Public health crisis? Analysis of equity of access and utilization of health services in Uganda

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ABSTRACT

Background: The government of Uganda faces a multitude of challenges in the health care system from ensuring provision of drugs, to physical infrastructure, human resource and delivery of service in the most fair and equitable manner. This study examined equity of access and utilization of health care services in Uganda with a view to selected factors that influence access and utilization. This research is based on data from various waves of Uganda National Housing Surveys (2005/06 and 2009/10) and other sectoral surveys such as the Annual Health Sector Performance, Panel surveys and Integrated Household Survey (2004/05 and 2010/11). It is driven by objectives that seek to describe and discuss current health care issues in Uganda by highlighting existing policies meant to drive equitable access to and utilization of health care services (in relation to key killer diseases such as malaria, TB and HIV/AIDS); analyses their extent of implementation in the context for which they were put in place. Thirdly, this study analyses a number of factors (both supply and demand) that affect access to and utilization of health care services in Uganda such as education, age, household expenditure, outpatient department utilization, hospital and bed capacity, deliveries in health facilities and distance from health facilities.

Results: This study established a number of actions that have been undertaken in policy implementation especially in main key policy areas like malaria, TB and HIV/AIDS. The analysis shows however that despite efforts to improve the wellbeing through improvement of health outcomes for the people, there still remains mountain high challenges. For instance, living close to essential health services, though it works as an incentive to use care, does not necessarily ensure that health services will actually be used. Secondly, the removal of user fees in all government health facilities, rates of use of modern health care facilities especially government providers remains constant and at a cost with increased catastrophic expenditures.

Conclusion: There have been changes in policy to align them with the needs of the people and improve their health outcomes. Despite increased investment in health infrastructure, there seems to be an increasing gap in access and use of these facilities. Low use of government facilities spells more challenges and questions about the quality of facilities and care received by both urban and rural poor. There have been studies that have confirmed how quality of care significantly affects people's use of health care.

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LIST OF ABBREVIATIONS

ACHPR	African Charter on Human and People's Rights
AGHA	Action Group for Health, Human Rights and HIV/AIDS
ANC	Antenatal Care
ART	Anti Retroviral Therapy
ART	Antretroviral Therapy
ARVs	Antiretrovirals
CEDAW	Convention on the Elimination of All forms of Discrimination against Women
CRC	Convention on the Rights of the Child
FHRI	Forum For Human Rights Initiative
GDP	Gross Domestic Product
HC	Health Centre
HCT-HIV	Counseling and Testing
HFS	Health Financing Strategy
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrom
HMIS	Health Management Information System
HSQIFSP	Health Sector Quality Improvement Framework and Strategic Plan
HSSIP	Health Sector Strategic and Investment Plan
HSSP	Health Sector Strategic Plan
ICESCR	International Covenant on Economic, Social and Cultural Rights
IPH+	International Health Partnerships and Related Initiatives
ITP	Intermittent Presumptive Treatment
LC	Local Council
MDGs	Millennium Development Goals
MoH	Ministry of Health
MoH	Ministry of Health
NDA	National Drug Authority
NDP	National Development Plan
NGO	NonGovernmental Organisation
NHP	National Health Policy
OECD	Organisation for Economic Co-operation and Development
OOP	Out of Pocket
OPD	Out Patient Department
PEAP	Poverty Eradication Action Plan
PFP	Private For Profit
PHC	Primary Health Care
PLWHA	People Living With HIV Aids
PNFP	Private Not-For-Profit
SWAp	sector-wide approach
TB	Tuberculosis
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHS	Uganda National Health Survey
UNICEF	United Nations Children's Fund
UNIDO	United Nations Industrial Development Organisation
UNMHCP	Uganda National Minimum Healthcare Package
VHT	Village Health Team
WHO	World Health Organisation

CHAPTER 1: Introduction

A priority of health care policymakers in many developing countries is to ensure that the vulnerable groups of people (particularly women of child birth, the poor, elderly, children) have access to high quality health services. Policymakers try to ensure that access in terms of distance (or time taken) to a health facility and cost are affordable to these groups and therefore not a deterrent to service utilization. Consequently, a sizeable proportion of public resources may go to construction of additional health structures directed at decreasing distance travelled to health facilities and increase the likelihood that these health services will be used. Perhaps what should be noted is that a mere presence of services within a reasonable distance (as a result of standing structures) is not enough to ensure use of those services. Likewise, monetary cost, which is usually mentioned as the major barrier may not always be a deterrent to access and utilization of health services. It is not uncommon therefore to find that many individuals, mainly those using government facilities in developing countries will not use available health services even when they are free or nearly free. One of the explanations for this is the perception that government facilities are of low quality and are of low efficacy.

Worldwide, public health has become an international topic of concern over the last decade. There are arguments that public health, in many parts of the world, has reached crisis levels: over 14 million people are killed by infectious diseases each year (90% of which are in the developing world); over 40 million people globally are infected with HIV/AIDS (90% of which are in the developing world); over 500 million people are infected with malaria each year and the disease kills upwards of two million people annually; over eight million people develop active tuberculosis (TB) each year and the disease kills over two million people annually (95% of those afflicted and 99% of deaths resulting from TB are found in the developing world)[1]. Perhaps, even more surprising is the fact that while most illnesses – especially infectious diseases – are preventable or treatable with existing medicines, the World Health Organization (WHO) estimates that over 1.7 billion people have inadequate (or no) access to these medicines (WHO, 2004). The paradox in most developing countries is the fact that governments focus more on building and expanding health facilities that are largely underutilized by the poor and the non poor alike. Worse still, services offered are often of low quality that even the poor do not find it worth their time and cost in accessing them.

[1] Doctors without borders (Medicines san frontiers-MSF)

Yet health services use a considerable amount of economic resources and count among each country's major employers. They also foster a feeling of security in individuals and a climate of confidence in society, factors which are important for the development of the economy and more generally for the society as a whole" (Health 21). Consequently therefore, "everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided" (Whitehead, 1992). Perhaps, Whitehead argues, this definition does not necessarily mean complete elimination of all health differences so that all people can enjoy the same level and quality of health but defines means which reduce and (or) eliminate inequities that may result from avoidable (or unfair) factors.

1.1 Motivation for the study

Having grown up in Uganda's rural setting, a country for which this research has been focused, I have developed more interest in affairs that affect poor people who seem to be 'less considered' by the political regime(s) of the day. Major national, regional and international newspapers have published news on the condition of health services and the challenges faced in and about Uganda. All these have raised my curiosity to dig into experiences at national and organizational level research using attained documents and policy guidelines. In one of the Ugandan weekly papers, the following was published:

> *"After three days of illness at home, Evelyn Adyero decided to go to Kaladima health center III, Lamogi subcounty, Amuru district, walking three kilometers to the facility. After waiting for more than six hours, Adyero was diagnosed with typhoid-causing by drinking dirty and contaminated water-but there was no medicine. 'A nurse gave me two options; either to pick drugs after two days because typhoid drugs were out of stock, or buy them from private clinics', states Adyero. The drugs she was told would cost her at least 20,000 shillings (US$8), money that was so much that she decided to take the first option…..after two days, she went back to the health center and queued for four hours before she was told once again that there were no drugs. ….Later Adyero said she would try some local herbal medicine and if that failed she would sell two of her cocks to raise money for drugs."* (The observer newspaper[2]).

[2] http://observer.ug/index.php?option=com_content&view=article&id=26662%3Awho-will-heal-ugandas-ailing-health-system&catid=57%3Afeature&Itemid=69

This situation is not exclusive to any specific health center or any region, there are many more like this countrywide especially in rural areas where government facilities are more concentrated. There are many patient complaints of health care workers who first tend to their gardens before reporting for work at health care centers. Many a time, health units especially in rural areas neither have electricity nor a generator, with insufficient supply in urban areas (also known as load shedding). At night, health workers use phone torches or paraffin lamp to carry out minor operations or attend to birth. In reference to the above challenges, a shadow minister after a recent tour of public health facilities across the country described the situation as "*pathetic with sick facilities that need help*". For instance, they found out in Moroto regional referral hospitals (in North East Uganda) that there was "no running water, had only two doctors, the theater was dysfunctional while electricity only visits." In another instance, the same health services committee of parliament visited Kabale referral hospital in south-western Uganda and found that the hospital has only one doctor (a gynaecologist) spelling trouble for operations (and surgeries) other than the doctor's specialty which in some instances are carried out by clinical officers or in worst cases, nursing assistants. More surprising is that eight out of ten doctors are located in urban areas, leaving only two in the rural areas where 80% of the population leaves. However, all this points to the gravity of the health care system that requires more urgent intervention to fill existing gaps that will improve access and utilization of health care in both rural and urban areas.

1.2 Background of the study

Uganda already faces a multitude of challenges in the health care arena, from ensuring that health care services are delivered in the most equitable manner, to structuring the health care delivery system to be most effective and waging campaigns against the leading causes of mortality and morbidity (World Bank, 1999). Uganda's estimated GDP per capita is US$532 (according to the 2010 estimate) with 24.5% population currently living below poverty line and about 41% likely to slip below poverty line. There still exist significant differences and challenges to improve the quality of service delivery and address continuing health status issues such as high infant and maternal mortality (MoH, 2011). Inequalities exist between rural and urban areas and the different regions of the country (UBOS, 2006), while primary health care still remains difficult for some to access in light of inconsistent quality of care. Hospitals and health centers are severely underfunded, understaffed and existent workers unmotivated.

Furthermore, communicable diseases like HIV/AIDS, malaria and TB are still placing a feasible huge strain on the already fragile and leaping health system in Uganda. Many services, including those related to HIV and TB, are not well integrated into the general health care delivery system and continue to be provided vertically (MoH, 2011). Yet there are evident links between malaria, TB and HIV/AIDS, which, for long their link has been largely ignored[3]. It is widely acknowledged that HIV infections result in a greater risk of death from malaria while malaria itself leads to an increase in HIV viral load among adults and possible increased mother-to-child transmission of HIV during pregnancy. Additionally, over 50 percent of TB patients are infected with HIV and 30 percent of AIDS-related deaths are attributed to TB. Amidst all these challenges, it remains to be seen whether access and use of health care services is fair across different groups of people as stated by Whitehead (1990) "equal access to available care for equal need". A critical look into factors that affect equity of access to and utilization of health services to vulnerable groups (particularly the poor, women of child-bearing age and young children) in Uganda would help understand trends in fairness and use of existing health facilities in Uganda.

1.3 Uganda's health sector

In the early 1960s, Uganda had one of the best health care systems in the region, it had a referral hospital, district hospitals and a network of health units that were well equipped and staffed (Ssewanyana *et al*, 2004). The political turmoil and economic decline of the 70s and early 80s resulted in a deterioration and virtual collapse of health care system that is still recovering. With this decline in health service provision came increased demand for medicines and health supplies, partly due to natural consequence of the population's growth; the increase in local pharmaceutical manufacturers and the rapid increase in the number of pharmacies and chemist shops across the country (UNIDO, 2010). While efforts have since been focused on renovating and rebuilding previously existing services, the extent to which these efforts have been successful is debatable. For instance, since 1972, the number of public, nongovernmental, and private facilities has increased by almost 400 percent and population has more than doubled while the number of trained medical personnel has increased by far less, approximately 14 percent (World Bank, 1999). In fact, the number of doctors has actually declined by 18 percent, leaving the number of people served by one doctor even greater than they were in 1972.

[3] AMREF; an International African organization working with local communities by providing knowledge, skills and means to maintain their good health and break the cycle of poor health and poverty (http://www.amref.org/)

Trends in overall health status in Uganda show slow progress in the already poor health status evidenced by; under five mortality rate of 137 deaths per 1,000 live births, Infant mortality rate of 75 deaths per 1,000 live births, Maternal mortality ratio of 435 deaths per 100,000 live births (UBOS, 2006). Several media reports and community surveys indicate that the quality of services in public health sector leaves a lot to be desired because: a) Ugandans do not receive services they need in terms of missed opportunities leading to waste and inefficiency, delayed care leading to dissatisfaction and ineffective services or systems; b) Ugandans receiving services less needed; c) Ugandans being harmed by the services they receive (MoH, 2011).

1.4 Statement of the problem

In developing countries, Uganda inclusive, several factors impede accessibility (and therefore use) of health services including cost of services, distance to health services, lack of available transportation hence high transport costs, poor health care facilities and lack of independence by women to make choices on matters that directly affect their health (Tawiah, 2011). Malaria remains the most and leading killer disease in Uganda with 70,000 to 100,000 deaths[4] and over 10 million malaria cases are seen in OPD annually. Clinically-diagnosed malaria accounts for 25-40% of outpatient visits at health facilities, 15-20% of all hospital admissions, and 9-14% of all hospital deaths; despite improvements in TB detection cases, Uganda is still ranked 15th of the 22 high burden countries. Communicable diseases in Uganda are mainly attributed to poverty and so make it difficult for families and communities to get out of the poverty cycle (UNIDO, 2010). AIDS has created an explosion of TB in many countries, with many people affected by both illnesses. A recent study in sub-Saharan Africa suggests that people with HIV are twice as likely to catch malaria as those without[5]. Perhaps, it should be noted that the death, sickness and absenteeism caused by these illnesses affects everyone and suffocates economic growth. In addition, an increased demand for public spending on treating these diseases increases pressure on government's limited resources from other healthcare and sectoral needs.

An examination of issues of equity of access to health services raises questions on the extent to which healthcare services influence health status and the extent to which existing health

[4] The New Vision, 26th April, 2012. "Malaria is the leading cause of illness and death in Uganda" accessed from http://www.newvision.co.ug/news/630620-malaria-is-the-leading-cause-of-illness-and-death-in-uganda.html on 28th Oct 2012.
[5] ibid

policy supports equity of access and utilization of health care services. Uganda's Ministry of Health states that in spite of the numerous efforts to restore the functional capacity of the health sector (through relevant policies), there still remain significant challenges in matching need for health services with available resources, making equity or fairness an important issue for advancing national policies for the population as a whole (MoH, 2007a). Perhaps, a an analysis of existing health policies, their organization, structure and distribution will inform this study of who accesses and uses health care services particularly for malaria, tuberculosis and HIV/AIDS among the poor and vulnerable groups.

1.5 Main aim of the study

To analyze the extent to which vulnerable groups in the population experience inequity (equity) to access to and utilization of health care service in Uganda.

1.6 Specific research questions

1. How do Uganda national health policy documents respond to ideals of equity of health services to the total population?
2. How do intentions stated in national health policy documents match the actual organization of health services (as these are stated in relevant official documents)?
3. How does actual organization of health services reach out to different socially and politically positioned public (as this appears in relevant scholar literature, official statistics and documents)?

