring their performance. Some of the private health care providers operate without registration. Traditional healers are not formally recognized as important actors in health care provision. By now there is a change as the MoH through the districts have provided some training to the traditional birth attendants (TBAs) and traditional healers on safety measures (UNFPA – Uganda 1995: 2). Also the MoH provided delivery kits to the trained TBAs.

Health care services are inadequate both quantitatively and qualitatively. Quantitatively there is only one health unit in the local jurisdictions, giving a health unit to population ratio of 13,674, which is far greater than the national average of 11,953 (MoH, 2000).

The Health Facilities Inventory (2000) indicates that the population within 5km (1 hour walking distance) from one health unit in the Pallisa district is only 33% compared to the national average of 49%. Even the health centre ratio of 2,352 persons per centre is too high compared to the national average of 760 persons.

In its analysis of one the smaller municipalities of Uganda UNICEF(2003) revealed that accessibility and use of safe and adequate water coverage in Lira by county has an estimated improvement over the 1993 status of 25% and a 53% increase in decentralized health service provision units. The UNICEF hygiene intervention, in its situation analysis 1994 noted that excreta disposal and latrine coverage in the Lira District is 36.6% with the Lira local jurisdiction ratio of 4:1. Excreta disposals for children are mainly dumped in the compound or around the homestead, 58%, latrine 39% and other methods, e.g. burying 6%. These findings by UNICEF are not unique to Lira, as other local government centres have similar situations and circumstances as the next sections show. The study conducted by UNICEF in Lira further indicated that the excreta disposal facility was on average 31 meters or further from the water source. About 85% on average are 11 meters or more away from the house in which people live. The common problems reported by locals to the UNICEF study team for not constructing latrines at all are: hard rock, lack of digging tools and lack of cover materials, all of which have a direct implication on the poverty status of the local communities in the Lira district.

2.5 Health Inequalities: Geographic and Social Factors

The study of the local jurisdiction's three year rolling development plans contained in the Uganda MoH Draft National Health Development Plan 1999-2000), is informative. This report reveals that immunizations coverage is 34% for children under five, yet the service targets all the children under five, females of child-bearing age and pregnant mothers. The services are carried out at the local jurisdiction health centres once a week. The MOH's health strategy is for each district or municipality to implement a minimum of 6 out-reaches per selected local centres per month, but due to lack of means of transport and staff motivation, the report acknowledges that these out-reaches are non-operational in almost all districts and municipalities in the country.

Health services in decentralized health care service provision units include district hospitals, which handles all sorts of cases district wide. A single hospital per district has proved insufficient in handling public demand for health care. Supplementation by private clinics, drug shops and maternity homes have emerged in many locations all over the country. There are also traditional medicine centres for those who venture to go there.

Olico-Okui (1994:5-16) from the Makerere University Institute of Public Health, in Kampala, has examined the public health concerns, calling for reforms of health care reforms in Uganda. Olico-Okui's report has pointed out that the coverage of safe water supply in decentralized health service provision units has increased in the town centres especially since the revamping of the National Water and Sewage Corporation (NWSC) and investment under Peri-Urban Infrastructure development (PUIP) micro-works. The situational analysis, however, notes that other sources of

water are accessed by 92% of the population. According to Olico-Okui (1994), many people don't think of water as a public health issue, noting on the contrary that water is the biggest public health challenge for Uganda as it is for many poor nations.

Most Nigerians in rural areas get their drinking water directly from rivers, streams or ponds; which include unprotected springs, water holes, swamps and rain water (Olico-Okui, 1994). These sources are often responsible for outbreaks of water-borne infections such as cholera, dysentery, diarrhoea and typhoid. Olico-Okui's paper further complements the efforts directed at increasing latrine coverage from 92.1% to 99% by carrying out sanitation campaigns, contribution of Ventilated Improved Pit (VIP) latrines to schools, markets, sanitation education in schools and other public places. The report has also revealed the appalling mechanisms used on waste management, which consists of solid waste collection from sources like residences, commercial premises, carpentry workshops, local brewing points, markets, medical centres, industrial centres, restaurants, and wrappers (buvura) that are often thrown by the roadsides, and from school locations. Waste collection is mainly done with the assistance of poorly designed wheelbarrows, open trucks and skips. This is delivered to temporary collection points from where the trucks or tractors ferry the waste to final dumping sites. These sites are themselves often located near community settlements, with poor design of landfills which simply concentrate toxic pollution to air, soil and water.

According to the American Red Cross (2001), the Africa Women's Initiative (AWI) is a joint effort by the American Red Cross and African Red Cross societies to reduce the high rate of maternal and child mortality in Africa. AWI is a five-year, integrated, community-based health education and advocacy programme with a gender component. Spanning

from July 2001 to July 2006, the programme aims to recruit and train a large number of volunteers who educate women about health issues. Through AWI, youth volunteers are engaged to work with their peers to develop family life skills and prevent infectious diseases such as HIV/AIDS and STDs. Local volunteers are also trained to help women and young girls develop vital family life skills and learn about reproductive health and other primary health care issues.

AWI started in Namibia and Tanzania on a pilot basis. Through AWI, the American Red Cross is working in partnership with the local Red Cross societies, Government Ministries of Health and local stakeholders to improve the long-term health status of women in these countries.

In most countries, disparities in health care service provision have been found to exist by sex, race, ethnic group, language, occupation and residence. Researchers in Bangladesh, for instance, have found multiple disparities in childhood vaccination, with girls, ethnic minorities, and children in isolated regions less likely than others to be immunized (Chowdhury, M.A., 2002). The effects of poverty on health are often exacerbated by discrimination and exclusion from health, education and other services. Disparities by social group can be more pronounced than differences based on income alone. For example, in South Africa, as reported by Gilson and McIntyre (2001:198), in 1993, under apartheid, black children in South Africa were 5.5 times as likely to die before their first birthday as white children. Poor children of either race were 2.9 times more likely than better-off children to die during this period.

Women and girls often face discrimination in health and special obstacles in accessing health care. In India, Haub and Charma (2003) noted that the mortality gap between boys and girls has been increasing over time.

They noted that at the time of their study, an estimated 2 million girls age six and younger were “missing” due to sex-selective abortion and neglect in health care and nutrition.

When services are difficult to reach, travel costs may be more prohibitive for women than for men. The main reason for this is that women among the poorer communities generally earn less than men and have less control over how household resources are spent (Carr, 2004:8). Cultural norms and domestic chores and responsibilities may also restrict women from travelling long distances, especially alone, to obtain access to health services.

Landman and Hendley (1998) describe the approaches and experiences pursued to meet the urgent primary health needs of rural South Africa. Guided by the notion of *Phelophepa* (a Zulu expression meaning 'good clean health') a Health Train was established in 1993 with the support of the South African government. The initiative covers remote rural areas in South Africa using the extensive rail network. It is innovative in that it both provides specialist audiometry, optometry and dental clinics at the train stations and uses the railway access to provide the same service to nearby rural schools. The Phelophepa Health Train (PHT) was conceived with a strong primary care emphasis. Training health promoters from the local community to educate rural people and support the work of community nurses is one example of its capacity building objectives. Another is provision of health promotion and screening, a programme of school visiting and screening by health teams, whose function is provision of counselling and dental services.

The emphasis of the various strands of PHT demonstrates the central place given to primary care in the recent White Paper of the Republic of South Africa which outlines the re-organization of its health care system.

The equity question of Primary Health Care is well brought out by Albertyn and Goldblatt (1998) who note that in 1994, when free primary health care was introduced as part of the new government's ambitious attempt to make its health system accessible and equitable the notable outcome was, that the gap between black and white patients remained. Albertyn and Goldblatt (1998) observed that when the Government of the African National Congress headed by President Nelson Mandela came into power in 1994, seven times as many black infants died as white infants, with the classic preventable conditions of poverty, like malnutrition, diarrhoeal diseases and measles, taking a heavy toll on the communities. They also note that in 1994 nationally in South Africa, each doctor had to care for 1,340 patients. But in the ten black homelands some 15,000 people had to share one doctor. Furthermore, two-thirds of the country's total spending on health, and nearly two-thirds of the country's doctors were devoted to a tiny one-sixth of the population, almost entirely white, who could afford private care. This is exacerbated by the fact the state services were concentrated in cities, leaving rural areas unserved.

2.6 Impediments to Successful Implementation of Health Delivery

The South African Primary Health Care study by Albertyn and Goldblatt (1998) has interesting pointers to challenges of health care provision. In their analysis of the Phelophepa Health Train (PHT) initiative, they note that PHT cannot attempt to tackle chronic diseases, although its screening activities do uncover new cases referred to local national health workers. Lack of continuity, the shortages in permanent services in

many areas make follow-ups difficult, and the huge unmet demands in rural communities as the train pulls away can be seen as indicators that the PHT is clearly an imperfect solution.

But, for rural areas where apartheid had meant no investment in the health of communities, all solutions are likely to be imperfect in scale and provision for some time to come. It is at least providing a minimum level of service across these remote rural areas. It may play a role as a catalyst for the development of services and, perhaps most importantly, at best; keeping people's hopes alive (Albertyn and Goldblatt 1998).

The governments world-wide are not necessarily working on health care service delivery in isolation, but with some partners either in provision of funding and/ or in actual delivery of health services directly to beneficiaries. A number of such aid agencies work in partnership with government. The challenge here is on the matter of a collaboration framework and assignment of responsibilities. This study identifies three areas of concern. The first is the importance of the process in developing contracts or agreements on division of responsibilities. The second is the link between inter-governmental contracts and the integration and co-ordination of the health system as a whole within the decentralized set-up of health care services delivery. Thirdly, there is the link, between inter-governmental contracts and the philosophy and principles of the primary health care approach in the country.

A comprehensive drug system study to investigate the structure and mechanism of national distribution of drugs in Uganda was conducted in 1992. The report of the study provides a clear picture of the critical needs for coordination and accountability for all essential medical supplies as a mechanism to improve fundamental goals for PHC. If essential drugs are

available, clients are more likely to come to public health facilities to receive care. Thus the plans derived from the drug system study for improving drug supply will be especially important in expanding PHC services, particularly into rural areas.

One of the most challenging but potentially valuable strategies in equity considerations are raised by Albertyn and Goldblatt (1998) who state that the emergence of private health care providers will increasingly raise debates over matters of user fees, and the implications of these to establishing functional public/private partnerships. As secondary and tertiary interventions as per “Community as Client” model, these partnerships involve the private sector in improving access of public-sector clients to quality, affordable health care services in three ways:

- 1) make the services of private practitioners and entities available in public facilities at a reasonable cost;
- 2) sign contracts with private providers to provide services in public facilities at no cost to clients who cannot afford to pay; and
- 3) produce a source of potential income for public hospitals by allowing private patients to use the facilities and pay a fee for doing so.

