Understanding the Impact of Decentralization on the Quality of Primary Health Care in Pallisa District in Uganda: A Study of Users' and providers' experiences and perspectives.

By

Wakida Patrick Kamiza

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LIST OF ABBREVIATIONS

ANC	Antenatal Care
CAO	Chief Administrative Officer
CFO	Chief Financial Officer
CIDA	Canadian International Development Aid
CMR	Child Mortality Rates
DANIDA	Danish Aid for International Assistance
DDHS	District Director of Health Services
DFID	Department for International Dev't
DHMT	District Health Management Team
DHS	District Health Services
DISH	Delivery of Improved Services for Health
FGD	Focuses Group Discussions
GoU	Government of Uganda
HCII	Health Centre Two
HCIII	Health Centre Three
HSD	Health Sub-District
HUMC	Health Unit Management Committee
HUMIS	Health Unit Management Information Services
IMF	International Monetary Fund
LCII	Local Council Two
LCIII	Local Council Three
LCIV	Local Council Four
LCV	Local Council Five
MCH	Mother and Child Health
MMR	Maternal Mortality Rates
MoH	Ministry of Health
NRM	National Resistance Movement
PHC	Primary Health Care
SAP	Structural Adjustment Programme
UBOS	Uganda Bureau of Statistics
USAID	United States Agency for International Dev't
WHO	World Health Organization

ABSTRACT

This is a study of the experiences and perspectives of the users and providers of primary health care. The study analyses the users and the providers' experiences and perspectives with regards to the decentralization policy and its impact on the quality of primary health care delivery in the rural district of Pallisa in Uganda since its implementation in 1990s-2005. This is mainly a qualitative study in which both users and providers were interviewed although quantitative data was applied to add meaning where necessary.

The study has shown that decentralization in Uganda is a new form and means of service delivery. The planners aim at getting every segment of the population to participate in all aspects of service delivery. There is evidence to show that the policy has had a positive impact on the structure of the health sector as a whole. However, the systematic processes of cost containment measures has resulted in the general economic hardship in the operationalization of the decentralization policy in Uganda and has resulted in varied experiences and the way decentralization is viewed in Pallisa. The study noted that hardships have resulted from increasing responsibilities given to lower level of government amidst declining state support in terms of funding and manpower development. The study notes that the apparent changes brought by the overall restructuring of health services have resulted in the 'commercialization of social relations which has changed the way people live and view public goods which also contributes to hardships in service utilization.

This study shows that although health service delivery and its quality in rural Pallisa is an old problem, there are feelings among the users and providers that these problems have worsened in the recent past transforming health care consumers and providers into a new category of social actors who have taken different approaches to survive a midst poverty, exclusion and the declining state support system.

Although this study does not recommend a return to a centralization system of service delivery in the health sector, it does however, find implementation problems which will have to be addressed if the intended benefits are to be realized.

CHAPTER 1: INTRODUCTION

1.1 Background information

Uganda is a Sub-Saharan country of over 24 million people, with a female population of 12.6 million, 12.1 million men and the majority 82 % living in the rural areas. Pallisa district where this study was conducted is located in the eastern part of the country and is regarded as the poorest district in Uganda with a population of 500,000 according to the 2002-2003 censuses. The main economic activity in the district, like other districts is petty subsistence agriculture. Uganda as a country has poor mortality and morbidity patterns and a heavy burden of preventable diseases. The main killer diseases are HIV/AIDS, malaria, diarrhoeal diseases, maternal and child disease, both preventable, which still cause death annually. Life expectancy at birth is approximately 47 years, one of the lowest levels in the world. The maternal mortality rate, estimated to be between 500 and 2000 per 100,000 live births is high. The population per doctor is 18,700 patients and even more to an average nurse. The per capita expenditure on health is US $12.0, lower than that recommended by the WHO of $ 30.0 (UBOS, 2002-03) Despite promised gains from decentralisation, evidence suggests that decentralisation has not been able to arrest the deteriorating health services in many developing districts such as Pallisa (Francis and James, 2003:333). Data on access to and the state of health and utilisation of medical care in Uganda show that overall between 1980s and late 1990's Uganda's health indicators have not improved, with some health indicators getting worse (UBOS, 2002). For example, the health survey report by the Uganda Bureau

of Statistics showed that the IMR increased between 1995 and 2000, (UBOS, 2002). Moler's study on child mortality concluded that the country's child mortality rate has not improved since 1980s, when the CMR was 120 per 100000 (Moler, 2002, See also, WHO, 2004). Mboye found that the MMR was higher than 846 per 100,000 live births (Mboye, 2000). Major causes of maternal morbidity and mortalities in Uganda have been identified, some of which are preventable if appropriate interventions are provided (Safe Motherhood, 2002). These have been listed as facility regulations, limited capacities of the health facilities to manage complication, lack of equipment and supplies, which also include drugs in most health centres.

Recently the Ministry of Health released an analysis of ten years of decentralisation entitled "The health system agenda in Uganda; issues for reflection". Areas of examination included health care access and equity. The report noted that health disparities persisted between districts and individuals, and health indicators have only slightly improved since decentralisation was implemented more than ten years ago (Ministry of Health 2003).

The importance of persistently high mortalities is profound; it defies and questions the success of decentralisation that the government and structural advocates have always talked about. There is a need to relate these health characteristics to the reforms in the health sector in order to understand their contributions. My earlier readings on this topic suggest that few studies have analysed the impact of decentralisation from the users' and providers' perspective, and yet they are important sources of information precisely because they are the consumers and providers of these services.

1.2 The thesis: decentralization in the health sector

This thesis is about the impact of decentralization on primary health care in Uganda. Decentralisation and its impacts on health as a social economic and political issue have become a dynamic issue. A multiplicity of interpretations has been brought to it, usually from anthropological and sociological perspectives, to moral and ethical standpoints, in improving the health service delivery among poor societies. Social and economic landmarks like Structural Adjustment Policies (SAP), and their impacts on the economies of governments, and the resulting structural development in societies are the health users' and providers' experiences that needs to be investigated in order to understand the actual impact of decentralisation on the quality of the health service delivery. Furthermore, global systems in economics, culture and politics ensure that primary health and its related issues of quality and access are no longer isolated social issues with purely local origins. Adjustment policies, with their origins in global political and economic forces, have been a watershed in all aspects of life in Uganda. This study is therefore based on the central proposition that Uganda's political economy, epitomised by the implementation of SAP, since 1980s through 1990s has burdened families, monetised social services such as primary health care, and increased the pressure of the providers and consumers of primary health care and therefore is of greater experience to them.

This thesis then sets out to analyse the impact of decentralisation on primary health care in Uganda in the district of Pallisa and its relationship to the current state of health outcomes. The decentralisation process in Uganda began in 1986, when the new government led by the National Resistance

Movement came to power. Decentralisation in the health sector has taken place within the framework of the overall decentralisation of the public sector. The planning and management of primary health sector takes place at the district and lower levels with the "involvement of the communities". The ministry of health was restructured to assume reduced roles of health policy formulation, standard setting, technical support, regulation, supervision and inspection. On the other hand the district health system was restructured to enable it to take on enhanced roles.

Decentralisation of the health sector in Uganda was undertaken in the context of other health reforms through which the government intended to: mobilise resources for health services and develop alternative financing mechanisms such as user fees; community repayment, and medical insurance, relocate resources among different levels of health care system to redress past imbalances; to concentrate resources on a cost -effective package of services based on the analysis of the disease burden; to bring about efficient facility management, including the consideration of autonomous management at tertiary levels. It was also hoped that it would strengthen the overall delivery of health service, especially by bringing services closer to the people, and hence improved quality and access would result from these changes.

While recognising that the decentralization programme is still on going, this study reviews its impact on the quality, access and the delivery of primary health care in Pallisa district. The study summarises some of the achievements and challenges that the users and providers of primary health

care identify and develops a methodology for analysing the impact of decentralisation and other social reforms.

1.3 In search of answers: Objectives and intentions of the study

The review of the literature on the impact of decentralization shows that the directions of enquiry are often on the structural implications of decentralisation and the implementation programme of the decentralisation strategy within the public primary health service delivery (Hutchison, 1999; Mwesigye, 1999; Ken, 2001; UBOS, 2002). They provide little connection between the current state of primary health care (quality and access) and to decentralisation, especially from the perception of the consumers and the providers of primary health care.

This study does not aim to disprove any current position about the impact of decentralisation on primary health care but rather aims to build on the existing literature to bring a thorough knowledge about the impact of decentralisation on the quality, access and delivery of primary health care. Understanding the impact of decentralisation is a very important area of research, given its relationship to service delivery and the scale and forms of governance in primary health service delivery has taken, especially over the last two decades. Since its inception as a neo -liberal policy in 1980s, a number of studies have questioned the reliance upon this form of service delivery in improving health service.

From slow beginnings, the literature on the impact of decentralization on health service delivery has grown substantially in the last two decades. As it has developed, recurrent debates and themes have become more nuanced,

although the tendencies are still to explore its impact and whether decentralisation has achieved the promised goals of quality, access, public participation and better primary health service delivery.

The extent to which decentralization has improved health service delivery; the characteristics of service delivery and the degree to which the new system of primary service delivery has been integrated into the former centralised system of public service delivery are now dominant themes. Within the literature, however, two biases can be identified. Much of it has focused on higher health settings in urban areas, while other studies have tended to see health care impact of decentralisation as a genre.

Like many other areas of social research, very few studies have used the experiences of both users and providers in reaching conclusions. The aim of this study is to listen to (users, health staff and the managers over what they have so far experienced and their perception of the way the decentralisation policy has affected the primary health service delivery, quality and access and their interpretation of the current state of health services vis- à-vis the previous system of delivery. This study, like many other studies challenges the dominant perception of the impact of decentralisation on quality and access to primary health care. The study challenges the reliability of decentralisation in improving health care delivery. The study offers another methodology for analysing the impact of decentralisation on health services, thus the use of the users' and providers' experiences will illuminate knowledge that can be used to better understand the impact of decentralisation on the social services such as primary care.

There are several reasons why users of primary health care should form a vital part of the study of the impact of decentralisation. These include the substantial numbers of users who live within the rural communities, and the subsequent difficulties they encounter in seeking health care. Users are capable of narrating their experiences since unlike the urban based population which keeps shifting, people live in the villages generation to generation, so they have seen the previous centralised system and are now experiencing the decentralised way of service delivery, hence they can be relied upon in knowing the progress or lack of progress made in so far as service delivery is concerned.

1.4 Focus of Research

The study sets out to explore the impact of decentralisation on the quality, access and the delivery systems of primary health care in Pallisa district in Uganda. The focus is less on the organisational impact of decentralisation on primary health care and more on the experiences of the users and providers with the way services are delivered, their perception of the quality of services. Quality of care here is used to mean the availability, accessibility, costs of care, public participation, distance, cleanness, good prescription, keeping of confidentiality in decentralised health services. "Quality" generally is used here to mean offering health care according to a standard. The limited research that exists has tended to come from quantitative sources, government data, and international research organisations which sometimes try to depict the outcomes of decentralisation as a panacea, since they are the

pushers of the policy. By contrast the approach taken in this thesis is to use the oral testimonies of the users and the providers as a primary source.

This thesis is based on the testimonies of 29 users and 17 health staff, 7 health managers and volunteers. The original aim was not to seek big numbers of respondents but to seek a small representative sample, which has experiences with the service delivery under decentralisation, and use their experiences to write this thesis. No specific intervention in primary health care is used but the term 'primary health care' is used here to refer to the health care that is delivered at the lower levels from the health HCIV (Health Sub-district) downwards to HCII (Health centre two at the parish) at the periphery, which are mostly outpatient providers of care (Donabedian, 1988; WHO, 1999). In some cases maternal and childcare has dominated the analysis, but this is due to the fact that the majority of the users of primary health care in Uganda are women and children (UBOS, 2002; Hutchison, 1999). Traditionally men in Uganda do not seek health care except when an illness is regarded as very serious, unlike the women. In Uganda a man is not supposed to "cry" over minor pain; if he did so, he will be regarded as a "woman", so most men stay with their pain and only go to the hospital when the sickness is regarded life threatening. It is also women who are responsible for taking their children to the health centre, not men, so the majority of people found at the health centres are women.

The original aim of the research was to explore the impact of decentralisation on the way health services are delivered, the quality and access of care, to see if their experiences concurred with or contradicted what has already been said

about health service delivery under decentralisation, or, indeed, if it offered new ways of thinking about the effect of decentralisation on primary health service delivery. The aim was not to disprove what is already known about the effect of decentralisation, but to add more meaning to understand the impact of decentralisation on the primary health care delivery. The aim was not to deconstruct themes such as quality, access, participation and service delivery p*er se*, but to contribute to our knowledge about the quality of primary health care by focusing on the users and providers and, perhaps raise questions about the reliance of decentralisation in improving the quality, access and the general primary health care delivery.

Organised around quality and access of primary health care, this thesis now seeks to explore how primary health care users articulate a sense of self with regards to primary health care services under decentralisation. I am concerned about the way they talk about health care, and the overall context in which primary health care services are perceived and negotiated by the users. My respondents provide a means of investigating the disadvantaged positions of users of primary health care during a particular period (1997-2005) and the actions some users and health staff made in response. It explores the experiences of service delivery and the opinions the users and providers have claimed. In so doing, it aims to say something not only about primary health care delivery under decentralisation, but more generally about the impact of neo-liberal policies on public service delivery as well as observing the complex ways in which public service delivery are formed and displayed under decentralisation. Quality of care is important because asking

users especially to narrate how they get health services provides a unique insight into how they interpret experience and respond to their social circumstances, which are generally hidden in the quantitative data.

1.5 Key Themes

Certain themes have emerged from this research and driven its analysis. As stated above, the central platform around which this thesis is constructed is quality of primary health care under decentralisation and more precisely the interconnecting impact of decentralisation on primary health care "quality". With respect to quality of care, the forms of service delivery available enable an exploration of how the users and the providers both perceive and negotiate a position for themselves within a decentralised system and the wider world of primary service delivery. The users' experiences are used to explore the ways in which the primary service delivery under decentralisation are perceived whether it is a better way of delivering primary health care or not. Analysing participation and localised service delivery in relationship to quality of care in rural settings provides a new angle for exploring notions of governance.

Because impacts are neither formed nor lived in a vacuum, this thesis seeks to explore the impact of decentralisation on primary health care from a wide perspective, looking at how users and providers construct themselves and feel constructed by others as users of primary health care, as citizens as well as in relationship to class and status etc. This particular theoretical approach highlights fundamental inter-dynamics within the impact that are often lost in

scholarly focuses on individual variables (for example social exclusion) that tend to subsume other aspects of policy implications.

Given that stories about health service delivery and its quality precede the date before decentralisation was implemented in Uganda, and because the knowledge about the impact of decentralisation is constructed over time in relation to previous experiences as well as present circumstances, the users' lived experiences prior to decentralisation constitute part of the enquiry. The time framework of the research, determined by the period of the implementation of decentralisation, spans several years of experience 1997-2005). This broad time frame is both a feature of research and a theme within it because we construct ourselves and are constructed by others moment by moment, over time and retrospectively. Related to this point, one aim is to develop or highlight the connections between health service delivery and context, whether social- political or economical.

1.6 Contributions and significance of this study

The central value of this research lies in its empirical originality. Until now, very few studies have taken the users and providers of primary health care as the source of knowledge about the impact of decentralisation on the quality and delivery of primary health care. As a neglected area of academic research, this thesis makes a significant contribution to the knowledge about the impact of decentralisation on public health services. Examining the impact of decentralisation on primary health care provides policy makers with tools: first, understanding the effects of decentralisation on the health service delivery relationship can help to predict the likely consequences of

further decentralisation processes, most of which originate as a political decision outside the health sector; secondly, if PHC is accepted as a proxy for other public services, the analysis will illuminate the broader effect of the decentralisation of public services as a whole. Primary health has got a number of basic characteristics, so its use as a proxy for all public services is important.

And within a given limits of space and time, the study will provides useful lenses through which to examine the impact of decentralisation in a qualitative way using the users and providers experiences and perspective about how they view the delivery and quality of care under decentralisation before and during the decentralisation period. There are few studies based on experiences that explore the perception of the users and how users interpret and regard health service delivery under decentralisation. Other new areas are also explored: the timescale of the research spans several years, incorporating the user's and health staff's experiences before and after decentralisation as well as their experiences since then, and up to the contemporary period. In addition, this thesis gives more serious consideration to the way primary health services are delivered than has been the case in other studies, which have treated health care as a general subject suggesting that decentralisation affects health services delivery in a similar way, which is not necessarily true, given that primary health care has got some unique characteristics.

As an interview-based study of users and providers in rural based care, it adds to the canon of oral presentation and development studies by contributing to

our knowledge about the experiences of users and providers generally and, in particular, disadvantaged groups especially hidden in the statistical data that have dominated the previous studies. The value of this study is that it adds to our knowledge about the impact of the neo-liberal policies popularly known as Structural Adjustment Policies, which became the beacon of development in the 1980s and 1990s in many developing countries such as Uganda.

1.7 The structure of the thesis

In this section of the introduction, the chapters that follow are outlined to indicate the structure of the thesis. In the first section of Chapter two, the literature is critically reviewed: Literature on decentralisation and structural adjustment programmes in Africa and Uganda in particular, that pertain to primary health care specifically; and the impact of decentralisation on the health sector generally. In addition to highlighting gaps to be found in the material, the ways in which each of these sets of literature have influenced this research are outlined. The questions that have guided this research are also posed to give the reader a clear sense of its objectives. In order to explore the impact of decentralisation on primary health care by use of experiences and narratives, a theoretical framework was developed. This was drawn especially but not exclusively from previous works which have focused on the impact of decentralisation on health services; the notion of 'decision space'; this framework is elaborated in the second part of chapter two.

Chapter three offers a frank description and a critical discussion of my experiences collecting data, through an engagement with current debates within a qualitative semi-structured tradition as well as outlining the process

of data analysis. Particular themes explored in this chapter include the significance of power as a dynamics within the interviewer-interviewee relationship and the practical and intellectual issues associated with turning narratives into thesis. The main purpose of the chapter is to establish and illustrate the process by which this thesis came to be produced.

Chapter four provides the reader with the background information and describes the structure of the health sector in Uganda. One of the aims of this research is to understand the changes in primary care delivery structure brought about by decentralisation and its interconnection with the way services are delivered and the quality of it. Especially consideration is given in this Chapter to the following: levels of primary health care delivery, sources of funding for the primary health care, and the levels of autonomy given to planning and to implementing policies independently and its relationship to quality of primary health care delivery and the role of the communities in doing so.

Chapter five analyses the impact and experiences of the health staff. Although the primary focus of chapter five is to examine the impact of decentralisation on the health staff, the implicit relationship between this impact and the quality of care they deliver is the main point of reference. This chapter presents the way the health staff feel about their current circumstances and the attempt is made to relate decentralisation and the conditions under which health staff have found themselves. The chapter examines the way health staff interpret the self with regards to their social economic conditions, their work environment, workloads and the social

status that result from their work as a health staff as managers and implementers of the decentralization strategy. In this chapter, reference is made to the period prior to decentralisation and compared to the present situation under decentralisation.

Concentrating on the same period with reference to the period before decentralisation, chapter six examines the actual outcomes of decentralisation with reference to quality, access and consumption of primary health care. In this chapter variables such as availability of drugs, cost of drugs, availability of providers, distance to the facilities, quality of the health units, and the quality of medication processes including prescriptions and medical examination, patient confidentiality and privacy during medication, are analysed from both the providers' and the users' perspectives with the purpose of revealing the underlying quality of care concerns and their interconnectedness to decentralisation. The chapter opens up an under-researched area, exploring the 'natural' versus 'constructed' basis of health care delivery before and after decentralisation, and delineates decentralisation as a key process in the current state of health care delivery and therefore an important prism through which to understand users' accounts with regard to health care services.

Chapter seven is the conclusion, which brings together the main arguments that have been gathered in the previous chapters. It explores what the study reveals about the users', managers' and health staff's sense of quality of care in relationship to decentralisation. The aim of this chapter is to bring together the main findings that form knowledge about the impact of decentralisation

on primary health care previously examined in separate chapters, to explore the inter-connections and inter -dynamics between them, and to use this synthesis to raise questions about the way the quality of health care has been traditionally looked at. The concluding chapter brings these matters together and puts them in the context of the existing literature examined in chapter 2 while also providing some recommendation for the way forward.

CHAPTER 2: LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

1.1 Introduction

2.1.1Scope and structure of the review

This chapter reviews current debates and studies on the impact of decentralisation on the health services in Uganda and internationally. The chapter attempts to highlight the following with respect to decentralisation experiences in Uganda:

1. Effects of decentralisation on the health system with respect to organisational arrangement, community participation and accountability, and management capacities of the decentralised units.
2. Effects on health system performances, with respect to quality, access and utilization of primary care.

Lessons learnt from other countries are documented, and gaps and opportunities for integrating primary health concerns into decentralisation processes are identified and questions are there upon shaped.

In the second part of the chapter, the conceptual analytical framework developed to understand the impact of decentralisation of primary health care is described. This is followed by a section which, using the analytical frameworks, discusses the experiences of decentralisation of the primary health services in Uganda as comparisons with other countries are drawn. The final discussion summarises the lessons, arguments, and points to topics requiring further research regarding the relationship between decentralisation and the primary health care quality.

2.1.2 Review methodology and strategies applied

This section outlines the literature search strategy and the selection criteria adopted for the review and provide descriptions of the types of studies reviewed. The methodological foundations upon which the reviewed research rest are then discussed.

1.1.3 Search strategy

The specific strategy adopted in identifying published and unpublished research is a continuation of what I presented for my MPhil upgrade to a PhD. However additional relevant research concerning the impact of decentralisation of health services as a genre was identified by searching in different data banks on health services in Uganda and internationally. There is no specific number of the databases searched because this search was a continuation, which also involved searching different library catalogues with specific terms relating to decentralisation and health services. Coventry, Warwick and Birmingham University libraries were the first point of search at which a number of publications were identified. Key articles were obtained primarily from the MEDLINE, Uganda Institute of Social Research, Makerere University Institute of Social Research and Makerere University Library. The Ministry of Health data bank was very useful because it provided a very important source of information. The Uganda Bureau of Statistics was another area, which offered the sources of data.

In order to secure relevant studies, the search terms remained broad. These were decentralisation and health, the impact of decentralisation on health services, decentralisation and the quality of primary health care, governance

and service delivery. No language restrictions were applied. Studies were eligible for consideration in this review if: (a) the focus of that study was on a health-related subject, the quality, access and availability of care under decentralisation, or the overall impact of structural adjustment on the overall economy and (b) if in that particular study there was at least one health quality variable.

To capture unpublished Ugandan research, personal contact was made with key researchers at Makerere University and research institutions such as Makerere Institute of Social Research and other organisations such as the Uganda Bureau of Statistics, the Uganda Ministry of Health Information Services and the District Health Information Services (HIMS).

Finally a comprehensive search was made on the internet resources in Uganda and internationally. A number of sites were searched although the primary sites used were the health and social care site, and the Uganda Ministry of Health.

1.1.4 Selection Criteria

The next step was a detailed examination of studies and papers, and at this point studies were excluded if the focus was not on decentralisation and health service delivery, or if the focus of that particular study was not on any health quality related variable, or if health was only a minor variable in the study, and if such study was likely not to contribute important information to the review.

For the studies investigating the direct association between decentralisation and primary health care delivery, the review includes all mostly longitudinal

studies investigating the performances of primary health care services under decentralisation. Longitudinal studies were seen as particularly valuable resources as they facilitate the testing of the relationship between the periods before or during the earlier days of decentralisation and the present, and enables the identification of developmental sequences and pathways, as well as the construction of the theoretical and analytical models which can be validated in future research. Cross-sectional studies which used large samples and a methodological design were also retained. However some studies with methodological weaknesses arising from small convenience samples, few factors measured, or weak data analysis, were included only when they provided possible insights not available from more vigorous studies.

1.1.5 Review descriptions

As with most research in the area of social sciences especially on the impact of decentralisation and health, the majority of the studies were comparative correlation, that is, they investigated the relationship between decentralisation and the delivery of social services such as health and interpreted the association found as showing a direct impact of decentralisation on health service delivery as a genre. The possibility of understanding the impact of decentralisation on health care, in which "quality" as a general term is taken to mean availability and access to primary health services from the users, and providers' perspectives, has been infrequently investigated. Thus, while most studies have investigated the direct association of decentralisation with the current trends in primary health

service delivery, it should be noted the findings reported may mask more complex relationships.

1.1.6 Methodological consideration of the review

Regarding the methodological foundations upon which the reviewed research rests, there are at least four issues, which must be kept in mind when considering the research outcomes. These are: (a) the nature and state of health service delivery; (b) the identification of the primary health care quality variables to be used; (c) the importance of considering the deferring levels of primary health care delivery; (d) and the comparability of cross-sector findings.

Studies which include government reports and those by proponents of decentralisation such as World Bank, IMF often claim improvements in the health sector performances and most often portray decentralisation as the best of all the social policies(for example Hutchison, 1999; Okwi, 2003).

Few studies have collected users' and providers' data together. Information from multiple informants can provide more complete picture, although again there may be relatively low rates of agreement between the differing respondents. It can be valuable to obtain information from both health staff and the users because they generally do not report the same levels of experiences and problems in their interactions and views on the current state of primary health care delivery. It is not always clear in the research when data was collected, but the design of the data collection, particularly of the users and providers through unstructured interviews or some times loosely structured, may have an important bearing on the results.

Finally, the review summarise both the Ugandan and to a lesser extent the global trend in primary health care and decentralisation, although because of the limited number of Ugandan studies on the impact of decentralisation on health, the international research is relied on quite significantly.

1.1.7 Definitions, themes and concepts

Decentralisation has been a central theme of governance in many developing countries such as Uganda (Fukasaku and de-Mello, 1999; Manor, 1999; World Bank, 1999; Shah, 1998; Crook and Manor, 1998). The purpose of decentralisation in the health sector was to break the grip of central government and entice broader participation in democratic governance (Olowu, 2000; Smoke, 1994). The assumptions were that bringing governance closer to the people would make it possible for local people to identify community needs easily and thus supply the appropriate forms and levels of public services (Enemuo, 2000; Rondinelli et al., 1989, Oates, 1972). In turn, it is argued, communities are likely to be willing to pay local taxes where the amount they contribute can be related more directly to services received (Livingstone and Charlton, 1998).

Decentralisation in this work is seen as the administrative changes, which have given the lower level of government greater administrative responsibilities in delivering health services. In Uganda, decentralization has involved changes in political institutions, and the primary health services have been put under the district health services, such that it led to the creation of the health sub district responsible for the delivery of the minimum health

care package.[1] It was assumed that if the state is primarily there to deliver services for people, decentralisation and in particular delegation of powers will improve accountability and governance by bringing governance closer to the people, such that the endemic corruption, inefficiency, inaccessibility in the public health services would be eliminated and health services delivery would improve. Yet, both approaches and results of decentralisation have varied. In fact, although it is generally regarded as having been assimilated, and decentralisation as having been included in the health service delivery and so presumably having brought services closer, one leading commentator has stated that 'there are no real success stories as far as improved development performances of the health sector at the lower levels is concerned' (Ademolekun, cited in Francis and James, 2003). This stark finding is also corroborated by Wunsch (2001), who noted that the quality and accessibility of care continue to be difficult despite the reform efforts. Problems such as over centralisation of resources, limited transfers of resources from the centre to the local government, a weak local revenue base because of increasing poverty, lack of local planning capacity and the absence of meaningful local political process are some of the reasons given for the above conclusions.

These findings and observations have led reformers and researchers to question the sensibility of the decentralisation strategy in real situations in which they are applied in developing countries such as Uganda. The

[1] The minimum health package includes all the major health intervention such as immunization for major killer diseases such as measles, polio, and the treatment of diseases such as Malaria, diarrhoea, cholera, typhoid, and mother and child health care such as child monitoring, antenatal and postnatal care, HIV/AIDS prevention and treatment etc.

questions that have been asked and not well answered are: Under what conditions we can expect that increased local autonomy can improve access, quality, and representative in the health service delivery. How effective are the processes of decentralisation in communicating the real interest of the citizens? To what extent do the people themselves control these processes? And under what conditions can we expect local communities to control the politicians and ensure accountability? Are local officials through sheer proximity more accountable for their performances? Very few studies have asked the users and the providers about the above questions and yet they form the basis through which we can understand the way people (users and providers) perceive the policy of decentralisation.

1.1.8 The meaning of decentralisation

Public administration theory defines decentralisation as the transfer of authority in public planning, management and decision-making from the national to sub-national levels (Rondinelli, cited in Mills 1990).[2] With regards to the health sector in Uganda, decentralisation is concerned with changing the way health systems are organised and delivered. Conceptually it has involved a change in power relations between the national government (MOH) and other actors in the health sector such as districts and sub-districts in Uganda. [3]

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[2] As used in this work, the term "decentralised health system" refers to health system operating from below (District health services) and not deconcetrated health systems.

[3] Decentralisation in Uganda lead to the creation of a health sub-districts which is responsible for the delivery of primary health care. The health sub district is staffed by the senior health staff including the medical officer (doctor) and the senior nursing officers including midwives. The HSD is a kind of referral system for the lower levels.

In the 1990 book, Health Systems Decentralisation: Concepts, Issues and Country Experiences, Dr Anne Mills outlines the important institutional differences of four different forms of decentralisation: Deconcentration, devolution, delegation and privatization (Mills, 1990). Deconcentration refers to shifting power from central Ministry of Health offices but the offices remain accountable to higher levels of government.[4] Devolution refers to shifting political and administrative authorities for delivery and management to an independent local level statutory agency, for example municipality or local government. Delegation is where management responsibilities are transferred to a semi- autonomous entity such as health board. The aim is to free national government from day to day management functions. In this way the entity remains accountable to national government. Privatisation on the other hand refers to contractual agreements established between the public and the private sector for the delivery of health services (Mills, 1990). Usually the stated aim is to improve quality of care by encouraging consumer participation and competition and to improve efficiency. In this way the government retains some regulatory and overall coordination responsibility. The definition used here draws from Rondinelli, 1983; and Mills, 1990) and is equal to what they call "devolution", I therefore use the more general term "decentralization" to simplify comparison with its extreme opposite

[4] Deconcetration has been described as "centralisation in disguise", since it extends the geographical and policy reach of the central government with no guarantee that community participation, accountability, innovations, or any of the other proposed benefits of decentralisation will materialise. Case studies in the health sector have highlighted these weaknesses (Campos-Outcalt et al., 1995; Okwonzi, et al., 2000). On the other hand, deconcetration has been proposed as a way to getting the "best of both worlds". Like devolution, it brings governance "closer" to the community and facilitates access to local information; but it also preserves the consistency and parsimony of centralised decision-making and it maintains the relative ease of centralised policy implementation.

centralization. This definition also corresponds to the definition used in Beck and colleagues, (2000) which simply means 'devolving' responsibilities for planning, financing, management, supervision and delivery of the health services.