CHAPTER 2: Methodology

In this study, national and international policy documents (relevant to Uganda) are reviewed. These were used to assess the level of distribution of resources like infrastructure, human resources and funding for the health sector. They were mainly got from official reports such as Ministry of Health (Uganda), Makerere University School of Public Health, Uganda Bureau of Statistics, World Health Organization and UNIDO. Other key information sources included;

i. Uganda Demographic Health Survey (UDHS) reports
ii. Malaria Indicator Survey, 2010
iii. Health Sector Strategic and Investment Plan, 2010/11 – 2014/15
iv. Ministerial Policy Statement (MPS), 2009/10
v. Reports of Parliamentary Committee on Health, 2012
vi. The Second National Health Policy (NHP II, 2010/19)
vii. Health Sector Quality Improvement Framework and Strategic Plan, 2010/11-2014/15
viii. The National HIV Prevention Strategy for Uganda, 2011-2015 and related resources

Secondary data analysis was carried out on the socio-economic component of the Uganda National Household Surveys (UNHS 2005/06, 2009/10) and Uganda Demographic and Health Survey (UDHS, 2011). The former collects information on socio-economic characteristics at both household and community levels as well as information on the informal sector (which is important for tracking development performance), while the latter provides current data on key health issues. Additional data from the Uganda National Panel Data (2009/10) and country data from UBOS/World Bank (2009) is analyzed in line with objective of the study. Electronic sources like PUBMED, Google Scholar, (online sources) Ministry Libraries in Uganda were used as literature search strategy. Databases were searched using terms such as Human rights, access, health services, utilization of health services, Uganda, HIV/AIDS, health care, equity and equality.

Ethical considerations

Secondary analysis of already existing data and review of policy documents was done in accordance with ethical considerations of the owner of the information. Permission for use of available data was sought as per the code of ethics and regulations governing data from the respective institution (s).

CHAPTER 3: Review of Literature

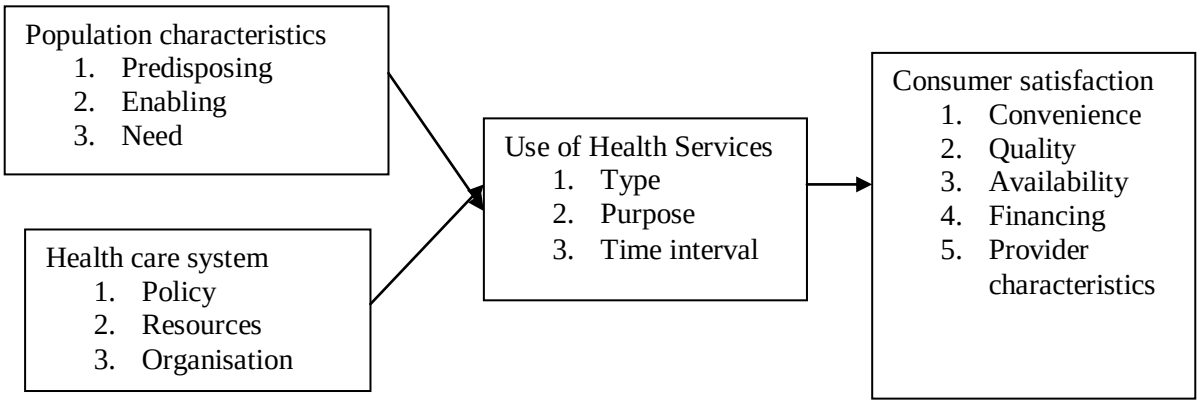
A priority concern for health care policymakers in developing countries is to ensure that vulnerable groups of the population (that include children, women and the poor) get access to high quality health services. In many studies, terms like inequalities, disparities and inequities are often used interchangeably in academic and policy literature (Pittman, 2006), and even when defined, there seems to be little consensus about their meaning or measurement (Macinko & Starfield, 2002; Braveman, 2006). In one of his studies, Ward (2009) states that equity becomes useful since it focuses research, policy and practice on exploring, attending to and monitoring healthcare, deemed to be unfair. However, assessing access to health care requires evaluating the factors that affect use of facilities (Hutchinson *et al*, 1999). Culyer *et al* conclude that the concern about access to health care stems from a concern about utilization of health care, which in turn stems from a more fundamental concern about health itself (Le Grand, 1991). This means therefore that by understanding theories advanced to explain health care utilization, it is possible to establish factors for access of health care services. In this regard, Andersen (1968) developed a health service utilization model which looks at different categories of determinants (Wolinsky, 1988b). Andersen's Phase-2 model of health service utilization (Andersen, 1995) combines both supply-side and demand-side factors that affect health care service utilization. For purposes of this study, this conceptual framework serves as a supporting tool to describe utilization of health care services specifically for Malaria, TB and HIV/AIDS among vulnerable groups in Uganda.

Defining "equity"

Equity is defined as the ability to impartially recognize the right of every person, sense of justice and impartiality being its guiding principles. Other terms that have been used instead of equity according to Braveman and Gruskin (2003) are fairness or (social) justice. Equity research has been directed towards financing of health care (Wagstaff *et al*, 1999), health care delivery (van Doorslaer *et al*, 2000), access to health care facilities (Goddard and Smith, 2001) or equitable distribution of health itself (Whitehead, 1991). For equity of access to be attainable, it is necessary to take into account some fundamental principles that aim to ensure a health system is appropriate given the social, political, epidemiologic and economic environment. It should also be noted that measurement of equity is dependent on which strand it takes – whether vertical or horizontal. Simply stated, horizontal equity refers to all cases being treated equally (or alike) while vertical equity means giving unequal treatment to

unequals (Cuyler, 2001). The common acceptable notion of equity is for people to access health care based on their needs and pay for such care based on their financial abilities. However, what constitutes 'need' in a sufficiently measurable sense by the health system is difficult to determine.

Figure 1: Conceptual framework of factors influencing utilization of health care services



Adopted from Andersen, RM (1995)

3.1 Health care system and health policy issues

The importance of equitable access to health care is recognized world over, both in the fight against social exclusion and poverty. Health is one of the fundamental human rights and national governments have an obligation to provide health to the people and ensure adequate and standard health services. Basic human right principles necessitate that health care is accessible and affordable to all irrespective of their race, gender, religion, region or income. From Andersen's model, health care system includes health policy, resources, and organization as well as their change overtime. Some studies have shown that barriers to access to health care services are influenced to a great extent by national health policy or trends and as such are less amenable to manipulation by actors and events in very localized realms (Fielder, 1981). The Institute for Medicine, Committee for the Study of the Future of Public Health (1988 in Brownson *et al*, 2010) adds that effective health policies and allocation of public health resources can substantially improve public health. Public health interventions occur at multiple levels and involve policy approaches that can affect large populations through regulation, increased access, or economic incentives (Brownson *et al*, 2010). In low income countries, evidence suggests that the cause of inequalities may be a reflection of the failure of health care services to reach the poor (van Doorslaer and Wagstaff, 2000).

3.2 Resources

3.2.1 Financial resources

In some instances, health systems perpetuate injustices and social stratification (Marmot *et al*, 2008). They further argue that in low and middle income countries, public money for health care tends to go for services that wealthy people use more than poor people. These cases are common where health care financing is highly inequitable. Notably, the purpose of health financing is to make funding available, as well as to set the right financial incentives for providers to ensure that individuals have access to effective public health and personal health care. Several categories of health care financing common to low income countries include taxation, donor funds, social health insurance, private health insurance, other private sources like NGOs own resources and out-of-pocket (OOP) expenditures. Perhaps, it is worth notable that allocation of financial resources to the general health services in sub-Saharan African countries is low and varying from country to country. Data indicates that total expenditure on health as a percentage of GDP in several African countries is way below 15% as agreed to by the Abuja Declaration. Therefore, in considering equity and universal coverage, it is important to look into who pays and who benefits, taking into consideration that majority of the people in developing nations are either below poverty line or are likely to fall below poverty line. Mills *et al* (2012) further argue that a comprehensive consideration of the whole system other than just the financing element is important if objectives have to be achieved.

3.2.2 Human resources

Resources comprise the volume and distribution of labour and capital, including education of health care personnel. Health workforce is a key resource if standard health care services and implementation of health programmes is to be effective. These should be adequate in number and should have the right skills mix. Central and local health systems and governments ought to ensure allocation of adequate financial resources and availability of adequate number of human resources for health towards effective implementation of quality health care services. In addition, health care staff must be adequately trained to competently handle health care challenges. In cases where there are gaps in staff training, there exist some risks of exclusion of some vulnerable groups of people. Research in Finland by Arinen *et al* (1998) found that health centers and public hospitals in rural and sparsely populated areas do not attract enough skilled staff and therefore create inequity in access to health care and differentials in health care use. Furthermore, the concentration of physicians and other health workers in urban

centers denies rural areas of the deserved staff leading to undersupply in certain areas regions within the country.

3.2.3 Infrastructure

Infrastructure plays a critical role in determining usability of the available health care services. Inadequate facilities such as laboratories, inadequate counseling rooms, physical structures, poor and inadequate storage facilities, poor or operational equipment de-motivates existing staff and creates inconveniences to clients.

3.2.4 Organization of the health care system

Organization refers to how a health care system manages its resources which ultimately influences access to and structure of health services. According to Andersen's revised model, how an organization distributes its resources and whether or not the organization has adequate labour volumes will determine if an individual uses health services. In general, rules and conditions of access to health care under public programmes are to a large extent established by contractual arrangements between payers and providers of health care according to the country's legal system (EC, 2008).

3.2.5 Health literacy, voice and beliefs

According to Andersen, predisposing characteristics involve demographics, social structure and health beliefs, while enabling characteristics refer to resources within the family and the community. Vulnerable groups not only shoulder the greatest health burdens but also have poorer access to information, communication technologies and face important shortcomings in their overall literacy levels or have general language barriers. Perhaps, it is also important to note that health literacy is closely linked to overall literacy levels (EC, 2008). A case in point is the OECD literacy tests which do not necessarily focus on health but whose findings are relevant for health policy. OECD reports acknowledge worrying levels illiteracy in which a number of people have limited capacity to understand, and interact with social programmes, and in particular those relevant to health (OECD, 1999).

Family resources include economic status and location of residence while community resources comprise access to health care facilities. It should be noted that the geography of health care services can pose different access hurdles for vulnerable people especially those who live in deprived areas with reduced service availability or who need to travel longer

distances to the nearest provider (EC, 2008). Geography and population density are currently highlighted as issues in relation to equity of access (Harkin, 2001). Need based characteristics include perception of need for health services, whether individual, social or clinically evaluated perceptions of need (Wolinsky, 1988b). It is argued that an individual's perception and (or) their social network's consideration of illness severity determines whether they will seek to utilize health care.

It is also argued that gravity is based on the assumption that the cultural beliefs classify illnesses by level of severity (Wolinsky, 1988b). Some scholars have argued that culture is a complex term referring to values, practices, meanings, and beliefs which are transmitted from one person to another through the process of enculturation[6]. Al-Doghaither *et al* (2003) have reported that in societies of the developing world, the set of determinant variables for the utilization of health services seems to be more complex than in the developed countries and additional factors are involved due to cultural differences, which include the different concepts of illness and health behavior and different socio-demographic characteristics. Wolinsky (1988b) further argues that culture, often considered a barrier to health services can influence knowledge and beliefs of illnesses as well as the course of treatment for illness.

Other factors that affect access and utilization of health services include affordability of health care services. This is not only associated with direct payment for health services but also includes cost of productive labour time, food, time spent seeking health services. Quality of health care as reflected by confidentiality, adequate supplies, skilled and available health workers, referral linkages to mention just a few. In conclusion, despite differences in health system size, structure and financing, evidence suggests that across countries particular sections of the population are disproportionately affected by barriers to access and utilization of health care. Some studies have shown that existing difficulties in accessing health care are compounded by poverty and social exclusion.

[6] Many scholars have defined culture differently.

CHAPTER 4: Policy and Equity in Uganda

4.1 Equity and equality of health care in Uganda

Some commentators such as Amartya Sen (2002) argue that existing inequalities in health are more worrisome than inequalities in other spheres. According to Amartya Sen (O'Donnel *et al*, 2007), "health is among the most important conditions of human life and a critically significant constituent of human capabilities which we have reason to value". This makes health not just the absence of disease but the ability of individuals to realize their potential throughout life. Ultimately, if people can access resources to enable them realize their potential health, the potential to generate well-being and future returns in the economy increases (Grossman, 1972). Consequently any inequities in health can limit opportunities for many people to lead a life they want, since their capacity to actively participate in productive life and get returns from their efforts is restricted. For instance, it is a fact that society especially among the poor is more concerned with poor children likely to die of preventable diseases before their 5th birth day.

In Uganda, the current equity landscape is of great concern. Whereas the Ministry of Health (MoH) admits having significant challenges in matching need for health services with available resources, making equity or fairness is an important issue for advancing national policies for the population as a whole (MoH, 2007). The Ministry however admits that health inequities exist in Uganda between the rich and poor communities, urban and rural districts, between social groups and across other social differentials. Additionally, economic and geographic barriers still pose a significant barrier to access to health care services. Together with other players, Ministry of Health has increased efforts through policies for equity in health and supports analysis and dialogue to strengthen knowledge and to support policy engagement on the implementation of comprehensive, universal, national health systems, centered on the role of people and of the public sector (EQUINET). This equity stand is further supported by the constitutional mandate to the Ministry and the people's rights as stipulated in various charters to which Uganda is a signatory. This chapter delves into existing policies meant to counter inequity (and inequality) in access and use of health services. It starts with the regulatory framework and explores more into various key policies. It further expounds on challenges and shortcomings in specific policy areas.

4.2 Health regulatory framework in Uganda

Uganda has ratified a wide range of international and regional human rights treaties related to the enjoyment of the highest attainable standard of physical and mental health ('right to health'), including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Elimination of All forms of Discrimination against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the African Charter on Human and People's Rights (ACHPR)[7]. At international level, Uganda is a signatory to a number of treaties and conventions, for instance, the Alma Ata Declaration, the UN Millennium Development Goals (MDGs), and other International Health Partnerships that provide a framework for leveraging health investments and achieving better health and health equity for populations (MoH, 2010). Uganda is also guided by other regulatory arrangements that include; The Alma-Ata Declaration of 1978 that issued a declaration indentifying Primary Health Care (PHC) as the key to the attainment of the goal of health for all. Also, the UN Millennium Development Goals (MDGs), and the International Health Partnerships and Related Initiatives (IPH+), among others, provide a framework for leveraging health investments, and achieving better health and health equity for populations (MoH, 2010).