Global 2000, a non-governmental organization, has made clean water its top priority. However, even with the donations it has received from the Gates Foundation and from drug companies, it lacks the resources for the major, capital-intensive projects that are needed to address the problems adequately. Those agencies that have the budgets like UNICEF, the World Health Organization, and the United Nations Development Programme acknowledge the need for clean water.

In one municipality in Uganda, a local jurisdiction’s three years Rolling Development Plan 2001/2-2004/5 revealed that there are a total of seven

primary schools spread throughout the four division of the local jurisdictions. However, quality and range of health management services provided at the only health unit is low and limited respectively, and there is a limited functional referrals system to enable school children to access health services which are not available at the lower level health unit. And that resulted in:

- a high rate of school drop out (21%)
- gender imbalance in primary schools enrolment favouring boys with a high rate of drop out for girls-especially in the upper primary grades (about 27%)
- poor performance of primary education in decentralized health service provision units (Lira 2001/2002 – 2003/2004).

Considerable improvement is required to ensure that decentralized health service provision units have basic resources and facilities for health service provision. The constraints faced by the decentralized health service provision units in the delivery of quality health management services are attributed to many factors. The factors include but are not limited to:

- 1) Inadequate local revenue sources (30.6%), which cannot purchase drugs adequate to cater for the ever-increasing number of patients.
- 2) Inadequate human resources to handle the overwhelming pressure on its services due to a population increase estimated at 60,000-80,000 residents per Local Council V level (Ref: Figure 1, Chapter One). The majority of the population 53.5%, are under five years which together with female population constitute the 'vulnerable groups' needing special care such as immunization, control of disease, proper nutrition, early diagnosis and treatment of diseases, clean water and sanitation.

- 3) Inadequate funding priority and expenditure (5.4%) to purchase necessary item needed for health care services such as the means of transport for mobilization, vaccination and supervision, uniform for staff, protective wear, opening of outreach centres, construction of dispensaries in all divisions and the construction of a recycling plan to turn the organic particles of refuse into useful products which can be sold for sustainability.

The Health Situational Analysis of selected local governments in the MOH-HSSP (2003) report reveals that poor reporting and record keeping is one of the major problems in health care services. This does not reveal the true magnitude of the problem for further action and intervention.

Funding for the health sector from the local jurisdictions is meagre because local revenue is low as a result of a poor population. Programmes to enhance household incomes coupled with vigorous financial mobilization are needed. The District Health Situational Analysis of local government reveals that there is an absolute and relative shortage of trained health personnel in the health facilities in the local jurisdictions. Local jurisdiction health centres are severely affected. Health workers are demotivated and demoralized; they have no job descriptions and are lowly paid (MOH, 1999c). Some health workers have no housing and do not even receive a housing allowance. Working conditions are not satisfactory due to a lack of equipment or because the apparatus is very old and in a poor state. The management of the health services is taking place in a weak policy environment. There is neither a written mission statement nor written policies. Policies defining Municipal Health Service (MHS) or on PHC and cost sharing are urgently necessary to give direction to the health sector (HSSP, 2003). Furthermore, planning is weak because of insufficient capacity, lack of

appropriate technology (equipment), poor data collection and management.

Transport requirements for the health services in the local jurisdictions are not quantified. The local jurisdiction health department has no motor vehicles. Management arrangements for means of transport are inadequate. A transport policy is needed to address these issues. Co-ordination of various actors in health care services in the local jurisdictions is lacking and needs to be strengthened. In this respect the use of a Health Management Information System ought to be strengthened. A referral policy and system need to be worked out and implemented. The role and relationship between the local jurisdiction, the Principal Health Inspector and the local jurisdiction health centre need to be clearly defined. Support supervision is both quantitatively and qualitatively inadequate and must be improved. An injection of resources and know-how are prerequisite. Community participation in health care other than through mandatory user fees, protection of springs, and the construction of latrines need to be strengthened. The reasons for the malfunctioning system at local level are the lack of mobilization of the communities, organization and poverty.

2.7 Public-Private Partnership in Health Care Provision

Governments may opt for alternatives to the direct delivery of services by developing partnerships with non-government providers (Gwatkin, 2003). As Gwatkin has argued, in many countries, non-government organizations (NGOs) receive public support to deliver health care services to the poor and vulnerable segments of society. Since many NGOs already work closely with the poor, it may be argued that they may be better equipped to identify and serve the poor than governments. Furthermore, in some countries, NGOs may also have greater flexibility

and more accountability than centralized, hierarchical bureaucracies (Bhuiya, 2001).

NGOs have been very effective in some settings. In Bangladesh for example, health and other development related services have been boosted by NGOs with benefits to more than 2 million families (Bhuiya, 2001: 229).

In other countries, public-private partnerships extend services to low-income or rural groups. In Ghana for example, private non-profit organizations, which make up what is popularly called the “mission” sector because they are mainly faith-based groups, reach an estimated 30% of those seeking health care, predominantly in rural settings (Chandana, 2000). Similarly in Bolivia, a non-profit organization was created within a private-public partnership to provide high quality health care services to low-income groups. This organization has grown from two health centres in 1985 to thirty in 2000, serving more than 500,000 low income Bolivians, at unit costs that are much lower than those of their government. Its staff and operations were more efficient, winning the organization greater trust among the client communities.

2.8 Implications of Decentralized Health Care

Service Delivery to Education

One of the most challenging health care problems since its appearance on the health map in early 1980s is the onslaught of HIV/AIDS scourge with over 20 million victims world wide, with cases in Africa constituting an estimated 90% Uganda alone has at least 1.5 million victims, or about 6% of the population, down from 18% in 1991 (Uganda Aids Commission Annual Report, 2002). The rapid degenerating health status of the victims arising from a collapsed immune system has immense medical and

psychosocial needs. Public awareness campaigns through media, public rallies, churches, mosques, including funerals have been used to educate the local population in Uganda on how to eliminate or minimize exposure risks to the HIV virus. Various medical and paramedical workers are trained on HIV/AIDS victims' management.

According to the results of a USAID study (1997) on national HIV prevalence survey in South Africa, which was based on women attending public antenatal clinics, HIV prevalence nationally has increased by 36% in one year compared to the 1996 data, to a level of 14.17%. The variation in prevalence rate among the nine provinces is dramatic from a low of 3.09% to a high of 25.13%. USAID's strategy for assisting the national HIV/AIDS/STD program in South Africa will likely involve three interrelated activities:

- 1) capacity-building, with a focus on the provincial level in selected provinces; 2) advocacy and political leadership; and
- 3) targeted intervention-linked research. USAID recommended that the bilateral agreement for this new activity be immediately executed, with implementation beginning soon after.

Following convincing evidence and pressure exerted by USAID, the South African Government conducted a training needs assessment for the more than 500 nurses in the Eastern Cape Province. This marked the first time such an assessment of skills was done in the province, and it highlights the critical training needs that governments need to undertake to ensure that nurses and other medical workers will have the skills and motivation necessary to provide high-quality, integrated PHC services. Based on the assessment, comprehensive training plans can be developed to target the highest-priority needs in the near future (USAID).

2.9 Summary of Chapter Two

This chapter has explored a range of national and institutional strategies and experiences in provision of health services to particularly the poor communities, drawing from several examples of countries and framework of operations. These have provided a backdrop to the explorations of this study, which can be seen later in chapters four and five. The next chapter presents the methodological designs that were pursued in this study.



CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This study set out to examine the challenges associated with the decentralization of health service provision in Uganda. To achieve this aim, the investigator followed a carefully laid out procedure, including the following:

- Deciding on a research design
- Setting a number of criteria for sample selection and scope of the study
- Developing a number of instruments for data collection
- Data Collection and analysis
- Identifying a number of key concepts to focus on

Details of these procedures are presented in the sections that follow.

3.1 Research Design

This study employed a descriptive case research design using qualitative research techniques. This research design has been selected because it is difficult for a researcher in this kind of study to manipulate the independent variables. Rather, the variables are taken as they occur in their natural setting. Cohen et. al (2000) contend that descriptive research is particularly suitable in social or educational contexts where the independent variable cannot be manipulated by the researcher. For example, variables like social economic status; sex or intelligence are outside the control of the researcher.

Questionnaires with simple structured questions, and interviews with open-ended questions eliciting common meanings, perceptions and experiences among various health workers, policy makers in the MoH,

patients and care givers of patients on health care service provision during a period of decentralization in Uganda. Document analysis was also undertaken to examine documented policy guidelines and plans as well as reports on the quality of health service provision.

The data collection was also enriched by the researcher's personal experience as a nursing officer for the last fifteen years, as this accorded my visits to various health units in sample areas an added insider's view, which enhanced observations of what was happening at various health unit sites. The responses of participants provided tangential paths for reflection and formed a basis for further discussions through interviews guided by key research questions as detailed in the procedures and research instruments as presented in the sections below.

3.2 Study Area

Six districts were randomly selected for this exploration, namely Soroti, Pallisa, Kampala, Wakiso, Lira and Gulu. In these settings, where it was feasible, urban and rural health units were considered and visited. The health units visited included Soroti Regional Hospital (urban), Serere Health Centre (rural), Entebbe Grade A Hospital (urban), Pallisa Hospital (rural), Lacor Hospital (rural: missionary owned), Kamuge Health Centre (rural), Lira Hospital (urban), Mengo Hospital (urban: missionary owned), and Mulago Hospital (urban: this is the national referral hospital in Uganda).

3.3 Study Population, Sample and Selection

Key participants in this study included three categories of informants, namely: health workers, patients or their attendants, and the district health managers.

Key participants among health professionals were selected for the purpose of this study from the following strata of health service providers: doctors, paramedicals, nurses and midwives on the basis of their professional registration status. A similar sampling strategy was used to identify participants among policy makers (government and local leaders and district health officials). Patients and attendants involved were those who freely volunteered to contribute their experiences.

In total of 54 health workers in government and non-government institutions were selected. Of the 54 there were four medical doctors, 18 paramedical staff (also called allied health professionals), 21 nurses and 11 midwives. All these participants were purposively selected on the basis of their willingness and potential to respond to the interests of this study.



A total of thirty-six patients/attendants willingly accepted to share their experiences of health services from the health units which were visited during this study. Among the district health management team members, 11 participants at the Ministry of Health headquarters, as well as at the district and health unit levels, contributed by sharing their views with the researcher. An additional 28 persons were included in six discussions at focus group level held in three out of six sample districts as detailed in Chapter 4. The setting for focus group discussions (FGDs) were purposively selected and linked to the alarming sanitation and health problems observed by the researcher while in the districts concerned.

3.4 Research Instruments

The instruments developed were interview guides; a questionnaire, a document review guide and an observation schedule.