The different forms described above are distinguished primarily by their legal status. The range of functions commonly decentralized to local level include legislative and policy-making function; revenue generation; regulation and monitoring of service delivery by governmental and non-governmental entities, planning and resource allocation; management; inter-sectoral collaborations; interagency co-ordination; and health providers training (Mills, 1990).

2.1.9 The meaning of quality of primary health care

Very few systematic studies have defined and measured the quality of primary health care. However a number of studies have tried to explain parts of quality of health care services. According to Donabedian, (1980), and cited in Simon, (1987), and again in Bruce, (1990), quality by its connotation implies standards in medical care delivery. It is not a standard in itself rather it is a property that all health programmes must have. Blummenfeld (1993) defines quality as "doing the right thing right". This means offering a range of health services that are safe and effective and that satisfy the client's needs and wants. Blumenthal (1996) define quality of health in many ways: From the public perspective, quality of care means offering the greatest health benefits, with least health risks to the greatest number of people given the

available resources.[5] It therefore means offering an appropriate array of health services interventions such as immunisation, antenatal care, family planning service, and proper medication to reduce pain, morbidity and disability. Generally, sometimes quality of care has been counted as synonymous with availability, equity or accessibility of services (Meads and Wakida 2005).

The World Health Organization defines quality of health care as consisting of the proper performance (according to standards) of intervention that are known to be safe, that are affordable to the society in question and that have an impact on mortality, morbidity, disability and malnutrition (World Health Organization, 1978).

The first emphasis from the definition is on performance. When the healthcare system and those who work in them put clients first, they offer services that not only meet standards of quality but also satisfy the clients. The second aspect is that of cost. It is clear that quality improvement does not have to cost a lot of money. In many aspects, quality of care should be cost effective and affordable to the users. In this work, I use the term primary health care to refer to both preventive and curative health services that are offered by the district and below namely: antenatal services, child management, drop in centres for headaches and minor injuries, outreach

[5] Blummenfeld, (1993) defines quality as doing the right thing right. Quality therefore is seen as offering a range of health services that are safe and effective and that satisfy the client's needs. In this work therefore quality of care is seen as offering the greatest benefits with least health risks to the greatest number of people given the available resources. Quality of care therefore means, good treatment, availability of providers, and less cost of treatment (Blumenthal, 1996 and Humber, 1994) While WHO, defines quality of care to mean proper performances according to standards of interventions that are known to be safe, affordable to the users and that have impact on mortalities, morbidity, disability and malnutrition (Roemer and Montoya-Anguila, 1988).

services, diagnosis done at the health centres which is mostly out-patient treatment, although some form of hospital treatment at the health centre four is included in this definition.

The objectives of primary health care in Uganda are to address the social-economic causes of poor health and make provision for basic health needs, which among other things include empowerment, providing preventive, curative, rehabilitative and palliative services. Other objectives of the primary health strategy include to prioritize accessibility, equitable and affordable health care, and to promote interdisciplinary, multi-professional and inter-sectoral collaborative teamwork for the development of the country.

1.1.10 The Rationale for decentralization in Uganda

During the last two decades Uganda embarked on the health sector reform. The reforms in the health sector in Uganda have been motivated by previous economic recession, deteriorating health services, ideals of democratising the state and donor driven pressure to enhance public sector efficiency and management (Gilson and Mills, 1995; Mills, 1990; Bossert, 2002). [6] Decentralisation of the health sector has therefore been a strategy for the

[6] Reforms in Uganda's health sector has been motivated by economic recession, deteriorating health services, ideals of the democratisation and donor driven pressures to reduce government influences in public service delivery as a way of reducing costs (cost containment measure). Proponents of decentralisation claim a number of benefits for efficiency and equity of government performance. On the efficiency side, it claimed that proximity of local authority to the communities they govern improves the quality of governance through factors such as strengthened accountability, reduced corruption and improved information on local circumstances and preferences (Morkherjee,2001).On the on the equity side, it is claimed that decentralising the responsibilities for targeting poor households improves the effectiveness of such efforts, again because of information issues related to proximity of local authorities to the communities they administer (Litvack, Ahmed and Bird, 1998). However Prudhomme, (1995) takes a more critical perspective and highlights a number of potential negative impacts. He points out that equity for example can suffer if decentralised local authorities are "captured" by local elites, and the motivation for pro-poor targeting may be les stronger at the local level anyway.

national and international agendas. The literature in Uganda defines two major forces that have motivated much of the decentralisation in practice: Technical or managerial motives, aimed at enhancing efficiency in management, and political motives aimed at democratisation of the state social services and ensuring greater accountability to communities (Brijlal et al., 1998). This certainly represents a search for more effective and creative ways of addressing problems of declining health service delivery (World Bank, 2000). Concerned about inefficient management systems in Uganda, donors and multi-lateral agencies sometimes used loans as leverage for influencing changes in the health sector. For example loans were given to Uganda by the World Bank, on conditions that the government decentralised the health system (Gyapong et al, 1995; Bennet, et al, 1997).

1.2 The impact of decentralization: Evidence from earlier studies

The lacunae in our knowledge about the "the impact of decentralisation" on the primary health services in Uganda have been much noted since 1990s (Bossert, 1998; 2000; Mwesigye, 1999; Mwabu, 2002; Bennet et al., 1997; Standing, 1997). This knowledge has been shaped by scholars, activists and journalists who are both critics and proponents of a decentralisation strategy in the health care provisioning in the developing world. The overwhelming part of the literature on "The impact of decentralisation" was published in the 1990s. Research on this topic has proliferated after the campaigns against Structural Adjustment Programmes, which have been launched in many countries that have undertaken neo-liberal social economic policies. Theoretical studies of decentralisation generally have predicted a negative

impact for health services with inter-jurisdictional externalities and public good characteristics (Basely and Corte, 1999; Badham and Mookerhje, 1998). These studies have noted weakening central functions; staff cuts through retrenchment, poor monitoring and health system support. Available literature also shows that decentralisation led to a significant reduction in central government involvement in areas such as procurement of drugs, policy development, monitoring and evaluation, quality assurance and disease surveillance activities among other things (Sooerarojo and Wilison, 2001).

Evidence in Uganda for example shows that the local government spent less on public and semi-public goods after decentralisation than before, with the consequent under-provision of essential primary health care (Hutchison and Strumpf, 2001). This seems to be the trend in many countries elsewhere as a cost containment measure. For example (Solomon and others, 1999, cited in Soerejo, and Wilison, 2001) noted the same experiences in the Philippines, noting that decentralisation had caused disparities in spending between curative and preventive care with the former taking precedence. The problem is that local authorities, under pressure to raise their own revenue and without much in the way of community support for public financing of the primary health care, turned to charging for the services. The impact of charging on primary health care is well documented (England, 2001).

Another prediction was that decentralisation would improve the extent to which local authorities are held accountable for the provision of primary health care services. This prediction was based on assumption that the people

have the power, and the information is readily available. Critics argue that there is no evidence that there is an increased investment in public information or education on health services (Kadar and others, 2000) and since there is little evidence that household demands plays a significant role in influencing primary health care coverage in information poor countries such as Uganda, it is unlikely that communities will use the "voice" mechanism even if they exist, which they often don't—to express concerns about health services, especially when faced by other pressing needs.

In contrast to many of these studies, experiences and perspectives in a qualitative mode has not dominated the literature in determining the impact of decentralisation on primary health care. Quantitative studies do exist about the impact of decentralisation on the health sector as a whole, which reflects the growth of knowledge about the impact of decentralisation on health care delivery as a genre. To some extent, research topics in these studies have matched current debates, issues or question in the process of implementation of decentralisation and these studies have influenced the campaigns for and implementation of decentralisation in the health sector. But even within these studies, however, there has not been much emphasis on the experiences of users and providers of primary health care. Most of these studies have tended to concentrate on the implementation process, structural modalities and the organisational abilities of the decentralised entities in carrying out the responsibilities devolved to them.

There is also recent research that is more focused on analytical and /or discursive questions, such as gender and equity (Montana, 2001; Standing, 2001, 1997), and studies on the organisational and performance, quality and equity of the decentralised health sector, (Bossert, 1998, 2002; Mwabu, 2002; Mwesigye, 1999; Hutchison, 1999; Gilison and Travis, 1997) in which they draw on institutional requirements for the successes of decentralisation in the health sector. By drawing attention to the scale of institutional failures of decentralisation, these studies challenge the misconceived stereotype of the abilities of decentralised entities in delivering previously national health programmes and conclude that unless such managerial and administrative issues are addressed, quality, efficiency, equity and availability will not be realised. However most of these studies argue that it is still early to begin counting the gains and hope that the institutional weaknesses will be addressed as the policy is implemented (Gilison and Travis, 1997; Bossert, 1998 and 2002).[7]

In contrast with these works which have exposed the weakness of decentralisation, there has been work which attempts to legitimise or defend the implementation of decentralisation, these include the apologists, such as the World Bank and IMF, and the governments (World Bank, 2002; Okwi, 2003, Hutchison, 1999) who argue that decentralisation is the basis for development rooted in the local social economic and political structures. These classic studies argue that decentralisation has helped to improve accountability, improved people's participation and responsiveness, (Olowu,

[7] By the time of decentralisation in Uganda, proponents had branded decentralisation as panacea, without due respect to institutional requirements such manpower, skills for planning and budgeting and mechanism for checking performances.

2000; Smoke, 1994) and therefore has led to better health service delivery rooted in people's interests (Enemuo, 2000).

Whereas the theoretical literature above cannot be minimised or their conclusions dismissed because they have helped in shaping our knowledge about the impact of decentralisation on quality, access and the delivery of health care, few of these studies used the users and providers to reach the conclusions.

This chapter draws on different approaches and conceptual framework to decentralisation in presenting the state of the quality, access, availability and the delivery of primary health care in Uganda. In order to map the readings of previous studies, I delineate three conceptual frameworks: Participation and primary service delivery, quality, access and utilisation of primary health care. The literature reviews current studies on the health sector as a whole, its performances in the last two decades, and the impact of decentralisation since its implementation more than 10 years ago with the purpose of understanding the state of primary health care and the different interpretation of the impact of decentralisation on the health service delivery.

1.2.1 Models and approaches for analysis of decentralization of health system

Since the early 1990s, much of what has been written about decentralization globally has consisted of descriptive accounts of the implementation processes. In the mid-1990s, a few studies employed an analytical approach, using empirical data to examine the impact of decentralization on health systems performances (Bossert, 1998; Standing, 1997; Agrawal and Ribot, 1999; Travis and Gilison, 1997) and therefore produced frameworks through

which decentralization could be analyzed. However none of these uses experiences of both users and providers together to make their conclusion. Secondly these studies have treated health care as a genre, hence no specific study have focused on primary health care in terms of forms of service delivery, processes and the health system performance.

A review of the literature especially on the African continent reveals three key studies that employ analytical framework to examine the impact of decentralization on the health systems. The first study by Gilison and Mills, (1995), applies an evaluative framework to assess potential impacts of decentralization on health system performance with respect to equity and efficiency. The second study, by Gilison and Travis, 1997, provides an overview of eight African countries (Botswana, Bukinafaso, Ghana, Kenya, Mali, South Africa, Uganda and Zambia), assesses the effect of decentralization on the health system changes, and attempts to analyze the effect of changes in overall performance indicators over time. These frameworks measured the process in terms of inter-sectoral collaborations, community participation, accountability and planning. They also analyse health policy development; needs assessment, human resource planning and management. On the overall performance of the decentralized health sector, the framework judged the health sector in terms of equity, efficiency and quality of care. They examined whether if decentralization may have had made any contribution to changes in health system performance.

Gilison and Travis (1997), concluded that assessing changes in the organizational process and system is more feasible than assessing changes in

overall performance over time. In respect to changes in performance over time, assessment was hampered by data limitation and by the reforms occurring simultaneously and by contextual on addition, Travis et al (1997) did not use the experiences as an input in their analysis.

1.2.2 The decision space approach

The decision space frameworks developed by Bossert and others, (1998, 2000) combines two approaches: First, the public administration typology which describes the forms of decentralization adopted, and secondly the principal agent approach that examines the range of choices that sub-national level agents have over different functions transferred from the national level.

(Bossert and co-researchers, 1998; Bossert et al, 2000; Bossert and Beauvais, 2002) applied the decision space analytical framework to empirical studies in Uganda and other countries to examine the relationship between the forms of decentralization, processes and actual outcomes (Health system performances). The "decision space model" accordingly is defined with reference to the amount of decision-making authority transferred to local officials for execution of health policies (Bossert, 2002)[8]. The strength of this approach over others is that it provides a framework for measuring the three most important elements of decentralization:

1) The amount of choice transferred from central institutions to institution at

[8]Decision space approaches is used to examine the relationship between the forms of decentralisation, the processes and the actual outcomes. It refers to the amount of decision-making authority transferred to local officials for the excursion of health services. This framework provides for measuring the choices local officials make, the amount of choices available and the effects of these choices on the operationality and performances of the health sector (Bossert, 1998, 2000).

the periphery of the health system and 2) the choice local officials make with their increased discretion and 3) the effect these choices have on the performance of the health system (Bossert, 1998). The advantage of this approach is that it gives the analysis of decentralization greater depth, revealing the complex relationship between the principal agents at national level and the agents of the sub national level and the multi-faceted nature of decentralization models employed in a localized situation.

The decision space approach assumes that the performance of decentralized levels in their new roles is dependent on how much discretion they have on a range of functions, which might be difficult to ascertain. Gilison and Travis (1997) concluded that assessing change in organizational process and system is more feasible than assessing changes in overall performances and concluded that sometimes this approach is hampered by data limitations and by the presence of reforms occurring simultaneously and some times by contextual factor which make it difficult to attribute the changes to decentralization a lone.

However, since the decision space approach and the public administration typology allow us to analyze various functions that are decentralized in the health system, including finance, service organization and human resource for health, governance and access rules, it is relevant to my analysis. As Bossert argues, "decentralization" should not itself be seen as an end; rather it should be seen as a means to the end of accomplishing the broader goals of equity, efficiency, quality and access to health care (Bossert, 1998).

Because Uganda has both devolved and deconcentrated the primary health

services delivery, excluding this analytical framework from my analysis would seem to mislead and miss a point of the policy significance in Uganda: namely what happens when the MOH move the operation closer to the people. By use of these models each category of funding, service organization, and human resources for health; access and governance rules are evaluated to determine its impact on the quality of primary health services. Because this model divides finance into sources of revenue, fees allocation, access to funds and freedom to spend and the decision on revenue sources, it permits us to evaluate as narrow, moderate or inefficient the space provided and its implication for service delivery. Viewing decentralization of the health sector through these lenses provides useful models of analysis that separate analysis of decision-making for fiscal decentralization from those of health service administration. This separation is crucial for analysis of the health system as it produces institutional arrangements that could potentially affect primary health outcomes. The added strength of Bossert's model is that it ranks degree of decision-making authority as narrow, moderate or wide for each decentralized area of the health system (Bossert, 2002) and therefore can be used in measuring the levels of autonomy in decision-making, and funding choices available for the local government, which all affect health service out comes.

Because, Bossert's model delineates between fiscal decentralization, decentralization of service delivery and human resources, and also measures the level of local decision decentralization making for each area of decentralization, it provides a more holistic approach to analyzing the

decentralization process and its impact on the delivery of health services.

All these sets of studies were plagued by data limitation, so measuring performance was very difficult. Health system performance is generally measured in terms of specific performance indicators, such as: staff adequacy and efficiency as a measure of efficiency; patient waiting time as measure of quality of care; and facility utilization rates as a measure of equity. Unfortunately such indicators are not routinely available, or are unreliable in many countries due to poorly developed or non existent health information systems. Travis et al, (1997) and Bosssert, (2002) recognized the difficulty of isolating the impact of decentralization as one among several health interventions for any change that might have taken place in the health system performances. In both the studies, experiences are not used and hence users are not asked about their interface with health services. I will use the frameworks applied in the previous studies, using both users and providers experiences as the main sources of information, how they talk about the state of health, and their daily interface with health services to analyze specific indicators of quality and access to primary health service delivery under decentralization. For example I will apply the decision space model for access rules to ascertain whether a decentralized program has successfully targeted the majority of rural people as a "priority" and similarly, whether decentralization has incorporated communities into local decision making process by analyzing the extent of their involvement in primary service delivery, management and ensuring accountability.

1.2.3 My research Questions and Concepts

There are so many studies on the construct of decentralization and how it impacts on development and service delivery, but there are not so many available on the "experiences and perceptions" of those who use services and those who are directly responsible for delivering the primary health services (Health staff) used together to construct the knowledge about the "impact of decentralisation" on the primary health services under decentralisation, and how such experiences are used by them (Users and health staff) to create a particular action. Most studies have been devoted to the investigation of the "impact", which makes such studies ignore the importance of "voices" i.e. experiences of users and providers and their perceptions about the quality, access and availability of services in analysing the general development of the health sector under decentralisation. In order to analyse the impact of decentralisation on primary health care services using the experiences and perception of users and providers, the lead questions are grouped into two broader questions namely:

My first question is: What are the impacts of decentralisation on the users' and health staffs' experiences of the quality of primary health care? This question addresses the issues of quality, availability of and access to primary health care. The question addresses the medication process under decentralization and identifies the obstacles for accessing primary health care under decentralisation. It further addresses the issue of primary health staff, their perception of their self (social economic) and how they interpret the current state of their work and the self and their relation to quality of care they deliver.

My second question is: Which organizational changes have contributed to these impacts? This question addresses issues governance in the health sector. Issues such as community participation and how local people are involved in the health sector are part of the study. The question analyses the strengths and weaknesses of the primary health care structure.

Unlike other studies, these questions analyse access to and the quality of medication and the process of medication, which includes drugs, health staff, and the medication process such as prescriptions, confidentiality and privacy, and not necessarily health structure which has dominated the recent literature on decentralisation, although references are made to the quality and access to the primary health structure in regard to its influence and development since decentralisation. The questions therefore go beyond the structures and touch on the actual medication process as a measure of quality and access to good care.

The above questions emerge as unanswered or some how neglected by the previous approaches or as questions that have been raised but have been answered in different ways. Since issues of access, quality and availability are central to my analysis, the dichotomy of the impact of decentralisation of primary care, and the experiences of the users and providers are used in this analysis to reconstruct the knowledge, to untangle the interweaving of the results of SAP on quality, access and the delivery of primary health care services.

Using the above questions, the study strives to analyse the texture of the ideology of "localised primary service provisioning" and the practices of

decentralisation in service delivery from the viewpoint of primary health care users' and providers' experiences and perspectives. The study argues that experiences and perspectives should not only be 'added in' for the study of the impact of decentralisation on health services, but are brought together in a thoroughly integrated fashion in analysing the experiences of the users and providers of primary health services in order to construct knowledge about the outcomes of decentralisation on the primary health services.

1.2.4 Decentralization and the quality of primary care in Uganda

This section reviews the available literature on the impact of decentralisation on quality and how the changes in the primary health organisation affected the quality of primary health care. These approaches are made on the understanding that changes in health system organisational structure directly or indirectly affect the delivery of health services. The key questions include: Does decentralisation improve the quality of care? What are the limitations and opportunities for enhancing quality and access to primary health care?

A number of studies have looked at the impact of decentralisation on quality of care. Most of these studies have used the traditional themes such as availability of providers, distance to the provider (Health unit) and human medicine, and financial costs of medication (Mwesigye, 1999, Mwabu, 2002). For example, Mwesigye's study of the impact of decentralisation on quality analysed the distance to the facility and concluded that as compared to the past, the distance had reduced, and hence quality of primary health care seen in terms of distance was seen to have improved. The importance of

distance to care is that it reduces the time spent to travel to the facility that can be affected by transport, congestion and any other road conditions. However, using the records on the medical supplies, the study showed that there is a reduced supply in medicine that could not match the increasing demands resulting from reduced distance (Mwabu, 2002). This corroborated earlier qualitative study that had noted that there was increased individual purchases of drugs in Uganda, which they attributed to reduced or absence of medicine in health facilities. Mwesigye noted that 8 in ten patients who attended for primary health care were asked to buy some sort of drugs that was missing on the prescription. Both Mwabu and Mwesigye for example attributed these circumstances to low budgets, or cuts in the spending on public health that is always blamed on the World Bank and IMF policy of cost containment.

1.2.5 Cost containment measures and the quality of care

In addition to proximity, costs and their relationship to income have been found to have important effects on the use of health care. Therefore health care costs are included as a standard for measuring quality of care. It is argued that quality services should not be expensive as it drives away the would-be consumers and can cause inequity in service utilisation. Monetary costs can be both direct and indirect costs of services. Direct costs may include any payment for transport and payments for services that require liquid money e.g. to pay for drugs and treatment etc. On the other hand, indirect costs include the opportunity cost of absence from work due to time spent seeking care and the production forgone for both the ill person and the carers. Both

direct and indirect costs are considered in this analysis so as to get the proper interpretation of the impact of decentralisation on services.

Studies in Uganda have shown that the requirements for money in order to get treatment have more than doubled under decentralisation (Mwesigye, 1999). The implication is that the responsibility for treatment therefore rests much more on the individual patients under decentralisation as the state continues to retreat from its responsibilities in the name of devolution. Increased household expenditure means increased strain on how to get the money to spend on the part of the patient, which might mean borrowing, selling of household properties, overworking or getting involved in all sorts of activities to raise revenue for their household health bills. While health planners might see increased household expenditure as progress made so far, however, increasing money requirements can be detrimental in the sense that it can repel the would-be service consumers. The dilemma is that no study has asked the households their experiences in raising the money, or their sources of income that they spend on health bills. Questions such as how do people buy drugs and its relationship to health care remain unclear in the literature. Users can only answer what are the sources of their incomes from their experiences, which can help to understand how they feel, and how the process has affected them.

England (2001) provides another yet very important piece of evidence of the impact of decentralisation policy on quality of care. Still considering costs, England noted that costs that were introduced under decentralisation continue to limit the utilisation of health services by the poor (England, 2001). He

concluded that while there was a greater diversity in the way services were delivered, users of health services were complaining about the costs involved, such that some patients could not afford the charges and stayed way to avoid being asked to pay. The requirement for money in the health sector can mean that only those with money will attain health services at the expense of the poor disadvantaged groups who continue to suffer with pain in silence; hence it bred the ground for inequality in health service utilisation.

This requirement for money in the health sector is a result of what Mamdani (1996) calls the marketization of public services. The issue is how do those who are affected feel, how do they talk about their current state of health amidst the new policy and changes that have taken place within the health sector? The dilemma is that if the poor are asked to buy for example their own medication, they can chose to buy half doses just to reduce pain which is more dangerous than not taking at all, hence it is not a standard required in quality of care.

2.2.6 Confidentiality, privacy and the medication processes

While quality of care has been seen in terms of availability of drugs, cost of treatment, on which conclusions have been drawn, these studies leave out the importance of the medication process of treatment: prescription and confidentiality and privacy which are major components in the quality of care and can determine the rate of utilisation. The importance of confidentiality and privacy in determining the quality is that patients will be less than willing to seek medical attention if he/she perceives that the information they give

will not be kept private. On the other hand, where privacy is badly managed, it can lead to stigmatization, job loss and many other social ills.

Privacy and confidentiality have come to forefront of medical ethical concern in the early 21st century due to the advent of electronic health records, information technology, and the large databases, which have resulted from the mass consumption of health care in the west. Internationally, legal initiatives have proposed solutions to the dilemma posed by health information. In Europe and North America for example, such initiatives have led to restrictive legislation and are recognised as part of quality care assurance measures (Gostin, 2001; Chalmers 2003; Kmietwicz, 2003). Gostin for example recommends that any health policy should aim at protecting the consumers, both the type of medicine they consume, the nature of treatment and the process of treatment which includes the way the information sharing between the users and the health staff and the general public is managed. This he argues will encourage users to be more than willing to talk about and seek treatment when needed, but he argued that the opposite can occur if the information is not well managed.

Very few quality studies have attempted to analyse the question of patient information as a measure of quality of care under decentralisation. Questions such as what is the state of patient information and confidentiality during treatment are important in the analysis of the impact of decentralisation on quality of care, since a change in the structure, organisation and the management of health sector has generated many issues. There are issues such as plurality in primary health care delivery, private practice and lack of

facilities, all of which have a direct bearing on the confidentiality question in health service delivery. What are the implication to service utilisation in a society that has suffered with HIV/AIDS, poverty and illiteracy? This question is applicable to our analysis because during decentralisation, the country has experienced a multiplicity of private providers of primary health care. Primary health service plurality stems from privatisation or economic liberalisation (Bennet, et al, 1997; Mwesigye, 1999).

But even more the failure of the public health system to meet the needs of the users creates markets and demands for alternative providers, such that patients in Pallisa shop around between different providers; traditional, and private allopathetic such as drug shops, pharmacies, markets, traditional healers, in search for health care of any kind. The relationship of this to quality is that poor practices ranging from sale of expired drugs, under doses and providing of totally palliative treatment (Mwesigye, 1999). However nothing is yet known how confidentiality and privacy are maintained in these circumstances and how it has affected the patients and the providers alike.

Secondly, the study argues that quality of care should be seen in terms of prescription, which not only means written medical forms, but medical examination properly done by professional health staff. Mwesigye, (1999) in his study also noted that cost containment resulted in reduced health service spending during decentralisation, such that most health centres lack stationery for prescription (Mwesigye, 1999) such that health staff struggle to find papers on which to write the information for the patients. In fact in Uganda, patients are asked to buy their own "prescription books" which

replaced the medical form five previously provided by the government. This is another form of cost sharing in health services in Uganda. The extent to which decentralisation affected prescription forms is well presented; however, little is known how medical examination is affected by decentralisation and yet it is the foundation for clinical care. Decentralisation can affect medical examination in a number of ways: firstly where there are more patients than the staff can handle, the health staff will not be able to examine the patients as required; or the poorly motivated health staff will be less than willing to do so.

Without seeing prescription solely in terms of information written on the medical foams, this study uses a general term prescription to mean proper patient examination when ill to determine the causes of illness, and the course of treatment to reduce pain and disability.

1.2.7 Decentralisation, the health staff and quality of care

Mwesigye (1999); Bennet et al. (1997)[9] noted that decentralisation resulted in retrenchment and rationalisation of the human resources for health and reduced the number of health staff as a cost containment measure. The management of the health staff is one of the responsibilities devolved to the district under decentralisation. Mwesigye noted that under decentralisation, the district is now responsible for the management, recruitment, and

[9] Economic and the Ministry of health restructuring led to the reduction in the number of health staff, but at the same time the number of patients has increased which suggests that the few health staff available are struggling with the increasing number of patients. The District is now in charge of recruiting, remuneration, promotion and redeployment. Because of the new arrangements questions such as job security, load of work and the social status of the health staff have been overlooked while most studies have concentrated on studying the reaction of the health staff, in which most notably has been their involvement in the private practice, (Mwesigye, 1999; Benet et al., 1997).

remuneration etc of the health staff. The importance of health staff to quality is that they are the engine through which decentralisation has been implemented. Therefore analysing how they feel about the policy provides a holistic way to understand how services are delivered. Two major concerns are found in the literature: Firstly, the experiences of the health staff in working in decentralisation; secondly their perception of their work environment, work loads, working conditions, job security and their general standard of living are issues that need to be understood.

The lacunae about the impact of decentralisation were first provided by Assimwe (1997) cited in Bennet et al., (1997). These studies included themes such as wages, working environment and morale of the health staff. In their conclusion, Assimwe, (1999) concluded that the health staff in Uganda is now better off economically than before decentralisation. In their qualitative study in Western Uganda, Assimwe asked the health staff to compare their working conditions, economic conditions before and after decentralisation. The majority of his respondents were senior staff who mainly work in hospitals. The study concluded that as compared to the period before decentralisation their work conditions are better, and they are economically better off than before. This was attributed to a number of factors: Increased wages, which was also paid on time as compared to the time before when the health staff waited for many months before they were paid; secondly decentralisation had diversified the earnings of the health staff since they were now allowed to do business like any other person, hence earning more income.

However, to the contrary, since then these conclusions have been criticised. This has been backed by evidence that health staff in some other regions of the country cannot afford to take their children to school or afford a decent life for their families, (Mkutu, 2003; See also Macro international, 2001). Under decentralisation all the benefits that the health staff used to have were scrapped, for example Mkutu noted that in the past the health staff used to have privileges such as free education, housing and medical treatment for their biological families but all these were removed under the health sector restructuring. The importance of these privileges is that they defined the identity of the health staff as people of higher class such that parents struggled to see their children become health staff because it offered opportunities for good life and future prospects and rewards which went with the profession (Mkutu, 2003). In another study, health staff narrated how they live: their children not going to school and they have to come and work which they said made them less interested in working (Kolyangha, 2003). This could explain why some health staff prefer working for the private clinics or operating their own drug shops so as to subsidise their incomes. The impact of private practice by public health staff is well documented (Dasult, 2003; Kolehmanen-Aitken, 1998). For example it was noted that as a result some health centres are open half the day (Dassault, 2003). This was attributed to the shortages and the inabilities of the public health sector to recruit and retain the health staff, and secondly, to the private practices of the public health staff, which makes them absent most of the time from the public health centres (Bennett et al., 1997). Bennet for example showed that the health staff

under decentralization spend much of the time in private practice. After documenting the private activities of the public health worker in Uganda, Mcpake (1999) concludes that it has become a cultural given in Uganda for the health staff to steal or to work outside the public structures. Mcpake noted that as a result health staff under-dose their patients with the intention of selling the medicine or diverting the public supplies, which result in poor medication. The private practices of public health staff have a number of implications for the quality of care: the absence of the health staff at the centre can lead to overcrowding and increased workloads to those few who remain, which can result in poor medication processes such as screening and examination of the patients hence resulting into poor quality; increased waiting time for the patients and, on the other hand these practices can lead to poor relationships between the provider and the users where they begin to see each other with mistrust, leading to the erosion of the intimate relationship based on trust which is so important in the delivery of health care. There is less in the literature that connects decentralisation and the relationship between the staff and the users and how it affects quality of care.

I will argue that if the patient perceives the health staff as not caring, that perception cannot provide the psychological care that is very important in the care process. Likewise if the health staff perceive themselves as marginalised, their efforts in providing good health care will be derailed and they will be less than eager to provide better care. While it is important to analyse the institutional impact of decentralisation, it is equally important to treat the impact as a social occurrence that has greater bearing on the way

users get services and the way health care providers react to the circumstances they live in under decentralisation. Health staff who feel marginalised can turn to charging or receiving "under the table payments" or absenting him/her self from duty or be less motivated to do so. While contributing to the knowledge about the impact of decentralisation on the health staff as a measure of quality of care, the questions that need to be answered are what are the motivating factors for the actions reported in the literature (absenteeism, drug pilferage, back handers or under the table payments that health staff receive etc.) And what bearing has it had on their social status and how they are regarded in the communities. These actions of the public health staff should be seen within the context of reform programme. Seeing it this way provides room to question these acts and makes us understand and see these acts beyond liberalisation and privatization, rather as social economic factors imbedded within the reform programmes that need to be addressed.