Internally, there are a number of policy and legal frameworks from which Uganda derives its mandate. Uganda's health policy is guided by the Vision 2025 – the 25 year national development plan that was launched in 1999, and the 20-year Poverty Eradication Action Plan (PEAP, 1997-2012), the national planning framework (MoH, 2010). The Uganda Constitution adopted in 1995 obliges government to provide basic health services to its people, and guarantees all people health rights and opportunities in the form of assured access to health services, clean and safe water as well as other social services (MoH, 2009). This makes right to health a legal instrument - a crucial and constructive tool for the health sector to provide the best care to patients and to hold the government accountable. The constitution further includes provisions against discrimination and others related to specific groups such as the rights of women, children, persons with disabilities and minorities.

The above notwithstanding, there is a limited capacity for people to demand for these health rights due to low awareness that compromises their need for health. According to the Ugandan Constitution, the mandate to formulate national health policies and plans, set

[7] Fact sheet on Health and Human Rights in Uganda (WHO). Accessed from http://www.who.int/hhr/news/hhr_factsheet_uganda.pdf

standards and guidelines, carry out capacity building and monitoring and evaluation are vested in the Ministry of Health by the Uganda Constitution. Furthermore, implementation of government project is done under the decentralization policy (1992) and the Local Government Act (1997), which operationalize policies and effectively ensure delivery of key social services (including health services) at local levels. (More is discussed later in the consequent chapters). Key in Uganda's regulation platform are National Health Policies I and II which were formulated between 1999-2020, the first having been developed in 1995/1996.

4.3 Health Policy priorities

Uganda's health policies and regulations have been developed through a participatory multi-stakeholder process. The National Health Policy and Strategic Plan frame were formulated within the context of the provisions of the Constitution of the Republic of Uganda (1995) and the Local Government Act, 1997 that decentralizes services to local councils and boards. The first National Health Policy derived guidance from the National Health Sector Programme and the Poverty Eradication Programme (now National Development Programme). This is to ensure that every citizen has a right to access to high quality health care. The Uganda health policy seeks "to reduce mortality, morbidity and fertility, and the disparities therein". This also focuses on "Ensuring access to the Minimum Health Care Package is the central strategy to this end." The major contributors to the burden of disease at all levels, according to Ministry of Health, include malaria, STI/HIV/AIDS, TB, diarrhoeal diseases, acute lower respiratory tract infections, perinatal and maternal conditions attributable to high fertility and poorly spaced births, to mention just a few.

4.3.1 National Health Policy II

This is a key policy statement that puts the client and community at the forefront and adopts a client-centered approach with consideration of both the demand and supply sides of healthcare. The Government of Uganda is guided by two comprehensive National Health Policy documents (NHP); National Health Policy I (1999-2009), and National Health Policy II (2010-20). The NHP I set a pace for building of a strong health foundation by putting into place policies on which any subsequent health improvements would be based. The second National Health Policy (NHP II) is therefore a continuation of NHP I and covers a ten year period 2010/11-2019/20 with a corresponding Health Sector Strategic and Investment Plan (HSSIP) and health sector component that clearly identifies with the National Development

Plan (NDP) 2010/11- 2014/15, the overarching national policy and strategic framework governing the vision for development in Uganda.

Following the NHP, the Health Sector Strategic and Investment Plan (HSSIP) meant to operationalise the NHP by guiding interventions and investments in the health sector was developed. The main focus of NHP II is on health promotion, disease prevention and early diagnosis and treatment of disease. It is also concerned with provision of adequate quantities of affordable, good quality essential medicines and health supplies accessible to all who need them (MoH, 2008b). All these aim at increasing access to essential medicines as part of national efforts to deliver the Uganda National Minimum Healthcare Package (UNMHCP), that puts particular emphasis on communicable diseases especially HIV/AIDS, malaria and tuberculosis and must be accessible to all people in Uganda (HSSIP III, 2010:1). All these frameworks emphasize principles of equity and equality that can be achieved through adequate funding and efficiency in allocation and utilization of resources to promote, protect and preserve the health of the population.

These policy documents sought to enhance health status of the population through:

a) Uganda Minimum Health Care Package (UMHCP) that is intended to be a cardinal reference in determining the allocation of public funds and other essential inputs. This minimum package core strategies are aligned to the Millennium Development Goals (MDGs) to which Uganda is a signatory with emphasis on the poor, women and children. The NDP (through sector plans) and the HSSIP 2010/11-2014/15 are being implemented in a sector-wide approach (SWAp) which addresses the health sector as a whole in planning and management, and in resource mobilization and allocation. The focus of this health care package is on most cost-effective priority health care interventions and services that address high disease burden that are affordable and acceptable with the total resource envelope of the sector. Key to this package is the control of key communicable diseases like malaria, HIV/AIDS and Tuberculosis, and other related health initiatives.

TB and HIV/AIDS

Health Sector Strategic Plan (HSSP III) argues that communicable diseases such as malaria, HIV/AIDS and TB account for over half of the total burden of disease and are leading causes of ill health and mortality in Uganda. Key to evaluating health care utilization, health sector

monitors performance in malaria, TB and HIV/AIDS. The interaction of TB and HIV is increasing the burden of both diseases (MoH, 2006), with HIV being the biggest risk factor for the development of active TB among individuals infected with M.Tuberculosis. Currently, an estimated 60% of TB patients are also co-infected with HIV (MoH, 2011) while an estimated 30% of all deaths among People Living With HIV Aids (PLWHA) attributed to TB (MOH-NACP, 2003). According to The Modes of Transmission Study and sero-behavioral survey estimated in 2005 that HIV prevalence was higher among women compared to men, and that urban residents were significantly more affected than their rural counterparts (Wabwire-Mangen *et al*, 2009). According to MoH (2009) HIV prevalence among women attending ANC was at 7.4% in 2007 while only 50% of the Health Center IIIs (HC III) offered HIV Counseling and Testing (HCT) services. Twenty percent of new infections in 2008/09, according to MoH (2010e), were children who contracted it via transmission from their mothers. The incidence of TB (per 100 000 population per year) was estimated at 311 in 2008 while the prevalence of TB (per 100 000 population) was estimated at 281 (WHO Global Health Observatory). Detection rates are at almost 50% in 2008 which is well below WHO recommended TB control target of 70%. Treatment success rate has increased from 68.4% to 75.1% in 2009-10 according to Government of Uganda (GoU, 2010a). While other reports noted that detection rate increased from 50.3% to 57.4% after 2008, it later dropped to 54% in 2010-11. Additionally, the smear-positive tuberculosis was estimated at 70% below the WHO recommended 85%.

Furthermore, prevalence rates differ among urban and rural dwellers, ranging between 6% to 30% in some areas and communities (for instance island communities on Lake Victoria). HIV/AIDS is responsible for 20% of all deaths and a leading cause among adults. A total of 373, 836 people living with HIV (by September 2008) in Uganda required ART but only 16,000 were on ART. As of September 2009, 200 213 patients were on ARVs of which 8.5% were children. There are efforts to extend ART services to rural and urban locations. There still exist differences in distribution of ART sites across the country with some areas less or no sites as compared to others areas. Data also suggests that many women lack access to services for prevention of mother-to-child transmission of HIV, given numerous efforts to combat this problem.

Comparing urban and rural comprehensive knowledge of HIV, 20% of females from the poorest 20% population between 15-24 years of age possess knowledge on comprehensive knowledge on HIV, while 47% of the richest 20% possess knowledge of HIV in the period

2007-2011. On the contrary, 28% of males in the poorest 20% aged 15-24 have comprehensive knowledge of HIV while 47% males of the richest 20% have comprehensive knowledge of HIV. Ultimately, one may argue that other factors remaining constant, the poor cannot manage such things as radios and TVs where such information about HIV is mostly transmitted in Uganda. It may also be true that the poorest 20% do not know how to read and therefore cannot read any form of informational source available to them. This certainly leads to health inequity among the population dependent on socioeconomic status.

MALARIA:

Malaria remains one of the leading diseases that cause morbidity, mortality and economic losses. The current estimated annual number of deaths from malaria ranges 70,000 to 110,000[8]. Clinically-diagnosed malaria is the leading cause of morbidity and mortality, accounting for 25-40% of outpatient visits at health facilities, 15-20% of all hospital admissions, and 9-14% of all hospital deaths (MoH, 2009). A significant percentage of deaths occur at home and are not reported by the facility-based Health Management Information System (HMIS). It should also be noted that prevalence of malaria varies between rural and urban areas. For instance according to Malaria indicator Survey (2009) malaria prevalence among children between 0-59 months, was higher in rural areas with 47% against urban areas with 15% using microscopy. Furthermore, the Survey report (2009) also states that malaria prevalence ranged from 5% in Kampala to 63% in the mid-northern region.

Additionally, the proportion of pregnant women reportedly receiving a second dose of Fansidar for Intermittent Presumptive Treatment (ITP) of malaria has been increasing overtime, with 43% recorded in 2011 against 40% in 2010. Malaria was ranked highest cause of morbidity during the last five years while it was ranked number 1 cause of mortality in 2010/11 at 20.9%. HIV/AIDS was ranked second at 9.4% while TB came in the 5th position with 3.9%. In terms of age groups, the highest number of mortality was among males above 5 years (36.1%) followed by females above 5 years (25.1%). Mortality for males under-five was 20.2% with females under-five being 18.5%.

[8] Uganda Malaria Control Strategic Plan 2010/11-2014/15

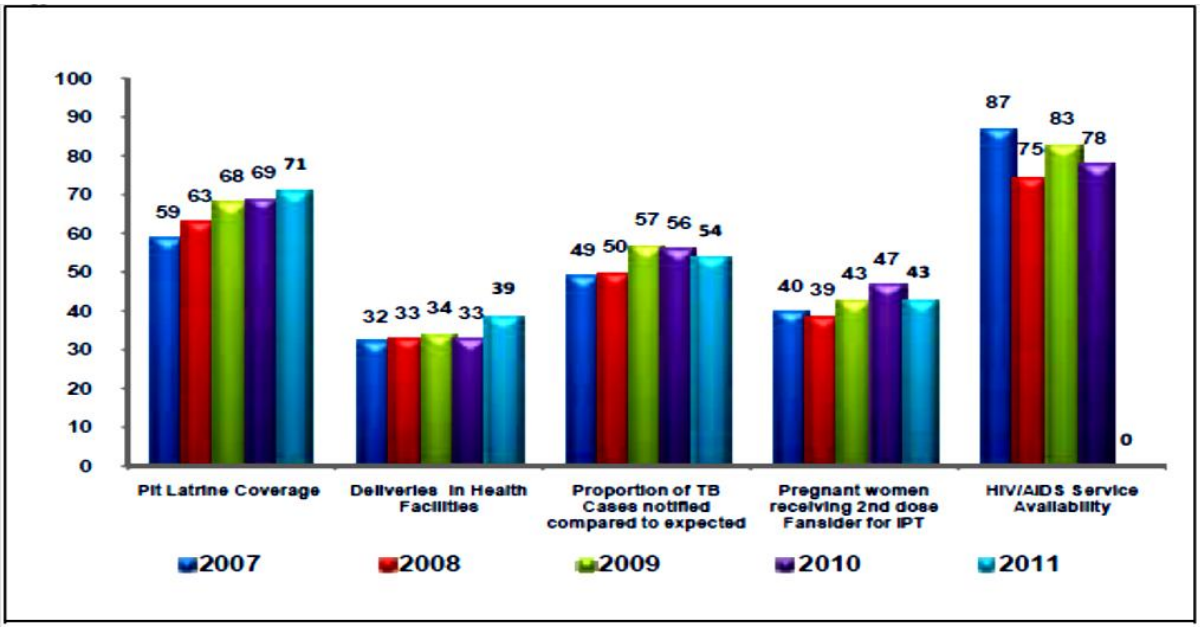
Table 4.1: Top ten causes if hospital based mortality for all ages in 2010/11

IPD Diagnosis	Under 5 years	Above 5 years
Malaria	27.16	16.99
AIDS	2.61	13.67
Pneumonia	11.37	5.58
Anaemia	12.10	4.74
Tuberculosis	0.90	5.74
Perinatal conditions(in New borns 0 to 28 days)	7.78	N.a
Septicaemia	4.99	1.42
Other Types of Meningitis	0.96	2.40
Respiratory Infections (Other)	2.72	1.26
Injuries -Road Traffic Accidents	0.49	2.55
All Others	28.93	45.66
Total	**100.00**	**100.00**

Source: Annual Health Sector Performance Report, 2010/11

Among children under 5 years, malaria is the highest cause of mortality (27.2%) as seen in Table 4.1, followed by anaemia. AIDS and TB are ranked low at 2.61% and 0.90% respectively as shown in the above table. However, care must be taken on the current statistics presented since a significant number of people have other sources from which they seek medication. For instance, HRFI survey (2010) states that people especially in "rural areas are frustrated by lack of doctors and medicines in health units and have eventually turned to mushrooming yet unregulated traditional healers for treatment".

Figure 2: Trend of Selected Health Sector Performance Indicators in Uganda



Source: Annual Health Sector Performance Report, 2010/11

Fundamental to equity of access in respect to HIV/AIDS, Malaria and TB policy (for the case of this study) is the perspective in which it is viewed, either from the patient or physicians' view. From the patient's perspective, the issue of access has more to do with treatment being delivered in the best way, good therapeutic options and the lowest cost (or no cost for public funded health). My view perhaps is that client's (patient/consumer) expectation of quality care, which depends on the attitude of the health worker, need not be overemphasized. Patients, at all times, expect a comfortable situation where they can freely ask questions and interact with friendly and helpful health workers. This therefore brings the issue of consumerism into picture, in which the customer then is the king, whether in private or public health settings. In either case, health care workers are paid to deliver meaningful and quality care to their customers (or patients) and must, as a principle provide that. However I find this convention doubtful in circumstances of scarcity (of health care workers) and a lot of health constraints (such as poor financial funding) hence doubtful for a patient (or consumer) to be king especially in a poor rural health setting. Consequently, it remains widely acceptable that many patients' expectations still need to be met by health care workers. From the physician's perspective, access to health care means service for all patients in a way that meets their treatment needs. Uganda's situation seems contradictory given the current health worker – patient ratio that leaves a lot to be desired.