The Interview guides (Appendices 2 and 3), which also doubled as a focus group discussion (FGD) instrument, consisted of both semi-structured and open-ended questions. The semi-structured questions were designed to guide the participants to respond to key aspects of the research questions (Miles & Huberman 1994). The open-ended questions, in addition, “accorded opportunity for the respondents to express their perspective on the issues under discussion” (Neuman 2000:261). The health workers’, managers’ and patients/care-givers’ narrations of their experiences, feelings, beliefs, ideas, and actions (Merriam 1998) were elicited in this regard.

Questionnaires (Appendix 1) consisted of closed-ended and semi-structured questions and were used to survey health workers' biographical data, as well as their experiences of health care service delivery before and presently, during the decentralization process at the various levels of health units in the study locations.



The observation guide had provisions for the researcher’s personal assessment of infrastructure, health equipment, health unit set-up and operational activities. I was able to function at this level given my long-term professional profile as public health nurse and educator with more than 15 years of experience.

The document analysis was guided by the themes derived from the research variables as embedded in the objectives and research questions.

3.5 Validity and Reliability

Validity of an instrument as used in this study is consistent with the definition provided by Miles and Huberman (1994:37), as the “extent to which the items in the instrument measure what they are set out to

measure.” The validity of the questionnaire, interview guide/focus group discussion guide and observation schedule, was established through the critical assessment thereof by senior researchers at the Makerere University Institute of Public Health, in Kampala, and by the constructive criticism provided by the supervisors and fellow graduate students participating in the University of the Western Cape’s Graduate Students of Science, Mathematics and Technology Education Seminar Programme during the years 2002 and 2003. The comments and suggestions from this credible review audience were used in reviewing the instruments to assure their validity.

Reliability, according to Miles and Huberman (1994:48) “has to do with the extent to which the items in an instrument generate consistent responses over several trials with different audiences in the same setting or circumstances”. Besides the constructive suggestions from credible reviewers, the reliability of the questionnaire and the interview guide was established following a pre-test procedure before their use with actual research respondents. The questionnaire for health workers was pre-tested among the health workers working at Butabika hospital. Similarly, the interview guide for the patients and/ or their attendants, was administered by the researcher to the patients who had come to the same hospital for treatment of physical ailments rather than psychiatric conditions (Butabika hospital is a national referral psychiatric hospital).

The pre-testing of the research instruments were carried out satisfactorily, which re-assured their validity and reliability (Carmines and Zeller, 1979), because the instruments were found to generate data which could be linked to the research questions. The use of the various approaches (questionnaires which generated some quantitative data, and qualitative methods based on interviews, focus group discussions, observation guides and document analysis) provided a suitable basis for

the triangulation of data, which, as Guba & Lincoln (1985:283) argue, strengthen the reliability of the data captured.

3.6 Procedure of Data Collection

The researcher reported to the office of the Director of District Health Services and explained the purpose of the visit in order to obtain permission to carry out the study in the health units. Permission was granted and the sampled health units were visited and permission was also sought from the medical superintendents in the case of hospitals. In the case of health centres, oral permission was obtained from the officers in-charge. Having been granted permission to proceed with the study, the various cadres of health workers were identified, the purpose of the study was explained to each of them individually and oral consent was obtained from each before being issued with the questionnaire.



A period of one week elapsed before the researcher collected the completed questionnaires from the health workers. In the meantime, as the researcher waited for the health workers to complete the questionnaires, patients/attendants were interviewed after obtaining informed consent from each one of them. In the case of very ill patients or children, their attendants were interviewed instead and observations were carried out using an observation checklist. The key informants' interview guide was employed for the district health team members. The open-ended questions in the interviews accorded the necessary opportunity for free expression, which is in line with the argument of Cohen et. al. (2000:604) that:

Sharing beliefs openly upon beginning a study of a controversial topic and sustained, small group..., discussions that encourage sharing of the practices could bring beliefs to the surface to be examined not by

authoritative figure, but by a colleague- collaborator- and finally by the believer herself... (p.604).

Data, which is both qualitative and quantitative, were collected through the questionnaire and key informants' and patients' interviews as described above. The survey was conducted by means of a questionnaire and 54 health workers responded to this instrument. The survey respondents answered questions that were focusing on the social and economic background, then on perceptions of decentralization, aspects of decentralization and how decentralization has influenced health care services delivery and the challenges faced in the decentralization arrangement.

By assuming the role of participant observer, accorded by my more than 15 years' experience in the nursing profession and public nurse educator, some important technical information about the health units, and an understanding of some of the normal daily operations taking place, were logically placed into context.

The data, which were collected through key informants' interviews, was to supplement and validate the data collected from the 54 health workers. The data obtained was analyzed and the results are presented in chapter 4 starting with the socio-economic background of the respondents.

3.7 Data Analysis

Quantitative data gleaned from questionnaires were summarized in tabular form. A basic statistical spreadsheet was used to prepare some of the graphics to aid description of key variables. The qualitative data was analyzed using a thematic approach, through which common themes emerged from the qualitative data obtained through the interviews, the

document analysis and the health site observations. As Patton (1990:390) advocates, the common themes were collated and presented to highlight the specific characteristics as evidenced by the various data sources. Where so displayed, data interrelationships from various sources are pointed out.

3.8 Ethical Considerations

The ethical considerations pursued during the study focused on what Neuman (2000) upholds in social science research, namely: anonymity or confidentiality, and informed consent of the respondent. During this study, various informants were approached and their permission to participate and/ or provide information appropriately elicited. The process was preceded by informing them of the intents of the study, as well as their right to participate, abstain or withdraw from the study. All the informants were assured of anonymity and confidentiality.



CHAPTER FOUR

PRESENTATION OF RESEARCH FINDINGS

4.1 Introduction

This chapter presents the findings using tabular summaries of data as well as narrative descriptions of the statements gleaned from the research respondents, the document analysis, and the participant observation episodes. The analysis of what is presented in this chapter is an attempt to answer the following questions:

1. What is understood by decentralization in the context of health care service delivery in Uganda?
2. What changes in health care service delivery resulted from the decentralization with regard to initiatives, management and process, facilities and information flow in Uganda?
3. What were the challenges to implementation of decentralization in the health care service delivery in Uganda?
4. What implications might decentralization of health care services delivery have on the education of health professionals in Uganda?

The findings of the study are presented in pursuance of these questions, with discussion of their implications in the final chapter.

4.2 Overview of Context of the Study

Under the 1995 Constitution and various legislatures including the Local Government Act of 1997 and draft health policies in Uganda (1999-2004), the government is mandated to deliver a range of services to the population. These services include those in the health sector, particularly Primary Health Care (PHC), which entails provision of safe water, sanitation, information dissemination and regulatory services.

Table 4.4 below summarizes the health policy that is currently in operation. This policy which is a draft policy of MoH governs the key operations in health care service delivery.

Table 4.4 Summary of the Major (Draft) Health Policy in Uganda (1999-2004)

Policy Priority Areas of Government	2 Objectives of the Policy
1. Primary Health Care	<ul style="list-style-type: none"> To improve access to basic health care for all
2. Decentralization	<ul style="list-style-type: none"> To bring the management of resources closer to user/target groups. To improve efficiency and effectiveness of health care services
3. Health sub-district	<ul style="list-style-type: none"> Further decentralization of management to lower levels below district to improve equity of access.
4. Minimum health care packages	<ul style="list-style-type: none"> To identify and address priority issues in health care.
5. Health financing	<ul style="list-style-type: none"> To find alternative financing mechanisms for health care
6. Partnership with the private sector	<ul style="list-style-type: none"> To make the private sector a major partner
7. Strengthen laws and regulations	<ul style="list-style-type: none"> To review and develop relevant legal instruments to govern and regulate health and health-related activities
8. Sector wide approach	<ul style="list-style-type: none"> To provide effective coordination of all partners in the health sector.
9. Human resource development	<ul style="list-style-type: none"> (i) To address major constraints of inadequate numbers and inappropriate distribution of trained personnel. (ii) To ensure increased productivity in accordance with ROM (Result Oriented Management)
10. Community Empowerment	<ul style="list-style-type: none"> To make the community take responsibility for their own health.

Source: Ministry of Health Draft Health Policy Document 1994-2004

A total of 54 health workers (with 42 females and 12 males) aged between 45 and 58 years working in government and private health institutions participated in the study. Six districts were randomly selected, and institutions within these purposively selected either because these were the only health units available, or in order to fulfil the requirement to cover rural and urban units as listed in Chapter Three. A total of the nine health units were studied, with their distribution as shown in Table 4.5 below:

Table 4.5 Distribution of Health Units visited

Health Unit	Rural (No.)	Urban (No.)
Hospital	2 (1P, 1PR)	5 (4P, 1PR)
Health Centre	2 (All P)	-

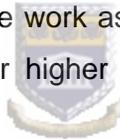
The numerical entries in Table 4.5 are the number of health units in each category. Of the two rural hospitals studied, one is public (P) and the other private (PR). In the urban setting, there were four public hospitals as opposed to one private one. All 54 health workers were supplied with the questionnaire, of whom 50 responded. The respondents with a nursing background were of different cadres and varied in areas of specialty, namely midwifery, general nursing and public health nursing. There was also a variety of job titles that were based on qualifications and seniority. The allied health professionals included clinical officers formerly known as medical assistants, laboratory assistants/technicians, dispensers, orthopaedic officers and radiographers.

The following table gives an indication of the duration of service of the respondents.

Table 4.6 Respondents by Duration of Service in Health Care

Years of experience	Number
0-4years	3
5-9 years	-
10-14 years	5
15-19 years	9
20-24 years	7
25 years and above	26
TOTAL	50

The majority of the health service workers interviewed had more than 15 years of service in health care work as Table 4.6 above illustrates. Such a workforce has potential for higher professional performance derived from their length of service.



4.3 Concept of Decentralization of Health Care Services in Uganda

The study had four objectives as outlined in the introduction of chapter four. The first objective was to establish whether and or how health workers understood the concept of decentralization. The health workers included four doctors, 32 nurses (including 11 midwives), 17 allied health professionals and one health economist. Fifty such respondents answered the question on decentralization. It was evident from their feedback that decentralization is regarded as simply involving devolution of power and decision-making. The probes during interviews revealed that although the respondents had the official technical, hierarchical viewpoint held by government on decentralization, they had their

misgivings about the impact of decentralization as will be illustrated later in this chapter.

The responses by respondents from different districts regarding the decentralization of health services are summarized in Table 4.7 below.