1.2.8 Decentralization, access and utilization of primary care

The concept of access here is used to mean when health care is within reach of those who want it; and they can get it easily without any deterrent such as costs, distance or the staff or other social-economic obstacles such as decisions, power, poverty and cultures which cause exclusion from social services. Social-policy documents and national reports on access to primary care have tended to brand decentralisation of the health sector in Uganda as a success story (Qadeer 2000, Okwi, 2003, Mwabu, 2002; Macro international, 2001).

Most of these studies have looked at access with regards to distance and transport in which they have concluded that more than 80% of the population live with in 5 km to the health facility and therefore have access to primary health care (Macro international, 1999; UBOS, 2002). These quantitative and econometric studies also noted that since decentralisation the number of primary health facilities has been increasing at annual growth rate of 6-9% from 1997-2000 (Ministry of Health 2001). After the implementation of decentralisation, the government undertook to renovate, and build new health centres with the aim of removing the geographical barrier to health care in Uganda. On the basis of the infrastructure development the government and international donors have concluded that decentralisation has removed the geographical obstacles of access to health care in Uganda since people now do not need to walk long distances when they do need to use the services.[10]

As argued by Hutchison distance is a major barrier to primary health care access in Uganda (Hutchison, 1999). Nevertheless, whereas these studies are important in shaping what we know about a decentralised primary health care delivery in Uganda with regards to access, in them lies an assumption that bringing primary health infrastructure closer to the users would translate into access.[11] Health facilities would remain useless if the users perceive the

[10] Walking to the health centre is the primary mode of transportation for patients, even for the pregnant women in Uganda.

[11] Current studies on access to primary health care have concluded that as a result of decentralisation, primary health facilities have been brought near the public hence improving access to primary health care. The distance that people walk to the centres has reduced from 15km in 1990s to just 5km (Okwi, 2003). The assumption in these conclusions is that bringing structures has translated into access to care, which might not be the case. If the facilities are not well funded, have no drugs as always has been the case, have no or poorly motivated health staff, then the majority of would be service users will continue to suffer

quality of care to be of poor quality (no drugs, no health staff or when the physical conditions are perceived to be not good enough) that would continue to make access to medical care difficult. Secondly, the health structures might be closer to users, but if the local authorities lack funds to equip them or if the public perceive the services offered as not good enough, the majority of the would be users would still continue to walk distances in search of better services and vulnerable groups in the society would continue to suffer voluntary exclusion from primary health services which is not always talked about by authors of these neo-liberal policies. For example access to the health staff, coupled with access to fertility regulation and skilled attendants at birth would lead to a substantial reduction in the number of maternal deaths (Safe motherhood, 2000).

The Ministry of Health and expatriate advisers have cited the reduced prevalence of HIV/AIDS (from 30% 1990s to 4.1% in 2004 (Gov of Uganda, 2004) and the increase in outpatient as due to increased access to primary health care which resulted from the decentralisation strategy, yet the reduction in HIV/AIDS was due to a political strategy of openness and public education and had little to do with decentralisation as a policy. Likewise, the doubling of the outpatients in the primary care settings cannot be attributed to decentralisation rather it was due to the abolition of the user fee in 2001.

Taking antenatal care services as a proxy, quantitative studies show that the absolute numbers of ANC users had increased in Uganda after

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inaccessibility to health care. Or if the users perceive the care to be of poor quality, hygiene and other quality considerations then, those who would be users would reject the services and will continue to look for other alternatives. Or if costs are attached to services then the majority even with their accessibility to facilities will not translate into access to services.

decentralisation was implemented (Safe Motherhood, 2003) to which it was noted that more than 95% attend antenatal services (Ibid-51) which represents an improvement in service utilisation during the years of decentralisation. Safe Motherhood attributed the improvements to reduced distance to the facility, increased providers and education of the mothers about the impotence of ANC (ibid-51-55).

However, the dilemma in Uganda is that whereas there are increments of more than 91% as noted by the Safe Motherhood, intuitional delivery remained at less than 48% (Ndyomugenyi, 2003). Ndyomugenyi for example concluded that reduced distance to the facility had not led to a substantial increase in the number of deliveries, noting that the majority of those who attend for ANC actually deliver outside the public health facilities. Factors given for this phenomenon range from costs involved to cultures and local traditions.

Costs and money requirements in the health sector in Uganda are attributed to cost sharing that was introduced within the health sector after decentralisation, but later was found to have no benefit and was abolished in 2001. The quandary in Uganda is that even when formal cost sharing was abolished, access to care remains a problem (England, 2001). This means that whereas costs are important determinants of access to care, there other major determinants such as "informal" or under –the- table fees or other costs that pose a significant barrier to accessing health care. Consideration of other social costs and other factors that may have been affected by the reforms in the health sector allows a holistic approach to health care improvement as a

development goal. For example the cost of accessing health services may have increased due to increased waiting time because of the absence and fewness of the health staff that resulted in a structural adjustment and retrenchment excise. The opportunity costs of accessing health care could be greater now than before decentralisation, hence affecting the accessibility of health care. Factors such as the interactions with the providers are very important to determine access and the behaviour of using health services among the poor. However no study on the impact of decentralisation on the accessibility to primary health care has related accessibility of care and the relationship between the staff and the patients under decentralisation.

This study argues that where the health workers are perceived to be hostile and unfriendly, many patients will not access the treatment for fear of being abused or being harassed. In Gaye's study patients narrated their ordeal with the health staff (Gaye, 1997; 2001) that ranged from physical assault and abuses to the extent that some patients were afraid of their health staff. These studies attributed this behaviour to language barriers between the staff and the patients and some irresponsible behaviour of some health staff that abused the patients and in no way treated this behaviour in the context of the decentralisation reform process and its impact on the health staff as general. The attitudes and conduct of the health staff that can limit access needs to be seen in the context of decentralisation. Poor morale of the health staff due to work conditions, poor pay etc can influence the way health staff will behave towards the patients. For example a staff whose child has been chased from school because she cannot afford school fees would be less likely to treat the

patient with dignity and this can result in the insult to the patients. Likewise poorly paid staff can turn their frustration on the patients making them the absolute sources of survival by charging a price which makes access for those without money excluded even when the structures are within reach. Similarly poor knowledge about patient management can result from poor training and orientation of the health staff, which are all functions of decentralisation and depend on the ability of the decentralised district to perform those functions. In this study, poverty and attitudes are analysed to provide knowledge about how decentralisation has affected access to primary health care. Social factors such as power relations, responsibilities at the household levels, attitudes, illiteracy and confidences can deter accessibility.

1.2.9 Local participation or representation: People's governance

One of the most commonly cited positive result of decentralisation in Uganda is increased community participation and a greater sense of ownership of health plans and health sector resources (Assiimwe and others, 1996, p.66). The actual empirical evidence on how participation has affected access and quality of care is scanty. Neither is there evidence to show how it has impacted on accountability. Decentralization in Uganda was meant to give powers to other actors in the delivery of primary health care. Popular participation in health service delivery is meant to encourage bottom up planning, decision-making, service management, and accountability and ultimately lead to improvement in service quality (Government of Uganda, 1994:2; Makerere Institute of Social Research, 1997, Hutchison, 1998b). Community participation in the health sector revolved around health

management committees at the health units and sub county levels. The health unit committees are intended to provide a direct link between the communities and service providers. Administratively, available literature showed that as a result of decentralisation, districts had gained the powers to plan and pass their budgets independent of central Ministry of Health and can determine the type, speed and direction of their development (Kapiriri et al, 2003). However, empirical evidence to indicate improved quality of services due to greater community participation was lacking. In a study by the university of Maryland on Uganda's model of participation and its impact on health service delivery concluded that although channels for community participation existed, these channels are not effective due to inadequate flow of information between the local government and the civil society and the limited usefulness of civic structures such as the health unit management committees (HUMC) (World Bank, 2001).

Similarly, Konte, (2001) noted poor participation and attributed the weakness of participation models in Uganda to the former traditional centralised governance, where care was provided for and not with the community, and secondly due to the failure of the government to rationalise the policy on public participation in health service delivery. Konte further noted weaknesses such as the technical and administrative weaknesses that included lack of skills and conflicts between the centre and the local authorities that continue to cause confusion. He noted that many newly appointed community health leaders have a poor understanding of the health system and priorities.

Another study by (Bardhan and Moorherjee, 1998), using a theoretical model of public service provisioning under decentralisation and centralised government, finds that decentralisation performs poorly when local authorities are prone to elite capture. Although, service delivery is a function of management abilities, social factors that affect the participants are as important in influencing the way they will respond and deliver health services. Social economic factors such as domestic work for the participants, power divisions at the household levels and representation, lack of information, perceptions of the participants, levels of mobilisation and lack of incentives are some of the factors that are likely to influence the way participants will respond and deliver the services required. Analysing participation this way provides a holistic approach to understand the impact of decentralisation on the quality of care. Poor participation and absenteeism can lead to delays in passing the budgets, or on the other hand lack of skills on budgeting and planning can affect the delivery of care.

Secondly although, these management committees were given the responsibilities to ensure accountability, supervision and management of the health units, less in the literature is known about their effectiveness. The questions that have been asked and not answered are: Can the local communities ensure accountability? Can they ensure better health supervision? What challenges are they likely to face in a society where people were groomed to fear and not to question the authority? How representative are the committees?

Rural communities in Uganda are highly differentiated by class, gender, age, and religion. It is due to this diversity that the question of community representation arises. I will argue that achieving quality, access, efficiency and availability benefit of participation is predicated on devolving decision-making powers and responsibilities to some individuals, or local communities, which means getting them involved. This requires empowering the participants in knowledge, and motivating them to do so.

The institutional participation in the health sector however, has been overtaken by the informal public engagement. Not only are people participating through the government channels (HUMCS), communities have taken upon themselves to deliver and support their primary health care services. In the 1990s, Uganda has seen a stimulation of different forms of social organisation (White; 1997; Birungi, 1998). Birungi noted that these voluntary organisations play a big role in the delivery of health services ranging from providing labour during the construction of the health unit, mobilisation for the national health interventions such as immunisation, transportation of the sick to the health centres, funding the health units through small contribution, while others are engaged in actual promotion and delivery of health services such as education on family planning and contraceptive use, HIV/AIDS. The communities do the work that used to be government responsibilities. Because of these Birungi (1998) noted that, the perception of the people had changed such that people now regard the delivery of health services as their responsibilities and not the government, which she attributed to political democratization through local councils.

Analytically this has two implications: first it represents a change in attitude among service users such that people begin to see themselves as not just recipients of primary health services, but as active providers, which can bring relief to the government; on the other hand however it might represent desertion of the government and social service uncertainties, social deprivation and the consequent social malaise that forces them to withdraw from formal demands, not by confronting the state but by self- provisioning which indicates falling public provisioning. The question that needs to be answered is what are the motivation factors behind these informal organisations and how effective are these forms of service providers in the delivery of quality primary health care?

1.3 Conclusions and perspectives

This chapter has attempted to do a number of things: to review the literature relevant to decentralisation and health service delivery in Uganda; to set out the research questions that have guided this research and so establish the ways in which these sets of literature have shaped the approaches taken; and to describe the conceptual framework adopted to analyse the impact of decentralisation on the primary health services. The impact of decentralisation on the health sector in Africa as a continent cannot be fully understood without the experiences of the users and the providers who are responsible for the daily interface with these services. However in exploring what has been written so far, certain themes such as equity, access, and quality emerge, as do manifest omissions.

The literature review in the first section of this chapter showed that although the experiences with service delivery under decentralisation have tended to be hidden in the studies which depict positive achievements about decentralisation and health service delivery, the growing body of research on the impact of decentralisation is beginning to challenge this preoccupation, influencing and altering the direction of these perceptions. However, neither in the activists' nor in the proponents' studies about the impact of decentralisation in pursuit of knowledge about decentralisation's impact on health services in Uganda, have users and providers experiences been used together to construct knowledge about the impact of decentralisation on primary health care. An exploration of studies of the impact of health reforms and decentralisation in particular in Uganda revealed unresolved debates concerning quality, access and the delivery system of primary health care.

In the later section of this chapter, the framework developed to analyse the impact of decentralisation was advanced to illustrate that the approach taken to devolution and health service delivery in this thesis is one that recognises service delivery as fluid and multiple; negotiated and contingent/contextual; and users and providers as actively engaged in the delivery of services. The approach is influenced by Bossert's decision space approach as well as the concept of public administration (Bossert, 1998, 2002; Gilson and Travis, 1997), which typically measures the administrative space provided between

the centre and the periphery and the role of the consumers of health services in the development of the health sector.[12]

[12] In this context," voice" refers to mechanism of participation of protest that induces service providers to improve performances. "Exit" refers to the practical ability of service users to use an alternative provider (Hirschman 1970).

CHAPTER 3: RESEARCHING USERS AND STAFF EXPERIENCES: METHODOLOGICAL ISSUES AND CHALLENGES

1.1 Introduction

For purposes of understanding and developing the practical interventions that carry with them the support of users and staff, their interpretations need to be treated as a primary source of information. This can be achieved through detailed interviews and observations of users and staff to obtain their own interpretation of the quality of care, experiences with seeking care. On the other hand, the experiences of the staff also offer a wider understanding on the way they work and how that can affect quality of care delivery since they are now the targets of decentralisation.

This chapter therefore deals with the methodological approach to achieving these objectives. It is divided into three parts. The research design is discussed as the first step, during which the choice of a qualitative research method is considered. The research questions underpinning the study are also raised as part of the design. The research process itself is discussed in the second part. In this part, the piloting phase, my choice of the study site and participants, the interview and observation are outlined. The analytical methods and issues of confidentiality, validity and reliability of the research process are also analytically presented. The third part discusses the problems encountered in organizing and conducting the research and their implications for the outcomes.

1.2 Research Design: The construction of the methodology

The first issue in designing the methodology was where to place my work with in the broader qualitative and quantitative traditions. Adopting a quantitative approach usually demands the use of questionnaires, hypotheses, statistical procedures and representative samples. All rests on the assumptions that the social realities can systematically be observed for rational explanation to be constructed. The general perception is that when general social research is undertaken in this way the intrinsic personal values and biases are not well represented, thereby leading to more objective findings. (See for example Blake, 1993; Creswell, 1994 and Crotty,1998). Nevertheless, the strengths of qualitative research are also its weakness in an increasingly socialised world. For example, in the quest for representative samples and objectivity, the researcher is often unable to explicitly explore the inner self and above all the conviction of those being studied. A shallow relationship is portrayed because of limited immersion and familiarisation with the social environment. May argues that social research is also an examination of the very basis of social existence, when both the researcher and the respondents are constituent part of the social world (May, 1993). A successful co-existence through greater involvement of a researcher as an outsider can ensure a greater understanding of the social structure and processes. The quest for deeper understanding of social reality has resulted in greater demand for respect, and the use of qualitative research in social research (Blaxter, etal.1996; Silverman, 1998).

1.1.1 Thinking Qualitatively

Even though both qualitative and quantitative methods are located in contrasting research traditions, they can complement each other in the search for rational and better explanations and especially in the construction of knowledge and explanations. Qualitative research offers dimensions that quantitative cannot, such as process, meanings, and experiences that people bring to their daily social lives by bringing it alive and by understanding the motivation that frame people's terms of reference and guide their lives. Accordingly, Crotty sees knowledge as not simply out there to be unearthed; rather we have to construct explanations or meanings based on how we have engaged ourselves with real society life (Crotty, 1998).

Research traditions such as interpretism, feminism and critical theory with the ontological assumptions involve lengthy periods of time in observing social actors, at which time a personal contact takes place between the researched and the researcher (See for example Hughes, 1990; Blakie, 1993; Crotty, 1998). My study follows the study of the traditions of such interpretive social research and uses the strategies of in-depth interviews of users and staff as well as observation in constructing their experiences with current health care systems drawing on past experiences. Thus the different social conditions of the users and staff, their perception of health service delivery and quality of care, the problems they go through and their multi-dimensional interpretation constitute knowledge to be interpreted and used to construct meaning with regards to health care delivery and how it is seen in the eyes of health users and staff.

What then is the logic behind the choice of qualitative methods and strategies? The opportunity of spending long periods of time and even more observing patients in health centres, and health staff at their work provides a more effective way of studying their lived experiences. Besides, it is the underlying social mechanism and process that are essential in the research rather than statistical correlation to a given hypotheses. The reasons why people go to hospitals is to receive health care, to reduce pain and disability which is a critical social problem. Users and providers therefore are the best evaluators of the nature of care of services. Thus following what users and staff ascribe to their own reality and how they rationalise their very existence through the programme of qualitative research, the objective of seeking to understand their everyday experiences in relation to decentralisation and social economic reforms answers can be found and knowledge can be constructed.

Furthermore, the approach promotes the understanding of the policy impacts, since detailed information not only from complementary but divergent background can be pieced together to build rational explanations of the impact of decentralisation. The inclusion of their social world through qualitative methods therefore facilitates the understanding of how they create the building blocks of their health characteristics and the survival strategies each individual patient and members of the health staff takes. Moreover, 'qualitative research' analytical methods of induction lead to the construction of descriptions and explanation about social reality (Marian, 1988). Some qualitative researchers may take back their findings to the participants for

their comments. While this sounds an important process of validation, the practical difficulty of tracing participants in the remote locations and their lack of ability to read the research outcomes limits the practice in this case. However, health staff, social workers and, government workers will be asked to comment on a number of issues that emerge from the interviews when this thesis is completed. I hope to give some of the summary findings to the district.

1.1.2 Selection Strategy

Qualitative methods were chosen because of the need to understand the social process that surrounds the quality of and process of primary health care delivery under decentralisation from the perspective of the users and the staff. Against this background, the issue of sampling and selection withered to non-probabilistic strategies. The goal was not to seek large and representative samples to generate 'surface patterns' but rather an in-depth understanding through specific respondents who reflected existing knowledge. Therefore, respondents were purposely selected to reflect a 'theoretically comprehensive' sample with variable backgrounds and contexts as the key 'informants'.

I continued sampling until I started feeling a 'theory-saturation point'. Among the factors taken into consideration are ages, gender, position and roles for the health staff, the period of stay in this area, type of treatment sought by the patient, the ability of the respondent to speak the Lugwere language[13]

[13] Lugwere is the locally spoken Language in Pallisa district.

3.3 The Research Process: Issues and challenges of dealing with Health Staff and Primary Care Users

A total of 29 primary health users and 17 staff and 5 health administrators were eventually selected as respondents and were studied over the seven months period from 15th September 2003 to 25th May 2004. The research covered a wide area in Pallisa district in Uganda concentrating on health centres. Seven health centres were the main stations where the study was conducted. These were selected depending on the level, for example health centre II, III, and IV were the major focus of study. In all, participants were aged over 19+ years since these are considered independent age ready to seek care by themselves and even more at that age one can explain the circumstances through which he or she goes through at the time of seeking health services. After the initial study, another visit lasting close to one month was dedicated to study the structure of service delivery at the Ministry of Health in Kampala, and at the district administration in Pallisa. This time, three District administrators including the director of District Health Services, Health Mobilizers, and some senior Health planners were interviewed. A meeting with the Deputy Minister for Primary Health Care and Community Services not only provided me greater understanding of the current structure of the health sector, but equally made me understand some of the weaknesses of the decentralized health system in Uganda.

1.1.1 Piloting

The interview guide was tested at the pilot stage. The first two weeks of the field work, during which six participants were interviewed and observed, was used as the piloting period. These were four users 4 respondents: one man and three women, and two providers who included one nurse and a clinical officer. The pilot stage allowed me to adjust the interview schedule. Even more it showed the participant's ability to comprehend the questions as well as the effectiveness of the interview process to be tested. It became apparent to me at this stage that the level of comprehension for most questions varied from one respondent to another. Sex, level of literacy and age was the determining factor. Age and literacy determined the extent to which the respondent was able to formulate an opinion about issues at stake.

The pilot study revealed that tape-recording the interviews unnerved some respondents, especially public servants. The solution was to engage in initial conversation on general questions that relaxed them and served to introduce the main and more sensitive ones. The interviews were then tape-recorded when the respondents appeared to be relaxed and willing to talk at length. Whereas some respondents were apprehensive of such intrusions, my background as a teacher and tribesman "mwana waiswe" (literally meaning our son) when divulged often reassured them. It often allayed their fears of whether I was working for the government of which most of them were quite suspicious.

The pilot study also served as a period for determining the study sites and planning the best way to tackle anticipated problems like interface with authority and negotiating with relevant levels of authorities .It emerged at this

level that, at this stage the goal of conducting the interviews in health centres or places where health care was offered would be difficult because of the nature of place. It was noisy, busy. Hence, quiet spaces within the health centre had to be negotiated to ensure a proper setting and meaningful conversation.

The pilot study was especially very useful since it shaped my initial understanding of the research environment. It allowed a trial for the interview process and provided insights into the behaviour of the social actors. The knowledge and experiences gained here greatly influenced the subsequent interviews by reshaping my approach, the framing of the questionnaires and choosing study sites.

1.1.2 Study sites and participants

Two key units of study and analysis 'social unit' and 'space'-were chosen. Health centres are common places where the majority of people seek health care, hence most patients and health staff are potential subjects of a study like this one. These were health centres of all levels. The fact that health staff work in health centres meant they were equally easily to be found in health centres. In Uganda health seekers can be found everywhere: drugs shops, private clinics, hospitals, and some prefer to remain at home. However, for practical reasons, for the patients, the study was narrowed down to specific health centres, or for the officials in specific places like offices, or some social places. Thus Kadama Health Centre III, Kabweri Health Centre II, Kibuku Health Centre IV, Budaka health centre IV, Bulangira Health Centre three and Naboa Health centres were respectively the centre for observation

and patients who were interviewed were mostly located in these centres. These centres were chosen because of their levels. For example a mix of different levels would allow me to understand how health care was delivered at different levels. Most of these centres are rural based, with the Health Centre two at the lowest end of the village. Health Centres three and four are also in the villages but can be characterised as trading centre based. The characteristics including the catchment population of each centre will be presented in Chapter four of this thesis.

Pallisa district was chosen because of its social economic dynamics. Firstly, it is the poorest district in Uganda; secondly it is the area I have in the past worked in as a social worker and community mobilizer. Besides this is a place in which I know the language thus neither communicating nor making contacts would be a problem because the majority of the people know me or know my parents and would make the quality of interviews better. The latter would reassure the respondents that there is no secret behind the research, although care was made so as to retain my neutrality, since if not well addressed this can cause contamination.

Locating patients and health staff was hardly a problem because of the large numbers of people who seek health care in Uganda. The majority of the respondents who participated in the study were readily found in the health centres mentioned above. Most of the patients and even the health staff come from surrounding villages and have considered these to be their health centres for a long time.

It was necessary to negotiate permission for the study. At first, I approached the deputy director of health services at Pallisa district administration but she did not allow me to conduct the study She asked me to get a letter from the national council of research in Kampala. I went to Kampala and in a period of two days, I was granted the permission. On returning to Pallisa, I met the Director of district health services DDHS, whom I knew personally and after explaining what, had happened earlier, he said it was very unfortunate. He gave me a letter and also helped me to identify health centres that would best suit my study. The apprehension by the deputy director of health services is very understandable. First, there is greater political attachment to health and the fear that research may disgrace their work by reporting to the authority in Kampala. Secondly the earlier objection could also be attributed to research fatigue. A number of studies by both Ugandans and foreign researchers had already been conducted on health related topics in this region.

Gaining access continued. Although I had the letter of permission from the DDHS, health care services take place at the health centre, thus there was always need to get permission from the person in charge of each individual health centre I visited. I always introduced myself to the staff and the head of each unit who also most times found me a room for my interviews.

The profile of respondents envisaged for the study were both men and women aged over 19+ years who either had come to seek treatment or are regular users of the facilities. The majority of the health users were mothers who either had brought their children for treatment, come for treatment or were pregnant and had come for antenatal services. I found that mostly mothers use

these facilities. For in the case of staff, as I said earlier, the position of responsibility, location of their workplaces and responsibilities were issues that I considered.

In the initial stage, I approached the respondents (users) and if they fitted the profile, then I would tell them my name; explain my intentions to gauge their interests. Most respondents were approached at random, but only if they looked the kind of respondents who fitted the prescribed characteristics. A number of them refused to be interviewed. For example one woman told me that she was hungry and wanted to go back home and cook food, while another one asked me if I was going to pay her, but the majority readily accepted, while others especially the health staff voluntarily expressed their interests. Those who refused either feared that I was a spy or they had no time. Some just were too ill to be bothered. The majority of the respondents were selected through the snowballing strategy. [14]The person in charge helped to introduce me to the patients, and carers and the staff. Eventually a total of 29 health users 17 health staff and four administrators were interviewed.

1.1.3 The interview

I used a loosely structured interview schedule. To achieve my objective, an interview guide consisting of the broad research questions enumerated earlier was used although not strictly followed. The interview guide was thematic and loosely structured to provide the prompts rather than specific questions.

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[14] The in-charge is the person who is the head of a particular health centre. He/she can be a doctor or clinical officer or a mid wife depending on the level of the care.

As I said this was however not followed in any specific sequence since the issues raised within the themes dictated the line of questioning.

Thus, within the qualitative tradition, the general approach adopted for the study was of multiple approaches. The specific method for achieving this was in-depth interviews that loosely followed the interview guide in appendix. This permitted the respondents to talk about their lives and their social reality in seeking health care, at home, on the way to the health care for the sake of users and the staff to talk about their life and work experiences, in the community during the decentralised period.

In all cases, after introducing myself and giving the necessary assurances about the study, I would then lead the participants into a quiet room for the patients and health staff, but for other officials most interviews took place in their office except for one interview that I conducted at a "malwa"[15] seating. These 'quiet' places were always within the participant's dwelling areas or working places so as not to inconvenience the participants.

The interview process for each participant began from simple questions about their background: age, home village, family, marriage status etc. and gradually became more elaborate. The elaborate questions centred, among other things, on the perceptions of the quality of care, economy, and their experiences before and after decentralisation with health care and above all life situation issues for the case of the health staff. I also explored their conception of exploitation and marginalisation issues. Work environment issues for the staff were explored as well as the structure change of the health

[15] Malwa is locally brewed jinn taken using tubes.

care delivery. The latter was the case with the administrators, especially at the District and at the Ministry of Health in Kampala. Other attempts aimed to know the utilisation behaviours of health care during decentralisation, the problems that the District faces in an attempt to deliver health care and what they thought about the quality of care being delivered. The purpose was to build proper understanding of the impact of decentralisation on the primary health care delivery systems.

Even though the interviews were loosely structured, questions relating to sex, age, and position of responsibility were standard and routinely asked. The other questions however were approached with greater freedom and improvising, and in all cases bordered on conversation with the participants. A copy of the interview schedule is attached in Appendix1.

All interviews were tape-recorded after the purpose had been properly explained and the respondent's permission obtained. This was done to calm their fears and anxieties regarding the purposes of the tapes. The apparent assurance most of them needed was that tapes would not be traced back to them[16]. These were mostly the case with the health staff and health sector managers at the district, which included the District director of health services, chief administrative officer, the finance officer etc. For example one health staff asked me if this was going to be for public consumption to which I assured him that he would never be identified as a source. The interviews amongst users were all conducted in Lugwere[17] but for the staff and officials,

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[16] This provided an insight into the unease some respondents felt about their lives with authorities.

[17] Lugwere is the language spoken by the inhabitant of Pallisa District in Uganda (Bagwere)

English language was widely used. The average length of each interview was some where between forty-five and fifty minutes, others as short as thirty minutes while other interviews generally took as long as one hour. Two specific focus group interviews of four women respondents were conducted in Kadama and Kibuku respectively. (One FGDS) in Kadama and another in Kibuku) during which topics such as availability of drugs, cleanness, availability of health staff, confidentiality and privacy, prescription emerged in the discussion and were compared to the past, especially by some elderly respondents. During the group discussion some emotions were generated which made me to feel the way they felt about certain specific issues. For example one participant in Kadama said her daughter lost her child because there was no member of health staff at the health centre and they were forced to travel to Budaka on reaching the child had already died. Another respondent was more concerned about the cost of treatment now as compared to the past when they said it was free treatment. I had an assistant who helped me to tape record the interview and to take notes as I led the discussions. On a few occasions, other participants would get involved in the interview of another person because they happened to be there. Each interview was transcribed and simultaneously translated into English on the same day. Considerable attention was paid to the translation to avoid any misinterpretation of the respondent's intentions and explanations.

1.1.4 Observation

The second qualitative method utilised was observation of the way health seekers got their treatment and of the social environment around the health

centre. I found observations very critical because they provided the opportunity for me to relate the perceptions of respondents to the real life situation. It also helped to present a direct representation of the participants, therefore eliminating the artificiality that may surround other methods like survey. Observation was therefore used for exploratory purposes to understand the dynamics of the social reality in the initial stages and subsequently as a source of supplementary information. Thus not only were observations used to augment the in-depth interviews of users and providers, they also served as a way of validating most information that was presented by the respondents in the conversation.

By participating in the social relationship through some form of observation, a wealth of information and knowledge was gathered as the building blocks for constructing meanings of reality. The main objectives were that even though social relationships vary, individual circumstances had to be appreciated and common traits and intra-group trends were formed. The observations were undertaken with both traditions in mind. While in the instances the essence of individual social economic circumstances was recognised, it was largely about studying him/her in their relationship to health services access, quality and their perceptions and the surroundings that also included the health facility. I observed the moods, the way patients received treatment, wards, the seating arrangements, the cleanness, etc. These were constituent part of the study of the impact and experiences of decentralisation in Uganda.

It was possible to engage in interactions with users and staff socially while the observations were going on in a non-structured and somehow participatory way. I gave a lift to some patients, and sometimes got involved in actual seminars, which normally were conducted in the mornings by the health staff. Considerable numbers of hours went into unscheduled visits to the health centres to generate the graphic familiarity of the general environment. On some occasions I visited some patients in their homes. The aim was to get a 'feel' of their individual circumstances and also to make myself more familiar to them.

A major part of the process was geared towards 'descriptive observation' in which case the background of the physical and social environment was documented as they appeared during the visits. The observations were linked to the interview process. I would sit at any convenient place after the interview and observe the situation in the care centre.

At a later stage in the fieldwork when I became known to some respondents, I would sit somewhere in the vicinity of the facility (under trees, facility veranda, in specified places etc). The health centres for example presented the best opportunities for observation since they were places I could enter at ease. But sometimes, the drug shops became a centre for observations. Here I wanted to learn how people buy drugs, if they buy full doses and generally what happens between the drug dealers and the patients. The latter became a very important source of knowledge since at that point no one knew what I was doing and the relationship between the drug sellers and the patients was well observed.

Brief notes and points of interest were inconspicuously taken and developed into comprehensive notes later. Several photographs were also taken at different times of the study, even though the participants were not directly photographed.

3.3.5 Confidentiality and Anonymity

Most of the participants looked very apprehensive and indirectly you could see an expression of their concern about confidentiality, in spite of my obligation to ensure that their identities were preserved anonymously. I made sure the research information and questions did not leak out. The research environment, individual respondents were anonymyzed or given pseudonyms, and some facts which might identify them were changed or omitted' for example the village names where the patients came from were given specific identifier names. The same thing happened to the health staff and other respondents. In fact most names used in this report are not the actual names of the respondents.