Important to note though is that the use of health care is seen from the perspective of individuals making choices while supply of health care is viewed from consideration of tools of constrained optimization. However, given existent constraints in the Ugandan health care system, it is widely believed that the notion that people make choices for the type of health care they need is far from reach. Consequently, I could state that the onset of ill-health is viewed as an act of fate not the outcome of any individual's own choices. Perhaps what should also be noted (according to Le Grand, 2003) is that not all health inequalities are necessarily inequitable since some may have arisen from individual lifestyle choices.

b) Health Financing Strategy (HFS) directed towards effective, efficient and equitable allocation and utilization of resources in the Health Sector consistent with the Poverty Eradication and Action Plan (PEAP, changed into National Development Programme-NDP). This approach emphasizes stronger donor coordination with basic principles of equity, that is, fair play and justice at the forefront.

Health financing further emphasizes full accountability and transparency in the use of available resources. Some scholars, such as Mills *et al* (2012) have suggested that any desire to improve equity lies at the core of many health sector financing initiatives. Therefore, the aspect of financing considers distributing the burden of financing health care services depending on ability to pay, need and the capacity to benefit such care. Uganda's downward trend of the national budget allocation to the health sector to less than 9% amidst increasing health care challenges is a manifestation of government's backtracking on its promise to dedicate at least 15 % (excluding donor financing) according to the 2001 Abuja Declaration. Perhaps it is also important to note that it is within this period of higher funding that Uganda shone internationally in its fight against HIV/AIDS with much of the funds coming from donors. Ultimately, it can be argued that positive results realized within this period of increased investment in the sector were no doubt related to increased donor funding.

Table 4.2: Selected Health Financing Indicators for Uganda and Comparison to Average for Peer Countries

Selected Indicators	Uganda	Sub-Saharan African Countries Average	Low Income Countries Average	Year of Data	Source of Data
Total expenditure on health as % of GDP	8.22	6.56	5.13	2009	WDI 2011
Per capita health expenditure in current US$	42.55	76.44	24.94	2009	WDI 2011
Government expenditure on health as % of total government expenditure	11.58	data not available	data not available	2009	WDI 2011
Government expenditure on health as % of total health expenditure	18.95	44.22	39.39	2009	WDI 2011
Donor financing for health as % of total health expenditure	20.90*	data not available	data not available	2009	WHO
Out-of-pocket health expenditure as % of total private expenditure on health	65.44	63.10	82.68	2009	WDI 2011
Out-of-pocket health expenditure as % of total health expenditure	53.04	35.20	50.12	2009	WDI 2011
Private expenditure on health as % of total health expenditure*	81.05	data not available	data not available	2009	WHO

Source: World Bank, World Development Indicators Database, 2011

Health financing is through government spending made through the health budget, a number of private sources such as on-budget and off-budget contributions from donors, OOP payments by individuals and households. Data in Table 4.2 above shows that household OOP expenditure was up to 65% of private expenditure on health in 2009. Uganda's health sector has mainly benefited from donor funding with up to 40-50%. With on-budget donor contribution reduction, there has been a sharp decrease in total amount of budgetary funding for health. Current per capita budgetary health spending of US$9 is far less that the US$28

that is needed to finance the implementation of its ongoing health sector strategy programs (Okwero *et al*, 2010). With this low government expenditure and its dependence on donor funds, Uganda faces major challenges in sustaining the financing for new yet expensive health interventions. Increases in OOP spending have eaten into household's income especially the poor and limited income populations. These challenges of inadequate financing are obstacles to ensuring greater access of individuals to the much needed health care. Inequity in financing of health care still exists due to differences in socioeconomic status and geographical location.

4.3.2 The National Medicines (Drug) Policy

The National Medicines Policy (NMP) document exists and guides all licensed retail private pharmacies (440) and all drug shops in the country (4742) by 2007/08. Sectors that dispense a substantial proportion of medicines to patients include the public sector, NGO/mission (PNFP and PFP) sector. The National Medicines Policy is operationalised by the National Pharmaceutical Sector Strategic Plan which sets out activities, responsibilities, budget and timeline. The strategic plan is implemented by the National Drug Authority (NDA), a regulatory authority, funded through the regular budget from the government/fees from registration, importation and exportation of medicines. Legal provisions are in place requiring transparency and accountability and promoting a code of conduct in regulatory work. NDA is further required to provide information on: legislation, regulatory procedures, prescribing information (such as indications, contraindications, side effects, etc), authorized companies, and approved medicines.

Nonetheless, there are serious challenges that have limited the operationalisation of these drug provision policies. A survey by HRFI (2010) reported that the government is obsessed with physical presence of health structures but not their functionality. The report also questioned the rationale for National Medical Stores (mandated with drug distribution) having to manage budgets of all public health institutions when the lower health units can hardly quantify their drug requirements over a long period of time leading to drug stock-outs. Consequently, patients return with their prescription forms home, staying without medication until drug deliveries are made. Stock-outs at public sector facilities, informal payments in the public sector (in order to be given faster service), and high prices in the private sector still play a bigger role in inhibiting the rural/urban poor from equitable access and utilization of health services. However, the viability of private health care business is still a far cry punctuated by inadequate personnel, lack of equipment and ill-performance. The result is the combination of

these vices on the patients, abuse of patients and in some cases death. Perhaps another key aspect common with private health care facilities is the provision of their services at a cost more often an amount that the vulnerable population may not manage to raise. This therefore limits access to essential health care and the 'need' factor in equity is violated. This is a challenge to about 65% of the households in the lowest socioeconomic bracket which face monthly catastrophic expenditures on health care. Other reasons that could explain this severe stock-outs is underfunding regimes, inadequate coordination between donors, medical stores and local health centers, and inadequate pharmaceutical human resource. There are always reports in national media that majority of clinics and hospitals regularly run out of essential medicines while only a third of facilities delivering babies are equipped with basics such as scissors and disinfectants. While this policy is well intentioned, there is a gap in relation to its funding. Some policies are not backed up by the requisite financial resources for implementation, for instance, there was a change in malaria treatment policy from affordable but low-efficacy drugs to expensive but high-efficacy drugs without considering the funding implications for this policy change. This resulted into limited access to much needed drugs due to frequent stock-outs.

The condition is further exercabated by lack of pricing policy of medicines on the market and since there exists no social health insurance system, some poor people are denied access to essential medicines that cannot be acquired in public health facilities due to expenditure on such medicines. Those expenditures have been termed as catastrophic expenditures (which push people into poverty). In a 2008 study carried by Ministry of Health on access and use of medicines in Uganda, it was established that on average, 63% of households that were surveyed experienced catastrophic payments related to medicines (in a month preceding the survey). In this study, catastrophic expenditures were calculated as those expenditures higher than 40 per cent of discretionary expenditures[9]. What should be noted however is that these expenditures may not wholly be dependent on only medicines but such things as time and transport (distance travelled to access a health facility).

4.3.3 Human resource development policy

This policy measure is based on a) addressing the major constraints of inadequate numbers and inappropriate distribution of trained health personnel; b) development of guidelines for optimal deployment of trained health personnel, and c) Ensuring increased productivity in

[9] Xu K., The Lancet 2003: 362:111-117

accordance with the Result Oriented Management policy of government through effective and efficient utilization of health personnel, and the provision of an enabling environment which meets the special needs of both men and women. While this policy is in place, its implementation is still faced with challenges. Effective service provision has been faced with a severe shortage of already poorly-remunerated but overwhelmed staff. While WHO recommends a ratio of 2.3 health care workers per 1 000 population as a minimum to meet the millennium development health goals, Uganda's ratio currently stands at approximately 1.8/1 000. It should also be noted that many of these health workers are located mainly in urban areas, leaving the rural settings with insufficient health workers. In an ideal situation (as per the policy) every maternity bed should be attended to by at least two midwives. In real terms however, it is common place to find one midwife at a government facility handling between four and 10 expectant mothers per day.

Table 4.3: Level of health resources in Uganda

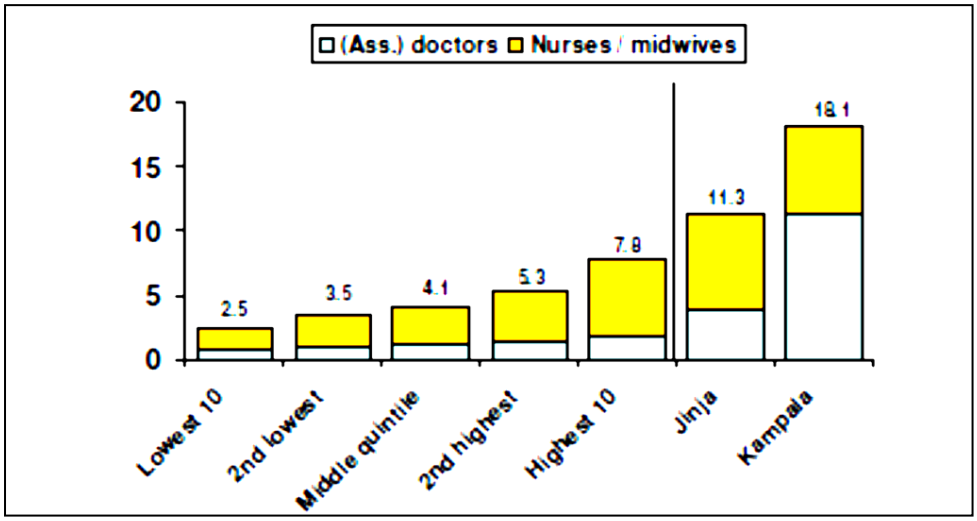
		Ratio of resources	
Health resources	Density of resources per 100 000 inhabitants	Highest to lowest district quintile	Capital to the rest of the country
Doctors	3	5.4	3.3
Assistant doctors	11	2.7	11.3
Midwives	12	4.0	2.6
Nurses	22	5.3	1.7
All health workers	46	3.4	3.9
Health facilities	10	2.9	4.4
Inpatient beds	114	5.6	2.7

Source: UNFPA, 2006

Uganda has 14 doctors/assistants per 100 000 inhabitants overall, ranging from 117 per 100 000 in Kampala (the city) to 3 per 100 000 in Bushenyi district (Western). There are approximately 11 500 doctors, assistant doctors, nurses and midwives countrywide with the 10 districts with the fewest health workers (lowest quintile) and the 10 districts with the most health workers having 25 and 78 health workers per 100 000 inhabitants respectively. However, Jinja and Kampala have considerably higher rates of health workers per 10 000 inhabitants (as seen in the Figure 4.2). In an ideal situation, the distribution of health workers should go where people are and the needs are greatest. While only 13 percent of Ugandan population is urban (WDI 2010), human resource distribution especially among high level professional cadres is skewed toward urban areas. Staffing levels are also skewed regionally with the central region better staffed as compared to others. For instance MoH (2011b),

Kampala city is 123 percent staffed over and above the required posts while staffing in some districts are less than 20 percent.

Figure 3: Number of health workers per 10,000 population by rural district quintile, Jinja and Kampala



Western regions respectively in 2006, reported a different human resource density with a range of 61 to 177 health workers per 100 000 inhabitants between Mbarara and Jinja respectively (Table 4.3).

Table 4.4: Density of health workers per 100 000 inhabitants, by district

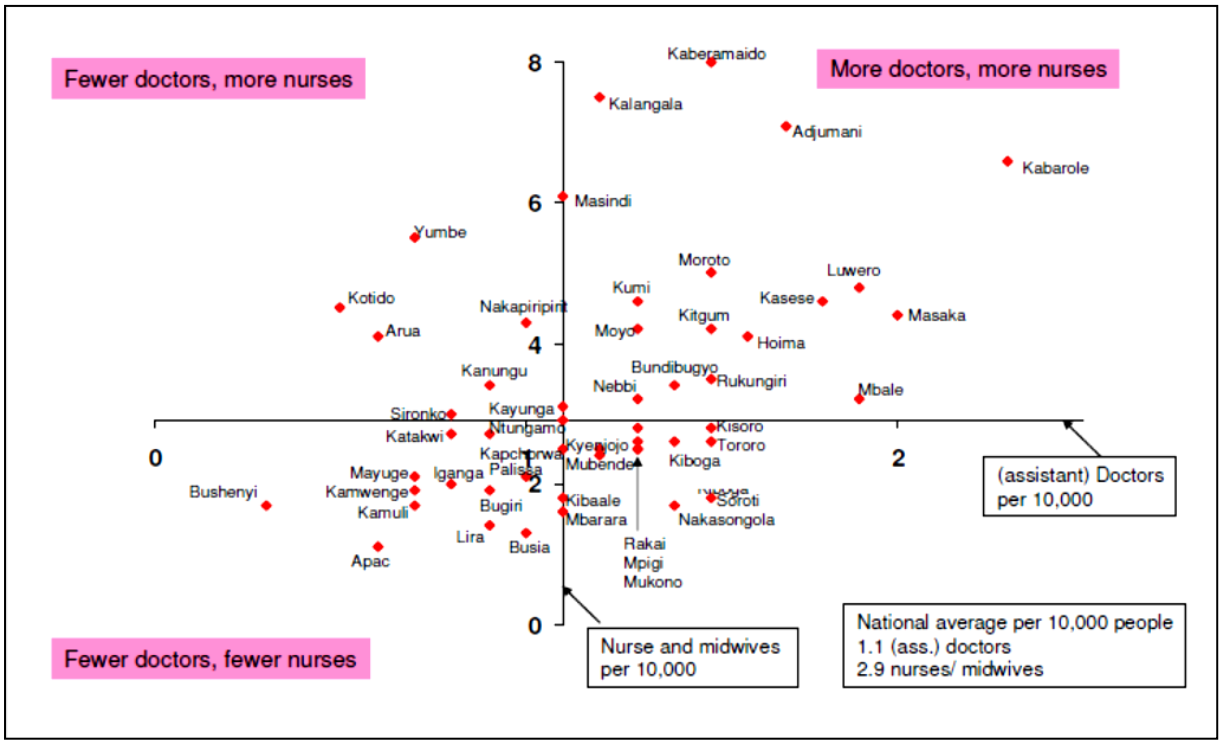
	Jinja	Kiboga	Mbarara
Physicians	10.7	1.3	3.2
Nurses	46.0	13.4	14.1
Midwives	33.7	15.1	12.2
Medical assistants/ Clinical officers	12.8	6.1	4.6
Laboratory technicians/ Technologists	4.6	0.9	1.0
Pharmacists/ Dispensers	2.6	0.4	0.3
Other health workers	67.7	42.8	26.7
Total health workers	**176.8**	**80.9**	**61.4**

UNFPA, 2006

This includes physicians, registered and enrolled comprehensive nurses, registered midwives, nursing assistants and nursing aides, dentists and dental assistants, laboratory technicians and technologists, laboratory assistants, pharmacists and dispensers, health management information system (HMIS) personnel and records assistant. There are further variations in human resource distribution in different regions and districts in Uganda. Figure 4.3 shows

health worker distribution by district. The upper quadrant shows districts with more doctors/assistant doctors and more nurses/midwives that the national average, excluding Jinja and Kampala (that have health workers in excess of the national average). The lower left quadrant shows districts where these categories are below national averages. Almost half of the few laboratory technicians in Uganda are in Kampala, leaving several districts without any laboratory technician while others have only one. Many more health workers are still lacking in various parts of the country.