Table 4.7 Decentralized Health Services Reported by Health Workers

Services	No. of Respondents
All services	18
District services	8
Primary health care	3
Drugs procurement	1
Planning and budgeting	2
No answer	18
Total	50

From the 50 respondents to the questionnaire item on of which health care services were decentralized, Table 4.7 above indicates that an equal number of respondents (18) were not clear about what services are decentralized as were those who felt that all services are or should be decentralized. This demonstrates some level of uncertainty, and perhaps contradictions in practice of decentralization itself.

4.4 Changes in the Decentralized Health Care Services Delivery

The second objective of the study was to identify the changes that have occurred in the health care services delivery system, as a result of decentralization of the services. The changes in health care services delivery arising from decentralization were assessed by examining the following areas: Roles of health workers, expansion of health facilities, diagnosis, equipment, drugs and sundries, patient assessment and treatment, and management of health services.

In looking at patient assessment and treatment, the study focused on diagnosis, drugs and other supplies, equipment, patient numbers, and on patients' perspectives of the services. Table 4.8 below shows aspects of health care services delivery that, have changed as a result of decentralization. Positive changes, according to health workers' responses to the questionnaire, were more marked in the areas of diagnosis and patient care and least in the areas of sundries and drugs. These observations were later confirmed by interview and focus group discussion data.

Table 4.8 Level of Quality of Health Services after Decentralization

Health Service	Significant Improvement	No Change	Worsened Service
Treatment of patients	2	11	37
Community out reach	29	-	-
Integrated services	36	6	8
Planning, budgeting and caring for logistics	-	-	49
Compound drugs and dispense	-	-	45
Carrying out investigations	11	17	22
Serve in any part of Uganda	-	-	46
Clinical duties	32	12	6
Infrastructure	12	6	32
Workload lessened	-	-	48
Activities planned from bottom	12	28	10
Training	-	23	22
Offer quality care to the sick	24	20	6

The numerical entries in Table 4.8 above reflect the number of responses from the questionnaire alluding to a particular view. It is evident that the respondents had some positive views on decentralization on such activities as community outreach, integrated activities and quality care for the sick. Conversely, they expressed a negative view on the effect of decentralization on the general treatment of patients; planning, budgeting and logistical provisions; dispensing of drugs to patients; freedom to serve in any part of the country; workload (many complained of increased workload); infrastructure (this was seen as limited, with many patients

lying on floor or in the verandas of health units due to lack of beds and space); poor investigations and professional development/competence building.

Among those who expressed that there has been a change in their roles, the majority mentioned on the point of change as simply being a work-overload, with limited elaboration as to how decentralization was the cause, with little elaboration of how decentralization was the cause or not otherwise.

Based on the data of Table 4.8, it would appear that the decentralization of health care service delivery has not paid much attention to capacity building, or made provision for individual effort to upgrade knowledge and skills.



The patients interviewed comprised both inpatients and outpatients. Some were suffering from medical conditions like fever (malaria), cough, diarrhoea; some had sustained fractures while others had been surgically operated upon.

When asked what services they had received from the health units or health workers, they mentioned the different drugs they had received, the procedures and investigations carried out; for example, those who had fever had received anti-malarial drugs while those with infections had received antibiotics. Some treatments were administered by injection while others were orally administered. From observations based on the study of their medical forms, some of the diagnostic investigations were basic laboratory procedures, and others involved imaging techniques like the use of the Ultra-sound scanning.

To the patients and their care-givers or attendants, the advantage of decentralization has been the establishment of health units in some locations which

...has brought services nearer to us. We do not mind buying the medicine when they tell us that it is out of stock. At least we know that it is what will cure the problem, and not by guess work like we used to do. (A malaria patient who confessed to frequent malaria attacks in her family. Wakiso, December 2003).

Proximity of the health facility was of prime importance to the above respondents. Lack of drugs meant purchase, and those without the means lived with the health problem. Some of the health conditions required assessment and attention by expertise not available in health units, calling for referrals. This is where the costs affect the rural poor. One physically handicapped mother had to travel 30km for her daughter's X-ray assessment, and feared for the costs of getting there, leave alone for the actual investigation, and later, the treatment.

Among the resources they would wish to have improved in the health care, the patients decried:

...shortage of drugs, shortage of health workers who delay reporting for work, and we end up spending the whole day waiting for treatment which may even call for a referral These health units have no toilets for us the sick. Those available are for staff, and are locked. Even water is not available here for us the sick. (A T.B. patient, Pallisa, November 2003)

The above experiences are exacerbated by the lack of drugs, which the patients only get to know after assessment and diagnosis. Timely

response to assessment of a health condition, and provision of some basic amenities like water in all health units would greatly support patients and their attendants.

At Soroti regional hospital, the health workers acknowledged the problems cited by the patients on the limitation of the health resources, pointing out that the county and sub-county health units which are usually in the rural settings (refer to Figure 1) had greater limitations.

At the regional hospital level as at lower health unit levels, the staff reported the original policy expectation of these decentralized establishments to competently handle most cases for out-patients department services, antenatal care, maternity care, immunization, and family planning (reproductive health). The HIV/AIDS counselling, malaria control, treatment of sexually transmitted infections, sleeping sickness control, laboratory services, environmental health, among others.

These views expressed by health workers notwithstanding, inadequate staffing, slower and often-late release of funds which is never adequate for health needs, shortage of medical drugs, poor motivation, lack of equipment, inadequate transport and the poor roads. The high turn-up of patients or clients, lack of sufficient accommodation for health workers, the delay in procurement of drugs and districts reluctant to release the staff to go for further studies/training for fear of attrition.

Other problems the health workers mentioned include the difficulty in securing funds for training, as districts do not have sufficient funds, and disharmony between the district and district health management, when it

occurs, gravely affects funding as the former control all funds in a given district.

On matters of personnel, the district health management team noted slow appointments, confirmations, and promotions. A delay in payment of salaries for all civil servants in districts was identified as a common occurrence. This observation on delayed payment of salaries ties with remarks from all health units visited about low morale of workers. It is also likely that the concern by patients about health workers reporting for work late is a consequence of delayed payments of salaries.

Table 4.9 The Ways Decentralization has Influenced Health Delivery in Health Units in Respect to Diagnosis

Positive Influence	No. of Respondents	Negative Influence	No. of Respondents
Provision of special investigations in some units e.g. labs in health centre IV, CT scan, ultra sound, mobile X-ray, ECG, ECHO in national referral hospital	11 	No update of knowledge and skills	1
More staff posted to health centre IV (Rural location)	5	Delay in diagnosis and referral	5
Services are nearer the communities	3	Lack of adequate personnel	7
Improved health services	2	X-ray machine not working	2
Know disease pattern and burden and budget accordingly	1	Lack of reagents in laboratories	6
Nursing aids trained	1		
Contribution to community awareness campaigns	1		
No change in service delivery	3		

Other than improvements in the single national referral hospital, the respondents clearly presented a view that there were minimal positive improvements to decentralized health units. They drew attention to

services such as diagnosis, deployment of competent health workers, and equipping of diagnostic services as wanting in the decentralized units. From interviews and personal observation, the rural health units established within the decentralized framework are most in need of facilities, personnel and treatment resources.

The following were the suggestions presented by the health workers on improvement of diagnosis in the decentralized health services delivery.

- Hospitals should be fully equipped
- Health centres should be provided with portable X-ray machines
- More staff should be recruited into health care
- All Health Centres should be equipped with laboratory services
- Effective supply of laboratory reagents and improve laboratory services
- More workshops should be organized in order to update knowledge of health professionals
- Revert to centralization of health services
- More funds should be availed for diagnostic equipment
- Reintroduce cost sharing
- Special investigation such as CT scan, ECHO, ultra sound, nuclear medicine, be cost-free or at affordable rates for the poor
- Emphasis should be on preventive health care
- Patients/ clients should be attended to promptly and appropriately
- Medical Workers should be adequately remunerated to motivate them to work
- Maintenance of equipment

According to the respondents, the following improvements are required in the decentralization of drugs.

- Drugs should be delivered promptly to ease shortage

- Purchases should be in surplus
- Supply should be constant
- Better planning and management required
- Staff should be encouraged to keep a breast with new knowledge pertaining to various drugs
- More funds should be provided
- Drugs should be supplied by DDHS³ rather than by sub district
- Allow local purchase
- The centres should carry out the purchase and supply
- Re-introduce of cost sharing
- Revise the essential drug list
- Estimation of drug indicators should be on disease burden and not out-patient attendance

The key message of these statements is that the medical drugs available are limited, do not span the range of ailments addressed and are often out of stock at the health units. The view that the District Director of Health Services (DDHS) be involved in matters of medical supplies appears to be a call for a presence and direct involvement of a higher authority, to oversee and enforce accountability. This itself reinforces an underlying view by patients later on in this chapter, that some health workers are redirecting medical supplies for personal benefits.

The questionnaire also raised a question on the influence of decentralization on availability of sundries and medical equipment in general. The following were capstone responses:

- Sundries should be purchased according to need, and not left to chance (stocks often ran out)

³ DDHS represents “District Director of Health Services”

- Simple and rapid procurement and supply arrangements for sundries, reagents and equipment should be made available to all health units
- Regular assessment of requirements of sundries and equipment should be carried to assess needs of health units
- Periodic maintenance and or replacement of equipment is required due to frequent breakdowns
- Staff need regular orientation to use and maintenance of new medical equipment

It would appear that the respondents were concerned about discordant delivery of medical supplies and in availability and or dysfunctional state of sundries and essential equipment in health units, thus rendering the health care service delivery problematic, incomplete and unsatisfactory. It was also apparent that the health units had a lack of funds for emergency response, such as power generators for X-ray equipment or the purchasing of missing supplies, or maintenance of dysfunctional equipment, or transportation of emergency cases.

The questionnaire had an item on level of patient care as experienced by health workers in the decentralized arrangement.

Table 4.10 Influence of Decentralized Health Care on Patient Care

Positive influence	No.	Negative influence	No.
• Improved patient care	6	• Poor living housing and living conditions of staff, poverty among health workers	7
• Provide quality care	3	• Increased workload	9
• Services nearer the community	3	• Low staffing	6
• Adequate patient care	2	• Low morale among health workers due to poor pay	6
• Community involved	1	• Lack of equipment, sundries, drugs, mattresses	2
• Improved nurse–patient relationship	2	• Infection control is a problem	1
• Mobilization of community on primary health care	1	• Health workers and patients are prejudiced against each other	1
• Lower health units manage minor diseases	2	• Health workers dodge patients	1
• Follows professional standards	1	• Lack of transport and meals for patients	1
		• Self referral of patients due to sluggish services in health centres	1

The numerical entries in Table 4.10 above represent the number of research participants among health workers who provided the responses. It is evident from Table 4.10, that the workers, acknowledged some positive offshoots from the decentralized health services such as improved patient care due to establishment of health centres nearer to people. But the participants enumerated in a rather repetitive way, the challenges they face concerning low staffing, which translates into increased workload for the few personnel at the centre; as well as a lack

or limitation of sundries, equipment and medical supplies. What is new in Table 4.10 is the notion of prejudice. In the interview, it was stressed that patients have natural suspicion that the health workers are responsible for the lack of medical supplies (beds, mattresses, drugs and sundries are believed to be in low supply due to theft by health workers). Patients further attribute corruption to health workers who are seen as money-hungry, and seekers of bribes. On the other hand, the workers see some patients as demanding too much attention; do not recognize that they (the workers) deserve rest and time for their personal and family needs.