Considerable efforts were made in my study to adhere to principles of confidentiality according to the standards laid down in the department of sociology at the University of Warwick. All the participants were given pseudonyms. While my respondents were associated with the village they came from, they could hardly be traced. On the other hand, the staff and the manager's names were rarely written down. But as for the users, since the majority came from their homes, the names of their villages were altered within the village, thus the patient from Kadama was made to look as if he/she came from Kibuku. Kadama and Kibuku are two completely different

villages. These were efforts to protect them from any traceable possibilities and to protect them from any eventuality.

Moreover, even though a number of pictures were taken of these areas to provide graphical background, care was taken not to photograph any one who was directly involved in the study and are not used in the text but only served to remind me in the process of writing and generating meaning.

3.3.6 Data Source and Analytical Approaches

The primary source of data was information gathered from the participants through interviews and observations of the health delivery structures and systems under decentralisation. Field notes were also compiled about the work environment during the many visits to the health facilities during the study periods. The visits were deliberately scheduled to take place at different times or days in order to capture the contrasting scenarios. The third source of information came from both district and Ministry of Health officials. There were cases when I met people in social places and introduced the topic, and considerable data would be obtained that supplemented the interviews. The officials provided information about the structural functions under decentralisation and other information about the functions and roles of each levels of government under decentralisation.

Lastly, secondary data relating to utilisations, budgets, demographic reports, reports amongst other were collected from the Ministry of Health in Kampala, the Uganda Bureau of Statistics in Entebbe, and some data from the Institute of Social Research at Makerere University in Kampala. More data were collected from the district administration in Pallisa. There are other

research organisations in Kampala that provided me with some data; these include the Pathfinder and DISH International. All these conduct annual research on health related subjects so their data was very important.

This data provided the basis for analyzing the political and the social economic condition of not only Pallisa district but Uganda as a whole. The usefulness of this data lies in the opportunities it provides in validating and augmenting information gathered in the field. The data was compared with the respondent's testimonies, stories and perceptions.

The analysis of the data began in the field and has continued until recently when I started writing this work. The effort was to determine what constituted relevant knowledge from the vast amount of data gathered from interviews, observations and many other sources. It must be recalled that those who participated were only a sample. The descriptive categories were made up of descriptive nouns, adjectives and phrases provided by the participants. These were used to build up a descriptive picture of daily social health experiences of both the service users and those who provide care. On the other hand, concepts related to the research questions were dealt with that provided possible explanations to the research questions. Each transcribed interview was numbered and skimmed. More careful readings were then undertaken during which notes relating to the categories were made in the margins of each transcript. As the categories appeared, each number identifying a participant was noted under the category and themes on a broad sheet. These entries were shared according to the depth of the views or interpretations the participants had given. The result was a simplified thematic chart for each

category or theme. It directed me to which participant and pages in the transcript were to refer for interpretation or appropriate quotations to support a discussion. Even though no a priori hypotheses were generated for this study, a pattern–matching analysis was also done to link the respondent's interpretations to existing knowledge in a bid to discover new meaning or related existing ones.

3.3.7 Issues of validity and reliability

The validity of the research design was considered crucial to the overall significance of the study since it would enhance the credibility of the eventual conclusions. It was therefore necessary to ensure that the research answered the questions it set out to answer. For this purpose, multiple sources of evidences were built into the research design to present different angles to the same issues or themes. Besides, different study sites with contrasting social background were also chosen (levels of delivery).

However considering the initial objectives of the study to treat patients and health staff and any other participants as the best source of information on their lived experiences, they were considered as valid and reliable sources of data. Thus, the detailed descriptions presented by patients (users) and health staffs especially were in themselves treated as powerful evidence that validated their experiences. As Hakim (1987: 27) argues, the detailed accounts that emerge from in-depth interviews of this nature will in themselves be 'sufficient details for the result to be taken as true, correct, complete and believable reports of their views and experiences' (See also Silverman, 1998).

Regarding the issue of reliability, the question to answer is whether or not the research can stand a test of replication. Exact replication is impossible in this study or later let alone in any other qualitative research, hence the criterion of reliability was not so much a factor considered at the design level of the study. While the interview guide and similar observation techniques could be used in future work, this study like other studies is a rare and unique experience within the broader qualitative traditions and therefore does not leave a precise trail for replication because of its originality.

1.4 Methodological problems and Limitations

There were a number of limitations and problems that I encountered during the study. Although some had been anticipated before I left for the fieldwork, some emerged during the study. These included study sites, participants, permission and ethical issues. Although these problems did not hold back my research schedule, it is possible that the time framework for the study could have been shorter had I been problem free.

Many patients and the health staff whom I approached were very apprehensive at the start because of the political alienations and politics of intimidation practised in Uganda against any one who talks against government policies, and given the history of Uganda where opponents of government policies were either imprisoned or killed during the previous regimes. A number of respondents therefore were suspicious of the intentions of the study and feared they might be stigmatised or even lose their jobs, although later these fears were overcome.

The women were often more willing to talk in the absence of their husbands. This could be because of the oppression that women still experience in Uganda. Health staff were more willing to talk, which can be explained by a sense of political boldness and a feeling of 'I don't care what happens'. There was an element of what do I get from it especially from men who only expected to be paid for their time if they were to sit for an interview. Some patients on the other hand thought if they told me all their problems, I would help them get treatment easily despite explaining to them that this was purely academic work.

There was a problem where some were not able to articulate issues because they were either sick or did not understand the question. The distance sometime was too much and I had to commute from Mbale to Pallisa (20km) by taxi or sometimes I used my brother's car to reach the places. The other thing that I found unbearable was the rain that continued after December to March. This greatly affected my work schedule.

There are always ethical problems of conducting research on politically related subjects. But these did not so much feature because I had got permission from higher levels of government from the very start and did not identify myself with any political group to ensure neutrality.

But I think the biggest difficulty was what constituted reasonable private space for interaction with the patients. An attempt to conduct the interview within the hospital vicinities made some patients very apprehensive. There was that look of 'maybe the health staff is seeing and hearing what we are talking'. The interview was always conducted either under the tree or within

the provided room within the health facilities. The officials at the Ministry of Health (MOH) were more relaxed and I did not sense any tension during the interviews. On the other hand too, health staffs of lower cadres felt less relaxed due to the feeling that their superiors may be hearing what we were talking. Most of these ethical problems were experienced at the start but later as the staff and patients came to see me regularly, that apprehension died off naturally.

Another practical difficulty was the need to translate the interview questions into a local language (Lugwere) for the participants to be able to understand as well as translating the responses back to English. This is a universal problem confronting researchers in Uganda but it assumes greater significance if the participants are in rural communities. The questions in this case had to be reduced to the lowest level. This was condescension towards the ability of each respondent, because it was essential that they understood the questions in order to generate best responses.

In addition, some people related the performances of the health structure to leaders but even more there were those who talked about a period before independence here. Variations could be seen because most of the women for example of reproductive age, have only seen one ruling government of the National Resistance Movement of Museveni which came to power in 1986 and therefore could not make any comparison with the past. However, others were able to use their historical knowledge from their elders to express what they feel now about health care delivery. For example a participant told me that her mother had always told them that in the past

medicine were in the hospital and doctors were there which some used to construct their understanding about the current situation.

1.5 Conclusion

While there are some points of convergence with patients and staff experiences with health care under decentralization, there are a number of unique stories on both the staff and patients' experiences of health care under decentralization in Uganda. The best way to tell these stories was by spending more time with the respondents, rather than through a survey research for example. The choice of a qualitative research methodology was therefore most appropriate since it facilitated some immersion in the lives of those affected. The daily interaction with them, the negotiation of spaces and the continued talking with them all generated a sense of familiarity that deepened the level of understanding and presented the best illustration of the social reality. The natural settings of the health care, offices and other social places eliminated most incidences of artificiality and provided the appropriate backdrops for direct allusion in the course of the interview. The fact that I was doing the study amongst people with a culture and language that I understand reduced several difficulties I would have faced had it to be in a foreign environment.

In order to understand the category of those who uses these health services, and the profile of staff in Uganda, a compiled profile of all participants and an analysis of their experiences will be presented in the next chapter.

CHAPTER 4: "THE PEOPLE'S GOVERNMENT" THE STRUCTURE, ORGANIZATION AND OPERATION OF THE PRIMARY HEALTH CARE SYSTEM IN UGANDA

4.1 Introduction

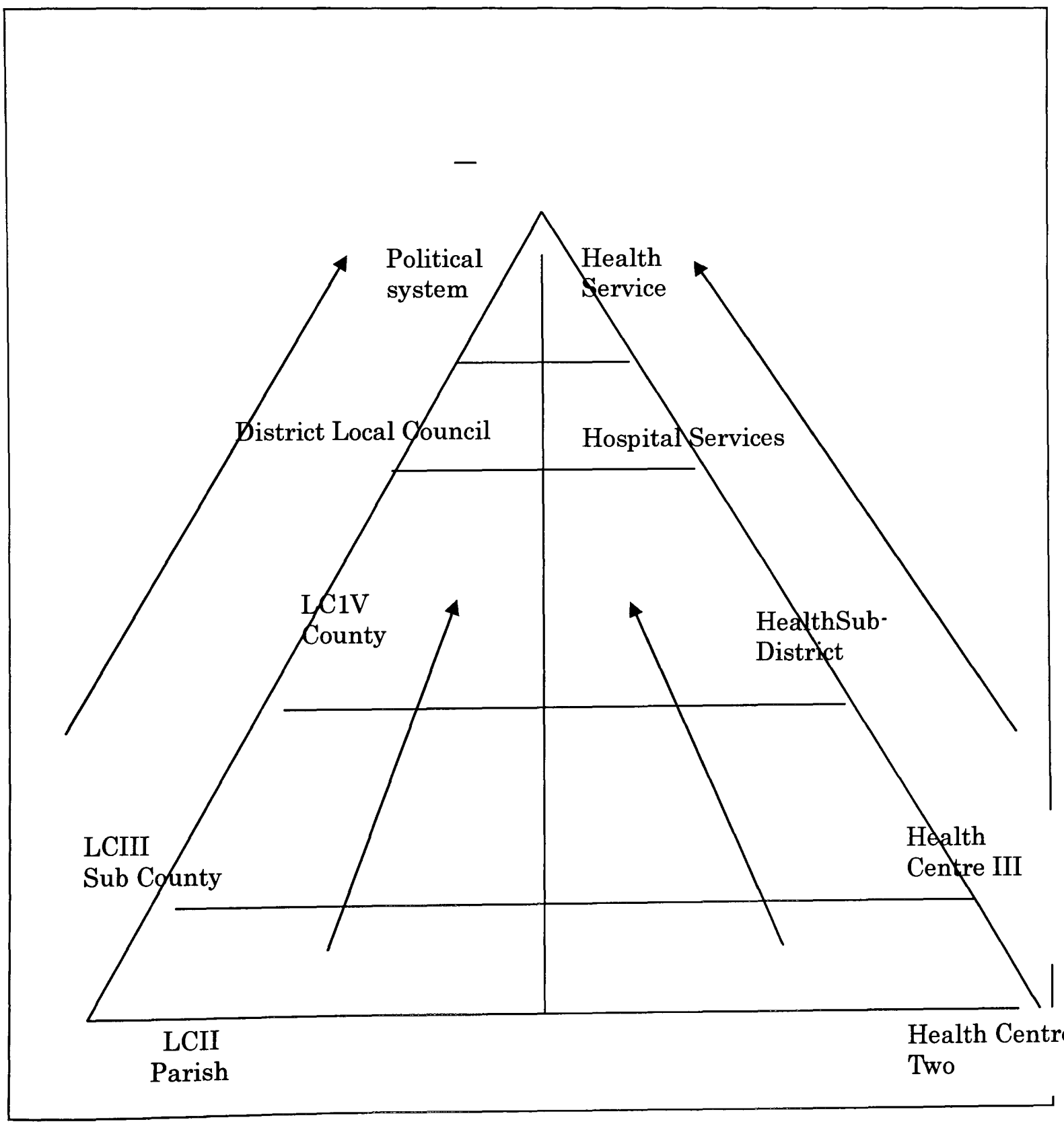
One of the major health service reforms introduced under decentralization was the restructuring of primary health service delivery. The delivery structures of health services in Uganda is divided between the central Ministry of Health which is responsible for policy, planning, resource mobilisation and general standard setting, and the district administration popularly known as local councils which is responsible for the implementation of the policies and the delivery of primary health services at lower levels. The functions of the districts also include supervision, planning and budgeting for the health services at the lower levels. The purpose was to involve the communities and bring services closer to the consumers. This, it was hoped, would increase choices and efficiency, which would eventually lead to better quality service delivery based on local choices targeted to the needs of the communities. Since implementation a number of studies have been conducted to analyse the feasibility of this model of service delivery (Okwi, 2003; Hutchison, 1999) and other annual studies such as the Health sector surveys, 2002, and 2003. Many of these studies are conventional in nature and tend to use statistical references, which lack the personal feeling of those who work in these organisation to a certain extent, those served by the organisation themselves (users) and those entrusted to provide the services.

The focus of this chapter is on the district and below. Firstly, in this chapter, the study describes the changes in the health sector structural organisation and the roles of each level in the delivery of primary health services. It is hoped that this chapter will offer the reader proper understanding of how the health sector functions and how it is organised in delivering primary health care. Administratively, the chapter provides an analysis of how the primary health services are financed including its sources of funds. The aims here are to provide knowledge about the choices available for the local government, the levels of flexibility and the choice to spend on priority areas available to local government. Funding mechanisms can help us to understand the social dynamics in the delivery of health services.

Thirdly, the chapter, in an attempt to analyse the organisation and the delivery of primary health care, analyses the planning processes for the health services. The purpose here is to understand how the planning is done and how different plans from different ends are harmonised to make a district plan. This section goes further to analyse the levels of participation the communities in planning and implementation of the health sector plans. This would answer the question commonly posed as to what extent local people can input in the planning process of their social services and what are the limitations. The last part of this chapter summarises the experiences of users, health staff and the local leadership with regards the decentralisation and participation strategy of primary health service delivery in Uganda. This chapter offers recommendations based on the findings in the last section.

This chapter is based on official policy publications from both Pallisa district and the central government in Kampala, personal interviews with a number of district leaders and national health leaders (medical officials, councillors, members of the health management committees, opinion leaders, volunteers and health users) and observations of the operation of the health units during the whole research period September 2003- May 2005

Table 1. Delivery structure of primary health care in Uganda



Until the late 1980s, health care and other social services in Uganda were centrally delivered and centrally managed because the central government preserved the social contract with the people. This contract was such that the people paid the taxes and the government provided social services such as primary health services. Decentralisation of the health sector in the 1980s and 1990s has taken place within the framework of the overall decentralisation of the public sector...that includes responsibilities, roles and the management structure. The public health sector structure is roughly parallel to those of governmental Ministries and other political entities such as the local councils.

4.2 Restructured health sector

The district health system was restructured to comply with the devolved responsibility to deliver the primary health services. Administratively Uganda is divided into 54 districts headed by the District local council chairpersons who is the political head of the districts (LC5) and further subdivided into counties/constituencies (LC4), sub counties represented by the members of parliament in the national parliament, and the local council three (LC3) headed by the chairpersons of the sub counties, and further down to the parish levels (LC2), and villages (LC1). The health services delivery in Uganda have been organised to follow this political structure described above: thus, Health centre 1V (HSD) at local council 4 (constituency level), HC111 at LC3, (sub county) HC2 at the LC2 (Parish) and HC1 at the LC1 at the village level. Pallisa, unlike other well-established old districts such as Mbale have got one hospital which functions as a consultation and referral centre for secondary health care. It was noted however that the structure

named above is responsible for the delivery of primary health care as seen in the graph above.

4.2.1 Delivery levels of primary health care in Uganda

Primary health services in Uganda are delivered at different levels in a hierarchy of five levels, which develops from below at the smallest unit to the bigger units of service delivery. The levels of service delivery are explained next in following sections.

4.2.2 Health Centre Two

Currently the health centre two is the smallest unit and the lowest in the hierarchical structure. This is basically an outpatient health post located at the parish level with the catchments population of approximately 5000.[18] The HCII is staffed with the enrolled midwife and nursing aides, and the assistant health educator responsible for the delivery of primary health services at the parish levels. The HC11 currently is the first point nearest to the household members, although there are plans to institute a health centre one further down to the periphery. The purpose, it was noted, is to reduce geographical hindrances of access to primary health care (distance and information hindrances). This point of primary health services is supposed to provide MCH services such as family planning education, antenatal check ups, child monitoring, malaria control, and first aid treatment). Complicated cases are referred from the health centre two to the health centre three which is slightly bigger in its operational responsibilities, as we will see later. The organisation

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[18] Every health centre II is located at the parish levels. It serves about 5000 people of that village.

objective of the health centre II other than providing treatment is that it works as an education and mobilisation centre for the communities on health related issues such as immunisation, family planning and home based hygiene. In terms of how it is managed, the health units at this levels is supported by the Health Unit Management Committee, which is composed of the enrolled nurse, the local councillor, and an elder of the place where it is located, a woman and a youth. The organisation structure at this level reflects the diversity and representation enshrined in its structure.

4.2.3 Health Centre Three

The rationale of this centre levels is to work as a referral for the lower levels. The effort under decentralisation has seen the growth of HCIII from 18 centres in 1997 to 22 centres in 2003. This is the result of the efforts by the government to renovate and upgrade health units as a means of improving the delivery of primary health care in Uganda. The difference between the health centre level two and the health centre level three can be seen in the levels at which each is located. While the previous HCIIs are located at the parish level, HCIII is located at the sub county level and slightly bigger in the organisational structure and its functions.[19] These centres are managed by clinical officers (clinical officers are midlevel health workers; they train for four years and are holders of a diploma in clinical management). The person

[19] Health Centre three is located at the Sub county levels. It is parallel to the local council three which is the sub county council responsible for the planning of the areas. It is with a catchments population of approximately 20,000 based on demographic demarcation of sub counties (Uganda Bureau of Statistics, 2002).

in charge at this level performs both clinical and administrative functions. Administratively he/she is supposed to supervise the lower health centre twos in his area; secondly the person in charge is responsible for supervising his staff and ensuring that issues relating to finances and administration at the health unit levels are well handled.

The staffing standard of this level is such that it is staffed by a midwife, the nursing assistant, nurse, laboratory assistant, health educator, and record assistants, although none of the centres III (Kadama, Bulangira and Naboa) adhered to the standard due to both financial and human resources shortages which the district experiences. The services offered at this centre are both outpatient and inpatient services. At this level in the structure there is supposed to be a laboratory, although none of the health centre three visited during the study had a laboratory.

The catchment population for the Health centre three is approximately 20,000 people living with in the surrounding villages. Services at this centre include family planning, minor surgery conducted by the clinical officers, deliveries and antenatal services, health education and general diagnosis and treatment of diseases such as headaches, small cuts and malarial diseases which are presumed to be the main killer diseases. This level also works as a referral centre for the lower health centres in the sub county. Administratively, the person in-charge of the health centres three reports to the DDHS (District director of health services) who is the head of the district health services. At this level there is a Health Unit Management Committee to assist in the day today running of the health unit.

As with the case of the Health Unit Management Committee at the health centre two, the committee at the HCIII is composed of nine members; the person in charge of the centre who acts as the secretary, the chairman of the local council, normally politicians, the local chief who sometimes become members because of their social status, the secretary for women affairs, the youth representative and any other member who may be a mobilizer or health educator. The functions of the committee at this level are to identify primary health needs of the health unit, to maintain the unit, to plan and budget for the health unit and to ensure that issues concerning the management and running of the health facility are harmonised. In the administrative hierarchy of the primary service delivery, the HCIII is basically the administrative centre for the delivery of social economic services at the lower levels.

4.2.3 Health Centre Four (HSD)

The concept of the Health Sub District in the primary health care delivery is one of the innovations of decentralisation in the delivery of primary health services in Uganda. There are a total of four HC1V in Pallisa corresponding to the number of constituencies (counties) in Pallisa District namely Kibuku, Budaka, Pallisa and Butebo. Within the district there are established smaller zones named Health Sub-Districts (HSD) with a team of health workers that have the operational responsibility for delivery of primary health services. The team ensures that the minimum health care package is delivered:

The (HSD) are situated at the county...it is supposed to be a self-contained sub system headed by a Medical Officer and supported by other medical cadres.[20] *(Personal interview with John Gaifuba, a senior civil servant Kampala Ministry of Health, January 2004)*

The catchment population is approximately 100,000 people. Ideally the HSD is supposed to be staffed by senior midwife, a medical officer, public health nurse, two clinical officers, health educator, dispenser, registered nurse, laboratory assistant and a record officer, although none of the two HSB (Budaka and Kibuku) adhered to the staffing standards. The staff available did not reflect the staffing standards. For example in Kibuku, there was only one midwife, no laboratory attendant, and many other cadres. This level of service delivery has both the inpatient and the outpatient department. This level is a kind of mini-hospital with some in patient treatment also provided. The inpatient department has between 12 and 16 beds. (Kibuku has 12 beds while Budaka has 16 beds). The organisation structure shows that primary health services to be performed at this level include general treatment for adults and children services, dental services, surgeries, deliveries, outreach services; laboratory and blood transfusion services, although most of these services were not available due to constraints. According to the DDHS,

The HSD in the organisation structure of primary health delivery is seen as a mini referral hospital for the lower health centres, which should take on cases referred from the lower health centre three at the sub county... the problem is that people still find no medication...generally the operation is still difficult. For example we cannot check on the lower health staff because we don't have the resources...under the operational guidelines we are supposed to send the staff on outreach but this rarely happens,but we hope that in future it will be better but now, it is still very hard. (Personal interview with the DDHS, Pallisa, 2004)

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4 Health sub district is self-contained supported by a doctor and other medical cadres.

Administratively, the HSD is responsible for the supervision of the lower primary health unit, thus the staff from this level supervise the lower levels of primary health centre to ensure that services are delivered. The person in charge of the HSD reports to the DDHS who is the head of the district health services. Some of their duties include outreach services, which rarely happen due to constraints as noted by the DDHS.

However, most staff in this study appreciated that the HSD as a strategy to increasing access to health service delivery is very important, as one respondent summed up:

The structure of the Health Sub District would be one of the achievements of decentralisation because it would facilitate access to health services to the rural communities...you see they are located in rural areas, unlike the hospital which is in Pallisa town. The problem is the lack of resources to operationalize them, which makes the idea almost a theoretical and not practical one, such that most services supposed to be delivered here are not, there (Personal interview with DDHS, Pallisa, 23/01/04)

The DDHS in the above quote noted that the creation of the HSD is a well conceived idea and it is well understood and is considered relevant in the district as a means through which access to service delivery can be achieved, however, at the same time the DDHS noted the constraint upon prompt resources to operationalise this level, which creates frustration amongst the majority of the health managers in Pallisa in an attempt to deliver health services. The DDHS's perception in this way corresponds with the 2001-05 mid term review report on primary health (Uganda health midterm review, 2003) in which it was noted that government bottlenecks in central support system to the lower levels are resulting in obstacles to the health sector

strategic plan implementation. The study however, noted that extensive delays in higher level decision-making, a complicated maze of procedures for approval and release of funds or inefficient medical procurement system, and unclear lines of communication severely hamper rather than facilitate the level of operationality of the HSD. The study however, noted that there are proposals made for correcting these anomalies of which being the on going restructuring of local government and the imminent implementation of the fiscal decentralisation strategy would hopefully alleviate these bottlenecks.

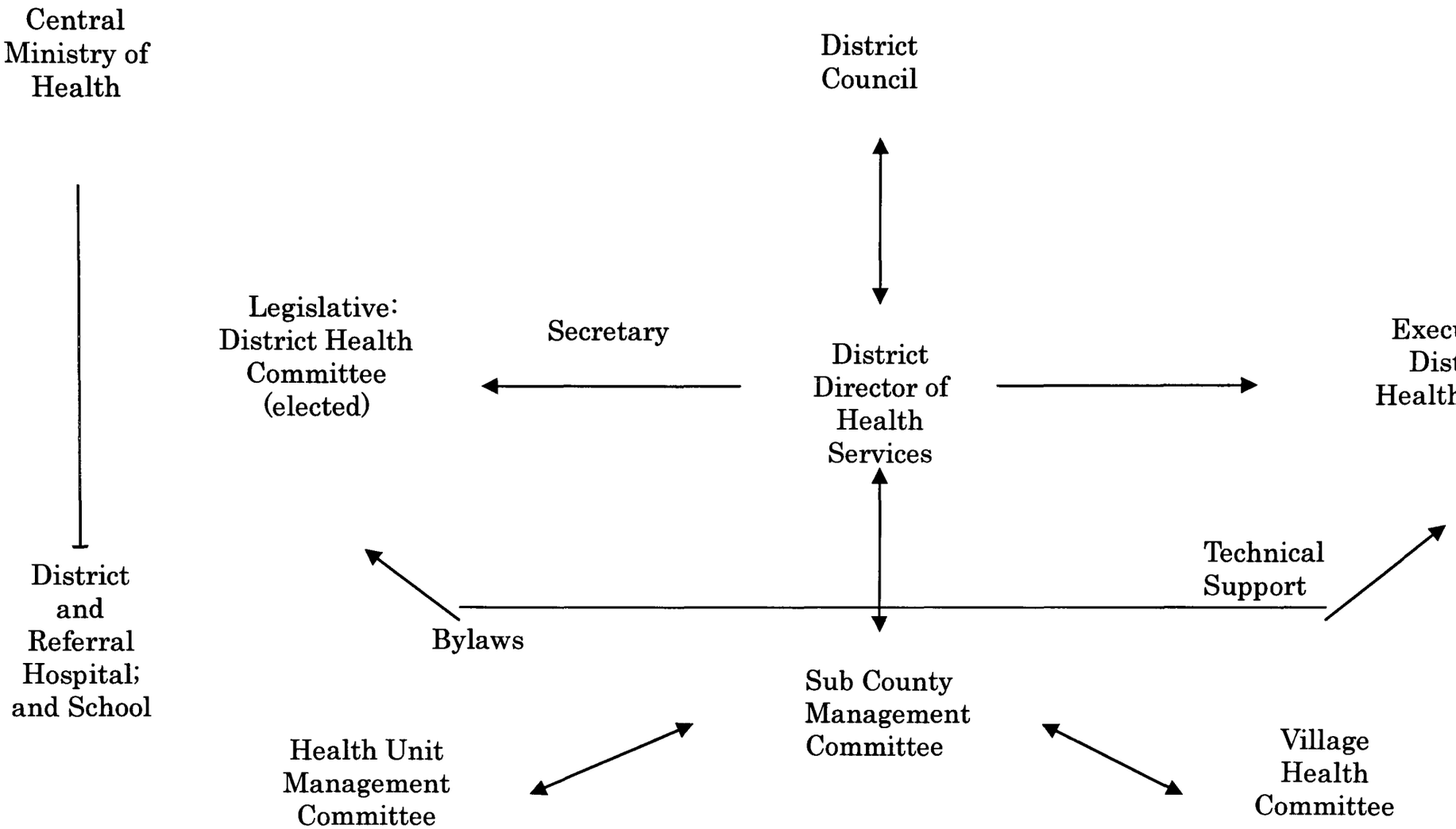
4.2.4 District Health Committee (DHC)

As can be seen in the administrative structure in the graph below, the structure of the health sector in Uganda is parallel to the political administrative structure of the local council (LC). The Director of District Health Services is the head of the health services and reports to the district local council, which is the political organ of the district. The Chief administrative officer who is a senior civil servant in the district supervises the DDHS and reports to the district council. The district health sector is managed through the District Health Committee, which has got members from the district local councils[21]. This committee is composed of the DDHS who is the secretary of the committee, the district health inspector, the health visitor, district leprosy and tuberculosis supervisor, and district health

[21] District health services are managed through the district director of health services. He is the secretary of health services and answerable to the District Council, supervised by the Chief administrative officer who is the senior civil servant and the accounting officer in the District.

educator. A medical Superintendent who is the person in charge of the district hospital is a member of the District Health Technical Committee too. This committee is responsible for planning, policy formulation and budgeting for the health sector in the district. The committee reports directly to the district local council. Implicit in this structure is the change in responsibilities and job titles that came with decentralisation. The head of the district health sector, previously called the medical superintendent, acquired a new title of the District Director of Health Services, and unlike his predecessor who was a diploma holder, under the new structure, the DDHS is supposed to be a university medical graduate. The rationale is that he/she is supposed to be technically well informed. See the administrative chart of the structure of the district health services on the next page.

Table 2 The Administrative Structure of the District Health Service in Uganda



4.3 Learning to crow: The dilemmas of new local governments...

Decentralisation of the health sector in Uganda has created two tier levels of government, thus central and district government each playing different function. At the centre is the ministry of health and the district at the periphery as seen in the Table1. The Ministry of Health at the centre retained the traditional functions of policy formulation, planning and technical guidance and the supervision of the two-referral national hospitals of Mulago and Butabika, whereas the districts are responsible for the actual delivery of primary health services on addition to the supervision of the district hospitals.

4.3.1 Financing of District Health Services: The question of autonomy and flexibility.

The questions that need to be answered here is whether decentralisation can promote autonomy in a localised environment with little resources. It is clear that like many developing countries, Uganda's so-called reform was due to influence born from outside, with the pressure to reduce the central government presence in both financing and administration of the public sector. Just like any other reform under the Structural Adjustment Programme, the health sector reforms in Uganda were introduced and defined by World Bank as market reforms (World Bank, 1993). These reforms were based on four cardinal market principles which are: individuals, charities and private organisation should be made responsible for health care, public funding should be restricted to health promotion and prevention of diseases, central government roles to be restricted to policy formulation and technical

guidance, with delivery of primary health services left to private sector and local authorities. In accordance with these principles therefore, the Central Ministry of Health abdicated service provision to local government and individuals.

This section looks at the districts' sources of funds, allocation of funds, and the state of flexibility and autonomy at the district that was promised by the proponents of decentralisation such as the World Bank/ IMF (World Bank, 1993, Hutchison, 1999) and the Museveni government which took upon itself to promote and implement the policies on their behalf and its relations to the delivery of quality primary health care.

4.3.2 Sources of funding for PHC: Powers without authority…

Funding for the health sector in Uganda is contained in two budgets: recurrent and development capital that are prepared annually. The funds in both budgets include revenue from the central government with much funding coming from external donors such as the World Bank, the IMF, European Union, CIDA, USAID, and other "development" partners such as Action Aid, and DFID etc.

The district recurrent budget includes allocation for salaries, administration costs, and other priorities, some of which are identified by the district and others are part of the national projects. A significant portion of the recurrent expenditure is also contained in the development budget, although the latter is supposed to consist mainly of capital expenditure. Data from the district chief finance officer reveals that the primary sources of revenue are still central government transfers and donors. The central government transfers for

example amounted to 38% of the district revenue in 2003-2004 budgets, while the donor funding accounted for more than 48% (Pallisa District Budget report, 2003-2004).