Figure 4: Health staff by district: (ass) doctors and nurses/midwives per 10 000 population, excluding Kampala and Jinja districts.



Source: SAM 2006

Current World Health Organisation's (WHO) revised definition of a health worker refers to a combination of a doctor, nurse and midwife. WHO's new guideline states therefore that this cadreship of medical professionals should handle 1,000 people, of which less would put a country in crisis position. It is certain therefore that under the new guidelines, Uganda, according to the former Minister of Health, is significantly operating below this new WHO standard. This makes the system vulnerable to stated guidelines and leads to a potential public health crisis. The imbalance in human resource poses major barriers to access (professional) to quality health care in rural, remote and hard-to-reach areas. This is supported by Arinen *et al* (1998) who found that less attraction of skilled health workers to rural and remote areas

creates inequity in access and health differentials in health care use. The explanation for this occurrence is the failure of the system to attract health care workers to fill existing posts and retain them after recruitment. This is also brought about by existing possible health worker destination like emigration (due to large salary differences with other countries), employment with international NGO projects (specifically in malaria, TB and HIV/AIDS), movement from public sector to PNFP or PFP sector and other sectors.

In terms of performance management, there are few studies that have been done on health workforce in Uganda. With many challenges facing the public sector, the set mechanism for regular performance is inconsistent and this makes organization of staff development activities inconsistent with the needed staff skills. There are also claims of lack of promotional avenues and incentives within the district health system that makes the performance appraisal a ritual other than a tool for performance improvement and career development. The quality of pre-service training programs is also essential to producing better qualified health workers. A study by UNFPA – Uganda (2009) found that tutor-student ratios stood at 1:60 against international standards of 1:10. There are more questions on the quality mechanisms in teaching processes, inappropriate learning environments with limited staff and tools. All these challenges have exposed health system to potential increases in health service disruption and imbalances in health worker distribution.

CHAPTER 5: Health Structure organization in Uganda

This chapter describes Uganda's health system, decentralization of health services and health care delivery systems highlighting the major underpinning policy change that laid a basis for local engagement in management of the local resources. Under the decentralization system, local government is availed with powers to run the existing structures, plan, monitor and implement the policy to achieve the required results. This chapter also expounds more on different health care levels from the top national referrals to the lowest Local Health Center I, further detailing on their respective coverage mandate. It concludes with a discussion of the issues and challenges that have faced current decentralization policy and these challenges have affected access and utilization of health care services in different ways.

5.1 The National Health System

The National Health System in made up of the public and the private sectors. The public sector includes all Government health facilities under the Ministry of Health, health services of the Ministries of Defense (Army), Education, Internal Affairs (Police and Prisons) and Local Government. On the other hand, the private health delivery system consists of Private-Not-for-Profit providers, private Health Practitioners, and the Traditional and Complementary Medicine Practitioners. The National Health System is decentralized with services managed and delivered at district level. Several health sector reforms have been implemented, including abolition of user fees, introduction of public-private partnerships in service delivery, and decentralization of health services at district and lower local government levels in order to extend services to the local people. This section is important because the basis of health care provision as provided through health policy resonates across political spectrum and greatly plays a role in national election campaigns. This is because different national cultures and political experiences within Uganda, since independence, have long constructed different institutional arrangements for funding and delivering health care services. There exist questions on whether this type of arrangement has the ability to accommodate key aspects of modern systems, that is, whether these decentralized units are more or less sensitive to equity issues.

5.2 Decentralization of health services

Decentralization reforms in Uganda involved three main components: political, administrative and financial decentralization. Political decentralization transferred all political and administrative authority from the central government to the local government authorities (Resistance Councils later renamed Local Councils), including power to approve district budgets. Subsequently, administrative decentralization (1993) and later financial decentralization were gradually introduced. This policy was adopted to increase service provision to the people, particularly the rural population to politically increase local democratic decision making processes based on local needs. As a result, political and administrative units (districts) were increased from 34 in 1990 to 112 in 2010. This administrative and political change necessitated changes in policy that led to the enactment of the new legislation, the Local Government Act in 1997. With these changes, the role of government changed to policy guidance, technical support and supervision-leaving management and delivery of services a responsibility of districts.

5.3 Health service delivery

The delivery of health services is by both public and private sectors. Government owns most of the health care facilities (as reflected in Table 5.1).

Table 5.1: Number of functional Health units by Ownership and Facility level

		Health Facility Level				
Year	Ownership	Hospital	Health Centre IV	Health centre III	Health centre II	Total
2004	GOVT	55	151	718	1,055	1,979
	PNFP	42	12	164	388	606
	PFP	4	2	22	830	858
	Total	**101**	**165**	**904**	**2,273**	**3,443**
2006	GOVT	59	148	762	1,332	2,301
	PNFP	46	12	186	415	659
	PFP	8	1	7	261	277
	Total	**113**	**161**	**955**	**2,008**	**3,237**
2010	GOVT	65	165	847	1,578	2,655
	PNFP	57	12	243	489	801
	PFP	9	1	26	958	994
	Total	**131**	**178**	**1,116**	**3,025**	**4,450**
2011	GOVT	66	166	860	1,588	2,680
	PNFP	61	16	278	516	871
	PFP	16	8	40	1,366	1,430
	Total	**143**	**190**	**1,178**	**3,470**	**4,981**

Source: Ministry of Health (HMIS) annual report 2011

5.3.1 The Public Health Delivery System

Public health services in Uganda are delivered through VHTs, HC IIs, HC IIIs, HC IVs, general hospitals, Regional Referral Hospitals (RRHs), and National Referral Hospitals (NRHs). The range of health services delivered varies with the level of care. In all public health facilities – curative, preventive, rehabilitative and promotive health services are free (or supposed to be free) since the abolishment of user fees in 2001. User fees however exist in private wings of public health facilities (hospitals). Whereas there is a claim that 72% of the population live within 5 km from a public or PNFP facility, utilization is limited due to inadequate human resource, poor infrastructure, lack of medicines, low salaries to health workers, other health supplies and other factors that affect access and quality service delivery.

5.3.2 The Private Sector Health Care Delivery System

Uganda's private health sector plays an important role in the delivery of health services covering 50% of the reported outputs. The private health sector includes Private-Not-For-profit, Private-for-profit, and traditional and complementary medical practitioners. PNFP sector is more vibrant (more structured) in rural areas while PFP sector is more concentrated in urban areas. Surprisingly traditional and complementary medical practitioners sector is present both in rural and urban areas. However, traditional practices vary between local and imported medicines, mostly dispensed in some urban areas. With the current public hospital challenges, the private health sector is important in supplementing government efforts in health delivery. The government in turn recognizes the contribution of private health sector by subsidizing the health facilities, training institutions and some private health facilities.

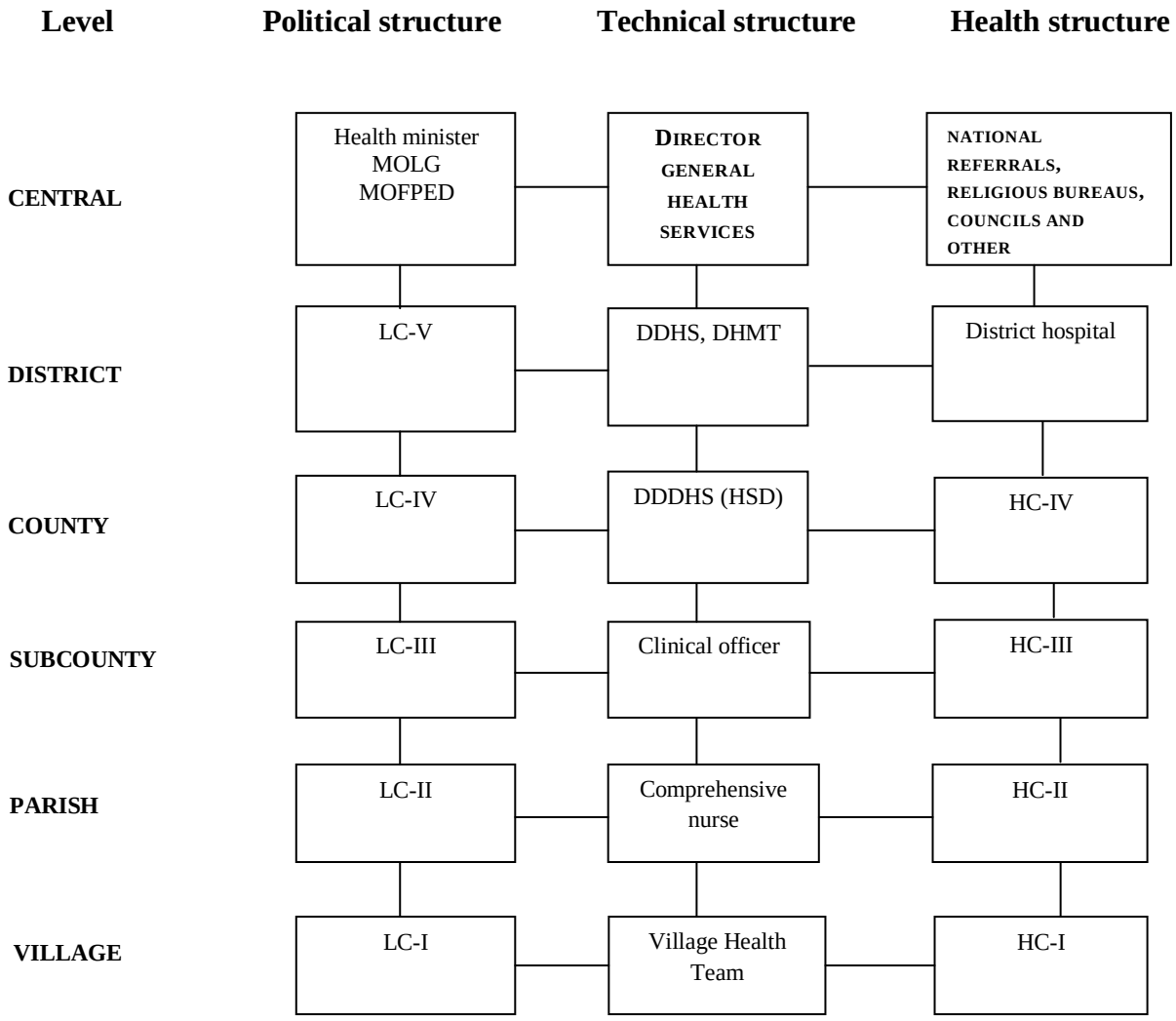
5.4 Sector organization, structure and management of health services

Uganda's health service provision has been decentralized with district and health sub-districts (HSD) levels playing a key role in delivery and management of health services at those respective levels. With no regional or provincial arrangement in Uganda, health services are structured into National Referral and Regional Referral Hospitals; general hospitals; Health Center IVs; Health Center IIIs; and Health Center IIs. Health Center I (HC I) has no physical structure but a team of people (Village Health Team-VHT) that works to link health facilities with the communities. These lower level teams are responsible for health promotion,

community based service delivery, community participation and empowerment in access to and utilization of health services.

In terms of management, the decentralization of the health sector is an integral part of the Ugandan government reforms. The political body governing the health sector of a district is the District Health Committee (DHC), whose members are from the Local Council V (LC V). Non-hospital based care is headed by the District Director for Health Services (DDHS) and reports to the Chief Administrative Officer (CAO) who is the civil head of the district. However, the managerial structure of the regional and national hospitals is still directly under the Ministry of Health.

Figure 5: Key officials in the political/health sector



5.4.1 National, Regional and General Hospitals (The Public Sector)

The National Hospital Policy, adopted in 2005, spells out roles and functions of hospitals at different levels. The main objective is to improve access to equitable and quality hospital services at all levels in both public and private sectors. There are currently 56 public hospitals: 2 National Referral Hospitals, 11 Regional Referral Hospitals, 43 general hospitals, 42 PNFP and PFP hospitals.

5.4.2 District health systems

Local governments at district level plan, budget and implement health policies and health sector plan as provided for by the 1995 Constitution and the Local Government Act of 1997. They also recruit, supervise, deliver health services and monitor all health activities including those of private sector in their respective areas. Districts are now responsible for the health centers, dispensaries and all other units that provide primary health care services (as stipulated but the Local Government Act 1997) under the district medical office. New health committees were created with a district health management team composed of a district drug inspector, district health educator, district health visitor, district ophthalmology clinical officer and the district vector officer. These health teams implement health programs as well as coordinating health policies and activities of other players (or service providers) such as NGOs. Under the decentralized policy, the LC Vs are tasked with the responsibility of providing health services to their local area residents, and therefore whoever provides health services in the district falls under the LC V. Operation of these district health systems have also not been spared either.

5.4.3 Health sub-district (HSD) system

The HSD is a lower level system and serves at a county (or parliamentary constituency) in the hierarchy in the district health service. It is concerned with planning, organization, budgeting and management of health services at this and lower level health center levels. It is also concerned with PNFP and PFP service providers within its area of coverage. This facility can be termed as a mini hospital with all lower level facilities in addition to having men's, women's and children's wards. This hospital should also be able to admit patients and therefore should have two doctors; a senior medical officer and another doctor as well as a theatre for carrying out emergency operations. These health sub-districts also offer elective surgery and they are established to bring qualified health care workers closer to the people.

5.4.4 Health centers III, II and I

HC IIIs provide basic preventive, promotive and curative care. They also provide support supervision of the community and HC II under its jurisdiction. Health center III facility serves a sub-county (Local Council III) and should have about 18 staff led by a clinical officer who runs a general outpatient clinic and a maternity ward. It should also have a functional laboratory. However, there exist great regional variations in the status of health infrastructure as well as staffing patterns. These differ between urban and rural areas, with areas around the capital having better infrastructure than areas far from the capital especially in the north and north-eastern regions of the country.