The final questionnaire item on the second objective of the study focused on the management of facilities, personnel, and resources in various units under a decentralized arrangement. Table 4.11 below summarizes the responses of the participant health workers on the matter.

Table 4.11 Influence of Decentralization on Management of Health Services

Positive Influence	No.	Negative Influence	No.
Improved or good services	11	Poor coordination of services with central government on health matters	8
Services nearer to the people	3	Management is a big problem	4
Referral system working	1	No immediate and direct supervision	2
		Hospital management committee composed of members who are not health oriented	3
		Interference by local authorities [politicians]	2
		Workers fixed on location, no transfers	3
		Public funds are personalized and misused	3
		Difficulty in transporting referred patients	1

The respondents revealed that the management of health services has its problems originating from the overall policy, which in their view appeared to have underrated or ignored the need for a monitoring and evaluation role by the centre (or independent body) over the matter of quality assurance. The responses indicate the archaic and out of focus management and supervision of important functions and roles embedded in service delivery at local health units. During the interviews, one health worker, a medical doctor, felt that decentralization was probably not well conceptualized and planned when she said:

We lack health services with quality care, support and monitoring from the centre, and transport and accommodation for patients. There is too much bureaucracy involved in the requisition of funds or any support to provision of health services locally. Yet most of the time, there is urgency, which when not attended to leads to loss of life! (Female medical doctor: Lira. November, 2003)



These remarks point to poor monitoring or lack of it. It would therefore appear that the original vision for decentralization has, in as far as the views of the above respondents hold, had sub-optimal success concerning the management thereof. The notions of *bringing services nearer to the people, districts handling their own affairs, improved planning through a "bottom up" approach* afforded by decentralization, *supervision of staff decentralized to the health sub-district (HSD)*. Similarly the *communities participating in planning and monitoring of services* and the *patients or clients knowing their rights, with freedom to comment on the quality of care*, are all objectives yet to be realized (the emphasis reflects paraphrased statements of the decentralization policy).

4.5 Challenges in the Decentralized Health Services

The thrust of this study centred on determining the challenges faced by the health care system in Uganda in its decentralized framework. From the previous sections, the matter of shortage of qualified staffing and low availability of medical supplies, funds and equipment, constitutes part of the wider challenges in Uganda's health care system. One of the health workers said, "Where the drugs are available, there is no competent staff." This scenario could mean that the drugs were either available because some of the health workers could not prescribe the drugs for the patients or the patients utilizing the health facility were very few hence the presence of drugs at the health unit.

Regarding poor inter-personal relations, one district official in Lira made the following observation:



... The health care givers are rude and neglect patients. They give few drugs (inadequate) and are slow at handling emergencies (policy maker and an administrator; Lira.)

Poor quality of services, teachers in a primary school in Wakiso shared the following view:

... There is limited proper diagnosis and treatment may not always be adequate because of lack of drugs in the health centre (teachers and head teacher at a Municipality in Wakiso district. April 2003)

Concerns over bureaucratic processes in accessing the funds and the lengthy delays caused by “red tape”, often by non-health professionals at district level, are presented in Table 11. In one of the study districts involved in this research project, the researcher visited a construction site of a rural health centre over which there was some controversy following a disagreement between the district management and the district health officials.

The researcher’s assessment, as a health professional, of the design, size and quality of construction confirmed the view of the district health officials of very poor workmanship. The building was much smaller than originally intended; the walls were sagging, the roof rafters were of low quality timber, making it vulnerable to collapse and low resistance to strong winds. This brought to doubt the allocation of contracts and supervision of the construction by the district engineering department.



Information collected from documents at the MoH headquarters showed that 66.6% of rural households have never been visited by a health worker, and 1.7% households have been visited once a year for the year 2002 (MoH, 2003). This indicated weak or non-functional outreach activities to communities. On immunization services, which target the children under-five, females of childbearing age and pregnant mothers, the records showed 34% compliance for the children under-five.

Availability of professionally qualified staff in all units emerged as a common complaint among both the health workers and patients. Table 4.12, shows the staffing status as at the time of data collection in one sample health unit meant to service about 5000 to 10000 people.

Table 4.12 Staff Disposition for the Department of Health in Kamuge Health Centre in Pallisa District

Department	Approved Number	Filled Positions
Doctor	0	-
Clinical Officer/Medical Assistants	1	1
Principal health Inspector	1	-
Senior Health Inspector	1	--
Health Inspector	1	-
Health assistant I	1	-
Health Assistant II	1	-
Assistant Supplies Officer	1	-
Laboratory Assistant	1	1
Enrolled Nurses Grade I	2	1
Midwives	2	1
Nursing Aids	4	3
Field Assistant Vector	1	-
Mosquito researcher	1	-

Table 4.12 above shows the extent of lack of health staff in divisions. All the established (available) health staff positions are only established in this rural centre, but not filled; leaving the division with a shortfall of the needed human resources. The challenge here is the implementation of a viable staffing policy, in which the Ministry of Health and that of Public Service need to examine and identify areas and points of strategic staffing interventions.

Inadequate health staff. The staff for preventive health services is inadequate in practically all sample health units studied. So, the local district health centres only carry out immunization and other services

delivery using the same medical and public health staff, who are compelled to carry out both preventive and curative services, leading to the work overload they mentioned earlier.

A key challenge compounding staff shortages is also knowledge and skills gaps amongst staff. When staff, have to stand-in on other technically challenging tasks, they need integrated knowledge skills, calling for in-service courses to improve their effectiveness as agents of health care services transformation needed in the communities under the current circumstances. However, before this happens, a needs assessment to determine the skill and knowledge gaps might have to be undertaken.

When poor staffing is coupled with low distribution of health units into the countryside among the rural population, people are constrained in accessing health care services. This kind of situation may drive the population to private practitioners or to give up their pursuit for medical attention altogether.

The records for the year 2003 in Pallisa district headquarters indicated that Malaria, at a 40.2% incidence, is the leading cause of morbidity followed by intestinal worms at 13.8%, cough at 13.8%, and diarrhoea at 12.5%, common cold 6.9%, measles 1.3%, headache 6.9% and skin disease 4.1%. The clinical officer at the rural center commented: “Even where health services are available, it is not always the case that the communities have automatic access to these.” He elaborated on this point by pointing out that the small fees for medical forms, laboratory fees or purchase of medication is a “turn-off” for most patients in the rural locations. From this observation, it would appear that, the government efforts to make the health services available need to be coupled with a

critical understanding of ways that could provide better accessibility and use-responsiveness of health services to local communities. Logically, access should start with an awareness of the government as a service provider of supply and demand patterns of health services in order to realize appropriate access to the benefit of the community.

Above all else, the community's perception of the usefulness of health care services advice is fundamental. It determines whether or not the community will seek advice or respond when called to attend health care meetings. In this study, local community members were asked to assess the usefulness of the health advice provided or visits made to them by local jurisdiction health workers.

Personal observations at a number of study locations revealed another challenge in health care service provision as the condition of the environment. One striking example was at the Wakiso district headquarters and the immediate communities in the urbanizing setting. Due to activities such as brick making for construction works, manual stone quarrying, and a range of other activities that affected the land cover, pools of water have been established in this clay-soil environment, creating nuisance and breeding sites for mosquitoes. Complaints about worms, skin diseases and malaria in the locality were also not surprising. Urban planning with a view to address health matters is urgently needed.

Sanitation in an upcoming township comes with challenges of disposal of solid waste. The study noted in Wakiso that solid waste comes from sources like residential, commercial premises, carpentry workshops, local brewing points, markets, restaurants, and schools. The collection and disposal mechanism was none existent, leading to accumulation. Occasionally, burning provided a faster means to reduction of the heaps

of solid waste. The township abattoir has no drainage system, creating an unhygienic environment.

There is a challenge related to non-government health care providers. As alluded to earlier in Chapter One, a number of non-governmental agencies are involved in the delivery of health services in decentralized health service provision units. These too have shortcomings and challenges in their operations as discussed below.

Lack of technical staff: the majority of non-government organizations (NGOs) and community based groups or organizations (CBG/Os) involved in health care activities do not necessarily have staff of their own. What this study noted from among private health units, is that they hire the government workers, particularly those with technical skills, e.g. radiographers, eye specialists, HIV/AIDS counsellors and others on a part-time basis, which may also lead to a form of brain-drain. This challenges the public health system to come up with interventions to assist these private health providers to improve their capability for effective delivery of quality health care services.

Weak collaboration and co-operation with other government departments: the notion of sector-wide approach in the health policy. It was observed during the study that most non-governmental service providers and government departments are working independent of each other with limited or no collaboration, in offering health services. One NGO health worker remarked, “in the past we used to be invited for pre-seasonal planning workshops but now all our interaction is ad-hoc”. Without collaboration and co-operation, the wastage of scarce resources, duplication and perhaps conflict cannot be ruled out. An improvement over the current lack of coordinated working partnership may demand

that the government and non-governmental organizations in the health care provision need to establish well-defined mechanisms for collaboration through, information sharing, joint planning and reviews.

4.6 Implications of Decentralized Health Services Delivery to Education

The fourth objective was to establish the implications of the health services delivery decentralization process might or might not have on the education of health professionals. Although training was not spontaneously reported among areas where positive changes have taken place, indirect responses indicated that this is an aspect of health care where there is a problem. As informal discussions with several health workers in some units revealed, there is stagnation as far as staff development is concerned. For example, complaints about having had no chance to pursue further training often emerged from the discussions during interviews with health workers in particular. Implications of the views expressed about health care on education are discussed in the final chapter.

4.7 People's Views Of Decentralized Health Care: Voices Of The Marginalised

Focus group discussions with two Head teachers, four teachers, 18 school pupils (six of whom had disabilities), two local jurisdiction health workers, two district administrators and policy makers were separately conducted to collect the views of the people on the state of health and health concerns in their immediate surrounding in three out of the six sample districts. The focus group discussions were seeking views on the following themes:

- 1) The people's major health problems and what they perceive to be the determinants of their problems.
- 2) Adequacy, accessibility, functioning, quality and effectiveness of the present health care system/services
- 3) The special needs of women, disabled and the disadvantaged generally.
- 4) People's participation in ensuring their health and their contribution to delivery of health care; in particular, the issue of school health.