In terms of their share therefore, both the government and donor funding rose from 28.4 percent 1999 to 55.1 % in 2003. This shows that under decentralisation the levels of dependence of the districts increase in poorer circumstances.

The study noted that an attempt to introduce formal cost sharing as another source of funding for primary health services in Pallisa just like in any other part of the country, proved unsuccessful such that in 2001 the president abolished it. Other sources of funding include retention of local taxes and permit charges in graduated taxes, which contributes less that 5% of the required revenue.

Funding really is still top down flow...it is still the work of the central government and donors to finance primary health services. We wait for the funds because there is nothing to generate income in Pallisa. The people are poor such that the tax revenue is too small even to buy drugs for two days for the whole District. People who have the money buy their own treatment and I am sure they spend more on health than any other period in their lives. (Personal communication with the Chief finance officer, Pallisa District, March 2004)

Funding for primary health care from the centre comes in the form of a conditional grant, which is allocated based on a weighted formula that includes district population, geographical size, and infant mortality rate. Critics argue that this formula contains pervasive incentives for some districts to try not to reduce mortalities since doing so would mean small grants. This study did not investigate this likelihood and would not make any comment on

it. The largest component of the district recurrent budgets for both health and non-health activities are salaried, at approximately 54.3 % of the budget for 2003-2004. The other component includes the unconditional grants 24.5%, conditional grant at 10.5% and delegated non-wage allocation at 8.8% (Ministry of Health 2002/2003).

4.3.2 The state of district control over resources...

Although one of the objective of decentralisation in Uganda was to give autonomy and power to the local authority in the management and to have a wider discretion in the planning and choosing the projects, there is less evidence that this is about to happen, rather the opposite is felt in this study. Decentralisation has introduced major obstacles to service provision that many have seen as a product of lack of control over resources. The study noted that although districts such as Pallisa now have 'more' control over where resources "go and come" from and can assign a greater portion to the health sector, the experiences of the managers in Pallisa shows that the powers to spend and allocate such funds is still held by the source (central government and donors).

In fact from the data, (page 12 on sources of funding) it is visible that districts remain dependent on external sources (donors 48%, and central government conditional grant allocation 35%) of funding for the majority of their programmes; sources which according to the study places a significant restriction on how funds may be used:

Most funds distributed to the districts have been earmarked by donors and the Ministry of Health for specific uses...the district authorities have to use the funds as directed and we are not allowed to deploy them or divert them even when the need

arises. In fact we have had a situation where we needed money to construct safe water springs but even when there was some money, it was not meant for that and we have been trying to get permission from the central ministry but it is not some thing very easy (Personal communication with the Chief finance officer, Pallisa, 23/01/04).

The CFOs perception of the present status of the district control over resources suggests that in many cases the flexibility apparent in policy documents (decentralisation statute, 1993) is not present in reality. Implicit in the CAO's assertion is an attempt to show that even under decentralisation, specific local priorities such as water supply, or specific needs are often not addressed more so when such projects are not deemed part of the designated projects in the plan guidelines from the centre. This assertion by the CAO clearly shows that districts or local government still face the problem of a carrot and stick policy which in his understanding is a cause of considerable concern, especially if it does not permit flexibility in spending to priorities identified by the local authorities. The CAO's assertion therefore shows that decentralisation has caused disparities in the nature and quality of health services with some interventions such as curatives being neglected at the expenses of the favoured intervention such as prevention and prommotive strategies. On the other hand, his (CAO) perception, in so far as resource autonomy and flexibility is concerned, therefore shows that even with decentralisation, the decisions on the use of a large share of funding for primary health care in Pallisa are still outside the districts' control. This is a complete contrast from that of Kameme's (2001) quantitative study that had indicated that local authorities in Uganda are attaining autonomy in so far as

spending is concerned under decentralisation. To emphasise the lack of autonomy and flexibility, the DDHS noted that:

When the funds come in from the Ministry of Finance, the district can only allocate the unconditional grant for PHC, which constitutes approximately one–quarter of the centrally allocated government funds, certainly no one can alter anything and you must seek approval from above if any diversion is to be made...certainly this causes delays here and there. (Personal interview with the District Director of Health services, 23/01/04)

Looking at the total resource availability to Pallisa district's annual plans for 2003-2004, it is apparent that the district has only flexibility with less than half of the resources approximately 25-50 percent of the activities in the district (Pallisa District Budget, 2002/2003). What is clear is that the sources of funding for primary care services for a poor district in Africa such as Pallisa are still outside the district control even when devolution has taken place. This lack of control and flexibility in fund allocations adds to the already chronic problems of financial deficit the district faces amidst increasing needs, coupled with untimely release of funds from the centre which restricts the primary health sector activities and affects the delivery of quality care. Some respondents saw this influence as the cause of delayed payments to the staff and poor medical supply, including drugs that are chronically absent in most health units as we will see in the next chapter. In trying to characterise what happens as far as funding for decentralised funding is concerned, a health manager noted that

Even when we can come up with ideas, if they are not priority areas for the donors, even when they will appear very important, there is no way we can implement...we have not achieved the level where we can do what we wish...so we still depend on the donors and in most cases they direct our course of action...the funds are not enough

and besides the funds are also released late (Personal interview with District health manager, 27th /01/04)

Whereas the district realises its plans from below (bottom up planning approach), there is still a feeling by the a number of primary health managers such as the one noted above that most times donors want to by-pass these district priorities. Donors such as Action Aid, Care International, and DANIDA were identified as some of those, which are so restrictive. The manager noted that donors come with their programmes and would expect the district to implement them even when some are not deemed major priorities. While trying to talk about the level of flexibility and autonomy, the county chief noted:

You see most revenue we raise now is not adequate...the poor people are exposed and you can now see where they belong...If you look at the figures you realise that without grants from the central ministry, nothing can be done...And because of this power of resource flow we have to dance to the tune of what comes in the plan guides...We have to follow what they tell us because we don't want to annoy our bosses but sometimes it is not the right thing... You See my people here identifies some projects such as water springs because really people suffer here during draught with lack of water, but the next thing I saw was that RUWASA (Rural water and sanitation programme under Danish Aid) was coming to survey for boreholes...that is not sustainable and after one year it will break down but when we say that, nothing is done (Personal interview with the County chief, Kadama Sub county, 12/03/04)

Implicit in this quote is the perception by the county chief that decentralisation in fact increases dependence by poor districts such as Pallisa on the external sources of funding and reduces the choices available for them when it comes to spending on public services. The county chief noted that because of the status quo the districts are put on the receiving end, which

automatically reduces their bargaining power and choices on how to spend on priorities of the district, a complete contrast from what has been much published in the literature in which decentralisation has been hailed as a means for increasing resources and achieving local autonomy in funding (See Hutchison, 1999; Okwi, 2003). The study noted that this lack of autonomy also translates into lack of flexibility and choice to spend on major interventions by the local governments, since the powers to spend remain with the source but not the district. Implicit in this quote however is the fact that sometimes those activities that appear priorities in the eyes of the district planner, are left out especially if the donors do not see them as priorities.[22] Certainly this was the feeling of other local health managers such as Mbogo:

Getting more funds will depend on how you adhered to the rules set for you in the previous financial year. For example CARE INTERNATIONAL was here with the project of construction of health centres...Many people thought it was not necessary to have all those centres but they went ahead and constructed...some centres are now not functioning because they lack facilities...this is what we said from the beginning that instead of many centres, we could have few but well equipped no one listened and now people continue to suffer shortages of health services even when those health structures are there. In fact some of them are becoming habitants of bats and rats. (Personal interview with Mbogo Clinical officer in Bulangira health centre 29/03/04).

Mbogo, like many other respondents here characterises the way resources are used, with much emphasis on the still predominant influence by the external donor agents such as Care International and Action Aid, who even under decentralisation still want to implement specific vertical projects, even when

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[22] Respondent noted that donors come up with vertical projects, but some times such vertical projects, which the donors want, implemented are not the priorities of the District.

such projects may not be seen as priority for the district. In fact this observation was also made by Meads and Wakida, (2005).

An example is given here of the massive construction of a primary health centre every where from the parish to the county, even when such centres would not be operational because of limited resources to run them available at the district. The heavy reliance on donors and central government allocation is stems from the district inability to raise its own revenue due to poverty that has characterised Uganda for years. Mbogo like others sees less evidence to support the always publicised optimism that decentralisation leads to a locative efficiency and financial autonomy-a slogan of the World Bank and IMF (Olsen and others 1997, p.35). Instead Mbogo shows the opposite of increased dependence on donors and central government transfers and lack of flexibility in allocating resources to priorities, which accordingly is a considerable cause of delayed primary service delivery.

This conclusion corroborates with Hutchison's study of allocation efficiency in Uganda in which he perceptively warned that it might require measures if decentralisation was to lead to a locative efficiency of resources. Hutchison just as in this study, noted that as a result of decentralisation there were some levels of improvement in planning, although it is still filled with various contradictions so far as planning and financing is concerned, which makes it fitting to think that there should a revision in the fiscal policy (Hutchison 1998b).

In his contribution, the chairman of the district local council noted that the decision on how to spend and allocate both recurrent and development funds

should be the responsibility of the local managers, but he noted that an attempt should be made by the district to train competent financial managers in various skills and a national measure to combat corruption should be put in place to check the resource flow:

Allowing local government to allocate resources according to priorities will give a more realistic meaning to the policy of decentralisation and in practice will enable local councillors to participate at a wider level in the development of their own district. Increased autonomy of resource control would lead to improved cost effectiveness of the development funds in the district...but I also think funds should be allocated to training and monitoring and evaluation but surely this is still a problem (Personal interview with the chairman of the district council, Pallisa)

Implicit in this quote is an attempt by the respondent to outline issues that need to be addressed; close and careful negotiation between donors and districts on where to spend the money, flexibility in plans to allow reallocation of funds for local priorities, development of a clear plan for continuing activities, and a gradual increase in the local contribution to development activities through investment so that the district takes over full responsibilities for planning and implementation. At the same time the study suggest that an attempt should be made to identify the need for capacity building in accounts, financial management, planning and appraisals to give reasonable capacities both human and economic to the district. These are issues, which have always been at stake among districts that have decentralised in Uganda (See for example the decentralisation Secretariat, Kampala, 1997, pp.76-77) recommendation to the local government. The study therefore has noted that the devolution of responsibilities by the state to

the local government to deliver primary health services fell short of resources; sources of funding, skills coupled with the limited authority to allocate resources to their choices, which makes the planning and implementation process of the primary health services at the lower level a complex issue resulting in further PHC inefficiencies and shortages in primary health services.

4.3.4 Planning without plans: How bottom up is planning under decentralization?

In theory decentralisation in Uganda has emphasised bottom up planning, an effort that was meant to increase local contribution in the planning process of the primary health sector.

The plan guidelines say the plan must start from the lower levels...this has been well understood and encouraged. Different councils come up with their proposals, which are sent to the district where such proposals are analysed and form the district plan proposals, which are sent to the headquarters in Kampala. (Personal interview with Gaifuba, senior civil servant, Entebbe Uganda, 2004)

The planning cycles for the health services in the district was described surprisingly alike by different health units' staff and District Health Management Teams (DHMTs). For example respondents noted that planning for the health services starts at the HCII at the parish level and HCIII at the sub county level together with the Health Management Committee. The plans at this level are sent to the health Sub-District, which compile and edit these plans and add their own plans for the HSDs. The heads of HSD together with the heads of HCIIs and HCIIIs evaluate these plans before forwarding them to the DHMT that brings the HSD team together and produces preliminary district plans that in turn are worked upon with the District Health

Committees. The district health plans are reviewed together with other sector plans and approved or rejected and amended by the district council every financial year. Spontaneously, the majority of the managers were aware of the plan process:

The aggregation of the whole district plans from all counties forms the District plan. These are the parish; sub county and county plans which becomes the hallmark of the District plans. I think this is good because then you come to know different priorities of different areas. (Personal interview with CFO, Pallisa district, 2004)

The small plans and proposals from the sub counties and counties form the district plan proposals. The study noted that the approved plan from the lower levels (level I-5) is thereafter forwarded to the Ministry of Local Government and Ministry of Health for final approval and eventually to the ministry of Finance, Planning and Economic Development. Before funds are allocated, to the District, a quarterly plan has to be presented based on the annual plans.

In the health sector, district level priorities are identified through reviews of reports and meetings with sub county and health unit management committee... by the end of the calendar year, the office of the DDHS, prepares a draft health work plans. After endorsement by the District Health Committee, the District submits it to the central Ministry of Health for comments and reviews. (Personal communication with Pallisa leaders in January 23 2004).

The central line Ministry provides guidelines for preparing the annual work plans, and receipt of funding generally depends on adherence to those guidelines. In addition the annual health work plans are supposed to be in line with policies set out in the principal Ministry of Health policy document: the 1993 White Paper on Health, the Three Year Plan Frame 1997-2001 (MOH, 2003) which emphasises the implementation of the minimum health package. (Malaria control, immunisation, HIV/AIDS control and diarrhoea, health

education, reproductive health etc.[23]) These interventions are assumed to be cost effective and have the largest impact on reducing mortality and morbidity and therefore are the priorities for both the central government and the donor communities.

In Pallisa we have got major killer diseases such as cholera, respiratory infections, women dying during and after delivery, malaria...these are cases that must be addressed...we have asked for mosquito nets, asked for malaria drugs because that is the most effective way controlling the spread of malaria. I discussed with the officials from the Ministry of Health about the possibilities of providing mobile clinics to help pregnant mothers in the villages who find it so hard to go to the health centres but the government is so adamant. We should establish health outreach so that we can take treatment to them, but no budget is there for this and yet this, would be most effective way of reducing the death of mothers who die when delivering, to monitor children whose parents cannot bring them to the health centre but this is not the government position so we are there. (Personal interview with the DDHS, Pallisa, 2004)

The study noted that the major killer diseases in Pallisa are malaria, respiratory infections, and maternal death during and after delivery, respiratory infections, cholera, HIV/AIDS ranked according to the ten major killers diseases in Uganda. The study therefore noted that any primary health interventions should focus on improving these interventions in order to reduce mortalities and morbidity in the district.

4.4 Perception of the district health managers on planning: How local is the planning process?

The overall perception of the health managers about the planning process under decentralisation is both pessimistic and optimistic in nature. There is an outlined assumption among the donor communities and especially the

[23] The central objectives of the minimum health package are to reduce morbidity, by promoting interventions such as malaria control, immunisation, MCH etc.

reformists that the views of the people would be paramount and would translate into policy to alleviate the difficulties in primary health service delivery that many people are facing (Hutchison, 1999). Without being negative to the whole policy of decentralisation, the study however, noted that there are some important achievements that have been scored as noted by some managers.

Unlike under centralisation where the districts were passive recipients of policies, under decentralisation, the districts are empowered to prepare annual work plan that list all the activities the district intends to undertake...the planning process is such that it keeps on rising from the bottom until it reaches the district and then to the Ministry of Health in Kampala. (Personal interview with Bob, chairman Pallisa district council, 2004)

Observationally, the structure of the decentralised health sector planning in Uganda offers cosmetic and unrealistic choices by the local governments to come up with some form of plan. Through the local councils, and the Health Management Committees at the individual health unit, local managers are allowed to take part in the planning and budgeting for the health unit. The study noted that those who participate this way have developed a feeling of involvement. This was especially true to the local leadership who now unlike in the past feel that they have some inputs in the planning of the district, which certainly is a credit that must go to the policy of decentralisation.

In fact people now support the projects and when we call them they come...I think that is good but it is still far from being the local initiative because I think much of what comes from down (village level is never taken in especially where there are no fund. (Personal interview with Amos, Budaka healths centre.

The advantage of this form of planning is that it generates support from the community as people begin to see everything as theirs not for the

government. Perhaps it is on this basis that (Olsen 1997) had noted that people in Uganda had now started to feel that these structures are "ours" and not government owned. Analytically this does not necessarily mean that they have accepted the status quo, but the fact that they pay, they supervise, and take part in most activities makes it "theirs" in that sense. This could be because of their perception of the state's reducing roles in the local health service delivery and the increasing pressure on them to deliver services.

The study therefore noted that since the government retreated and left the public to take care of themselves, then a feeling of ownership should not be miss interpreted to mean progress in primary health service delivery, but rather an expression of dissatisfaction with state service provisioning of social services such as primary health services.

Yes we have been planning now for many years...they say it is our responsibility to do the planning. This form of planning really is good...the councillors say what they want from government and the proposals are sent to the district. What happens to them after that we don't know! I am sure the wise people up there "fixes" them but it is good for us we tell them what we want...these files are here you can see these are the budget proposals for our health centre and when planning, we must follow the plan guidelines which comes from the Ministry of Health in Kampala (Kadama) Personal interview with the Sub county chief, Kadama, 2004)

What surely emerges from this stage of the study is overall appreciation of the planning model, which allows the views from the lower levels, which in theory makes the district planning to look as if it is people centred. According to the sub county chief, decentralisation has allowed some form of planning interplay and participation through their local leadership; however, there is a strong feeling that district dependence on the plan guidelines from the central

ministry still limits their activities. This was the view of some managers who thought that the central government still plays a central role in the planning process:

The Ministry of Health provides guidelines for preparing the annual work plans and receipt of funding depends on the adherence to those guidelines... These are actually instructions "soft instruction sayings please do... from the centre in the process of planning. (Personal interview with the District planner, Pallisa district, 2004)

The view by the district planner reinforces a quantitative study by Dauda (2001) in which he had noted that district planning was still a complex issue under decentralisation. He noted that it would require experts to draw and develop better planning procedures, which most districts were lacking in Uganda. Officers interviewed in Pallisa recognise that bottleneck even when they noted the goodness in this form of planning,

All this we are talking about requires skilled manpower, to plan, budget and deliver the plan which is still the constraint Pallisa is facing...we cannot rely on unskilled labour in this field because you have to be accurate when developing these plans...(Personal communication with the deputy Director of Health services, Pallisa, 27th/01/03)

The health managers in this extract recognise the lack of skilled manpower as one of the constraints of decentralisation in so far as health sector planning is concerned. While the DDHS accept that the planning process can be improved under decentralisation, the capacity for planning is still poor. Since the health management committees do the planning, almost all respondents interviewed noted that the health management committee still lack of the technical skills required for this responsibility.

The health unit management committees are not composed of technical people but mostly laymen (school drop outs) so they find it so difficult to plan...the problem is that the health unit that has not been able to plan properly suffers because they only

receive for what has been planned...in fact although this form of planning can take into consideration the needs of the local people when planning, in practice this is not the case here. (Personal interview with health manager Pallisa, 24th/01/04

Implicit in the quote is the constraint of lack of skills by the members of the health management committee at the health unit, which is supposed to be the driving force behind the planning process in the decentralised setting in Uganda. Health managers noted that decentralisation tends to entrust responsibilities of planning and management of the health sector to unskilled people such that most times the plan proposals turn out to be "wish lists" or outlines of plans as one staff noted

Planning is a technical process...it requires knowledge in budgets, priority settings and relating proposals to the reality of the funds available. But unfortunately what has happened in Pallisa is an abdication of this very important function to local management committee without first giving them the skills. The central government is now realising the impotence of these skills but it is still far from what is supposed to be.(Chief Administrative Officer Pallisa)[24]

The CAO's concerns just like the DDHS are the lack of skills at lower levels of governance. The lack of technical people in planning, budgeting, priority setting is what the CAO sees as a constraining factor to decentralisation at the planning level of the primary health care in Pallisa.

The lack of planning capacities was noted to be a major constraint that many local councils are facing in Pallisa district. With this evidence in Pallisa, this study shows corroborative evidence to that of Kibaki, 2003's study of the planning abilities of the HUMB in which he noted that at most they lacked basic skills in planning and budgeting. The study noted that lack of skills in the planning in Pallisa for example had led the health units sometimes to

[24] The CAO (Chief administrative officer) is the senior civil servant at the District, plying as the accounting officer and main technical person at the district levels.

under budget or over budget. The implication here is the utmost need by the local government to train the members of the management committees in planning if they are to efficiently administer substantial plans for their communities. This adds to another constraint of delayed information on planning, as we shall see in the next section.

1.5.1 Use of plan guidelines: Coping with the "soft instructions"

Despite the efforts by the districts, the district work plan varies in quality and in the reflection of reality. Activity planning is so much influenced by the priority areas as set in the plan guidelines as noted by the respondent in the quote below

Donors and central government still determine the extent to which some intervention can be implemented...they decide on the money and sometimes that is reflected in the work plan guidelines...it is in most cases uniform for the whole country as if we have similar problems...it cannot be that all the time the problems in Pallisa are same as that of Mbale...it makes it so hard for us to move resources in case of an outbreak of cholera or calamity. This happened to districts that were affected by Ebola...by the time the ministry of health acted, many people had died.... This is the lack of flexibility we are talking about. (Personal interview with the Manager in Pallisa, 27th/01/04)

The way the health manager in this quote perceives the planning process for the health activities in Pallisa contradicts much assertion about decentralisation. For example the perception in this extract is that what the government sees as planning guidelines are in fact according to the respondent a 'soft instruction' for them to follow which allows little room for change. In this quote for example is an expression of limited freedom in the planning process, which is enshrined in decentralisation statute 1993, which calls for local government to have the freedom to plan for what affects their

communities.

According to the study, there is an apparent danger in this form of plan influence in Pallisa, which promotes commoditisation of primary health intervention during the planning process offering little flexibility on the part of the district managers. This limited flexibility was attributed to the central government and donor control over resources, and implementation of specific primary health interventions, such that even when a district such as Pallisa has instituted a bottom up planning approach in which the district bases its annual work plans of sub counties and health units, planning is still centrally influenced, as a result consensual issues identified at lower levels are marginalised at the implementation stage as one manager noted:

While this approach has not significantly changed the priorities and the content of district health plans, it has generated consensus and made the public begin to understand the issues surrounding health services... but the danger is that what people identify as major issues are not in the end implemented. (Personal communication with the health manager, January 23, 2004 Pallisa)

There is general acceptance by the health managers that under decentralisation people's participation in planning has increased and is some how valuable. However what emerges at this stage of this study is the question of to what extent issues that the people identify through their participation are taken as priorities at the implementation stage? This conclusion offers policy makers a lesson to be learnt especially those from poor districts such as Pallisa, which struggles with poverty. Such districts have continued to suffer lack of autonomy and continue to suffer from influences outside the districts in the form of what to include in the plans, and

what to spend on which affects the delivery of quality primary health services. For example the chairman of the HUMC noted that at one time in Kadama they included in their budget that they needed two nurses and a clinical officer but nothing was done about it; instead a nursing aide was sent here. The respondents noted that external influences come in the form of conferences by donors, and workshops by officials from the Ministry of Health who indicate the availability of funds as the health managers noted:

There are always conferences and workshops by donors at the districts, or regional basis in which we are told how to spend, where to spend and it is very strict. Donors indicate where their money should be spent and how it should be, and the next funding in most cases depends on how well you did in the previous year. (Personal interview with the District Accounting Officer, 23/01/04)

You cannot claim to have autonomy when you're still being told do this and the other...the central government still tells us in fact what to do...But we are the people on the ground...we know our problems but nobody wants to hear us and they keep saying the power is given to you...this is just another way of confusing us more, because when we ask for this they instead don't give. (Personal interview with Dr Malo, Budaka health centre, 2004)

Health managers such as Dr Malo, sees these conferences as a way to alert the district that however good your plans and ideas are, implementation basically depends on "us" donors. The study noted that even under decentralisation, which is supposed to allow for local views, some very important conceived ideas from the lower levels are not necessarily implemented because funds are released according to national or donor priorities with very limited space for manoeuvring. When asked if the Ministry of Health guidelines for work plans and types of activities to include in them were restrictive, the majority of respondents noted that such guidelines were sufficient for work plan

preparation, but they lacked more explicit performance targets and flexibility, hence there is still a feeling among some district managers such as Malo that health planning is still fairly top- down which contradicts the principles of decentralisation which assert that people at local levels should be able to identify issues that affect the communities in which they are applied.

Implicit is the lack of choice by the district planners and the limited flexibility at their disposal in allocation of priority projects across the health sector during the planning period, particularly for primary health care. The apparent reason for the lack of choice as identified by the respondent is rooted in the strong influences of the donors in the health sector in Uganda and Pallisa in particular. Approximately 30-45 percent of funds in the work plan come from donors. Some respondents noted that generally donors require that the district follow their guidelines, which are fairly stringent regarding what their funds can be used for:

You see we are not saying that donors are bad because they give us the money, but donors' programmes, while greatly appreciated, include components which leave little flexibility for meeting specific district needs...for example the type of drugs needed... We may have the money but we cannot channel it to require needs...sometimes these are need- based planning. (District Director of Health services, Pallisa

This study offers evidence to believe that in many poor countries pursuing decentralisation, planning process is still " fairly top down" rather than bottom up, implying that local participation in the identification of priorities is still minimal, which according to the study results in services by chance other than actual priority and intervention that affect the people. According to the study, the implication of this form of planning is that it results in leaving

out such programmes which poor districts such as Pallisa deem very important to the population which defeats the very notion of efficiency which decentralisation is supposed to bring. The finding at this stage corresponds with Olsen's (1997) study of a locative efficiency under decentralisation in which he noted scepticism in the planning processes at the periphery.

Conclusively at this point, it is plausible to argue that decentralisation does not lead to resource/financial autonomy of poor districts as has always been presented by the World Bank and the ruling governments, but rather in the circumstances of poor districts such as Pallisa it increases and exposes their dependence on the external and central government transfers. The silent implication of this is the very fact that decentralisation under poor circumstances cannot lead to flexibility in planning and implementation of the locally identified projects, until such a time when poverty and the capacities by poor districts to raise their own revenues has been achieved. The policy implication therefore is that it is of objective necessity to empower the districts to achieve some degree of self reliance in resources both human and financial so as to achieve a bottom up planning enshrined in the decentralisation statute (1993). The next section looks at the extent to which communities are engaged in health services delivery, including the forms and implications of these community engagements.

4.5 Participation and the delivery of the health services: The missing factor in quality?

Decentralisation in Uganda has emphasised community participation in the health sector service delivery especially at the primary health care levels. The

most common form of participation in Uganda is through "democratically" elected representatives from the communities. Ideally these should represent the interests of the public and should be in constant contact with their communities (Government of Uganda, 1997). However, poor public participation was noted in Oslen et al, (1996); Kapiriri, (1999;) Okwonzi and Lumbaga, (1997) which has been attributed to the former centralised traditional governance, where social services were provided for by the state and the failure to operationalize the policy on public participation in the health sector.

However most studies done in this area were carried out soon after decentralisation. Since then the government has moved a step ahead to operationalise the policy of public participation, but the latest studies still show that public participation has not yet reached satisfactory levels (Kapiriri, 1999; UBOS, 2002). This section explores issues of public participation from the public and the health providers' perspectives in order to inform the current debates on the feasibility of public participation and also facilitate efforts geared to improvement.

Three questions are answered: firstly, how does the primary health structure involve the public in the delivery of care? What are the strengths and weaknesses in this form of health service delivery in poor circumstances? What are the measures and mechanisms that need to be included or strengthened with in the health system if the system based on social service provisioning is to be based on the people themselves away from the traditional state provisioning? The method for doing this included a

qualitative exploration approach. Sampling involved different tiers of the decentralisation system: the district authority, sub-county and village levels. Data collection involved in-depth interviews. A number of respondents were interviewed, especially those who live and work in these communities (service users, community health workers, health unit health workers, local leaders etc). Participants included women, male and female youth who were chosen at random. Most of the participants were service users who had come for treatment at the time of the research and health staff who were working in these centres, although some were met at different locations such as sub-county, district headquarters etc.

4.5.1 Public participation. The structure and organisation

There are two levels at which the public can participate in the health service delivery in Uganda. It is either through the health management committees or through the social networks, which have association with primary health service delivery. The study noted that the formal arrangement at the health centres in Pallisa is such that each health centre has a management committee through which elected and appointed members of the communities participate. Observationally, in each health centre that participated in this study, there was a Health Management Committee. Some committee members such as the health unit in charge noted:

It is a requirement for each unit to have the committee...the roles of these committee members varies from level to level but mostly they are involved in the management and running of the health unit...they make budget estimates, plan and identify major requirements of the unit which are forwarded to the district...These units are fundamental to the running of the units...I think the idea is to let the community members do things their way. (Personal interview with the person in charge

Bulangira health centre, March, 2004)

Participation through HUMC is a strategy that emanates from the government (MOH, 1993)[25]. The planning of the health sector has attached greater importance to the management of the health sector, hence as a policy the government instructed the entire health unit to form the management committees, which was aimed at furthering community participation and local engagement in the provision of primary health care. The formal participation channels are dependent on the level of primary health service delivery as can be seen below:

4.5.2 Village Health Committees...

The village health committees are an additional mechanism for enforcing formal community participation in the delivery of primary health services in Pallisa. These committees are responsible for: identifying the community's health problems and taking appropriate control measures, selecting a person in the village to be trained as a community health worker, supervising community health workers, mobilising communities for health programmes (including construction, management and maintenance of the health facilities in their communities. To emphasise the importance of these committees, Amos noted:

The village committees are very important...they serve as a link between the communities and the primary health service providers...the only problem that I see is that sometimes they are by passed and they are not involved in every process...the members are still very inferior and can easily be manipulated, so I think that they could benefit from autonomy and greater sense of independence.(Personal interview with Amos, Budaka health centre, 2004).

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[25] All health centres have got health unit management committees.

Without underestimating its value, Amos noted that these committees link the communities to the service providers while at the same time also noting that the committee members are still not secure from manipulation from above. The respondent noted that in most cases they are bypassed by the bureaucrats who aim to influence everything, and are left as puppets. Amos's understanding for example is that there is need for independence and autonomy for the committee members in taking decisions on primary health intervention since they are the nearest to the communities, which makes them the best judge of the needs (NRM, 1986).

4.5.3 Sub County Health Committee

In the administrative hierarchy of the primary health care delivery under decentralisation, health III at the sub county level provides the administrative function. These committees are found on all levels of the health centre three. The committee members participate in the management of the health units, budgeting for the health units at lower level, drafting plans and supervision of the lower health centres and the staff. As a measure to increase participation and diversity, these committees comprise the person in charge of the health centre, for this case a man, the finance secretary, the health educator, the local councillor, the sub county chief, the youth and the secretary for women affairs. As noted by one member of the health committees:

The committee has 9 members that include politicians, the medical professionals, businessmen, youth, women, chiefs who sit together to decide the health requirements, which may be renovation, staff, and supplies. They come up with the health unit plan and budget, which budget is sent to the District through the Assistant Chief Administrative Officer at the county.(Chairman, local council three, Kadama Sub-count)

Decentralisation introduced the Health Management Committees in the management of the health sector in Uganda, changing from the previously

central control, which had existed up to 1990s as a means for improving accountability and efficiency. Nine people form the committee and by the way of composition, the committee must reflect diversity, social inclusion and representation of all stakeholders in a way to promote primary health service delivery based on local engagement and fairness. The study noted that the committee rather than being purely policy and management agent of the state as enshrined in the statute, 1993, is however supposed to help in the monitoring and evaluation of the health facility to ensure accountability. The question that needs to be asked here is whether the local people can hold their leaders to account. And how accountable is the system of service delivery to the poor people whom they represent? To what extent are the leaders accountable to the people they represent.