HC IIs provide the first level of interaction between the formal health sector and the communities. According to the health policy, every parish should have this facility. They provide outpatient care and community outreach services with an enrolled comprehensive nurse as key to the provision of comprehensive services and linkages with the VHTs. Other staff at this level should be a midwife, two nursing assistants and a health assistant. This lower level health facility should be able to treat common diseases like malaria. The VHTs (HC I) has been established to facilitate health promotion, service delivery and community participation and empowerment in access and utilization of health services. While this is key in promoting health in Uganda, with 75% of VHTs established in Uganda's districts, only 31% of the districts have trained VHTs in all the villages. There is further low morale to work among VHTs due to lack of emoluments[10].

5.5 Contextual considerations for existing structures and systems

Politically, decentralization looks at structural issue as well as the values under which institutions are established and ultimately, health care decentralization is affected by the role played by politics and since decentralization involves the distribution and sharing of power and political control, it unavoidably has a strongly political dimension. Under this decentralization context, delivery of improved quality health care services cannot be done by health providers alone. Certainly, communities, service users and co-producers of health have an equal responsibility too. These are critical in identifying people's needs and preferences and managing their own health with appropriate support health service providers. Quality of care in health must be delivered within the framework of decentralization, with Local

[10] Ministry of Health (2009). Annual health sector performance report, 2008/09.

Governments reserving the mandate to ensure quality health care service delivery as well as planning, coordinating and implementing the sector.

However, within this expanded administrative framework, the role of state in providing and overseeing resources encounters a threefold challenge: scarce resources, inappropriate prioritization (MoH 2008), and budget leakages and misuse (MoH 2011) leaving severe capacity constraints and ineffective service delivery. The central government continues to provide limited block grants to the districts for services planned for and delivered by the districts. It should be noted however that in practice, the allocation of funds to the districts does not correspond to the actual commitments made by the central government on behalf of the districts (ULAA, 1998). For instance, out of the recurrent national budget for 2013/14, lower health facilities will receive, on average, approximately $47 (Ushs 120,000) per month. Only $1,614,173 (Ushs 41bn) has been allocated as recurrent budget to run health service delivery in 137 local governments with over 4,200 lower level health units.

From limited medical supplies, to congestion and limited beds, some of these national and referral hospitals have become a death trap hence defeating the objective of these institutions' establishment. On a recent visit to the main national referral hospital (Mulago) by the shadow cabinet of Ugandan parliament, the leader reported that "sick people are sleeping on the floor yet others get medicines while standing"[11]. The leader of opposition further stated that the "hospital is sick and needs urgent help before it is too late". He further questioned the rationale for one nurse attending to 80 patients. In addition, the executive director further expressed his fears over the state of affairs at the hospital by noting that "poor staff remuneration is a serious problem, with staff currently getting US$ 44 consolidated allowances monthly". He further argued that the "the allowances should be increased to at least US$ 130 per month but the hospital budget does not permit this". He also stated that since they lack funds, the hospital cannot provide food to patients, let alone providing medication which forces patients to purchase from private clinics around the hospital.

These challenges have directly affected equitable distribution of health services especially in instances where distributive allocations of funds is made on the basis of what is available than what is needed. Consequently, central government still has financial power that affects districts, leaving a discrepancy between the formal powers given to the districts by the Local Government Act and the financial means to exercise them. HSSIP (2010) contends that the

[11] http://in2eastafrica.net/mps-unmask-the-rot-at-mulago-hospital/

increased number of districts and subsequent administrative units has not delivered the theorized benefits of better service delivery, but rather strained the few existing ones and increased management and administrative functions and costs. It is also important to highlight that some counties were elevated to district status with barely any infrastructure, office space, furniture, electricity, water and other supplies and are still financially incapacitated to cover their own administrative costs as well as other materials and supplies. At this rate therefore, Uganda's healthcare system works on a referral basis; that is to say, if a level facility cannot handle a case, it refers it to a unit the next level above. But reference to higher level health facility that does not have the minimum required standards as reflected through financially constrained local management spells doom for the poor rural that cannot access the needed health care.

The above challenges notwithstanding, success of an equitable health system must consider financing and accountability at both national and local levels. There is evidence of differences in needs for health care across different geographical locations especially with decentralization in terms of health care and unit costs required to produce health care. From this view point, it would imply that if areas had to finance local health services through local sources (resources), there would be wider geographical inequality and hence unequal provision of health service relative to need. Understandably Uganda's current system of resource allocation as centralized in attempt to redistribute funds from the national coffers (including donor contributions) to ensure equal provision across areas of equal need. World Health Organisation (WHO) contends that local spending in decentralization as a portion of national spending is complex. This question of revenue sharing and incentives therefore brings about issues of efficiency and effectiveness of health care.

There exist evident tensions between national and local governments that arise when local levels need more financial resources but are unable to satisfy what they see as unnecessary standards from central government. With lack of adequate resources faced by local governments, there is clear lack of discretion and capacities in policy implementation to fully satisfy local preferences let alone the very basic ones. Certainly, one more contested issue is accountability which is required to monitor performance and ensure equal and fair resource use and distribution. More often, Uganda's local institutions are less enthusiastic about being accountable to central government, a thing that complicates the good intentions and mission of central government in a decentralized arrangement. This further complicates stated policies meant to ensure equality and equal of access to health care especially in rural settings.

Currently, health delivery issues have become a highly politically sensitive area of interest in which senior government officials and wealthy Ugandans have long used private hospitals or flown abroad for medical attention. In a recent media publication (The NewVision, 27 May 2013), it was reported that the Uganda government spends at least $150m (about Ushs 377bn) on treatment of mostly top government officials abroad that include Members of Parliament, senior army officers and other civil servants[12]. This is further backed up by an accounting official in Ministry of Health who revealed that government spends $50,000 (Ushs 130m) on each government official flown out of the country for treatment. In addition, while there is no national social insurance arrangement for Ugandans, many government officials such as Members of Parliament are registered with private health insurance companies of their choice, paid for by the tax payers. The poor and vulnerable are left to the disadvantage of the "sick" system where, according to the health sector report (2009/2010) shows that only 35% of health centers do not run out of essential drugs as well as faced by many other challenges.

To sum up decentralization policy and how existing structures support (or fail to support) equity in access and use of existing health care services, there is need to mention the gap that exists between policy makers and implementers. Important to note is that ideas and views are more readily accepted by local decision makers if local conditions can be discussed and incorporated during the negotiation process. Perhaps, current health policy system and strategic plan does not favour a decentralized system and therefore can be best be applicable at central level. This means that the central system's prescriptions are difficult to apply and embed in the local district and lower context. The complexities of these policies and their practices directly affect their implementation leading to gaps in supply of the required health care services especially in rural settings, hence their inequitable access and utilization. This is reinforced by Holm (2000) and Martin and Singer (2003) who state that managing health care at a local and institutional level is a challenge requiring careful balancing of policy goals, as well as tools needed (and available) to implement them. They further note that often, contradictory incentives, disincentives and power games affect implementation and presumably explain some of the gaps between policy and practice.

[12] The New Vision accessed from http://www.newvision.co.ug/news/643231-upgrade-local-hospitals-to-save-sh377b-spent-abroad-on-treatment.html

Chapter 6: Factors that influence Access and Utilisation in Uganda

This chapter partly describes the socio economic background in order to analyse equity in access to and utilization of health care services and how these factors influence health equity. Socio economic determinants as well as Income and expenditure data have been used in monitoring people's living standards and therefore provide information in assessing poverty incidence. Additionally, respondents in many household surveys (for the case of Uganda) are health care decision makers and so gender, age and education of respondents provide information about the characteristics of the main health care decision makers in a household. Perhaps, concerns for health equity can arise in the relationships that exist between health (or related behaviour) and a variety of individual human characteristics that include social class, age, sex, ethnic group and location. Perhaps stated otherwise, looking at the socioeconomic status helps assess and understand how health outcome or related behaviours vary with some measure of socioeconomic status. It should be noted (for this study) that gaps may exist in data quality and incomplete coverage especially due to spatial differences and representativeness in urban more than rural areas are of concern.

It is also imperative in this study that the health status of the population be highlighted. The UNHS 2009/10 sought to establish frequencies of occurrence of sicknesses, more specifically within 30 days before the survey was conducted. Overall, 43 percent of the population suffered from an illness or injury 30 days preceding the survey (see Table 6.1). It also shows a higher proportion of sick people from rural areas compared to those in urban dwellings. Additionally, more females reportedly fell sick as compared to men 30 days before the date of the survey. In addition, there are regional variations in occurrences of sickness with the Eastern region as the most affected with higher proportions of people falling sick in two survey periods (2005/6 and 2009/10). Other significant increases in sickness proportions are evidenced in children Under 5 years and the elderly 60+ years (also included in the vulnerable groups in this study).

6.1 Education

Statistics show that primary education completion rate in Uganda stands at 56% with 47.4% of women being enrolled at that level. Women's enrollment at secondary education level stands at 42.8% with a general illiteracy rate (by sex) aged 15+ standing at 30%. Further

statistics show that only 3% of Ugandans access higher or tertiary education. These figures show therefore that on average, more than 10 million people are illiterate (considering an estimated 34 million Ugandans). Education in health is important in a sense that some studies have assumed that certain behaviours (like visiting a health center or seeing a doctor for that matter) are reminiscent of people who have attained some level of education. However true this may sound, it is important to note that decisions (of meeting a doctor) are backed by individual variables. Therefore, meeting a doctor must be precluded by the need to special information seeking procedures about a certain medical condition in which the patient is interested. Ultimately, this puts the more educated people in a better position and competent to make their own decisions concerning appropriate care.

Table 6.1: Distribution of the Population that suffered illnesses within 30 days prior to the survey by Selected Background Characteristics (%)

	2005/2006			2009/2010		
Background Characteristics	**Male**	**Female**	**Both Sexes**	**Male**	**Female**	**Both Sexes**
Rural/Urban						
Urban	30.9	35.2	**33.1**	37.8	37.7	**37.8**
Rural	39.4	43.9	**41.7**	41.0	46.6	**43.8**
Region						
Kampala	24.5	28.0	**26.4**	35.4	35.3	**35.3**
Central	39.3	43.3	**41.2**	41.7	45.0	**43.4**
Eastern	45.4	51.8	**48.7**	47.7	53.4	**50.6**
Northern	38.8	43.3	**41.2**	37.8	42.4	**40.2**
Western	32.3	35.7	**34.0**	34.1	39.8	**37.0**
Age						
Under 5	55.6	55.4	**55.5**	58.0	58.2	**58.1**
5-17	31.4	31.8	**31.6**	34.1	36.0	**35.0**
18-30	30.1	38.5	**34.7**	32.2	39.1	**35.9**
31-59	39.0	51.1	**45.1**	40.7	53.1	**47.0**
60+	54.5	66.0	**60.6**	62.7	71.1	**67.1**
Uganda	**38.1**	**42.7**	**40.4**	**40.5**	**45.2**	**42.9**

Source: UNHS 2009

6.2 Age

Almost 70% of Uganda's population is below 24 years of age (and 80% below the age of 30) with 48.9% between 0-14 years, 21.2% between 15-24 years, 25.5% between 25-54 years and 2.1% being 65 years and above. According to 2013 estimates, total dependency ratio is 103.3% with youth dependency standing at 98.4% and elderly dependency ratio at 4.9%. A study by Action Aid: "Lost opportunity? Gaps in Youth Policy and Programming in Uganda" intimates that despite being the majority of the population and the bedrock of the labour force, the optimal contribution of the youth to the development of the country is hampered by unemployment, low skill level, limited opportunities and vulnerability. The study further states that more than 2 million youth are out of school and majority of these have no regular work making them even more vulnerable.

6.3 Household expenditure

Among the household expenditures, the 2009/10 UBOS report shows that the share of food, drinks and tobacco in total household expenditure remained highest at 45 percent, followed by rent, fuel and energy at 16 percent. There has also been an increase in consumption expenditure between regions with the Northern region registering the highest increase (34 percent) while the Western region registered the least (3 percent). The share of health care reduced between 2005 and 2010 as shown in Table 6.2. It should however be stated that 50% of household consumption expenditure is on health although no user fees are paid in lower government health units according to policy. Recent studies have shown that 35% of all ACTs are paid for, 28% of the households (in Uganda) are experiencing catastrophic payments with considerable variations by quintile and region, and catastrophic health expenditure actually increased from 8% to 28% between 1996 to 2006 despite the elimination of user fees in 2001.

Table 6.2: Share of household expenditure by item groups (percent)

Item group	**2005/2006**			**2009/10**		
	Rural	**Urban**	**Uganda**	**Rural**	**Urban**	**Uganda**
Food, drinks and tobacco	50	34	45	51	32	45
Rent, fuel and energy	15	20	16	15	18	16
Education	8	13	10	7	12	9
Transport and communication	6	10	7	7	12	9
Health	**8**	**4**	**7**	**6**	**5**	**6**
Household and personal goods	5	6	5	5	7	5
Clothing and footwear	4	4	4	3	3	3
Other consumption expenditure	2	4	3	3	4	3
Non-consumption expenditure	3	5	4	4	8	5
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: UBOS 2009/10

Poverty trend estimates in Uganda, according to 2009/10 survey data, show that 24.5 percent (approximately 7.5 million people) of Ugandans were poor while the incidence of poverty remained higher in rural areas (27.2%) compared to urban areas (9.1%). The bulk of the poor are mainly children and adults who do not constitute the labour force (due to many reasons including taking care of families). Additionally, there are many other poor people who participate in agriculture for livelihood yet are statistically characterized as being employed. This characterization gives a different statistical picture since most of the poor engaged in agriculture do it for home consumption with very little left for the market.

Conversely, a larger percentage of the urban poor population (59%) remained poor between the survey periods, though movements into and out of poverty seems to affect the rural dwellers more than those in the urban. Furthermore, there are indications, according to World Bank, that abolition of user fees led to an increase in government spending to 24% due to increased utilization of health facilities by the poorest 20% while the wealthiest 20% receive 16.6% (Okwero *et al*, 2010). Okwero *et al* further assert this abolition resulted in an 80% increase in visits (with over half coming from the poorest 20% of the population).

While the abolition led to increased utilization among the poor substantially, there is evidence that one-fourth of households experience catastrophic expenditure did not fall. This is in agreement with World Bank (2010) which states that twenty eight percent of Ugandan households still experience catastrophic health expenditure. The incidence of catastrophic health expenditure ranges from 24.8 percent in the richest quintile to 28.3 percent in the poorest quintile; and between 23.4 percent in the eastern region and 38.1 percent in the western region. This can partially be explained by the "frequent unavailability of drugs at government facilities after 2001 forced patients to purchase from private pharmacies, with extra payments for pharmaceuticals offsetting the reduction in payments for consultations" (WHO, 2005). As seen in the figure below, government's overall spending has increased overtime. However, it can be witnessed that despite increased government health care financing, out of pocket (OOP) expenditures increased up to 65% of private expenditure on health in 2009. The form of household expenditure includes purchase of drugs and supplies and informal payments at public facilities, while user fees are paid at PFP and PNFP facilities. With this arrangement, the poor and vulnerable groups accessing essential health care from these health providers are at risk of catastrophic health expenditure.