Altogether, six focus group discussions (FGDs) (two between teachers and head teachers, two between school pupils aged between 11 and 14 years of age, and one each between the local health district workers and health policy makers at the Ministry of Health's Headquarters.) Almost all the FGDs cited the following conditions in order of importance as the major health problems in their respective areas: malaria, diarrhoea, cough, worms, measles, HIV/AIDS, syphilis, miscarriages, infertility, and abnormalities during delivery. Other conditions that were mentioned by all the FGDs included epilepsy, false teeth, elephantiasis, schistosomiasis, tetanus, TB, meningitis and ulcers or wounds on the legs. A note should be taken of the medical terminology here because it reflects the advantage the study has had by the researcher's being a health professional, enabling the descriptions of the various health conditions to be identified and categorized.

Some of the stated health problems described by the school children as prevalent in their localities were perceived as not being treatable by modern medicine. They stated examples such as false teeth, epilepsy, mental illness, paralysis of any part of the body, elephantiasis, impotence in men and infertility in women. The school children regarded these

health conditions as treatable only by traditional healers because these health conditions are considered to be due to witchcraft by their local communities. The challenge here would appear to be community education, first of all, to assess the traditional medical practices and their viability in handling various ailments. Secondly, to mobilize and educate local communities towards engendering their trust in the medical services which are available in their health units.

The FGDs attributed most of the health problems to poor excreta disposal, unsafe water sources, too many sites for mosquitoes to breed and sharing of utensils and bathing containers in cases of TB and syphilis respectively. Crowding together was blamed for the spread of measles. Sexuality, especially promiscuity, was blamed for HIV/AIDS and other sexually transmitted diseases (STDs).



The following statements made by some of the FGD participants, quoted verbatim, will serve to illustrate some of the issues brought out.

... We think our poor health is a result of drinking dirty water, and due to poor excreta disposal, stagnant water, bushy compounds and living near a Town Council Sewage Lagoon. (Pupils and teachers in Ambalal primary school. October 2003.)

... We have no clean drinking water and the protected spring is near the municipal waste-water lagoon. (Teachers and pupils of Ojwina primary school. October 2003.)

Worms, diarrhoea, and meningitis were believed to be due to poor sanitation conditions.

... Those (malaria, worms, diarrhoea) are due to poor water supply, few latrines, and contaminated sources of water by animals (teachers and pupils of Modern primary school. October 2003.)

... We have unprotected and intermittent water springs, and those that were protected are broken down, the water sources contain a lot of earthworms. Even the improved ones [water sources] are either broken or infected with red worms. (School children. October 2003.)

... Boreholes in some schools are lacking, and /or have broken down in others (Policy-maker, health worker and administrator)

Uganda has had a protracted war in the northern part of the country for the last 19 years with the Lords Resistance Army rebels, who have been fighting the government, seeking to rule it under the 'Ten commandments'. This war has had devastating effects on the livelihoods of more than four million people in the region. FGDs held in the urban centre of this region provided pointers as to how insecurity and war have community health implications:

... Influx of people from rural sub counties due to insecurities caused by the Lord Resistance army (LRA) and destruction of houses has lowered our sanitary state, abduction of persons and domestic equipment has led to poor personal and domestic hygiene (head teachers, policy-maker, health worker and administrator. November 2003.)

One other consequence of the war was clearly pointed out:

... It scares health workers and they became ineffective and unwilling to execute their duties and over use our facilities meant for school children... (As above. November 2003.)

For malaria the one FGD participants had this to say;

... There are many old pots and dug-out pits for brewing in this slum that collect water where mosquitoes breed. (LiraTown. October 2003.)

... Malaria is caused by mosquito bites, eating cold things in the morning like mangoes, food left-overs, and water. Measles is transmitted by air, so sharing things or going to neighbours who are infected, while cough is caused by sputum through careless coughing, flies and sharing cups /drinking pipes, but there are different types of coughs (School children: Wakiso district. September 2003.)



These school children were communicating their day-to-day life as lived in their communities and families. What they are saying has a lot to do with poverty, as a result of which they drink unboiled water, eat cold food from previous days or meals, which are not (hygienically) preserved and warmed before being eaten. Furthermore, the communal life of scarcity means that they share the few facilities, utensils, and they even share beds with the sick, which makes them susceptible to communicable diseases. All the FGDS identified children, in particular primary school pupils, as most vulnerable to most of the major illnesses. Yet they cannot seek health care themselves.

The outspoken ones of the disabled children, expressed strongly that the disabled were more at risk and vulnerable to illnesses because some of

them cannot avoid having contact with the dirt on the ground as they crawl. They cannot access health services because of lack of specialized transport (wheelchairs) and poverty. This is what they said:

We are often helpless [as a result of disability] and transport is a threat for all. Accessing health units, where one has to choose next of kin like children or any others to help out is a nightmare... (Disabled in Adyel division. October 2003.)

The disabled children enumerated their health problems thus:

... All ill health that affects the normal also affect us. But malaria is peculiar to our type. There should be a move to eradicate polio. It affects the economy also... and our nutrition status and education is impeded.... As we get abdominal pains, and severe diarrhoea. But chest pains weaken us. The situation is aggravated through dirt, which we cannot avoid as we crawl. We fail to work for ourselves. (Disabled primary pupil; Gulu. May 2003.)



The wider problem of marginalisation even at community level was also mentioned, voicing a wish for emancipatory strategies that go beyond health and impact of the overall well-being and self-worth of individuals. During an interview, one young woman living with a distant relative at the peri-urban location narrated the following:

... people are not kind; they require us to be involved in all family activities regardless. We contribute money in lieu of jobs we cannot do ourselves. One man asked me for money to lift me across a pool, of water on the road. (Disabled female patient; Pallisa district. April 2003.)

Another patient in Wakiso district expressed similar concerns:

... The community looks at us as useless broken chairs; and yet taxes us... (A disabled male patient, Wakiso district, May 2003.)

The group noted the conspicuous lack of health programmes that cater for the needs and health problems faced by the disabled persons amidst the challenges of poverty.

... There are no specialized services for our group. People, including government look at us as a burden to society (disabled patient. Central Division; Kampala. April 2003.)

... why doesn't [local or central] government include us in their budget in terms of free and easily accessible health care; provide transport to health units, and make arrangements to provide sanitary facilities for us in public places so as to minimize on our vulnerability to infection (same as above, Kampala. April 2003)

One long-serving health worker shared her observation faced by patients over lack of medicine: "...shortage of drugs forces people to buy drugs in low dosage from the market for self-medication" (Senior Medical Officer, Mulago National Referral hospital, Kampala. March 2003.)

The experiences narrated by the various participants above highlight the plight of some vulnerable groups of the population, and the helplessness of the health care system to effectively respond to these glaring concerns. Part of the helplessness of the healthcare system is illustrated by the following acknowledgement by a policy maker at the Ministry of Health:

... Presently we have regular immunization but there is lack of immunization facilities, and when they are available, lack of adequate manpower, transport and vaccines makes it difficult for the exercise (Policy maker/health professional. June 2003.)

How could this situation have deteriorated without any proper evaluation of the situation? This probe elicited the following response from the same respondent:

... We need trained staff, a lot of specialized staff if we have to meet all the challenges health care is facing. We are trying to see where to place emphasis; the number of environmental staff should increase so as to facilitate home improvement, safe water sanitation. (same as above.)



Some of the research respondents expressed distaste for the cost sharing /user fees in government facilities. The main arguments advanced for this position by the patients, and non-health professionals were that people are already pay taxes which are used to buy the drugs that are brought to the health units. The cost sharing introduces inequality in accessing health care. Sometimes with serious consequences, that it promotes corruption on the part of health workers and that user fees are an imposition by the authorities on poor people. The vehemence with which charging of user fees was criticized was reflected in the language used during the discussions and the emotional tone. One such strongly presented position was the following:

...Cost sharing should be abolished. We pay taxes, why should we pay twice? Of what benefit is our graduated tax? And the medical staffs have taken it too far. They ask for a medical form five at the entrance, how does one get it before they have received

treatment? Let the government provide [them] forms. The medical staff will even ask for tip money. We also think [private] clinics should be closed. There is a relationship between lack of drugs in health unit and the mushrooming clinics, especially when the health workers in health unit operate them. (District official, Gulu. August 2003.)

Various categories of the respondents' views recorded from the questionnaire responses, the interviews and FDGs, have exposed a number of challenges in the health care system as presented above in this section. Behind these clear messages expressing dissatisfaction of the health services in decentralized units, were also the indicators of willingness and preparedness by some respondents to participate and contribute in ensuring that they enjoy good health care services. The areas of willingness were those of capital developments, such as construction of health units, protection of the springs and construction of pit latrines in their homes and schools.



... As leaders, we encourage people to dig latrines, maintain water sources like boreholes and we encourage health education in the schools. We involve people in competitions, giving praises to those who excel and encourage others to keep their homes, schools clean. Every home is encouraged to have a pit latrine and by using drama (by school children), the health problems have been put into perspective (Policy maker, Lira. September 2003.)

... We advise people on environmental health and advise them to have pit latrines and rubbish bins (Health worker Lira. September 2003)

In summary, the views collected from different sources are concurrent that health services are inadequate due to inaccessibility and of poor

quality. However, people are willing to participate in activities to improve the health care system, but not through direct cost sharing.

4.8 Implementation of the Three Year Uganda Health Sector Strategic Plan

During the study, a document analysis of Uganda's national Health Sector Strategic Plan (MoH, 2003), launched in August 2003 was done. The HSSP is a national strategy aiming at delivering significant improvements in health sector outputs through supply of basic health care services to its population. The strategy intends to stimulate demand for these services by almost totally abolishing patient charges. As a result, out patient attendance are expected to significantly increase and immunization rates are also envisaged to grow from current 34%. Output indicators for current health unit attendance of expectant mothers are also expected to rise from current level of one in five women who give birth in health units.



For now, the population has responded to these reforms by “voting with their feet”⁴. Given the scale of the anticipated increase of public health care consumption under HSSP, there are expectations that health outcomes (e.g. infant mortality rates) will start to show signs of improvement.

Table 4.13 below shows that the reforms to date have been achieved with only modest changes in the overall financing of the sector. The resource envelope had remained fairly flat increasing only 15% in five

⁴ *Voting with their feet* is an expression used by the disadvantaged poor: an expression literally meaning, “the people always walk whatever distances to get the little services they can get”, [with hope that the situation will improve]. This is a catch phrase among politicians and bureaucrats seeking community support by acknowledging their sacrifice of moving on foot in support of a national drive.

years. However, the Government of Uganda budget has more than doubled during this period, donor projects on the other hand have reduced considerably. Since 2001/02 the Government of Uganda budget has become the most important financing mechanism. User fees were abolished in March 2001 in Government of Uganda health units but had been contributing very little any way.