4.5.4 General experiences with participation: How efficient is it?

Most respondents appreciated the fact that people could plan and make their own decisions concerning their communities after decentralisation. There was disagreement however, regarding the actual beneficiaries and the extent of the benefit. Much as some respondents from the public appreciated the structural development, such as the involvement of some members, the majority felt left behind in the decision making processes in their communities. Between the groups, the adult men complained about the youths' and women's rights to participate in the decision-making processes. Both the staff and the local councillors reported low levels of actual participation. To some extent the public was reportedly to be involved in the protection of water springs, construction of health units, community

mobilisation, and some were involved in sensitization on health related issues such as HIV/AIDS, family planning etc which in most cases was a voluntary action that has developed in Uganda in the recent past. According to the local councillor

Participation, although time consuming, has given a sense of ownership and it facilitates progress to projects as people come to help. People now know what is going and it reduces suspicion of the public workers (personal interview with Kadyama, Councillor Kajoko parish March, 2004)

This opinion by the councillor however was contradicted by the community members who thought that their inputs are still marginalized. They questioned the legitimacy of the formal representative channels through the health management committees.

We have committees that represent the people in planning. However, one of the disturbing questions is to what extent do these communities represent the people (District respondent)

The people are not available; they do not attend even when you call them. Only 20 out of say 200 would come... if there was money involved, you could see how willing they would be ... (Local councillor)

Planning and priority setting, even at the village levels are still dominated by the locally elected political leaders and /or still the work of the so-called technical committees, where they exist. Poor attendances of public meetings, lack of interest, lack of monitory gains, cultural barriers and suspicions were some of the reasons given by the local councillors for this. They also noted that the public think that their representatives are paid so they ought to do all the work. Women, who had heavy workloads and lack of time required for such activities, dominate the primary health care committees.

4.5.5 Public perception of the model of participation...

All the discussants recognised that although it was their constitutional right to participate in the planning and decision-making processes, they were only doing so through their representatives. However contrary to the local councillors' interpretation of the public's poor participation, most respondents expressed interest in planning and decision-making. One overall complaint however was that leaders have not cared to consult with the people. The participant noted that the local councillors foregot about them, make all the decisions and just tell them what to do:

It is useless really...they just come here and say do this and the other but they do not ask us what we want. Who can ask you the poor person? I think they only consult those who have something to offer who are actively mobilised for planning meetings. Some of us are asked when most of the projects have been formulated, so it is useless to go there (Health users, Budaka health centre, 2004)

However, there were group specific reasons for poor participation by the poor and the way the people saw it. The youth in particular for example, felt 'exploited', being mobilised only for activities without monetary reward. Furthermore they felt individual tangible benefits should be part and parcel of participation:

We need to be paid...I cannot leave my work just to go and work for a thank you. I have my garden which gives me food, soap, salt, sugar and when I fall sick I need something to sell in order to get treatment, so if they want people to participate, they should come up with some form of incentive. (Youth respondent, Budaka, 2004)

Unless the economic conditions of the public are improved, mass involvement of the public in Uganda will always be limited. The respondents here find it so difficult to take part in voluntary works, which yield less actual

and immediate benefits to them. The case of the youth is the need for benefits, some kind of monetary gains but not just free services. The poverty situation in Pallisa means that people have to continuously engage in some form of production to generate survival; hence poverty is a cause for the low turn out.

4.5.6 Women's role is still marginalized: Few women participate...

Although efforts have been made in promoting gender balance and inclusion in the public administration, the study noted that in the delivery of health services, especially at the management levels, the roles of women is still marginal.

Observationally, on all the management committees of the entire six health units that participated in this study, their composition of 9 members reserved only one seat for a woman, otherwise the rest are men. The respondents noted that this arrangement creates imbalances during the planning as the voices of women are sometimes suppressed as one-woman member noted:

The whole structure is not fairly constructed...we the women are the majority in terms of population but when it comes to representation we are still very few...the majority of the committee members are men such that during the budgeting and planning they want to take the biggest share...we need to distribute power equally so that we can have fair distribution. (Woman member of the Health management committee, Kadama health centre three)

What the woman councillor sees here is the gender marginalisation that leads to unwarranted influences in the distribution of health resources at the planning stage. While the population surveys of Uganda show that there are more women than men in Uganda (Uganda population census, 2001)

Women's presence in the public administration such as on the HUMC is still minimal. The perception of the councillor in this quote suggests that there is need to increase women on such management committees at all levels so as to increase their levels of bargaining power during the budgeting and planning process. This feeling was also shared by other senior administrators as noted:

There is need to encourage women to take part in the whole process of health service delivery...If we are to realise meaningful participation and development rooted in the social structure, then women must be at the driving wheel...women should be there to argue out their cases...this will help identify major setbacks in antenatal, family planning, reproductive health, otherwise the policy will remain gender biased. (Personal interview with the CAO, Pallisa District)

There is a general acceptance that the issue of gender balance on the management committees needs to be addressed. Most respondents such as the CAO argued that perhaps it might be important to have half men and half women on the committee to reflect gender balance. This proposal is however seen by many as being very difficult to implement since the majority of women in Pallisa are not educated, so they lack confidence in themselves, such that even if they are elected to the committee, they will instead listen to the men who tend to dominate the discussions in that issues such as allocation of greater funds to MCH will be determined by the men. On the other hand the sub county chief noted:

If we chose to have more women on the committee it will be ok, but you see we are still behind in as far as gender is concerned...Most husbands here cannot allow their wives to come to public meetings. So even when we want to increase their presence, it is difficult to attract them...it will remain the work of men mostly. (County Chief Kadama Sub County, November 20th, 2003).

In this quote, the county chief sees women's limited participation on the

health management committees as being rooted in the cultures and traditions among the people in Pallisa and Uganda. Until recently women are supposed to be at home and cater for children, cook food and cultivate, but not to work in the public spheres. One of the credits given to the current Movement System has been the attempt to promote women participation in the public affairs to which the gender ministry was put in place. What is surprising however is that the Minister for Gender is a man! One can therefore note from the above quote the need to change culture wise, especially for men to allow women to participate in public affairs, and also to provide measures that can create confidence in women to be able to air their needs during meetings and public consultation forums to reduce male dominance, which marginalises them. Measures suggested were adult education, workshops, and seminars for both men and women and economic empowerment through offering of small loans to women to fight poverty since poverty is one of such obstacles to their active involvement in the public life, as one woman summed up

For me I want to attend these meetings...it is good because then we can say what we want even if they cannot listen, but the problem is poverty. You have to think of the way to present yourself...you cannot just go like this (shabby) but you must look very presentable and if you cannot afford to buy a gomasi (the women's dress), then you cannot go. We lack the ability to buy good clothes. The poverty is too much *such that when you think of going to the public that way you feel ashamed really (Woman respondent, Kibuku, 2004)*

In the quote, the respondent sees poverty as a major constraint to participation. She notes that poverty keeps people in inferior position. The lack of clothes to wear while going for the meetings is one kind of demonstration of its implications. For example, the woman respondent shows

that her inability to attend these participatory meetings or to be part of it is rooted in her economic inadequacies, which continue to restrict her entry into public life to assume power in their communities. Coupled with other power imbalances at the household levels, participation and the role of women remains marginal even when the structures for them to participate offers them the opportunity to do so.

The study noted that local level gender power imbalances are some sort of blockage to effective participation.

You see I have to be at home to cook for my husband and children...that is my responsibility...I have to grow food. When I cultivate rice I can sell and get some money and also eat. I cannot just come and work as an LC. I think that is one reason why most women don't want to come...some think this is the work of those who are educated so they don't come even when we tell them that they can do good work in mobilising women because men will feel more comforted if his wife is talking to a fellow woman than a man so we want but they don't come. (Personal unstructured interview with Kasifa, member of Kabweri HUMC, April, 2004)

There is evidence to show that the triple role of women in household production, income generation at the household level and community organisation may lead to higher value input into participation, but without a change in culture and funding to compensate for the time they lose and it also means that women are not able to commit sufficient time to lengthy meetings to have their concerns such as allocating funds, provision of family planning units and contraceptives addressed.

In many societies in Uganda women's roles are still bound up in oppressive traditions, unrealistic matrimonial cultures, traditions and knowledge denial. Solutions sometimes include quotas for membership on the committees,

mandates for women to participate in the decision-making process and yet as seen in the above experience these suffer from not being achieved, problems which at times have been attributed to limited funding sources and the will on the side of the management and politicians to promote women's agendas.

4.5.7 Has participation improved accountability? The public view...

Although decentralisation is seen as a mechanism for increasing accountability and a measure to check the public servants in the health sector, cited more often by the majority of the respondents was that of mismanagement of medical supplies at the lower levels by the very people who are supposed to fight graft. The study noted that this was said to be as a result of the weak management and monitoring tools available at lower government:

Although the idea behind HUMC was to increase the levels of accountability, the majority of the members on such committees are rural elites, or people with power in the community who use the money with impunity... You see, these people are thieves, they are rich and can do anything ...they are getting rich everyday at our expense...these so called members of the health management committees aim to get rich...they don't care about anybody...You see them getting rich every day. Where do they get the money? (Personal interview with Dr Malo, Budaka health centre, 2004)

Even health workers open the medicine kit and use the medicine without monitoring or control...how can we know what is happening to the medicine? ... It is just so difficult to reinforce because the mechanism is such a weak one. There is need to have strong system for monitoring and supervision of drugs because it is now a hot commodity and health workers may be attempted to sell... (Personal interview with Amos, Budaka health centre)

This study reinforces Asiimwe's (1996) study of 12 government facilities in

The Bushenyi and Iganga Districts in which he concluded that the Health Management Committees had little positive impact in so far as accountability is concerned. Reasons mostly given included such things as alleged leakages of both revenues and drugs and members of the HUMC "providing themselves" with special benefits, such as special contracts to themselves. This was attributed to corruption and weaker administrative control, weak monitoring and supervision of the health sector under decentralisation. What then comes out clearly is that the Health Management Committees can increase corruption, especially if there are no effective measures to regulate the conduct and activities of those working in them. It becomes a very important aspect of policy because corruption increases hardships, dislocates resources meant for the public and keeps them in dire need even when there are resources flowing from the centre. This conclusion corroborates, Cockroft's (1997) study of the effectiveness of the HUMC in reducing corruption and misuse of medical supplies in Mukono and Kabaale district in Uganda, in which he concluded that sometimes corruption was decentralised such that the HUMC allocated less revenue to primary health activities such as drugs and much more revenue was allocated to staff allowances, and the majority of funds were not being accounted for (Cockcroft, 1997).

It was noted that attempts by some members of the Health Unit Management committees to intervene had also failed, due to lack of support from their laid-back counterparts, and a strained relationship with health workers further undermined prospects for cultivating a mutually supportive relationship. In consequence, active members too have become apathetic and some have

given up trying to supervise the units. This was the case with Bulangira and Naboa health units. In these particular incidences some of the notorious health workers and members of the HUMCs are relatives or friends of powerful men at the top whom members did not want to alienate. The study therefore noted that local level management had delivered neither accountability nor probity, a complete contrast from what had been expected.

The rationale behind these committees was that they would work to help reduce the drug leakages and misuse of medical supplies by the health staff, but I don't think so, because some of the members want to be served first...We face them here wanting to influence everything, even things they have no knowledge about...For me as a professional, I would not put up with that because I want to do my job according to professional standard that is it and when I refuse, you hear them saying this and that...In fact they are responsible for some of the problems health units are facing now(Personal interview with Dr Malo, In charge Budaka health centre, 2004)

The respondent's view contradict the notion and the idea behind the formation of these committees, which among other things was to increase accountability, reduce medical supply leakages and improve on the primary health service delivery, but rather as noted by Malo, committees such as these have instead increased corruption, nepotism and pressure on the primary health service providers. The study noted that the formal structures for participation have been dodged by both administrative, organisation and management weaknesses apparent in the health sector under decentralisation. These weaknesses include: lack of skills and knowledge by the members of the HUMC.

Overall the study noted that a number of problems experienced in the primary health management committees generally appear to relate a lack of formal

training and guidelines. Lack of skills then becomes a major problem for these committees in carrying out their functions as watchdogs, and managers of health services. This perspective strongly reinforces the earlier study of 10 health units by UNICEF which had revealed that neither the Health centre person in charge nor the management committees had received formal training in Management, accountancy, record keeping or the administrative tasks for which they are responsible (Olsen 1997, p.35) indicating that local government have been given work and responsibilities without skills to do them. These committees, which have now been set up, are responsible for oversight of personnel, inspection and decisions regarding expenditures and the supervision of the health facilities with little or no knowledge about their responsibilities and work.

Knowing the responsibility of the job is one way of achieving efficiency in any form of work (Suzan Newell, 1995). This was found to be one of the factors affecting the delivery of health services. The study noted that even perceived responsibilities to the local communities by most members of the management committees including the person in charge appeared to be still weak in all the committee members that were interviewed. For example in Kadama one of the field study areas, the study noted that neither the HUMC nor the Health unit in charge did not spontaneously name needs assessment as part of their responsibilities. When asked specifically about their responsibilities for identifying local health needs for their people, the local councillor for example noted that this was not their responsibility. Mobilising communities for health education, or resource support to the units was seen to

be the most prominent responsibility known to them.

Another contradiction that this study noted was that the committee members are not even known by the public they represent, which shows that they don't consult them on issues that affect them:

In practice, health workers and members of the committees at units have little contact with the public...they just pick people and I don't think that the so-called members go back to the community to ask about their needs? (Health workers, Kadama health centre)

In fact most respondents especially, the service users, said that they did not even know their representatives on the health unit management committee or about the existence of one. This corresponds to earlier studies by Assimwe (1996) which noted that many community members did not even know the Health Unit Management committees existed or had little awareness of them, and how the committee members were elected, which defeats the principals of democratic governance enshrined in the decentralisation statute (1997:21) which says that services will be democratically provided with the representatives openly elected from their communities.

4.5.8 The perception of the problem by the communities

The study therefore noted that the skill and knowledge were not the only limitation that was faced by primary health providers; there were other problems such as supervision of the health sector and those who work, in it as one staff noted:

We used to have health supervisors; they could go from one health centre to another. The supervisors put the health managers to account... Surely that put standards in the system because they were professionals who ensured quality but under the current circumstances you cannot expect standard because the health supervisors are lay men (Personal interview with the Members of the health management

committee, Budaka, 2004)

The perception and experience of the respondent in the extract is that decentralisation had not eased the logical constraint of supervision and the quality of it that had long made professional supervision virtually impossible during the political turmoil periods of the 1970s and 1980s of Dictator Idi Amin's rule. Under decentralisation the role of enforcing standards also fell to local health committees. Neither the sub county health committees nor the HUMC, however, were able to measure up. For example it was noted that:

Where can you complain? ...even when you do so no one can hear you...I think this is frustrating. We have had some complaints, but when we complain nobody takes you seriously and this is not very good because it feels like you don't have support. (Personal interview with junior nurse, Kibuku healths centre).

Complaints by health staff about the misconduct of the managers and by the service users about the misconduct by the health workers rarely received any response, according to the study. In most health centres visited, it was noted that health workers were not subject to supervision by professionals with knowledge and capacity to carry out that function in a way they would have considered legitimate, instead they were purportedly under the supervision of local actors with neither the capacity nor interest to perform the function nor knowledge about what to supervise nor the backup from professional cadres from the district. The inability of local actor to carry the weight of supervision on his or her own is best described by the testimony of a member of the HUMC in Kadama Sub County

Those people are so difficult. We cannot control them. Whenever we try to say anything they threaten to leave saying they are educated and can find work elsewhere. Now we simply keep quiet and let them do as they please. Many of us on the committee are uneducated; how can we question those who are educated?

This testimony mirrors one recorded by Garfield and Williams (1989) from members of the people's health council in Nicaragua a country once famous for grassroots participation in the provision of primary health services:

"We want our communities to be healthy, so we carry out health campaigns...we tell people this and the other but the health staff do not want this...I think they feel we are taking their business or showing disrespect. I have to take this under consideration because we have few staff. What will I do if my child fall ill and he will refuse to provide treatment?"

This testimony not only shows the lack of power and the inability of local people to hold their leaders and health workers accountable, but also highlights the need for extra-local regulation and a fundamental aspect of rural life and the limitation of their powers to do so: namely skills, knowledge and self-esteem necessary to make participation viable and meaningful, let alone effective. Despite being local residents, as were members of the HUMCs, members had no idea of what was going on at the unit. This lack of knowledge could be attributed to lack of interest, lack of motivation or due to lack of facilitation. And the lack of self esteem can also be attributed to the social construction of this society, where in the past health workers were seen as 'demi-gods' while obedience was expected on the side of the subjects to their leaders, hence the possibility that local people could question the bad deeds of their health worker or their leaders would still take long to be a reality and hence as a result some resort to exit rather than voice mechanism. On the contrary, this state of affairs questions the assumption by advocates of decentralisation and participation and the very notion that local residence necessarily translates into better knowledge of local conditions and can hold

their leaders to account. The study therefore shows that in the current state, the demise of HUMCs affected the primary health service provision by removing the mechanism for local supervision and control, which created a leeway for health workers and managers to engage in unrestrained malfeasance.

In Pallisa, most health workers talked of extra sources of income, which included drug shops, *shambas* or any other form of business with ease to which they devoted more time and energy than the public health unit without being held back. Absenteeism of the health staff, especially the person in charge, was reported in Budaka and Kibuku and some health units opened half day or one member of staff was available. The latter was very common with the lower parish level health units such as Molokokyomo. A number of respondents attributed this phenomenon to the collapse of professional supervision and absence of the mechanism for receiving complaints:

Those in authority have taken advantage of this lapse...health workers come at any time they want but is this how it should be really? I am sure patients are abused but where can they report... who can hear them? Such mechanism is weak and there is need for it to be strengthened otherwise it is still hard...to talk about quality care in the rural areas (Personal interview with Amos Budaka health centre, 2004)

The requirement is that the drug kit should be opened in the presence of the HUMC to remove suspicion, but this is not done.... People used to say the health staff take the medicine so the committee was put in place to verify the quantity of medicine delivered but they don't come and you hear people say health workers are selling our medicine. Where are the people's representatives? (Personal interview with Byakatonda, Budaka, 2004)

Given the history of pilferage of drugs and medicine before decentralisation which had degenerated trust and respect in public health worker (Birungi,

1998; Assimwe et al., 1997), it had been imperative that such strict controls be put in place to ensure monitoring of supplies to restore the trust and confidence that the public can have in their respective health workers. This study shows that in this respect, decentralisation and participation had not delivered this opportunity, and supervision and monitoring of the primary health services is far less than was anticipated.

4.5.9 Policy implication based on the study

This report in this Chapter provides an intermediate evaluation of the structure of primary health care delivery under decentralisation and to a certain extent the performance of it in the rural places in Pallisa and Uganda as a country. A qualitative exploratory approach enabled the study to assess the public's own experiences with the current structures of primary health care delivery, which was one of the objectives. The use of different data collection approaches (in-depth interviews and observations) and a comparison of the perceptions and experiences between the authorities and the local communities improved the validity of the findings. However the result cannot be generalised to all communities or districts in Uganda, since purposeful sampling involving only a few people was done. Furthermore, since the participants were most of them found at the health centres, the study may have missed some vulnerable groups that do not normally come to the health centres and would not be mobilised anyway.

What has become clear is that structural changes that have resulted from decentralisation have altered and framed new roles for each level of governance and primary health service delivery. The central Ministry of

Health now focuses on the developing of policies and guidelines and setting standards of the whole health sector. The study further noted that the district to a certain extent on the other hand is no longer a passive recipient of plans and financing of the primary health and, to a certain degree if actively involved in assessment of their own primary health needs, and allocating of resources and implementing interventions in the agreed plans.

However, the concerns about the local government's capacity to absorb their new roles need to be addressed not only by the provision of technical assistance, but also by enabling the district to hire qualified technical personnel. This could be facilitated by effective financial decentralisation and proper autonomy so as to enable leaders to act on the decisions and plans they make (Jeppson, 2001; Bossert, and Beauvais, 2002).

With regards to participation, despite the political commitment, the appointed vehicles for participation seem not to be functioning as intended, at least not in Pallisa district. This was also documented in earlier studies in Uganda (Bossert and Beauvais, 2002). Although the political leaders such as the councillors and district administrators reported some ventures in which communities have been able to 'participate', this was primarily at the health structure benefit and programme activity levels. At other levels of participation, it is mainly through elected leaders. The public however expressed dissatisfaction with the current system of participation; they expressed interest and willingness to participate in priority settings and planning processes, contrary to their lack of interest reported by the leaders. Perhaps there is need for further investigation why the vigour by the public to

participate and the methods for absorbing them into this system.

Since the levels of participation envisioned in policy documents is from priority settings to monitoring and evaluation, means that there is need actualise actualises this process. The policy of participation gives public participation legitimacy, but it is therefore important to look at the identified hindrances to full implementation of the policy. The barriers identified at the structural levels were social economic and cultural issues and at the individual levels motivation and these were not peculiar to the people of Pallisa. Since the study showed different dimensions of barriers to participation, using a combined approach of simultaneously addressing both structural and individual barriers would need to be applied.

In this chapter, the most important structural barriers seemed to have been poverty, which disempowered the communities and their leaders in effecting the policy of public involvement. This was found to be a barrier to most community members', especially the youth's motivation, to attend meetings and participate in meetings and hence in the decisions making in their communities. If the poor are not well empowered and mobilised, they are not able participate and hence their needs are not voiced, which makes them even more vulnerable. This phenomenon has been documented among the urban poor in Kampala city where the poor are said to have no 'voice' (Kapiriri, 1994). The youths on the other hand, whose behaviours are unpredictable, were actually preoccupied with the survival and the need to be shown how beneficial some of the planned activities are before they participate. There is need to motivate them. One possibility would be to address their felt needs

(such as addressing poverty), so as to facilitate their individual empowerment and participation.

At the individual level, the patriarchal culture was found to still play an important role in the degree to which different people participate. Women are unable to participate, as they should. It is no wonder the 1995 Uganda constitution made special provision for them (Government of Uganda, 1997); however this seems inadequate in Pallisa. The women who are the majority still felt left out in decision-making. It is possible that even at the meetings the women are intimidated by the powers of the rich and the rural elites who are mostly men, which limits their proper levels of participation.

Innovative ways, in addition to economic empowerment, needs to be explored. A community is empowered if its people are individually empowered (Jakarta declaration, 1997). One of such tools may require the provision of information, the more so if the public is involved in the collection of that information. A participatory Rapid Appraisal method that seeks to involve all the stakeholders (users, providers) can be employed to facilitate this process. PRA can produce timely results, is relatively easy to adopt, encourages wide participation and leaves communities more empowered and feeling part of the process (Kellogg Foundation, 1998; Francis and Heggenhougen, 1999) Such an approach can be used in identifying needs as well as assessing community satisfaction with primary health care service, hence encouraging public participation in the improvement of the performance of the health sector as a whole.

Given the vast heterogeneity of communities, there is need to widen

representation. Disadvantaged groups that would otherwise not participate in planning need to be deliberately identified and given the opportunity to do so. Such approaches can facilitate the identification of community resources and the production of more realistic, transparent plans acceptable to all.

If participation is based on representation, as it is often the case in Uganda, it is vital that the leaders are encouraged to keep in touch with the people they represent, so that the interests of the people represented are expressed. However this study found an apparent gap between the leaders and the people they represented to the extent that most of the respondents said they did not know their representatives. This partly was blamed on the lack of resources to enable the leaders to consult with the people; however, the latter felt that their representatives just 'forgot' about them. Resources should be mobilised and targeted to communities disempowered by poverty, and also made available to the leaders to be able to mobilise communities to take part in the issues that affect them. This way, the project will receive the full support of the communities.

4.6 Conclusion

The study noted that Uganda has a political commitment to public participation in decision-making, and the structures are in place to facilitate this. To a certain extent there is a growing feeling of ownership of their local health units. However, autonomy is far from being achieved both in resource, choices of projects and the decisions to implement them. The district as seen in this chapter is still dependent on external sources of funding for their health activities. There is not much indication that this is about to end since local

revenue gathering capacities are likely to remain low due to low investments in the district and given the economic state of the district. However, dependence on external financing is not inherently a problem, assuming that funds are delivered in time and are not abruptly withdrawn, and, districts are not constrained to allocate resources in ways that do not correspond to their priorities, which is the case in Pallisa. Such a spirit is counter to the spirit of decentralisation. There is need to increase flexibility in planning and actual implementation of primary health interventions.

There is clear evidence that district spending for primary health care has declined in both monetary and real value. In monetary terms it is because of the requirements by the donor agencies for the government to cut their expenditures, a requirement of the World Bank and International Monitory Funds, and on the other hand inflation that has rocked countries such as Uganda in late 1990s. The nature of this funding, however, is an area of concern particularly for activities that will negatively affect the quality and of primary health service interventions such as family planning, availability of medical supplies in the outpatient department, proper antenatal services and the general delivery of primary health care, which creates harmony. There is some evidence to show that district allocation has gone increasingly to civil works, salary supplement or to an effort to train manpower. The funding situation for primary health care in Pallisa therefore presents an uncertain picture that requires additional review and careful monitoring.

Many of the negative indicators of the quality of health care under decentralisation cited in this chapter are intermediate and the government is

already taking steps to address many of them. Training and capacity building at the district levels will go a long way towards resolving some of the problems of personnel and weak operation of the Health management committees at the primary health units.

There is no doubt however about the degree of community participation in the delivery of primary health care in Pallisa and Uganda as a whole. We need to answer the question why would this framework apply to Uganda's context of local level service delivery and politics? One reason is very clear from the data and it relates to resource mobilisation and the struggle to develop a common front against the evils of poverty and destitution created by Structural Adjustment and the withdrawal of the state from service provision. The findings in this study therefore concur with the main Scholars of the IMF Riot, Walton and Sedon, who argued, "the shrinkage of the state under condition of structural adjustment generates a "broader trend towards the decline of state provisioning".

This study therefore can conclude that the main structural factors forging the unity of the Ugandan rural communities to participate the way they do in health services therefore, is the economic hardship. The conclusion that can be drawn is that community participation in the delivery of health services such as PHC is meant to stabilise an intrinsically unworkable arrangement created by economic hardship which has resulted in economic marginalisation, destitution, hopelessness and reduced resistance against governments for failing to provide or providing poor quality services.

Generally, this study just like that of Olsen (1996) notes poor public

participation and engagement in the health sector. One reason according to this study incorporates the former tradition where health care was provided for by the central government. But also, as seen above, lack of individual and community empowerment, failure to operationalise the policy on public participation in health, lack of commitment and time on the side of others such as women are some of the limitations. However there are also barriers such as economic, social, and cultural attitudinal and motivational which hinder participation, even when the spirit to do so exists.

CHAPTER 5: WORKING IN A DECENTRALIZED SYSTEM: THE CAUSE OF STATUS INCONGRUITY AMONGST HEALTH STAFF IN PALLISA

".... A conflict between our self –image of what it means to be the honest, hard working civil servant and the betrayal of our ontological image that results from the human nature of demands and unsatisfied needs..." Dr Nkolo Abel, Kibuku Health Centre, 2004

5.1 Introduction

Studies done in Uganda over the years post decentralization have shown that activities such as absenteeism, attrition to other sectors and engagement in market related activities by health staff are prevalent in Uganda (Bennett et al., 1997; Mwesigye, 1999; Mwabu, 1995). For example, Jitta and Van der Hidden (1998) and McPake (1999) in qualitative studies documented a range of such practices as involvement in business, attrition to the private sector, operating own drug shops and clinics, and absenteeism prevalent in Kampala and Mbarara in the South West of Uganda. Similarly, Mwabu's qualitative study of the informal economy of the public health staff showed that public health staff in the district of Tororo in the eastern Uganda engage in various activities inside and outside the public health facilities. As a result of these actions and activities by the staff, the general perceptions about the health staff is that, those under decentralization care less about their patients but are more concerned about gaining profitable ventures (Mwesigye, 1999; Bennet et al, 1997).

However, from the organizational perspective, a simple analysis of these studies is that the health staff are struggling to survive as professionals and to maintain a standard of lifestyle, that existed before, which also means that the health staff has not changed with the change and still look to the government as the body responsible for their survival. The central government since the colonial period is responsible for remuneration, maintaining the standard of the health staff and ensuring their welfare. This is partly a colonial legacy. By this analysis therefore, I argue that current studies, which have attempted to study the impact of decentralization on the health workers, have underestimated the importance of the very significant ingredients in the work place and life of the health staff. For example, Mwesigye's (1999) qualitative study conclusion that decentralization has resulted in better morale for health workers is based on the assumptions that an increase in money wage is a fundamental function in the health workers morale; this analysis did not consider other factors such as the cost of living vis-ã- vis the equitability of it in comparison to the cost of living, the conditions in the health organization such as the medical supplies and other health infrastructure, and job security, and career development which are the health worker's aspirations.

The importance of the health staff in the health organization cannot be underestimated especially during the decentralization period where they have become the implementers and managers of the policies. A motivated and well-catered staff is reflected in the quality of care delivered by them and generally the organization.

In this chapter therefore, I describe the development of social, economic and political changes in the form of SAPS in the health sector in Pallisa while analyzing its implications for the health staff status in Pallisa District during decentralization. The chapter incorporates the fact that social, economic and political changes brought by these reforms have impacted negatively on the local economies and hence local government face constraints in financing social services such as health services and maintaining the life styles of the health staff, hence creating status inconsistencies amongst the health staff which affects the way they relate with health users and their conduct towards them.

The chapter therefore argues that the social and economic change at local levels in Pallisa under decentralization is insufficient to provide a foundation for individual health workers' aspirations. Therefore health workers attempt to work and maintain a life style inconsistent with their economic standing, a variable I term status incongruity which as we will see later, has a direct bearing on the quality of life of the health staff and their abilities to deliver quality services. Here I describe how this factor is associated with the actions taken by the individual health staff within and outside the health sector and attempt therefore to broaden and modify this concept in local settings of health care provision under decentralization. The latter process, contextual modification, is illustrated by data from six health centres in Pallisa district. In this analysis, the impact of decentralization and status incongruity among health staff are examined in 19 lower cadres of health staff (nurses, midwives, nursing aides, clinical officers) and six

medical officers (Doctors).

While attempting to use Suzan Newell's (1995) concept of status incongruity and apply it in the real life situation of the public health staff under decentralization, I look at the working conditions of the health staff under decentralization with central focus on working environment, availability of medical supplies and equipment, while showing how this situation which is a result of SAP has affected the health staff's aspiration of and ability to provide quality primary health services. Incongruity model here represents an approach to capture the tension, conflicts, anxieties and ambiguities that individual health workers experience as a result of social economic and political changes in Pallisa and its implication for the quality of primary health care. In this approach, the social and psychological dissonance associated to the social political and economic reforms is presented and the relationship to the delivery of quality of care is made.