As a way to benchmark health sector access and utilization, Uganda's Ministry of health has identified a number of indicators on which to measure the performance of health care sector hence leading to health care service utilization. These indicators have been used to justify access and utilization of health care services though existing information and data about them are not readily available for both urban and rural areas. Some of these include the following;

6.4 Outpatient department utilization

The Uganda government considers the outpatient department visits per person per year among government health institutions and PNFP health units as an indicator of accessibility of the health services in the country. Comparing available statistics, there were 34.9 million OPD visits in 2010/11 as compared to 36.8 million visits in 2009/10. Therefore, OPD utilization in government and PNFP facilities ranged between 0.8 and 0.9 visits per person per year during 2004/05 and 2009/10. While there was an improvement, it was still below the HSSP II target of 1.0. In 2006, about 37.7% in the poorest 20 percent population reported health problems and 15.8 percent did not seek care. Conversely, among the wealthiest 20 percent, 36.8% reported health problems but only 7.9% did not seek care. According to Uganda HSA (2012), low utilization of government and PNFP facilities is as a result of inadequate personnel and frequent stock-outs at health facilities. While general hospitals have continued to provide a large output of outpatient (as well as inpatient) services, they continue to face serious resource constraints. This further contributes significantly to the reduction of the standard unit of output in these hospitals. Ultimately, this leads to less utilization of the rather unavailable services.

Data shows, as summarized in Table 6.3, that cost is the least frequent determinant for choice of provider. This is likely so because cost is incurred by the patient whether they go to a public or private health care provider. This cost includes out-of-pocket (OOP) payments and/or transport costs (both formal and informal). Proximity comes as a main factor in the choice of provider. It may be surprising however that many patients' choose Private-for-Profit (PFP) health providers despite their cost. This may be explained by their convenience in terms of accessibility, with less waiting times as well as longer operation times as compared to public health facilities.

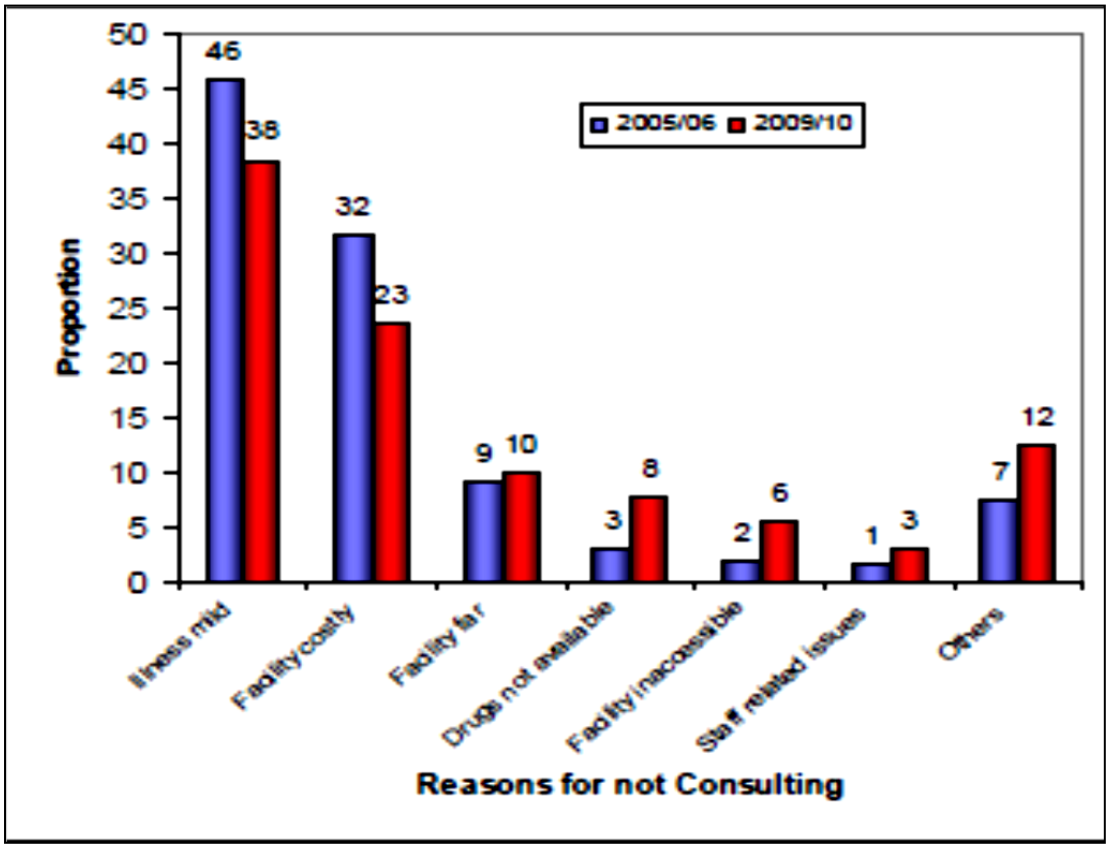
Table 6.3: Reasons for Choosing a Health Care Provider Among Household Surveyed in Three Districts in Uganda, by Type of Provider.

Type of Provider Visited	Number	Reason for Choice Of Provider		
		Proximity	Skills	Cost
Public	251	41%	45%	12%
PNFP	80	56%	41%	10%
PFP	269	59%	26%	11%
Traditional Practitioner	73	23%	34%	19%
General Merchandise Shop	6	83%	0%	17%
Totals	679	52%	29%	14%

6.5 Reason for not seeking medical attention

In the UNHS 2005/06 and 2009/10 surveys, households were asked for reasons why they did not consult for any illness they suffered. Thirty eight percent did not seek treatment because they thought the sickness was mild while 23 percent thought the facility was costly for them. There were drops in percentage points between two survey periods between mild illness and facility cost (Figure 7).

Figure 6: Major Reasons for not Seeking Medical Attention (%)



Comparing men and women who did not consult in the period between 2002 and 2005/06, it was established that the percentage for men doubled from 10.3% in 2002 to 20.3% in 2006 and women (10% to 28.8%). The percentage of girls and boys not consulting after an illness more than trebled (6.1% to 26.3%) and 6.2% to 24.6% respectively. From these data, it is seen that women received disproportionately less treatment when sick compared to men. In 2002, girls within both Male household head and female household head were accessing least health services despite suffering most incidences of illnesses. Some reasons for these barriers to accessing health services include long distances to health centers, unfriendly conduct of medical staff (especially demand for bribes) and poor quality of service due to unqualified staff whose attendance is also irregular.

6.6 Hospitals and bed capacity

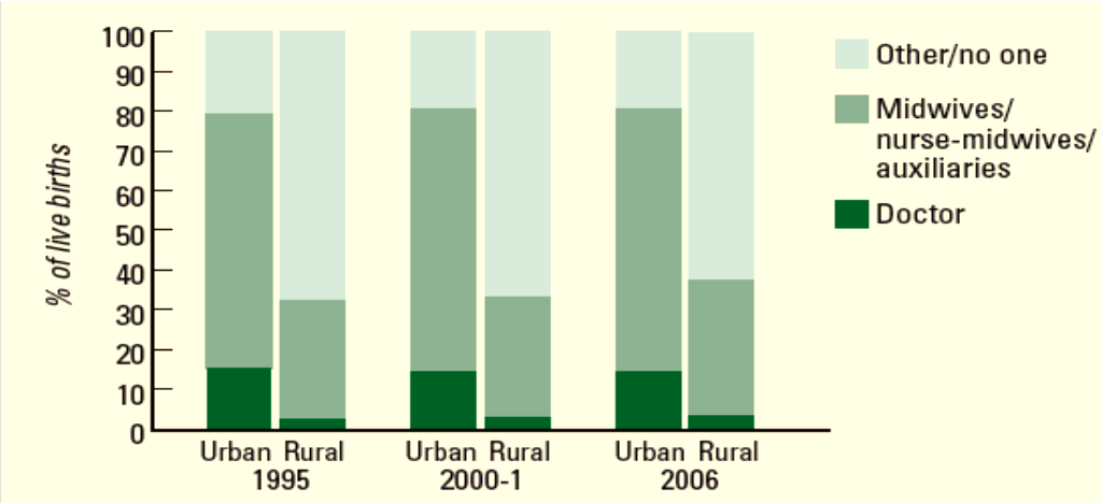
Hospitals in Uganda are categorized as Referral, Regional and General Hospitals and were 143 as of 2011. About 46 percent of the hospitals in the country are Government owned and 43 percent are Private Not-For-Profit (PNFP) units, leaving only 11 per cent as Private For Profit (PFP). In terms of beds, government owns 55 percent, PNFP owns 43 per cent while only 3 percent are owned by PFP. Within the context of this study, hospital beds include in-patient beds available in government, private, general and specialized hospitals and rehabilitation centers. According to the MoH (2011), the number of hospital beds per 1,000 persons was at 0.389, ranking Uganda 175 out of 181 countries in the world. In addition, World Factbook (2005) puts the number of physicians per 1,000 population at 0.117 though the number reduced to 0.1 according to the World Bank.

6.7 Deliveries in health facilities

This is considered important since it exposes mothers and their newborns to a safe environment with supervision of skilled birth attendants and other personnel. The advantage attached to this indicator is that contraction of diseases (especially HIV/AIDS) at the time of birth is greatly reduced with supervision of a skilled health worker. In 2008/09, 34% of the deliveries were in health facilities, posting a 2% increment from the previous year (2006/07). Available statistics 2005-2011 show that skill attendant at birth among the poorest 20% stood at 43% while it was at 88% for the richest 20%. Consequently, there are variations in infant mortality rates between rural and urban areas. For instance, in 2010, the under 5 mortality rate

for the rural population was 147 deaths per 1000 live births as compared to 115 among urban population; 172 among the poorest 20% and 108 among the richest 20%.

Figure 7: Who attends births: urban vs rural



Source: UNFPA[13]

This may partly be explained by differences in ability to purchase health services in private health clinics and facilities in light of challenges faced in public health facilities where many poor people (both urban and rural areas) go for medical attention. These challenges include lack of medical personnel, drugs and equipment for use. Consequently, they resort to home medication that may include drugs from clinics in addition to use of local herbs (traditional treatment). Figure 8, for instance, shows persistent low staffing levels in health centers (for birth attendants) especially in rural areas over a long time period. This may therefore explain why many pregnant women prefer to stay home or seek alternative services than hospitals and health centers despite rosy statistics presented at national and international levels. The situation is worse for the poor in rural areas (as well as urban areas) not only for deliveries but for other services obtained from health centers. Statistics from UNICEF show that 93% of women make one antenatal care visit while the number reduces to 48% for four visits.

Like in all other lower health units, the Anti-Corruption Coalition of Uganda report, notes that its visit to several health centers across the country revealed "a chronic shortage of beds, drugs and medical personnel" and therefore conclude that "service delivery and general care

[13] Accessed from (http://www.unfpa.org/sowmy/resources/docs/country_info/profile/en_Uganda_SoWMy_Profile.pdf)

is almost not there"[14]. This assertion is further confirmed by the government, according to the 2010/11 annual health sector performance, which states that "Lack of adequate resources is still limiting hospitals to provide the services expected". It further states that "in many instances, basic emergency infrastructure, supplies and specialized equipment are inadequate".

6.8 Distance to health facilities

One important factor behind inequitable health outcome is the distribution of health care infrastructure. While urban centers (like Kampala city) have 1 facility per 5,295 people, the national average is 1 per 8,785 people. Notably, in some rural districts the ratio is much worse at 1 per over 20,000 people (Health Facilities Inventory, 2006). Other reasons can be advanced to explain why less than usual numbers access health facilities for deliveries. Some of these reasons include (but are not limited to) distance to the nearest health center (which also affects other health care services to the population). Table 6.4 below shows results of the most common means of transport to the facility for treatment of major illnesses 2009/10 surveys.

Table 6.4: Most common means of transport to the facility/provider (2009/10)

Health facility	Walking	Taxi/ Car	Boda boda	Bus/ Minibus	Bicycle	Other*	Total
Health unit Government	72.1	5.6	6.7	2.6	11.7	1.4	100
Hospital Government	16.3	31.4	10.5	23.1	13.3	5.4	100
Health unit NGO	35.8	19.0	11.2	9.5	19.9	4.5	100
Hospital NGO	12.9	28.3	11.1	28.5	13.4	5.9	100
Private clinic	68.9	3.9	7.4	5.3	12.4	2.1	100
Pharmacy	30.2	18.2	9.6	23.2	14.7	4.1	100
Traditional healer	66.1	2.6	4.0	8.9	17.3	1.2	100
Traditional birth attendant	70.5	2.0	14.9	5.3	6.2	1.1	100

**others include motor cycle, boat, horse etc*

[14] The Daily Monitor, Saturday, October 1 2011. Accessed from **http://medilinkz.org/east-africa/uganda/35299-who-will-heal-ugandas-sick-health-sector.html)**

The distance an individual has to travel to access health care services usually has a bearing on one's preference of the type of health care source utilized. It is also a proxy for the time price of health care; greater distance generally means more travel time and more time away from productive labour. Consequently, given the statistics in Table 6.4, there is evidence of transportation costs that correspond to distance travelled since such means as taxi/car, motor cycles (also known as boda boda), buses/omni buses and other means are used.

In Table 6.5 below, results indicate that almost half of the population who fell sick 30 days prior to the survey sought treatment from private clinics (47%) within a distance 5km in 2009/10 followed by 24 percent for government health facilities. This does not mean however that on average the nearest modern health facility is 5 kilometers from the population since the survey population is generally not located directly in the village center of from the enumeration point.