Interviews with patients in various health units however, revealed continued direct and indirect user-fee charges. Directly through payment to see medical consultants at private clinics established within district hospitals, indirectly through purchase of drugs which are often prescribed but not in the hospital, and/ or through reference to a diagnostic units such as ultrasound scans, x-ray and or various laboratory tests not available in the government health units.

Table 4.13 The Budget-Allocations to District Primary Health Care Services

YEAR	ALLOCATION TO DISTRICT PHC (BILLIONS OF SHILLINGS ⁵)
1997	2
1998	11
1999	18
2000	38
2002	60
2003	71
2004	78

Source: Three Years of Implementing the Uganda Health Sector Strategic Plan. Ministry of Health, Kampala Uganda. October 2003

While the conclusion from the changes in Table 4.13 is that the Government of Uganda budget presents a more efficient and equitable

⁵ Currently (July 2004), the Uganda Shilling against the United States traders at 1US\$ for Ug. Sh1750

financing mechanism than donor projects and user fees, there are serious deviations when community health provision and performance of specific groups of health units in rural and peri-urban settings are analyzed.

As illustrated in Table 4.13 one could argue that the health expenditure with regard to health is most cost effective when it is spent in district primary health care services. Table 4.13 shows that the MoH has been vigorously implementing this policy with its recent budgetary allocations. However, the level to which the district primary health care services have been implemented to the benefit of the target group (the communities), is not reflected in available statistics or analysis by the Ministry of Health.

Table 4.14 The Breakdown of 66 Billion Shillings Expenditure by Five Large Health Sub Sectors

Allocation		Percentage of 66 billion
Non-HSSP activities	Technical assistance, Project overheads	68
HSSP activities	Human resources	3
	Drugs and supplies	10
	Other recurrent	6
	Capital –non infrastructure	9
	Infrastructure	4

Source: HSSP (2003). Three Years of Implementing the Uganda Health Sector Strategic Plan. Ministry of Health, Kampala Uganda. October 2003

This is most illustrated by the breakdown of the project funding of 66 billion shillings by health sub-sector in Table 4.14 above. Performance of decentralized health service on the basis of budget allocation is poorly inferred, as there are tendencies of local administrations to re-structure

and re-direct budgets to overheads, which do not directly influence health service outputs to benefit clients: the patients and care-seekers.

The health sector's modestly increasing budget would perhaps, by the "Community as Client" Model, go to increasing its efficiency in its most important aspect and output: attendance at health facilities. The MoH's claim of high patient attendance is not a fair indicator of efficiency of budget utilization. As one patient observed:

We keep going to the health centre because it is the nearest. The hospital is 25 miles away, needing Sh.5000 (US\$2.50) which I cannot afford for public transport. My hope is that I will chance the free drugs they keep talking about. (An elderly female patient, July 28, 2003.)

Thus the patients' attendance to health units is more of a desperate effort in search and in expectation of receiving due medical attention, not because they receive appropriate treatment. This was crystallized by a confession of one of the Health Unit workers:

The best we can do is to request them to come back in a week or so, hoping that the district hospital will send us something [medicinal supplies] (A Health unit worker, July 28, 2003.)

4.9 Summary of Chapter Four

Having all the points above based on the views of the health workers, local government leaders, patients/attendants and members of the committee, it can be concluded that under the decentralized framework, health care services delivery in agenda faces a number of challenges.

At conceptual level, the decentralization of health services has focused on a simple de-linkage of districts (local jurisdictions) from the (original) central management of health services. In this way the coordination and networking between the centre and decentralized units has missed-out. Furthermore, the sector-wide approach, participation of local communities and their leadership has not been built into the planning and implementation elements of health services delivery.

The key changes brought about by decentralization among the localities is that health units have been built in their localities or neighbouring communities, to bring about access. This access is however a physical proximity which lacks the sustained benefits of regular availability of basic medical services, comfort and committed personnel.

Where health services are available, patients have reported being often stressed out by charges of user fees, various unwanted services such as medical plan.

Lack of the basic laboratory equipment, diagnostic technology, such as X-ray machines, laboratory reagents, sundries and medical drugs are dominant challenges in all the health units. Poorly staffed by uncertified personnel, the public health units operate sub-optimally, with hardly any monitoring and/ or supervision by some central authority. The final chapter presents a discussion of the key issues that have emerged out of the findings of the study.

CHAPTER FIVE

DISCUSSION, IMPLICATIONS OF THE STUDY AND CONCLUSION

5.1 Introduction

This chapter has three main sections. The first section presents the final brief discussion about the main findings of this study. The second section highlights the conclusions reached. The third section is a reflection on the implications of the study, namely: health care provision policy, accessing of health care and education of health professionals. The discussion focuses on an analysis of the key findings in relation to the available literature. A comparison of the findings with conceptual debates provides a basis for making a contribution to our understanding of the provision of health care in Uganda and arriving at an informed conclusion. The chapter concludes with options for policy-making, management strategies and health professionals' development based on the findings.

5.2 Discussion

5.2.1 Decentralized Health Care Services Delivery

One of the aims of the study was to establish what was understood by “decentralization” amongst government health officials, local government officials, and health workers at the health units.

In spite of the relatively comprehensive policy guidelines on the scope of health services delivery (Table 4.7), the conception of most officials and health professionals who participated in the study was focused singularly on the policy component of the “sub district”, namely, decentralization as

a devolution of management to lower levels, i.e. districts and below to improve accessibility of health services to communities. The health policy provision for such aspects as primary health care – aimed also at improving access to basic health care for all was significantly absent in the responses received. From the participants' views on decentralization, it would appear that community factors, such as location, poverty and education, which are key determinants of health (Wagstaff, 2002), were not considered central in the planning for the decentralization of health care.

Document analyses of the policy itself on the guidelines for decentralization were not sufficiently informative due to the lack of a clear decentralization framework. What one would have expected from the policy, is a sector-specific statement stipulating the roles and responsibilities of various jurisdictions. In the health sector, it would have been useful for the policy to stipulate how to ensure that the poor majorities receive the benefits intended for them from public spending in a decentralized health system. For example, one would have expected the use of targeting strategies to direct more of the health care services to the benefit of those majorities in the rural communities (Gwatkin, 2003:83). Targeting as a modality of health care service delivery, is also examined by Tien and Chee (2002), who note that many health programmes employ multiple targeting mechanisms to ensure that more benefits flow to the poor or target the poor groups.

5.2.2 Changes in Health Care Resources and Facilities

The second aim of the study was to establish how the health care resources and facilities have changed during the decentralization phase.

All the groups of respondents, namely the senior policy makers at the Ministry of Health, the health workers/professionals in various health units, the patients and their attendants, as well as local government officials agreed that the key achievement of decentralization ought to be that of establishing health units closer to communities, particularly in rural areas. What is important to note, from the researcher's inside knowledge, is that the infra-structural development of health care units, as aimed at by the decentralization programmes, is not uniformly being implemented across the country. Some districts, because of the lobby-power of their political leaders, have had more local communities benefiting from health units than others.

In some situations, communities that had to travel up to 40 km to the nearest health facility had this distance reduced to 20 km, as one elderly woman respondent remarked.



Now I only have to travel 20 km to the health center in Aukot. Previously I had to walk or ride a bicycle for more than 40 km to Soroti.

Typically, the responses received in the study, indicate that health care services and trained health personnel are less accessible to the poor in rural and peri-urban communities than in the better – off urban communities.

Stemming from the national Health Sector Strategic Plan (MoH HSSP, 2003) one visible problem is that the bulk of funding available to the health sector, is directed towards technical assistance such as consultancy services, and to some extent towards hospitals in urban centres and specialist care at the expense of rural primary care facilities. As a result, primary health care facilities established in community

localities are often short-staffed and lacking medicines according to both the health workers and the patients.

Although the definition of primary health care varies, the ultimate goal is to improve health through the provision of basic health care services at an affordable cost. According to the World Health Organization (2000), primary health care is often perceived as providing services exclusively for the poor. In practice, it involves offering "... specialist advice to health care teams... in liaison with general practitioners... to deliver holistic service" (East, Brown and Radford, 2004:359). An important criticism arising from responses received in this study is that a number of primary health care programmes have not adequately taken the needs and interests of the poor, who are the intended beneficiaries, into consideration. The planners of health care services have tended to focus on the supply side issues (physical availability of infrastructure, medical supplies and personnel) that relate to reaching poor rural villagers with services. However, the issue of most concern to health care services users, such as the quality and relevance of services in relation to health needs has received less attention.

5.2.3 Challenges in the Implementation of Decentralized Health Care Services

Informed by common observation by the researcher as a practicing health professional, this study was premised on the desperation of those people suffering disproportionately from preventable diseases. In an attempt to understand the underlying reason for this reality, this study had, as one of its aims, the understanding of the challenges surrounding the provision of health services in a decentralized system.

The submissions by respondents, supported by the document analysis particularly of the national health policy in Uganda (1999-2004), reveal

that minimum (basic) health care packages, health financing, a sector-wide approach including private provider partnerships, human resource development and the level of community empowerment and mobilization significantly effect the health of the poor.

Concerns over malaria, worms, diarrhoea and sores raised by respondents indicate a need for an urgent and deliberate re-orientation of health care provision towards priority needs and issues in the health sector. As pointed out earlier, the use of targeting strategies focusing on techniques such as direct targeting, characteristic targeting or targeting by other criteria such as age or disease, or in combination with other strategies, as well for greater precision and impact in reaching and benefiting the needy. Targeting techniques formulate strategies for delivering health care interventions to communities (Gwatkin, 2003).



For the packaging of health care services, it is imperative to note that key factors such as the environment, access to clean water, safe housing and efficient transportation are more likely to impact on behaviour associated with poor health than the more economically able members of society. Social values and norms are also likely to influence behaviour associated with poor health such as early age marriages, large family size, and discrimination against women (Wagstaff, 2002:100).

The respondents in the study raised concerns of cost in health care and decried payments for health services as being unaffordable. The cost associated with ill health, including medical bills and indirect costs such as lost income, can be catastrophic among poor communities (World Bank, 2001). Ill health can deplete household savings and earnings and impair the capacity of adults and children to work and learn, fostering conditions that create and perpetuate poverty. Health care financing

systems can play an important role in determining whether the poor have access to health care services.

When health conditions are life threatening, shortfalls in public health units tend to drive people, including the poor, to by-pass public health services for private care or different forms of medical treatment altogether. In this study, respondents stated endemic lack of medical supplies, inadequate quality of services, absenteeism or late-turn up of medical professionals, as well as poor provider-client relations as being the main challenges facing health care in practically all the units visited in this study. This may call for the involvement of the private partners to extend health care services to areas where the need is greatest.