This chapter analyses the economic wellbeing of the health staff under decentralization and attempts to show how the health staff perceive their wellbeing in comparison with the period before decentralization and to relate it to the health staff's perception of their status and their abilities and motivation to deliver quality primary care. Status inconsistencies invalidate an individual's claim to a social position, thereby resulting in stress, anxieties and therefore represents a dynamic measure of the health workers experience vis-à-vis social political change in Pallisa that incorporates individual health staff as well as contextual factors to provide a more realistic and proximate representation of the problems facing individual

health staff in the context of on-going decentralization.

Thirdly, the chapter by use of this concept analyses the impact and experiences of health staff with job security, training opportunities and other employment benefits under decentralization. As used by Suzan Newell (1995) in her book "Fairness, Ethics and Effective Management", status incongruity can be associated with the falling economic status of an individual.

Therefore status incongruity in this context represents a link between global social economic and political processes of 1980s and 1990s and the social status of the health staff under decentralization in Uganda, and may also help to explain why the health staff behave the way they do now, but more importantly the impacts of that behavior on the delivery of quality primary care.

5.1.1 Health staff before decentralization: Dreaming of the past...

Without glorifying the past, the review of the health sector and the standards of the health staff in Uganda before the economic crisis and the subsequent introduction of decentralization and SAP programs in Uganda in 1980s as shown in chapter one shows that the economy of Uganda was stable and relatively prosperous, and the health system that was centralized was considered one of the best in Sub-Saharan Africa (Mwesigye, 1997; Assiimwe, 1995; Mcpake, 1999). Assimwe notes that health professionals from all over Africa had interest in working in Uganda because of the strength of the health organization. The review also shows that health

professionals, in particular, enjoyed a high social and economic status (Mwesigye, 1999; Assimwe, 1997). This was because of the government responsiveness to the needs of the health staff. The government paid good wages to the health staff, provided some benefits to them and their families, and the work support system was in place that made the health staff one of the admired civil servants (Bennet et al, 1997). A senior staff confirms this position when he says:

In the past, as a medical officer the government catered for you...they were well facilitated in a way that made them have the pride in their work. The could buy a car and have all these material things, but those were days, but things have changed because such things are no longer in place.(Personal interview, with senior civil servant, Kampala Uganda, 2004)

The health staff's ability to remember that before the decentralization medical graduates could buy a used car, have a house in town and offer economic support to their siblings and their parents reveals a sense of discordance and how important material things are valued in people's lives, and it defines the identities of the health staff as well. The material things such as a car or a house signify the social status of a person and show the wellness of that person. It is therefore presumed here that because the staff were able to acquire these material things and the health organization was effective in providing such opportunities, health staff received greater benefits, hence they were respected and regarded with high esteem, as one of respondents with the Ministry of Health in Entebbe notes.

As a doctor you were regarded as "rich" because you were given most of the essentials of life and this put you in some place...Studying medicine or science was seen as an end in itself. This was because one would be sure of the future when they qualified; let alone the respect one got in the community

because they actually saved lives. (Interview with senior civil servant, Entebbe, Uganda.

In this quote, the respondent perceptively draws together important aspects of the health staff in Uganda. The importance that was attached to being a member of the health staff and the fringe benefits that went with it prior to decentralisation was very important. This underlines the health staff's precariousness and the marginal importance attached to their welfare. The respondent sees the benefits that the health staff got made them more comfortable, hence creating a feeling of accomplishment amongst the health workers and they were able to work comfortably and serve the public. Some of these benefits have been removed under decentralisation. Districts struggling with budget deficits cannot afford to provide even housing for their staff, let a lone provide education and medical care for the family of the health staff. The apparent situation seems to be one, which has caught most health staff unaware, creating a feeling of dissatisfaction. Besides that because of the absence of these fringe benefits, the social status of the health staff that defined their identity has come under question. The staff draws on very important factors that brought respect in the past, among which was the health staff's abilities financially and their abilities to help others around them. In this regard, the respondent recognises the abilities of the centralised government in mitigating the basic problems of the health worker's survival.

On the other hand Amos sees his work as a health staff member as a representation of a social status as seen in the quote below

You see health workers were seen as a lifesaver. There was that pride amongst the health staff and because of that people respected us because that was what we were

known for...Health workers were very committed and you could not hear that such a health worker has a shop or a clinic "... The rule was that you have to work only in the public health care and that was it. I never heard that so and so has a shop until recently. (46 Years Old senior medical officer, Budaka health centre)

In this case, Amos draws the primary responsibilities of the health staff then that was to save lives. Under centralisation, all health staff that qualified were by rule not allowed to work privately or to engage in any other activity than that of working in public centres. This commitment was seen in the presence of the health staff being available at the facility, their responses to emergencies and their abilities to treat the patient. Working in public care was the ultimate objective of the health staff before decentralisation. It provided pride amongst the health staff and it increased their respect amongst the population. The extract indicates that under centralisation the health staff were not involved in any other activity than that of the hospital work and this is an attempt to classify decentralisation as a cause of this evil of private practice in Pallisa.

Amos ...Even if the salary was not high in monetary terms, the government subsidised the health staff...such things were covered under the employment contract, you were given a reasonable housing, school fees for your children were paid so the health staff were very comfortable. I think this made the public health workers more committed to the work to protect those benefits...

The importance of employment benefits among health staff before decentralisation cannot be underestimated among the Ugandan health staff. Although earlier studies on the impact of decentralisation on the morale and the wellness of health staff in Uganda had showed an increase in money wages (Okwi, 2003), such studies based their conclusions on money wage increments, neglecting the importance of other benefits such as housing, education for the children of the health staff which the health staff like Amos consider as having been very important. Amos therefore perceptively shows that benefits such as housing were very instrumental in defining their

identities while also recognising that such benefits have been eroded under decentralisation.

5.1.2 Copying with the change

As seen in the preceding chapters, decentralisation has changed the whole structure, roles, responsibilities, duties and function of the government. It has changed the relationship of the health staff and its employers. Decentralisation efforts in Uganda have delegated the powers to manage the health staff to the Districts, thus local authorities have taken charge of recruiting, retaining and firing and remuneration of any public servant employed at the district away from the central level employment. This created a two-tier employment system in the country; i.e. national employment through the National Public Service Commission and local employment through the District Service Commission. The test for local governments apparently is in the ability of each individual District to maintain the standards, life styles and benefit that the health staffs have enjoyed while they worked under the Ministry of Health, and to ensure that the benefits that accrue out of it are equally distributed to maintain the life style and aspiration of the health worker.

It has been stated in Chapter Two that up to late 1980s government health workers could not legally practice their profession privately during their services in government (Assiimwe, 1992; Bennet, et al., 1997; Economic Restructuring in Uganda 1987). But, by 1990s the government and especially the public service commission and the Ministry of Health increasingly became aware that many of the public health staff were practising medicine

privately (Health Watch, 1999, Mwesigye, 1997; Bennet, et al., 1997) such that by 1995 the majority of Uganda's health staff were involved in some sort of market oriented activity (Assiimwe, 1997, cited in (Bennet, et al., 1997. The situation in Uganda is that the health staff at all levels in one way or the other is engaged in various form of money generating activities. Some are employed outside the public sector, while others practice their business within the same places where they work. In the previous studies, Assiimwe for example noted that some health staff come with gloves or injection needles to sell to the patients because they know that there is nothing in the public coffers so instead of the patients going out to buy, they would readily sell to them. Other health staff sell food around the health centres. All these are attempts to raise money to be able to live a reasonable life.

Bennet et al. (1997) for example notes that the introduction of markets in health services which is a product of decentralisation... took away the protection the health sector and its workers had enjoyed under the central government, consequently the health personnel could operate their own clinic, work in private hospitals, and operate drug shops and many other businesses with less restriction (Bennett, et al., 1997). Implicit in this assertion by Bennet here is an intention to demonise economic liberalisation and want the reader to think that fundamentally the private activities of the health staff is a response of economic liberalisation, which in some way is the case, but this school of thought underscores the fact that such activities by the staff have been necessitated by need to survive the crisis.

For example , by use of the data for Pallisa District on private practice,

evidence shows that by 1999 alone Pallisa district registered more than 100 drug shops and 14 private clinics most of which were under passive ownership of public health staff. (Background to the Budget Report, Pallisa District, 2000: Paragraph: 14). The analysis derived from the above growth in the private practice in Pallisa therefore shows that this phenomenon does not only symbolise the development in health sector as the government assumes, but it symbolises the difficulties and challenges the public health sector faces under decentralisation. Two very important issues are recognised here: the growing markets for private medical care out of the failing public services; and secondly the realisation of the public health staff that they can best be served in the private sector, both are indication of the falling public health care under decentralisation.

5.2 Decentralization and working conditions: we want to work but we do not have tools...

Whereas the previous section aimed to give a historic perspective about work and lives of the health staff, in this section attention is paid to the current health organisation functioning. The commitment of the health staff is determined by a number of organisational and management factors. Health workers are motivated by a feeling of responsibility, technical and financial achievement, working in an environment that supports their work efforts and creates hope for the future professional development (Susan Newell, 1995). In this section, I examine the conditions under which health staff work and show how it has affected their aspiration and morale. The section examines and compares the available resources to the health staff to use while

executing their duties and shows how the current working conditions are inabilities and cause discordance among the health staff in Pallisa.

5.2.1 Working without basic tools...

The impact of structural adjustment on the health sector budgets financing is well documented in Uganda and elsewhere among other countries that were decentralized (Bossert, 1998; Bossert, 2002; Spar, 1994; Bennet, et al., 1997). In Uganda, current studies on the impact of decentralization on the health sector have shown that SAP policies have led to cuts in health sector funding (Mwesigye, 1999; Bennet, et al., 1997). The implication of these expenditure cuts on the health sector in Pallisa district can be seen in the shortages of the availability of all resources in the health sector, especially medical supplies, equipment etc. In adequate ward space and shortages of basic equipment and drug supplies are major factors in health centres in Pallisa. A check list of medical supplies delivery in all the six healthy centres that participated in this study showed that there was irregular supply of basic medical requirements such as drugs, gloves and most medical kits used in the primary health care delivery. Medical supplies in Pallisa are officially supplied quarterly but that means in reality after every four months. This means that drugs meant for four months (quarter lasts for 3-4 weeks meaning that the remaining period before the next quarter comes, these facilities are without these supplies. As a staff explained

You see the problem is the shortages in supplies...we are without drugs all the time and our work is reduced to just prescriptions without drugs. Even a simple illness that requires panadol, we have to tell the patients to go and buy...so that is the new system. It is difficult to keep telling patients there are no drugs every time they

come because that is not what they want to hear but they want to get treatment...they are in pain and as a health worker I must be able to help because this is my work. But see we have been reduced to that... You get a patient and what you're thinking about is how can I help? I get frustrated that way and keep thinking what is going wrong. It is our responsibility but we cannot do much in this situation. (Interview with the Medical Officer, Budaka health centre)

The health staff in Pallisa has been reduced from the position of providing treatment to prescribing agents of the state. The shortages in the supplies at the health centres have changed the staff's roles as a provider of care who wants to treat the patients. But because of the shortages, he now examines and advises the patients to buy drugs elsewhere, mostly in private drug stores. The failure of the staff to treat even a simple illness causes a lot of mental pain to a person such as the respondent above who desires to do a quality job. The frustration expressed by the respondents is part of the wider experiences by the majority of the health staff in Pallisa District and Uganda as a whole. In the delivery rooms the supplies of gloves were never there such that pregnant women are asked to bring the polythene bag used for building houses to deliver their babies on. Most pregnant women are asked to come with their own gloves or will have to buy on arrival to the centre. Technically from my observational point of view these are semi functional centres. It is evident, for example, that neither the two of health centres IVs visited, had a functional medical laboratory for screening of any illness, neither had an X-ray machine and yet these are regarded as basic instruments in the provision of health services under the new primary health service delivery.

This finding contrasts with the earlier politicized reports that have depicted

Uganda's health sector under decentralization as one of the best in Africa (DFID, 1999; DANIDA, 2001) and even more so contrasts with the likes of Mwabu whose report have in the past depicted the health staff as not interested in working but rather have become money magnets Mwabu's (1992), as cited in Bennett et al, (1997); Mwesigye (1999) Macrae (1995). The expressed frustration and anger by the staff here represents the wider experience that most health staff go through every day. He also shows that competence is one of the aspired goals he would want to achieve but also recognizes that given the imperfections in the health organizations such aspiration may remain a dream.

You stay all the time thinking what you can do for your patients ...it is not a good experience because when they come they expect you to treat them but because of the constraints we are forced to tell them this and that...we cannot help so the public sees us differently. You some times feel ashamed to be identified as a health worker anyway...

The quote above gives two major implications here. First the desire by the health staff to perform his duties effectively; secondly the existing limitations that have rendered them almost useless to their communities they are meant to serve. The statement that the public "sees us differently" gives an understanding of how the health staff in Pallisa constructs their public image under decentralization. If in the past the health staff were seen as a life saver, this depended on their level of effectiveness, hence incapacitated health staff will not be viewed the same way. The implication in all this is the impact such change would have on the status of the health staff, hence one would be right to conclude that health staff in Pallisa experiences status

incongruity which has been necessitated by the imperfection of the health sector organization.

"...Most of the time drugs are not available. This is very frustrating. Initially I was very diligent but I gave up. I used to run around looking for drugs for the patients here and there but there was nothing..." [Interview Clinical officer, Kadama health centre III, Date 17/January/2004].

The respondent's statement that he used to run around...to get drugs reveals the inherent desire by the health staff to treat the patients and a full realization of his responsibilities as a health staff. The statement that he gave up represents frustration and anxiety. Inherent in this quote therefore is the desire to work and the inability to do so because of the health sector organization inadequacies. Another staff adds to this when he says

Think of those patients what they think about us...can they trust us any more? This is why you hear rumours that we are less effective than those working in the private sector...and that we don't care about patients...don't forget that there was some medicine and medical standards at one time in these centres. (interview with staff, Bulangira health centre, 2004)

The respondent's attempt to understand how the public thinks about him is rooted in the inefficiencies in service delivery. He sees this beyond just work but the social construction of his relationship with the patients. The staff therefore see the apparent inadequacies as a cause of mistrust between the health staff and the patient. He also sees these apparent inefficiencies as a source of rumours and stained identities about the health staff while recognizing that there was some standard. The latter implies the staff's acceptance of the inefficiencies and an appreciation of the organization of the health sector before.

As another staff notes:

The history of this country shows that in the past there was treatment...that is why the people refer the previous health worker as having been better than the present. See we cannot diagnose and I end up guessing and prescribing broad-spectrum drugs hoping that they will some how treat whatever conditions the patient has. Even if treatment is effective, at the end of the day you don't know what you are dealing with. [Interview with the in charge Kibuku health centre 1V, date 31/March/2004]

Perceptively, the respondent, just like the others tries to appreciate the health sector organization in the past without glorifying the past. Reference is made here to availability of drugs, equipments and other facilities at the health centre. Abel indirectly accepts that as a result of the inefficiencies, health staff today are less effective than their counterparts in the past. However Abel recognizes that confidence and trust that the health staff receive from the public depends among other things on the abilities, standards and the provision of quality health services by the staff, which in turn is determined by the functioning of the health organization, which entails availability of medical supplies and equipments. He therefore relays the fears that most health staff have of the erosion of the confidence and trust that have been the fundamental principle of health care provision in Uganda as one of the causes of anxieties amongst the health staff in Pallisa.

You see there are many factors why you see many people going out of the public sector...most people think it is money which is attracting them, but this is not the only reason...I tell you there (Private sector) you work to the best of your knowledge, you exercise your skills, everything is there to use while you work and some of us take pride in our achievements and the appreciation that come with it. [interview with nursing Officer, Budaka health centre]

I want to ensure that patients are well cared for and performance standards are followed, but even more to it that my work is appreciated by the communities that I serve and when I don't get it, I feel so bad ...but now this our daily experience here in Pallisa. [interview with the medical officer Kibuku health centre]

Implicit in these quotes is that the health staff in Pallisa consider helping the patient to get treatment and the appreciation reward as very important in their work, but also the staff recognize that such appreciation cannot come because they do not deliver quality health services because of their lack of capacity due to constraints inherent in the health sector organization in Pallisa. Richard et al., (1998) reveal that each individual has different goals and always aims to promote those aspirations. Amos shows here that competence and standards are some of the goals that he as a health worker wants to achieve but, because of the absence of basic equipments, they cannot, hence health staff like Amos feel more demoralized than ever before. Absence of medical supplies reduces their abilities to save lives and to achieve standards and yet it is saving lives that defines their identities in the societies. But more stressful is the increasing pressure left to the individual health staff to bear under these circumstances, as the respondent puts it:

Health service seekers everywhere do not look at the underlying abilities or traits of the health staff, but they will describe and talk about their expectations which they are required to meet and which as a health worker I am supposed to perform... our experiences here are so bad that we don't want to talk about...We are abused by the patients who cannot understand why there are no drugs here because they used to have it before, so they abuse us. Some have accused us that

we 'steal drugs...that is the most painful part of it whenever you pass, as a health worker no one recognizes you as a good person but otherwise...it is happening. (Interview with the medical officer in Budaka health centre)

You see however good you are as a farmer, if you don't have a good hoe you will still suffer from hunger because it is the hoe that will help you to cultivate food in your garden without which you will not...even us health staff we need our tools. If we don't how on earth will one expect us to do any work...we come here every morning and look at patients but we cannot help them...some have died while we look on because we cannot help! It is painful because these are the people we live with, some of us were born here...this happens all the time...this is more stressful, my friend. [Interview with the, Midwife, Kibuku health centre]

Most staff represents here the experiences that most health staff in Pallisa has become accustomed to. He sees the shortages of supplies as a cause of the daily abuses from the patients that he endures at the centre. While an abuse is a sign of disrespect, it can also imply dissatisfaction and can reveal the inner feelings of the person. The respondet therefore represents a true picture of experience at the centre. Those who seek service and fail to get it continue to castigate the health workers as ineffective and inferior performers compared to those who work in the private sector. Because of the lack of medical supplies and his inability to provide treatment, Amos knows the community cannot appreciate him. He therefore sees this lack of appreciation of his work as health staff by the public as not rooted in his personal inability but as rooted in the health sector organization. The failure of the patient to understand the cause of the shortages in medical supplies can be rooted in the fact that in the past they used to get free medical care, secondly they fail to understand how medicine can be in the private

hospitals and it is not there in the public centres which causes the public to suspects that health staff use the medical supplies for their own financial advantage (See for example Mwesigye, 1999, Bennet et al., 1997). Although this is a fundamental factor in the lives of the health staff in Pallisa it is not known how much of this factor has contributed to the attrition and strike-related activities in recent times in Uganda. But certainly as seen from the data above it is one of the crucial factors affecting the morale and motivation of the health staff in Pallisa District.

5.2.2 Overcrowding: We have decided to work under the trees

The literature reviews on the impact of decentralization on health consumption in Uganda has showed that the consumers of health services have more than doubled (Hutchison, 1999; Okwi, 2003). Theoretically this increase has been attributed to the improvements in the health sector and its proximity to the house holds (Hutchison, 1999). Observation of all the health centres that participated in this study show that they are overcrowded. It is observable to see many floor beds particularly in the in-patient department at the (Health Sub-district). In these health centre for example, the majority of the in-patients sleep on mats with no proper bedding; most of those instead are covered in *"gomasi"* the traditional dress most women wear in Uganda. Patients here are mixed up. Children, women and men all are admitted to this one room ward, a 14 beds hall that was constructed by Care International (NGO). The out- patient department is not good either with people sitting everywhere as one health worker said,

The place is overcrowded... you cannot even have a space to pass...some patients sit

outside under the tree. There is not enough space in the ward. There is only one room for dressing, injection and prescription. [Personal Interview with, Male nurse Kibuku Health Centre, 17/0ctober/2003]

The place is so small for the population...when you mix children and adults it is dangerous because there are already cases of disease contamination here...you can see it now, these are for immunization, the other one is pregnant woman, she needs to be seen. One same room for everything... You cannot pass (interview with the, midwife Kadama health centre]

The congestion is too much and it might be leading to more sickness. See how people line up and when it comes to those inside it is the same thing. They sleep like that nothing to help them. You see these people need help that is why they come but see the conditions here are not very good. See for your self how dirty these places are. Is this the quality work we talk of? This ward should be swept every day but it can even take a week and sometimes we tell the carers to do the cleaning. You see in the past the cleaning was done on a daily basis, there was that person to do it, to make the beds and to ensure that the ward was cleaned but now it is not there (interview with the Medical Officer Bulangira health center)

Inherent in these extracts is increasing numbers of consumers of health services against the limited facilities (space) shortage. The out-patient department room is none existent in five of these health facilities that participated in the study. It is therefore either on the veranda or under the tree where treatment, consultation and any medical advice is given. People line up here under the tree for medical consultation, treatment, and even immunization. The inside room that is supposed to be the treatment room has one bed and because of the influx of patients, the health staff here operate their work under the trees.

The shortage of space and the inability to have separate departments like the pediatrics or the women's ward but rather a general ward is evident where

women, men and children are put in one ward. This apparent shortage of space can be attributed to the inability of the local government to expand the facilities, which is rooted in the economic decline in Pallisa and Uganda as a country. The direct relationship between these circumstances and the incongruity characteristics amongst the health staff is that such environment does not permit and motivate the health staff effectively. Implicit in the extracts above is an outright rejection by the health staff of this apparent condition of work, small space where the health staff have to perform their duties. The shortage of the space is directly linked to the economic inabilities of the district to construct more space, but its effect on the health staff and the subsequent consequences on the quality of care is the fact that it makes the health staff less able to do their jobs. The current condition, for example congestion and dirtiness inhibits their efforts in delivering services. Dirtiness or patients sleeping on the floor can result in more disease epidemics.

5.2.3 The workloads: We have more patients than before...

The increase in the workload, which has come as a result of increased consumption of health services, is an experience for the health staff in Pallisa. In this section I examine the implications and experiences to the workloads in an effort to tress elements of incongruity among health staff under decentralization.

Critics of decentralization argue that policy makers in Uganda underscored the importance of the health staff supplies (Bloor, 2003). Such critics argue that the planners relied on the assumptions that few health workers

would be manageable and efficient (See Uganda Civil Service Reform, 1995).

Unfortunately this lack of consideration for the workload of individual health staffs who are the actual implementers has resulted in increased workloads (Bloor, 2003).

As Lubowa, (1995) notes in his qualitative study on the impact of SAPS on the number of public health staff in Mbale District in Eastern Uganda, SAP programs led to a reduction in the total health manpower. These policies of cost containment led to overall retrenchment; hence the few staff that were retained have been struggling to cope with the increasing workloads. Although the actual number of health staff retrenched in Pallisa District is not provided here, the impact of public health staff rationalization and retrenchment in developing countries can give us solace to understand the extent of the problem in Uganda as a country (Bennett, et al., 1997; Bossert, 1998; Kiing, 2003, Lubowa, 1995). The result of these economic minded reforms has been that most health centres lack enough staff and those available struggles with increasing numbers of patients. For example data on the number of patients each member staff handles indicate an upsurge in ratios over time since decentralization. Although this study did not get specific data on workloads, there is surely an indication that by ratio health staff have more patients than at any other period. Although this increase can also be attributed to an increase in the population in Pallisa which has been growing at 2.5 percent, (See Uganda Demographic Survey, 2001) the

increases in diseases and subsequent decreases in the number of health staff under retrenchment can partly explain this phenomenon.

The experiences of the health staff with the increasing workload can be best understood as Abel and colleagues explain

We have too much work now...I come here in the morning and leave late in the evening...and even when I go home patients come crying for help and as a trained health worker I do help...so the work is too much...you see the communities are near the facilities and this is one reason why they come (Clinical officer, Bulangira health centre)

The majority of our patients are residents here; they don't need transport to come here so for any thing they come...and you find the place full. It is worse when they hear that they have brought drugs. (Interview with the in charge Budaka health centre)

In whatever explanation each of the respondents has tried to give, implicit are the ever-increasing workloads. The staff see the shortage of health staff and the increase in work load as a result of the District inability to retain the health staff that encourages attrition of many public health workers to private sector. It is suspected here that many health staff have either abandoned their work in public health centres or chosen to join other private practice. According to the district briefing, the district is losing experienced staff to wealth districts like Mbale and other wealthy Districts in the central region (Pallisa District Background to Budget report, 2002). In this study I found that many positions advertised by the district have not been filled. I later learnt that the district had suspended recruitment because they had not secured funding to cater for the staff. The study noted that the inability of the district to retain the health workers because of poor remuneration as

compared to other districts causes many to migrate or to abandon work in the public sector to go in the private, NGOS, or open their own business. Apparently, those health staff that remained have seen their load of work increase since decentralization. Given the above, a direct connection can be drawn between the health staff's aspirations, their desire to pursue their professional requirements and the limitations that are inherent in the health organization in Pallisa.

It is frustration because when he goes home the patients still come to him. This shows that the public in Pallisa recognizes the importance and values his work. Lack of alternative treatment makes the patient even follow him home since he is one of the few who are available for the population. The statement by the health staff that even when he goes home…his desire to have time with his family is limited because he has to be at the health centre all the time from morning to evening. Implicit in it is the health worker's desire to be with their families, the desire to socialize that has been denied to them because of the increasing number of patients.

The shortage of health manpower in Pallisa is well documented (HMIS Pallisa District, 2003; Uganda Ministry of Public Services, 1998). The study noted that most advertised positions at the district were not filled. In the absence of enough health staff, the available staffs have taken up the burden and their loads of work have increased. In the period of this study, there were long lines of out-patients waiting for hours before they could see the available staff, such that some patients who came in the morning were not

able to see the nurse or the medical officer on duty and were told to come the following day.

The government put health centres everywhere...but there are no staff. Patients come and line up and then because of delays their anger boils on you. We are forced to hurry through the work to try to see as many as possible...this is not quality services because as a health staff I am supposed to examine the patient from the head to the toe but when you attempt this...then you will hear patients screaming at you. (interview with the in charge Kadama health centre)

Because of the increasing number of patients, health staff members are forced to hurry to try to see as many patients as he can. The staff's desire to ensure that standards and all the procedures are followed is limited by the increasing numbers of patients; as a result he is forced to see as many as possible. Studies on the structural development of primary care centres in Pallisa indicate that there are more centres than before decentralization (Okwi, 2003) as a result of which the distance from the health centre to homestead has been reduced from 10km in 19990s to 5kms (Hutchison, 1999). On average hence as a result the patient find no reasons not to visit their centres. Distance in the past worked as a hindrance to public use of facility (See Mwesigye, 1999).

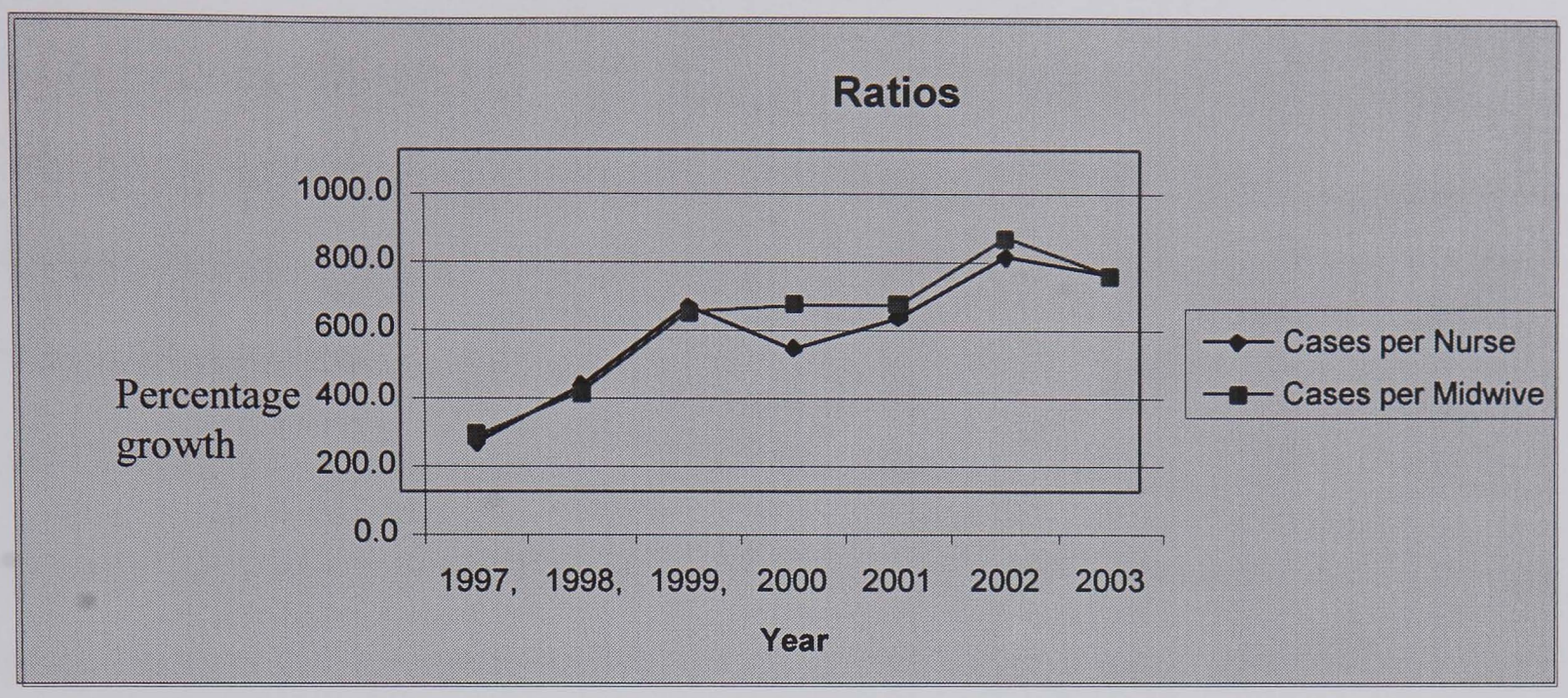
It is very important to note here that the construction and refurbishment of the health facilities in Pallisa has outpaced the health system's ability to staff and maintain them on a sustainable basis in Pallisa, hence most health centres which are supposed to have 9 health staff have four only. For example in Kibuku according to staffing norms and standards it is supposed to have two enrolled nurses, two midwives, two clinical officers, but the

current situation reveals that there is only one clinical officer, one Doctor, one Midwife supported by nursing aides hence the health staff have to forgo their other social life to stay at the centre. The apparent situation is made worse by the fact that decentralization has called for refresher courses, thus many health staff are always absent from the health facility, such that many standing health centres are un-staffed or understaffed and patient access to functional health services continues to be difficult and time consuming even if physical facilities are available. The relevancy of this is that given the increasing numbers of patients seen above, the few available staff continue to absorb increasing numbers of patients.

Under decentralization, different levels of health services were developed, bringing the total number of health facilities of all levels from 26 in 1997 to 32 in 2002 (HMIS Pallisa, 2003). But this left an imbalance in health staff. Doctors for example did not keep pace with the health staff growing in negative. For example the number of doctors was raised from 6 in 1997 to 9 active doctors in 2003. The number of nurses reduced instead from 51 in 1997 to 49 in 2003.[26] Midwives reduced from 47 in 1997 to 46 in 2003. Clinical officers increased from 17 in 1997 to 26(ibid) The district reliance on cheap labor is evident from the massive growth of nursing aides from 99 in 1997 to 117 in 2002.