Table 6.5: Distribution of type of facility for treatment of major illnesses by distance (%)

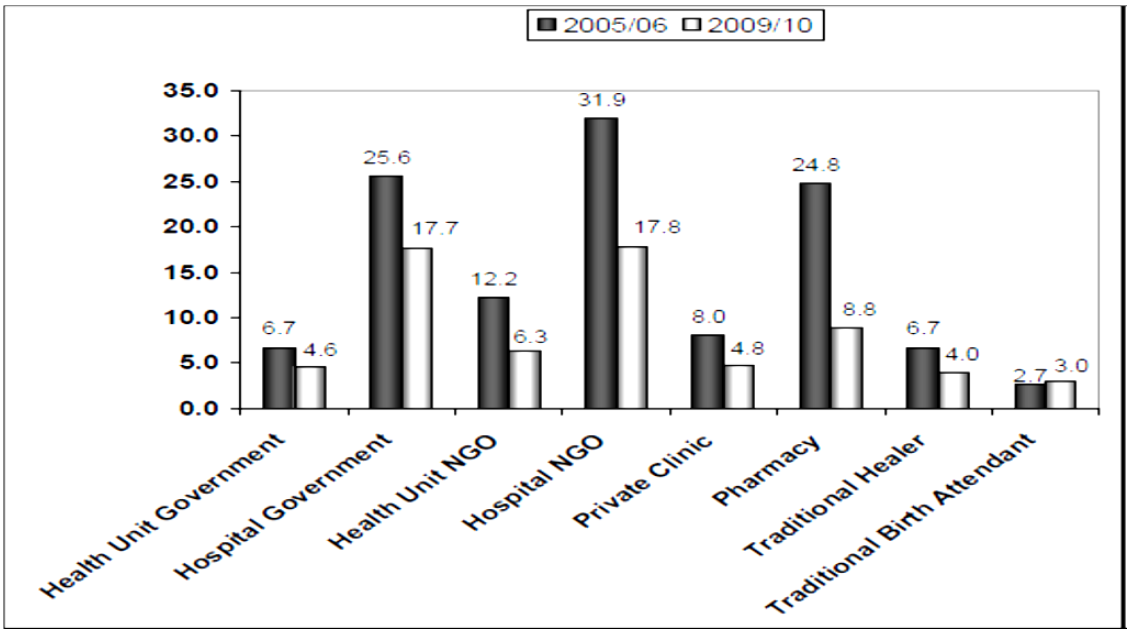
	2005/06			2009/10		
Health Care provider	**within 5km**	**Over 5km**	**Total**	**within 5km**	**Over 5km**	**Total**
Private Clinic	48.1	34.8	**45.9**	46.5	35.8	**44.3**
Government Health Centre	21.4	25.5	**22.1**	23.8	31.6	**25.4**
Drug shop/pharmacy	14.8	4.2	**13.1**	16.8	9.3	**15.3**
Government Hospital	4.3	18.4	**6.7**	5.7	11.9	**7.0**
NGO Health Centre	3.8	6.9	**4.3**	2.4	4.7	**2.9**
NGO Hospital	1.1	7.9	**2.2**	1.4	3.9	**1.9**
Ordinary shop	2.5	0.3	**2.1**	1.0	0.4	**0.9**
Community Health worker	0.5	0.1	**0.4**	0.6	0.1	**0.5**
Home treatment	0.3	0.0	**0.3**	0.3	0.2	**0.3**
Others	3.2	2.0	**3.0**	1.4	2.0	**1.6**
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: UNHS, 2009

On the contrary, 36 percent of people who fell sick sought treatment from private clinics at a distance of over 5km against 12 and 36 percent of government hospitals and health centers in the same period (2009/10). Comparing the two survey periods, there seems to be a slight increase in proportion of use of government hospitals both within and over 5km radius. However, while access to government health centers has increased within the 5km radius, there is also an increase in the people that sought care irrespective of distance.

In Figure 6.3 below, it is evident that traditional birth attendants, traditional healers (herbalists) and government health units are nearest health facilities to the community (within 3-5km) in 2009/10 survey period. On average, enumeration areas (the basis for measurement of distance) were closest to traditional birth attendants and traditional healers which lie within 3-4 kilometers in 2009/10.

Figure 8: Average distance to health facility available within communities (KMs)



Source: UNHS 2009/10

However, access to health facilities does not necessarily mean (translate into) utilization of those health services. Perhaps, what may explain few numbers of rural people that access health services may not be lack of infrastructure but such things as drugs, health personnel, water, electricity and other equipment essential for use in health centers.

Chapter 7: Discussion

Health service utilization varies across public and private providers and for different types of services. For access to be achieved, various dimensions that define access must be considered though they are not completely independent constructs (Haddad, Mohindra, 2002). These dimensions are actually interrelated and influence each other though in different time periods (of illness and care). One needs however to critically analyse whether access and utilization are actually similar terms or whether they can be differentiated. From Andersen's theoretical perspective, '*having access*' means 'all enabling factors for the entry into the system' while '*gaining access*' is operationalised by the use of professional health care. This model assumes a causal relationship between these two constructs, implying that existence of more enabling factors translates into higher utilization of services. An important aspect to consider is that enabling factors may determine access either from the socio-demographic characteristics of affected individuals and whether they seek professional health (or the demand side) or the regulatory side (or supply side) that may determine health service utilization at a macro-level. One example from the supply side is the abolition of cost sharing in 2001 in the health sector to facilitate easy access to health care services in all government health establishments and health centers. The argument was that these costs had earlier hampered utilization of health services. It is not simply the cost of treatment/services themselves that determine if services are affordable but also the capacity of people to pay for those services.

Nabyonga-Orem et al (2008) and Xu et al (2006) contend that the removal of user fees in Uganda led to increased pressure on the government to increase the drug budget to effectively deal with increased utilization of services. Perhaps the poor (vulnerable) people would be more interested in their health than the number of football pitches in their communities. Additionally, lack of a social health insurance system in Uganda (with low purchasing power among the poor) means that the utilization of health care is below that of the better-off despite their (vulnerable people's) need for the services. It is also not wrong to state that poor children are systematically more likely to die before their fifth birthday and that the poor are even systematically more likely to develop chronic illnesses. Ultimately, out-of-pocket expenditure therefore matters in a sense that if the poor (without their willingness) are forced to spend much of their income of health care, then there is likelihood that their remaining resources will be insufficient for their feeding and shelter.

A drawback to this policy however was the increase in informal ('unreceipted') payments and 'tokens' to public health workers to enable patients access drugs from public health facilities. Perhaps it could be said that abolition of cost sharing in the health sector in Uganda bled corruption and alternative ways through which health workers in public health facilities devised "means of survival" by charging patients illegal fees for services offered. Additionally, it culminated into a practice where health workers established private clinics outside public health facilities where patients are referred for paid-for medication. This continued practice is a deterrent to health facility (or some sections) utilization by the poor and vulnerable patients who pay more for health services. Perhaps this may help explain the reason why, despite the ever expanding health infrastructure in Uganda (also witnessed by the reduced distance to the nearest health center), rural and vulnerable people are increasingly opting for traditional healers (witch doctors, local herbalists) as well as private clinics despite charging a fee for their services. This also shows a vote of no-confidence in the health care system as a whole. In this view, Levesque, Harris and Russell (2013) support the argument that the possibility of a person to utilize the services of untrained practitioners (for instance, witch doctors, healers) cannot be equated to the opportunity for another (wealthier) person to utilize highly specialized services, if these services generate different health outcomes or satisfaction towards services.

The health care system in Uganda is lacking in its call to fulfill its constitutional mandate of providing health services to all people without discrimination. One of the explanations to this may be political where the parliamentary and presidential electoral cycle hampers genuine and constitutional mandate is related to service provision. From a political perspective, public servants who hold elective positions are constrained by term limitations (5 year each term) within which much of the needed visible and durable health care progress according to Ministry of Health cannot be met. Perhaps, success on the delivery of their manifesto promises is in most cases minor that may not necessarily involve much of health gain. Consequently, the politicians who are mandated with making a vote in their respective constituencies are tempted to concentrate on small things that can easily be delivered in the right time within the electoral cycle.

It has been argued that the care the individual receives is a function of the demographic, social and economic characteristics of the environment in which they live (Andersen, 1995). Whitehead (1992) also argues that certain barriers such as financial, organizational, linguistic and cultural barriers control people wanting to use services so that, although they may have a

right to health care in theory, their actions may be restricted in practice. The number of GP (and/or specialist) visits in a number of countries has been used to assess access to health care utilization. In case of Uganda, where the GP system is not used, lists (and other related records) of patients that access any health care center (public or private) to interface with health workers (or professionals) is used. In addition, existence of human resource essential to health care service provision and effective operation of health systems. This is an important aspect in attainment of Health Strategic objectives of Uganda. It is reported that while there are efforts to increase staffing in health facilities, staffing level is still very low and regional distribution remains inequitable. Such instances are experienced in areas that are poorly resourced in terms of social infrastructures as well as remote amenities.

The low staffing levels are further aggravated by poor retention of the available few, limited funding for recruitment, low training outputs and high attrition rates, poor motivational factors, work environment and remuneration, to mention just a few. Subsequently, analysis of access and utilization of health care services from Andersen's view may not give a better picture for purposes of this study. Andersen throws more light by further dissecting the model to evaluate 'need', that is, the proximate cause for utilization. Andersen analyses institutional characteristics of the delivery system in which access restrictions are introduced through policy with expectation to cost saving and more efficient utilization of existing resources. On the contrary, as noted in previous chapter, existing lack of efficiency is attributed to a faulty system which is underpinned by both health personnel and infrastructure inadequacies. These are drawbacks to system efficiency and hence affect equal distribution of health care services.

Existing infrastructure is compounded by inadequate and insufficient supplies (that include equipment - 60% of absolete equipment in health centers - medicines, human resources etc) that have made the structures ghosts of themselves. Functionality of health facilities largely depends on adequate staffing levels, financial inputs, availability of equipment and maintenance mechanisms, social services among others. Frenk supports the above statement when he analyses access and sees it as an adjustment between population characteristics and existing health care resources in which access is a functional relationship between the population and medical facilities and resources. Frenk concludes therefore that such obstacles as, prices of services, transportation time (and distance from the health center), waiting time, to mention a few affect access and utilization of health care services and therefore are more responsive to specific health policies. Frenk's view is further supported by Mooney (1983) who analyses access through supply and demand factors and hence involves the notion of

predisposing factors to utilization on one side and enabling factors on the other. Consequently, analyzing access and utilization from the point of factors that affect these two concepts (as this study highlights) is much supported.

Daniels takes the argument further by stating that a more comprehensive view on access should consider factors pertaining to structural features of health care system (eg availability), features of individuals (predisposing and enabling factors) and process factors (that describe ways in which access is realized). The analysis of this study fits well into this argument. The inadequate availability of health infrastructure in many parts of the country manifests a health system under constraint. Additionally, even the existing infrastructure is further constrained by lack of medical and health supplies (which as earlier stated) may be responsible for increased use of traditional methods of medication. This is further supported by HRFI (2010), which found out that rural area residents have been frustrated by lack of doctors and medicines, turning their attention to local traditional healers and herbalists. The report further notes that about 80% of Ugandans depend on traditional healers and herbalists for treatment. On the downside, these herbalists operate without oversight from the government, hence putting the population at further risk. Consequently, since utilization is used as a proxy of access (which is conceptualized by dimensions such as accessibility of services, acceptability, affordability, appropriateness and availability and accommodation) as stated by Penchansky and Thomas (1981), this study has highlighted these respective areas. It should be noted that the opportunity to utilize only services of poor quality is seen as a restriction of access to health care.

Conclusion

This report attempted to clarify issues regarding access to and utilization of health care services in Uganda. The analysis focuses on selected factors that form a basis of ongoing debate in Uganda.

Geographical proximity to healthcare providers has increased, as has been stated by other research efforts in this area. This is seen in the percentage of the population with regard to access to physical distance to health care services. There has been an increase in physical access over the years that has been largely attributed to significant expansion and investment in health infrastructure. This increase however does not appear to have a corresponding increase in utilization of modern providers for curative care. This is a serious cause for concern because there appears to be an increasing population choosing to self-treat or do nothing, especially amongst the poor. The current low use of government health facilities despite increased government investment in infrastructure creates more worries for policy makers. It is evident that even when a slight increase in use of health centers in rural areas, their use in urban centers is still low. The poor and vulnerable are now using more nongovernmental and private facilities than government health facilities. This therefore calls for focus of policy efforts towards filling gaps that exist between physical access and quality of health services provided. This conclusion is backed by the fact that there is a significant number of the population which utilizes health facilities yet live far from (over 5kms) the health facilities.

There is however a surprising finding of an increase in the reporting of sickness among urban and rural dwellers in the 2009/10 survey results. One explanation may be an increase in infections in HIV/AIDS to a country average of 7.3 percent and up to 25 percent in some areas in the country. There could also be changing perceptions of what illness is to people shown by self-treatment. The removal of user fees in all government health facilities in 2001 has surprisingly not yet achieved its intended objective of making health care services accessible to all. Public health facilities have instead resorted to introduction of private wings (within these facilities) which are looked at as a source of income to the facility. The result is diversion of attention and care from the non-paying section to the private wing which the poor cannot access due to cost. The removal of user fees also encouraged health workers to set up pharmacies to which patients from the health centers and hospitals are referred for purchase of drugs. Certainly, while physical structures exist to facilitate physical access, it becomes

difficult to pay for their medication cost limiting poor people and hence forcing them to resort to other means of treatment.

This analysis also identified existence of differences between care seeking behaviours and use of health care services between male and female. For instance, there is a tendency for the poor to use less modern curative services and instead prefer traditional medicines than the nonpoor. This is of great concern because it points to the fact that the poor are not getting proper and quality medication. There is ultimately a need to address quality of health care especially at public health facilities. The quality of care received by the poor and reasons for self treatment must be looked into. With all efforts to improve service delivery, there still remain major obstacles especially in provision of quality services as well as reemerging increases in HIV/AIDS. Primary health care remains difficult for some to access especially in a less functioning referral system due to costs involved. Persistent drug stock outs coupled with other inadequate supplies impact service delivery hence limiting use of services.

There is persistence under-financing of the health sector and it is evidence that it may be difficult to finance and deliver the Uganda National Minimum Health Care Package to all. With current suspension of donor funds, Uganda will have to use very limited resources for pro-poor and essential services. Increased OOP expenditure by households and individuals calls for consideration of a National Health Insurance Scheme to address this issue and improve equity especially to include those employed in the informal sector. Perhaps a public-private-partnerships in health may be useful in addition to improved district resource allocation.

There have been improvements in human resource for health. However, there is still shortage as well as pro-urban health workers (with some rural areas lacking certain health cadres). This remains an obstacle to access to quality health care especially in rural and hard-to-reach areas. The high wage bill in public sector has hampered the sector from filling existing health worker gaps as well as attracting more health workers into the system. Issues of pre-service training should also be addressed as well as wages to health workers that are low in Uganda compared to other neighbouring countries. These wage disparities have led to emigration of health workers to other countries and therefore affected the health sector especially in areas where human resource shortage is acute.

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