Community partnerships, when coupled with community mobilization and training, could provide another alternative mechanism to support public health care services. In Ghana, as Nyonator (2003) has reported, a successful model is operational in which each community builds a community health compound. The government appoints a comprehensively trained nurse to each community compound with a motorbike, medicines, immunization and family planning supplies. Supported by trained community leaders in social mobilization, the health care benefits to the communities, including infant mortality, have improved significantly.

5.3 Implications of the Study

In this section, the implications of the study on: policy, increasing availability of healthcare services and on community mobilization, education and professional development are presented.

5.2.1 Policy Implications

The question of how to direct health care benefits to the poor should take priority over other priorities on the agenda. The cash-trapped government has introduced user fees to raise revenue for public health services. When the poor have to pay for health care, they are deferred from the central need for health care. This will potentially lower the use of reproductive and child health care services among vulnerable groups (Creese, 1997; Gilson, 1997).

The decentralization health policy may require to revise mechanisms for targeting the needy in health care, using such mechanisms as direct targeting (through particular individuals or households as poor so that they receive programme benefits) or by characteristic targeting directly programmed benefits to population groups on the basis of factors such as housing, age, disease (HIV/AIDS), employment and nutritional status.

5.2.2 Implications for Increasing Availability of Health Services

In order for health services to be more accessible to the rural majorities, it might be useful to direct more resources towards primary-level facilities and care. By increasing and strengthening these services, health programmes could address important accessibility issues for the poor such as travel time and cost to the nearest facility or to a facility with needed or desired services, and residence in a rural or neglected area, where services are scarce or unavailable. As found by Lavvy and Germain (1994:21) in Ghana, “reducing the average distance to the nearest public clinic could increase use by more than 90%”.

Based on concerns over quality of services as posed by a number of respondents, the needs and interests of the intended beneficiaries – the rural communities – need to be taken into account, namely the issues of

main concern to health facilities, such as the quality and responsiveness of services.

In considering health care provision to communities, investment in areas such as transportation, water and education can significantly improve community health outcomes (Wagstaff, 2002).

Different strategies, carefully identified, could protect the most vulnerable from medical impoverishment. As a country in which people survive on agriculture, experience loss of income and are threatened by food security issues, rural Ugandan communities are vulnerable. Subsidizing a free health care system, including risk sharing arrangements or insurance plans, need to be explored to identify means to help protect the poor from health risks that result from poor economic conditions.



Government may opt for alternatives to the direct delivery of services by developing partnerships with non-governmental providers. Such partnerships may require public support to deliver health services to poor and vulnerable segments of society. Non-government organizations such as church or development organizations already work closely with the communities, giving them a better opportunity in the identification of their needs and serving them in relation to these needs.

5.2.3 Implications for Community Mobilization, Education and Professional Development

In order to innovatively address mechanisms to improve health services and achieve appropriate outcomes for the majority of the population, mobilizing community resources may be an option to pursue alongside other strategies. One possibility could be establishment of community-built health compounds, with the necessary professional competence

established for each compound, and working together with trained community leaders in mobilizing social support for health care and family planning.

Central to the fourth objective of the study, was the need to explore the implications of decentralized health care to the education of health professionals. These implications could not be exhaustively addressed in this study, recognizes the need for further research. What is presented here is based on “hunches” confined by the data gathered in this study.

Apart from the community education already mentioned, the professional development of health workers is paramount as the scope of health care needs, continues to expand and diversify. Practice in the communities is demanding as it encompasses virtually all aspects of health care.



Significant changes and demands in professional health care development include the expanded roles including a large variety of aspects of health care ranging from community assessment, diagnosis, treatment and evaluation to support (for example, based on “Community as Client” Model’ discussed earlier, (see section 1.9). The advent of HIV/AIDS and the associated opportunistic infections and of community responsive policies in health care, rest on the potential of appropriate education programmes to build the necessary skills and competencies in the delivery of better-quality and quotable health services.

5.3 Conclusion

There is a need to improve the health of all, especially for more and more people, affected by declining economic conditions who are feeling and experiencing the exclusion from both essential basic health care services and the world’s dramatic advances in health and medical technology.

This exclusion has taken an enormous toll on families, communities and societies, including the health professionals themselves, under the lightening grip of poverty.

Although the Ugandan government has attempted to implement a policy of decentralization, a policy to improve of health of the communities, the strategies designed could not be implemented successfully. Serious health care delivery between and within the various health units, and many of the common health ailments, which also constitute the leading causes of death are preventable and treatable, hence the need to address them. The provision of health care presently is often unresponsive to the needs of the majority and increases their vulnerability to diseases.

The weight of evidence from the study suggests that the poor health care service delivery can be addressed with some re-preordination and pursuit of community-as client policies (i.e. pro-poor strategies and models of health care). It would appear that a broad based policy, encompassing a wide range of strategies is the best avenue for redressing the challenges faced by Uganda's health care delivery in its current form.

In the long-term, a comprehensive pro-people and pro-community approach needs to influence the multiple social and economic determinants of health problems and disparities, improving access to vital services and opportunities and reducing discrimination and isolation.

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APPENDIX 1 ETHICS DOCUMENT

Dear Health Worker,

I am Rehema Mayanja a student at the University of the Western Cape (UWC) South Africa. I am carrying out a study on the challenges of

decentralized health care services delivery policy in selected districts of Uganda. The purpose of the study is for academic reasons. You have been chosen to participate in the study. The information you give will be treated with utmost confidentiality. You have a right to opt out of the study at any time you wish.

Thank you very much for your cooperation

Yours sincerely

Rehema Mayanja



APPENDIX 1 CONTINUED

QUESTIONNAIRE FOR HEALTH WORKERS

**THE CHALLENGES OF DECENTRALISED HEALTH SERVICES'
DELIVERY IN UGANDA**

IDENTIFICATION DATA

(1) DISTRICT.....

(2) NAME OF HEALTH FACILITY.....

(3) TYPE OF HEALTH FACILITY:

HOSPITAL HC IV HC III HC II

**SECTION A: (SOCIAL AND ECONOMIC BACKGROUND OF THE
RESPONDENT)**

1. Age.....

2. Sex Male Female

3. Highest level of education attained

.....

4. Professional Background

.....

.....

5.

6. Terms of service

.....

7. Period of service (state years)

.....

SECTION B:

Decentralization is devolution of power from the centre to lower levels i.e. from ministry of health to districts etc.

8. Are health services in this district decentralized?

Yes

No

Partly

Don't Know



9. If yes, which health services are decentralized?

.....

10. Indicate below your roles as a health provider.

(a) Before decentralization

.....

(b) After decentralization

.....

11. (a) Are there any change(s) in your role as a health service provider arising from decentralisation?

.....

(b) Comment on the change(s)

.....

12. At your health unit, in which ways has decentralization influenced health delivery in respect to:-

12(i) Diagnosis

.....

Provide examples

.....

Could you suggest improvement

.....

12(ii) Drugs

.....

Provide examples



.....

Could you suggest improvement

.....

12(iii) Sundries

.....

12(iv) Equipment

.....

Provide an Example

.....

Could you suggest improvement

.....

12(v) Patient care

.....

Provide example(s)

.....

Suggest improvement.....

12(vi) Management of health care Services

.....

Provide example(s).....

Could you suggest improvement.....

13. What in your view are hindrances or impediments (if any) to successful implementation of decentralization of health services delivery?

(a)

.....

(b)

.....



(c)

.....

(d)

.....

14. What are the main challenges that make health care service delivery sub-optimal in Uganda following decentralization?

(a)

.....

(b)

.....

(c)

.....

(d)

.....

Example(s).....

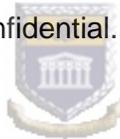
How do you cope with these challenges?

.....

.....

Could you suggest improvement.....

Thank you very much for sparing your time. Your views will contribute greatly to the process of understanding and improving the challenges faced in decentralized health care service delivery. The information you have given me will remain confidential.



APPENDIX 2

INTERVIEW GUIDE AND FOCUS GROUP DISCUSSION GUIDE FOR HEALTH PROFESSIONAL/HEALTH WORKERS, POLICY MAKERS/DISTRICT OFFICIALS AND SELECTED MEMBERS OF THE PUBLIC

Information to be read to all respondents:

This interview is seeking your views about access to, and the quality of health care services you receive in public health units. Your information will be treated with total confidentiality. You have a right to opt out of this interview/discussion at will and at any time. You can also have access to the transcript of this interview if you wish.



1. Uganda has pursued a policy of decentralization. What has this meant in the health sector, in your view?
2. What health care services are provided in the health unit(s)?
3. What health care services are decentralized?
4. What are the health care problems encountered in the delivery of health care services?
5. How is the health system addressing these problems?
6. Are the health care delivery problems being addressed adequately? By whom?
7. What additional interventions to these problems would you recommend?
8. How has decentralization influenced the level of care of patients/clients?

9. Do you think the care the patients and clients receive in the health units is adequate to foster their recovery/well-being? Why? /Why not?
10. Could you suggest ways in which improvement in the care of patients/clients could be carried out?
11. Could you suggest some practical ways of improving the decentralized health services?

Thank you very much for sparing your time. Your views will contribute greatly to the process of understanding and improving the challenges faced in decentralized health care service delivery. The information you have given me will remain confidential.



APPENDIX 3

INTERVIEW GUIDE FOR THE PATIENTS/ATTENDANTS

District.....

Health Unit.....

Sex.....

Age.....

Address.....

Information to be read to all respondents:



This interview is seeking your views about access to, and the quality of health care services you receive in public health units. Your information will be treated with total confidentiality. You have a right to opt out of this interview/discussion at will and at any time. You can also have access to the transcript of this interview if you wish.

1. What are you suffering from?
2. What services have you received from the health unit/health workers?
3. How do you find the health services being offered to you (your patient)?
4. Why is this unit your choice for medical attention?
5. How far is this health unit from your home?

6. What aspects of health services would you wish to be changed? Why?
7. What factors lead to poor health in the location where you live? How could these be reduced/eliminated?
8. What difficulties do you experience in obtaining treatment for your ailments? How could these difficulties be reduced/eliminated?

Thank you very much for sparing me your time.

The information you have given me will remain confidential.



APPENDIX 4

OBSERVATION CHECKLIST

State of Buildings	Dilapidated	Not dilapidated
Space between beds	Adequate	Not adequate
Equipment	Available	Not available
	Functional	Not functional
Laboratory	Present	Not present
Microscope	Available	Not available
	Functional	Not functional
Reagents	Available	Not available
X – Ray	Available	Not available
Sundries	Available	Not available
Drugs	Available	Not available