[26] Data from 2004-5 had not been released by the time when I undertook this field work so it has not been included in the analysis.

Table 3 Showing the increasing workload by the nurses and midwives in Pallisa District 1997-2003



Sources: HIMS Pallisa, 2003

Although the increase in the patient volume is attributed to the shortages of health manpower in Pallisa, respondents here find a great connection of these increasing workloads to HIV/AIDS in Pallisa. The health staff here notes that HIV/AIDS has increased the disease burden in Pallisa and Uganda hence increasing the health worker's load of work. The number of infectious diseases has doubled in Uganda in the 1990s, (MOH, 2003). The increase in patients leads to health workers burnout to the extent that they cannot do their job properly.

Some of our colleagues may be 'ill'...and even when one dies it takes a long time for that person to be replaced...but the patients keep coming and that is your work...You see it is not only the patients who are affected by this disease but a number of health staff have been affected. Some have died, others are sick, and because of this those who remain really take up the burden...even losing your relative...you see when you go there for burial if he /she is your relative you will not just come so, it is a coincidence and that is happening. (Clinical Office, Budaka

health center)

The clinical officer notes here that the impact of HIV/AIDS on the health staff in Pallisa District has lead to loss of energy and absenteeism. A direct relation of HIV/AIDS and the workload of the health staff can be seen in the health workers inability to come and work because of the illness or because of the death of relatives.

The health staff therefore notes that "slim" (HIV/AIDS) disease increases the levels of absenteeism of health staff at the health centre because of illness or death of their relatives hence the load of work for those who remain increases making it difficult for them to do a quality job. Tawfic and Kinoti (2001), for example estimated that HIV/Aids accounted for anywhere from 19% to 53% of all deaths among government health staff in tropical East African Countries.

Although this study was not in position to establish how many health staff were ill, there were strong feelings among the health staff that this was the case thus patients volumes per individual health workers continue to increase making it hard for the health staff to perform their duties properly and especially causing more anxieties among the health staff than before decentralization.

The number of patients keeps increasing and increasing. I think that people are poorer now than they have been before and want to get treatment so they come here. You can see that from the figures since the government abolished cost sharing we have experienced more than double the number of patients so poverty levels and increased costs now pushes here...even those who used to afford private care now come here because they can no longer afford it. (Health staff, Budaka health

centre)

The staff sees the increases in the consumers of public health services as being rooted in the social, political and economic dynamics that have affected the whole population of Uganda. Health workers here have a feeling that the increase in-patients volume in public health centres is also attributed to poverty. There is evidence that costs and ability to pay for medical services are a greater deterrent to health seekers in Uganda (Hutchinson, 1999). The sudden abolition of cost sharing in public health centres in the 2001 presidential campaign offered the poor the opportunity to come, so they come in big numbers… According to Amos, the failure of the government to anticipate the increases in health seekers and its failure to increase the capacity of the health staff is to blame thus the available staff have continued to absorb an increasing numbers of health seekers. Amos therefore contrasts with Okwi's study in which he attributed the patient increase to the health sector improvement (Okwi, 2003; See also Muhwezi, 2003 as cited in New vision, June 23, 2004).

Reports on poverty levels in Uganda indicate that Ugandans are poorer now than they were 10 years ago (Kawanga, 2003) hence many cannot afford the private provider. Because of poverty therefore the majority of people find solace in the government health centres, hence with the shortages of health staff the few staff have had to cope with increasing number of Patients. The problem is that because of increased patients, the abilities of the health staff to provide quality treatment is constrained because he/she will have to go through faster to avoid the bickering of those outside, hence in the process

less attention is paid to the quality of care.

5.3 Decentralization has increased the levels of anxieties to the primary health staff

In the previous section, incongruity amongst the health sector workers has been attributed to the imperfections in the health sector organization, under-decentralization. The section has showed that the health staff is under-resourced and hence work under pressure which has caused discordance amongst the public health sector workers. In this section incongruity is examined from the individual health staff perception of their well-being, job security, and opportunities available for them as professionals.

Dusult and Dubois (2003) noted that planners of decentralization have paid much attention to the structural and financial aspects of the health organization, with less attention paid to the social, economic and workers' development aspect. They argue that the ability and willingness of the health staff to act in response to local demands depends on number of social-economic factors. These include a worker's personal family and an economic situation, the attractiveness of the salary levels and other terms and conditions of services, such as opportunities for professional growth and career development, alternative employment opportunities in the labor market (Mike Ostron, 1999). All these affect the level of motivation and morale of the workforce and can bring out or deter their efforts (ibid).

5.3.1 Decentralization increases job insecurity: Survival of the fittest...

Job security is very important in all aspects of public and civil service therefore most health workers as public servants do value job security highly. Jobs are their survival, thus they want to protect them and be sure they are safe. Decentralization has changed the employment status of the district health staff from being national public servants to local employees answerable to the District administration. This change has threatened the stability and security of employment for all public servants. Mwesigye (1999) for example had argued that the district will best cater for their staff, it will know who to employ because they have the knowledge of their manpower needs. However, the fact that districts in Uganda are based on tribes and clans can bring about unfavorable employment conditions such as nepotism, favoritism, which some have termed "technical know who" Mwana wani meaning whose son is he any way which can erode the impartiality in employment that the public health staff have enjoyed in the past under the centralized system.

You reach a time and ask your self whether you're secure here...job protection under decentralization is tricky...you are responsible to the local politicians who might have a different agenda. (Interview with the staff Budaka health centre]

You cannot be sure for how long you will keep the job...I tell you we are living like that. Anything can happen any time...it worries me here every day because what will I do at my age if I lose the job...but that is very common. (Interview with the general nurse Budaka health centre]

Here you cannot be sure of tomorrow...job security is no longer there and you can be sacked any time...this is worrying...you hear them say this Muganda is not our son so he must not be here...you see the problem is that they even want to sack us but they do not have the replacement (Doctor Malo, Budaka Health Centre, IV, Date)

We used to have unions like the national medical associations...these were very active but all these are not there any more and this worries us because these organization stood in the way of any unfair treatment on the job...they even protected those who were victimized...but these are all not there...tell me where does one go in case of this happening...we are now like chicks without the mother which when the kite comes can just swallow us. (Interview with the in charge Budaka health centre).

Inherent in these quotes is the insecurity health staff has about their jobs here in Pallisa. Job security is what the health staff want that is lacking under decentralization. The staff sees the local government as incapable of protecting them against unwarranted dismissal. The health staff's experience here is explicit about career uncertainty and an increased level of instability in employment under decentralization. The different agenda Amos refers to is the desire by local politicians to employ their own political supporters or relatives. These findings reinforce earlier studies that had indicated that job insecurity is increasing in Uganda in the past decade (Mwesigye, 1999). Lack of job security can cause what Susan Newell (1995) calls 'status incongruity', a situation of mismatch between the individual aspiration for career progression and the realities of the job.

These increased worries by the health staff about the security of their jobs is what Alice describes as an experience. At 56, the staff sees her self as more vulnerable and can lose her job; hence that makes her more worried. She

expresses the pain of uncertainty that she suffers because she cannot be sure whether it will be her next to loose the job. It has been theorized in chapter one that rationalization of public health sector personnel in Uganda resulted in early retirements and a massive retrenchment (Aitken, 1999; Assimwe, 1992, Sorensen and Vladsen, 1992). Retrenchment in Uganda resulted in unfair dismissal and redundancy of many public servants in a bid (ibid: 31). This increased the job uncertainties and who will be retained. These anomalies in employment has been recognized by the International Labor Organization (ILO, 1998) when they noted that:

"There is a significant increase in the number of people employed under precarious forms of employment contracts in the world..." (ILO, 1998)

Decentralization therefore is seen here by the majority of the health staff to have weakened the degree of their protection that they have enjoyed under centralization. Unfair work practice and dismissal are now common under decentralization, which causes a lot of anxieties to the primary health staff not only in Pallisa district but also in Uganda as a whole. The workers perception therefore is that the national public service rule does not apply, when health workers are hired under local terms and conditions of services. The ineffectiveness of workers organizations, and the national medical unions makes the staff very worried and to believe that he has no protection against unfair treatment in case of victimization. In this case the staff in Pallisa see the traditional national public servant unions as having been weakened by decentralization, hence it has exposed the health staff to all sorts of uncertainties in their employment.

Thus, incongruity in this case is that of uncertainty or and lack of certainty of employment which makes the health staff see them selves as more vulnerable to losing their jobs than they were under centralization which remains very stressful amongst health staff in Pallisa. The breakdown and passivity of the medical workers Union can be traced in the breakdown of employment norms and standards in Uganda (Kagwa, 2001). Professional unions faced with the financial shortages have become more passive and unable to protect the health staff. Hence the worry that the health staff sees here is what happens if they are victimized?

5.3.2 Political pressure: Erosion of the staff's autonomy...

In Uganda, as seen from the above structure, both the political and social services have been lined up and assumed to work together. The impact of this is that the autonomy that the health staff enjoyed in the past has been reduced and health staff attempts to maintain it have registered little success. However, decentralization being political philosophy, it cannot be implemented without active political actors. In Uganda these are in the form of local councilors, chiefs, and traditional leaders etc who are included on the health management committee at every health centre. However, health staff such as Dr Abel sees many problems with this mix of profession. Firstly, he is worried by the extent of politicization of the employment in the health sector. Although it was not possible to generate evidence of victims of political pressure in the form of favoritism or influences, such fears are

very alive among most health staff that nepotism has increased and consequently job insecurity increased under decentralization. For example, 17 different health staff interviewed admitted to the fears of political pressure. Health staff therefore are worried by the extent decentralization and the apparent exposure of the health staff to the likes of politicians as one staff summed it up

The problem here is pressure from these politicians...they interfere in the whole exercise of service...they are always around and trying to influence 'certain things' just to be seen as active by their voters. I cannot have time off because they are always there and wanting to see me here. (Interview with the in charge Budaka health centre)

They are here every day at the health centres...they want to be seen working so they keep around telling people lies...and when you tell the truth they say you're against the government and you lose your job...we do professional jobs and we have to tell the truth but this puts us in antagonistic positions with the politicians here...they say they are the people's representatives.[Clinical Officer, 43 years old, Budaka health centre]

The politicians are strong here...they say they are the representative of the government...if you don't follow their ways you end up being sacked. (Nursing Officer, 39 years old Budaka health centre)

The quotes by the staff and her colleagues in Budaka, identify the presence of the politicians at the health centre every day. Decentralization is a political philosophy such that it would function less without the involvement of the political actors. Health staff want to maintain their autonomy that they enjoyed in the past with less political interference, unlike to day where politicians are part of the management of health services under the health Unit Management Committee.

Politicians in Uganda are very 'strong'; they have the power to influence the sacking or promotion or otherwise of a public servant. The implication of this quote by a nursing officer is that politicization of personnel recruitment, deployment and management of health staff has diluted the professional public service in Pallisa. There is a general feeling that politicians heavily influence the appointment of the staff down to the mid-level position thus the majority of health staff here feel that the impartiality of public service that many public servants have enjoyed in the past has been weakened by the decentralization policy. Influence peddling has made the dismissal or transfers of health staff almost a universal occurrence in Pallisa and Uganda as a whole. The nursing officer therefore sees decentralization as having increased the patronage system. Almost all the respondents in one way or the other identified such patronage in the form of who is to attend workshops and during the selection for those who are sent for further training, and promotions on job. Tribalism, political favors and all sorts of patronage are very rampant in Palisa.

The Bagwere, which is one of the tribes in Pallisa, want to see that their "sons" are favoured over the "Itesots" tribe. This seems to be a cause of contention. Incongruity in a sense can be seen in the form of patronage system, favoritism, influence peddling that has re-inforced the separation between job performances and job reward in Pallisa. Those given jobs are not necessarily qualified, but that is of no concern as long as they have got support from the politician or a big man. This situation threatens the job impartiality and security that the health staff used to have since all health

staff under centralization were employed though the public services, which helped to reduce elements of influence peddling.

5.3.3 Wages and Benefits: We get much more but it is useless…

In this section, empirical data from the field shows that the health staff in Pallisa want to maintain a standard of life and lifestyle that they had before decentralization. Advocates of decentralization have argued that since decentralization, the wage of the health staff has increased (Okwi, 2003). Such a conclusion aims to depict that the health staff are better off under decentralization than before, which is not necessarily true in Pallisa. Analytically using the empirical data and quotes from the field in Pallisa, this section argues that the increasing inflation that Uganda has been struggling with since 1980s has made the wage valueless, hence creating inconsistencies in the life styles of the health staff in Pallisa. Secondly by use of the qualitative data, I argue here that there are discrepancies in the salary structures, which has created inequitable wage imbalances to those who do the same type of job hence creating a feeling of being marginalized and deprivation amongst the health staff in Pallisa.

Theoretically, adequate and equitable remuneration, timely payment of wages and benefits and satisfactory working conditions are very important for the performance, productivity and motivation of the staff in whatever work place, be it health or else where (Suzan Newell, 1995, Cooper and Marshal, 1979). It removes the feeling of exploitation and inequity among

the staff. However, the economic crises that many developing countries like Uganda are struggling with means that countries such as Uganda may not afford a living wage for their public sector employees, hence causing them to experience life style inconsistencies. Studies on the impact of decentralization on the health workers' wages indicate that health workers salary had increased since decentralization and that the wages are paid on time unlike before when health staff could take months before they got their wages (Okwi, 2003, Mwesigye, 1999).

The problem that most health workers faced during the economic crisis in Uganda was delayed wages (Mwesigye, 1999; Bennett, et al, 1997; Mwabu, 1999; Mcpake, 1999; Otim and others, 2003). Although there is recognition by the health staff of this apparent money wage increment, apparently this increase does not permit the health staff to maintain the life style they used to have before the SAP. Absolute figures on the wage dynamics in Pallisa since decentralization were hard to come by, but health staff accounts show that the increase in monetary wages has not matched the economic inconsistence in terms on inflation, such that even though the take home package has slightly increased, it does not permit the health staff to fulfill their obligation of taking their children to school, paying for housing and generally maintaining a reasonable standard of life that befits the health staff:

We get more money than we used to get in the past but it is useless...the previous salary was small but was valuable...I could live on it, and save some money but

now as you get it as you spend it...it is useless. (Interview with the Male Nurse, Kadama Health Centre III, 15th/October/200).

Implicit in this quote is the realization of the valueless ness of the money that the staff in the above quote gets as wages today. Devaluation has been a major stabilization tool in Uganda since the 1980s. It has in most cases had a depreciating effect on the wages and incomes and resulted in price increases and higher cost of living. This in turn affected the day-to-day survival of the health staff hence making him fail to maintain his life style. The staff therefore sees the effect of such reforms as located in the increasing cost of living against declining real wages and incomes.

Data on the average price index in Uganda for example shows that between 1986 and 2002 the average price for goods is estimated to having gone up by more than 100%. Using the consumer price index for 1986 and 2004, it is evident that by 1986, the cost of a Kg of sugar was UGSH 50 as compared to the present UGSH 1500 in 2004 (Ministry of Finance and Economic Development, 1987a; Background to National Budget, Uganda 2004).

The impact of the inflation on the public sector workers can be seen in the increases in prices and the fall in the wage value, making them unable to purchase the necessities of life for themselves and their families. Incongruity therefore can be seen in the form of health staff's failure as a parent, to fulfill his social responsibilities of providing for their families, to see their children go to a 'good' school and be able to solve some of their personal problems. The reasoning reflected here by the health staff goes

beyond their individual wants but touches on the social responsibilities that the society puts on them and the increased hardship an ordinary person goes through in this poor district. This apparent need to and failure to do it has left many frustrated and less motivated in working for the public, as one staff put it

I need to be sure that as I work on other people my child is going to school, she is feeding well but when you work and come back your child has been chased from school, then it is not good. I cannot work for a thank you because that alone cannot sustain my family and me. My children as I talk are out of school...I need to pay up to Uganda shillings 400,000 but you know how much I earn her (,Midwife, Kibuku health centre]

Evidence in this quote is the apparent limitation that Alpo faces. Her child cannot go to a 'good school' because she cannot afford the school fees. Mwesigye, (1995) cited in Bennet (1997) notes that health staff in Uganda appreciate working in rural areas because their children can go to a cheap school. Whether this is true or false, the fact from Alpo is that such schools are of poor standards. These are UPE schools meant for poor parents, in which case the standards are so low that one cannot imagine joining the University from such schools. In the past because the health staff were able to take their children to good schools, they enjoyed a greater level of respect. Incongruity here therefore can be seen in the inability by Alpo to be able to pay school fees and keep here child at school. She sees the government failure to increase her wages as lack of appreciation for her job; hence this lack of it has caused anxieties to her.

Similarly, Amos sees the impact of decentralisation in a social context with

reference to the social expectation from such a profession like a health worker. In order to keep the traditional status in the society, Amos as quoted below feels that the position of material things like house and ownership of personal car defined them and brought with it respect and social status

Look, society expects us to have a house and a car. I can't buy a house...I cannot buy a car...I feel sitting in the emergency car, a public vehicle which is overloaded with some people sitting in the boot with my patients as humiliating...Sometimes when I am about to go and sit in the boot, patients tell me to sit in a proper sit and they sit in the boot..." [Nursing officer Budaka Health Centre, 15th/ December/2003]

...I am deprived and not happy...you see my family is in Kampala and I cannot even have time let alone enough money to go there. If you cannot see your family because you do not have enough money them, for whom are you living? It is a situation the government has to address as soon as possible or else the sector is being diverted from its objectives (, In charge Budaka Health Centre)

Clinical Officer...When people see you working every day they come to you especially relatives...they need this and that and you cannot give...it is very painful. I tell you last week my aunt's son was chased from school because of school fees but I could not help...these are things that the society requires of us...we need to be able to extend hands because we were also helped but we cannot. Relatives begin to say so cannot help (Clinical officer Kadama health centre, 2004)

Inherent in these quotes is the apparent social-economic discordances and inconsistencies that the health staff face here in Pallisa and the desire to maintain such standards. The respect, which the health staff enjoyed before, depended on their abilities to provide treatment but above all their identities as working staff were defined by their abilities to be able to buy a used car, and have a house in town as a show of prosperity. Amos does not want to be seen in this crowded 'matatu' and feels it is degrading for him to sit in the boot of the car or squeeze himself instead of having his own car.

Unlike in Europe, public transport in Pallisa and Uganda is one of the worst I have seen in my life. In a Matatu that is licensed to carry 14 passengers, in Pallisa it carries up to 30 passengers, with some passengers sitting while others are sitting on others not to mention with those who stand all the way, referred to here as 'tuula- ku kameme' literally meaning stand or quote here... The respect and high esteem with which "doctors" or all health workers are regarded in Ugandan society can explain this feeling. Health staff here as a model of the communities want to have their own transport, be respected and look different from the rest of the population. But given their wages, they are bound to use public transport under duress hence increased anxiety. This economic hardship has made health staff feel deprived.

The staff sees the impact of decentralisation as a cause of deprivation. His feeling of deprivation is rooted in his lack of time to go from Pallisa to Kampala where his family lives and the financial difficulty for him to provide for his family. His desire to meet his social obligation is constrained by lack of time and above all by the inadequacies of his wage to mitigate his personal responsibilities. It is a social responsibility and a measure of social status in the Ugandan society to be able to provide for the family and to the extended kin, the failure of which is what the staff sees as deprivation. It is therefore right to argue here that the economic hardship that the majority of health staff face in Pallisa has resulted in life style incongruity which can be also seen in life style inconsistencies amongst health staff in Pallisa District.

5.3.4 Inequitable Work Allowances: We deserve equal pay ...

While the previous section has dealt with the reduced value for wages and the sky rocketing cost of living that has resulted into a low standard of living for the health staff in Pallisa, this section identifies another element of anxiety amongst the health staff. Data from the interview show that the imbalances in the wage given to health workers by different Districts are a major cause of anxiety among the health staff in Pallisa, as can be seen from the following quotes

We all came from the same training and we would expect to be paid equally...for example, I do feel bad to here that the other staff who does exactly what I do, have the same qualification earn more than I do. It makes me feel so marginalized (Health staff, Kadama health center)

For sure those in Mbale get more money...it is very difficult to get a job in districts like Mbale or Kampala. I applied there but I was not considered because there are many people applying to work there...you see the District gives some good allowances and that can keep you going. Here there is nothing, so that by the time the months reach in the middle you have nothing left... (Clinical officer, Budaka health center)

Our colleagues in other places tell us how much they get and we compare...you will see that you're so behind them...it is painful and you begin to think whether you are less qualified than him...we need to have equal pay because we do a similar job. He is dealing with malaria, Aids patients, placating women so we do similar work but they get a better appreciation package... (Interview with health staff, Budaka health center)

The quote from these three respondents indicates the increasing levels of anxiety about the remuneration system in Uganda. The staff in the above

quote for example is concerned about the inequality created by decentralization system that causes them to be marginalized because of the places they work. Explicit in these data is the desire by the health staff to be treated equally since they do same type of work and they have the same qualification. The apparent imbalances in wage system therefore as explicitly identified from the interviews have resulted in a feeling of marginalization by the health staff. The data therefore confirm the report to the district council that as a result the district was losing the staff to the neighboring Districts and may give answers to why loss of health staff to other richer Districts is taking place. Relatively richer districts like Kampala have the resources to adjust the wages and the top up allowances to their staff but the opposite is true for the poor districts like Pallisa.

Evidence from the field here shows that although, there is a national salary standard for all health staff Uganda, work based allowances are determined by individual districts (Mwesigye and others, 2003). The impact of decentralization on the management of the health sector has been such that the central government has entrusted all the responsibilities of staff management to the district this includes the payment, management and other functions.

Nevertheless, comparative analysis of the top up allowances between Pallisa and Mbale District in 2003 for example indicated that a top up allowance for a clinical officer Pallisa was UGSH 50,000 while a clinical officer in Mbale earned UGSH 150, 000= in Mbale. Health staffs in Pallisa are upset about

the increased levels of inequities in the pay system. The data therefore shows that the decentralization policy as applied in Uganda promotes the principle of ability to pay for the staff which when applied has resulted in an inequitable pay system, hence health workers in Pallisa want to be treated like other in other district with similar wage levels.

The imbalance in the pay system has various implications on the health staff: Firstly it means that health staff working in the wealthier districts like Kampala, Mbale and the Central region earns more money than those in disadvantaged areas like Pallisa. Secondly, it also makes it difficult for such poor Districts like Pallisa to attract well qualified and experience health staff let alone to retain those they already have, as one officer at the District administration told me

The policy causes a lot of anxieties amongst the staff. Health staff respond to highly paying areas and a district like this one (Pallisa) will have a problem having good staff...we keep getting them here but we cannot retain them because they read in newspapers and see job advertisements in areas where they pay good allowances (Personal interview with the Chairman of the District Administration, Pallisa District, 23rd/January/2004)

Bob therefore sees decentralization as a threat to the concept of equal pay for equal work in Uganda. He observes this fragmentation in the labor policy as damaging. Hiring of personnel through two or more different mechanism lives a lot of anxieties. Implicit here is the differences in contracts in employment, i.e. local and national employment of health staff, that have resulted in different labour mechanisms for remuneration and conditions for the health staff with the consequences that two health workers

who hold same type of post and perform similar task have different earnings, hence health staff in poor districts such as Pallisa feel marginalized because of the wage levels and top up allowances accorded to them by their district. Incongruity in this case therefore can be seen in the change in pay policy and the desire by the health staff in Pallisa to be treated equally in terms of remuneration since they have similar qualifications and do similar kind of work.

5.3.5 Career and Professional Development...

Perceptively, there is an overall acceptance by both policy makers and health staff that the skill demands of the jobs in the 1990s as seen by the people in those jobs are dramatically different from those of the past (Kiing, 2003). The new demands for skills therefore has set a challenging agenda for the need for training and personnel development in Uganda and most countries that are carrying out these social economic reforms.

There is evidence that the government of Uganda with the help of donors have spent millions of dollars on training of health staff, to achieve an "integrated" level of services. (See Ministry of Health Budget Report, 2003:113a). According to government bureaucrats it means "few but efficient" health workers thus having health staff with all-round knowledge. However given the fact that this funding is donor given, these efforts by the government are facing a lot of constraints, as one health staff rightly put it

We want to be able to get our staff to go for further training in appropriate skills, but most times we are reluctant to release them to go for further training...there is severe staff shortage in that there may be no one to cover for those who do go a

way for training... (Interview with the in charge Budaka health Centre IV, 31st/March/2004)

The in charge sees staff shortages as a cause of limitations in training. Shortages of staff in Pallisa are well documented (HMIS Pallisa, 2003) thus the staff above sees that if all staff are released for training the centres will remain without staff. These are the complications and yet the jobs require new skills. Implicit here is the desire by the health manager work in charge to release the staff for further training, which is not possible because among other things the staff shortages. Published literature includes few examples of improved professional development opportunities as a result of decentralization. In many countries with poor resources, decentralization has instead reduced the prospects for developing and maintaining skills (Kanu, 2003; Wanda, 2003). But some health staff sees this in different perspectives

Maybe the district does not have the money to offer the training and you also know about this district...it is very poor and if they don't get grants then they can do nothing. But I think corruption is also increasing, such that the funds secured are not put to proper use. It also shows the lack of prioritization by the politicians...they only think of the structures, not knowing that without the staff such structures will be useless...that is the problem, (interview with the staff, Budaka health centre)

While recognizing the apparent poverty situation in Pallisa, Amos sees the problem of lack of it as rooted in reduced training budget allocation, isolation from national training opportunities and the weak local training capacities for the lack of appropriate capacity building opportunities and skill development in Pallisa. Although evidence from the data shows that there is some sort of training at the district and at the health facilities, health

staff such as Amos and Alpo however perceive that such training provided is sub standard and see those who get such training as half baked and not capable of handling patients.

Therefore using this empirical data and responses, it can be argued that although there has been an increase in the quantity of training provision in recent years in Uganda, there are several indications of training gaps: a "gap" between what is required by employees, and what they are actually getting from the training.

This perception by the health staff is rooted in the short time framework for the training, which is precipitated by resource shortages which Amos both attributes to both poverty but they also recognizes the elements of corruption and misappropriation of funds by the bureaucrats. The staff also sees the problem as rooted in the lack of prioritization in which case he recognizes the need to develop skills as much as the health structure. It is perceived here therefore that resource shortages are the reason why the government has abandoned the training of nurses and has resorted to training of nursing assistants called nursing aides. As one health staff explained:

Imagine these so-called nursing aides...they train for few days and they are brought here to work...they know nothing and I think the authorities are putting the public in greater risk. When they are posted here, because of the shortages in the staff, we entrust them with patients...some of them even dispense drugs (Interview with the Midwife Kibuku Health Centre IV, 18th/April/2004)

In this quote, the midwife mentions two important aspects: the attempt by

the government to resort to cheap labour (nursing aides) and the danger that it brings to the quality of health service delivery. Although the health staff here want to have continuous training, the resource shortages precipitated by the economic crisis under the SAP program in Uganda does not allow the local government to deliver such very important ingredients. Alpo though sees it as dangerous to under train the health staff who deal with patients.

There is apparent acceptance by the health staff here that as a result of resource shortages, training does not last long and everything is done in hurry without any due consideration for the services they are going to provide. One can therefore argue that incongruity in this case amongst the health staff is experienced in form of their desire for the 'right training' and the lack due to resource shortages in the District.

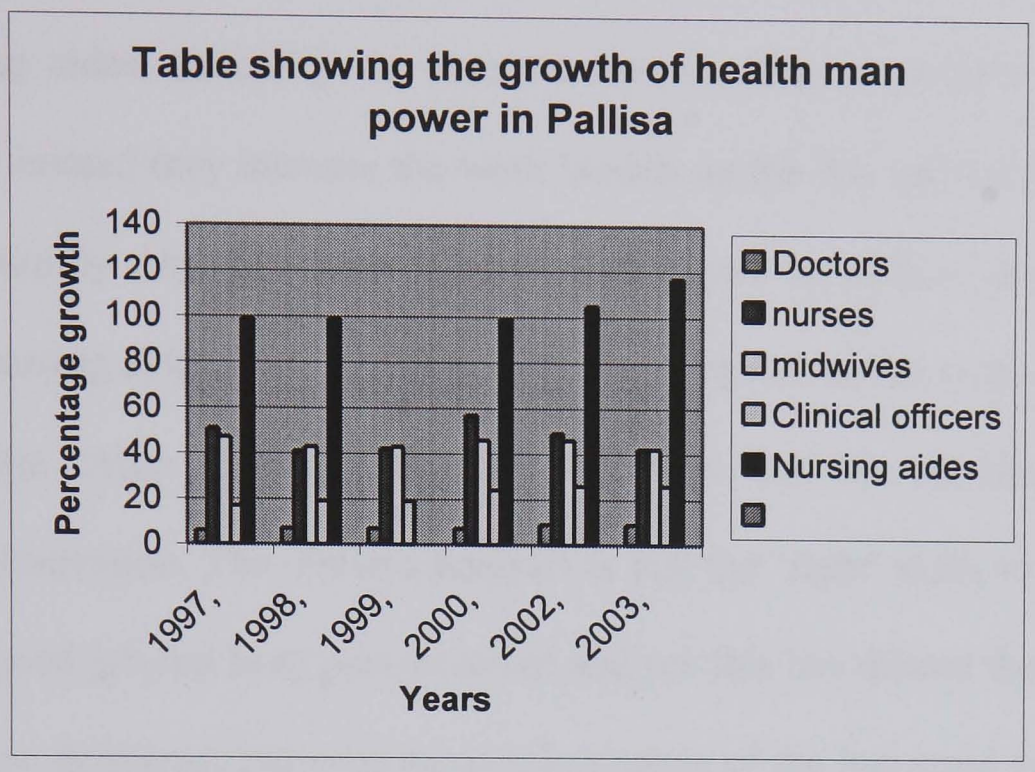
A checklist of the staff training records at the District during the study showed that a number of short courses are conducted in Pallisa. These are district and health facility based trainings in the form of staff work shops and seminars. The course contents of these seminars include patient management, community based care, dispensing, and treatment of illness with the majority of attendants being mid-level health service providers such as clinical officers, but mostly the nursing aides.

The obvious inference from this is that the economic hardships that the District of Pallisa experiences have pushed the local governments to look for the cheapest ways of providing treatment, thus major training opportunities for the health staff in Pallisa have been compromised. Lack of

training opportunities and skill development to which most health staff aspire is therefore increasingly a cause of anxiety and stress among the health staff such as Alpo. Evidence from quantitative data, as seen the table 4 on page 198 below, clearly shows that the local government gives priority to training lower cadres such as nursing aides at the expense of other traditional groups such as the midwives, nurses, etc.

Analytically therefore, it is right to conclude that since the nursing aides are relatively cheaper as compared to the medical officers and comprehensive nurses, midwives etc, the apparent policy on training under decentralization is economically precipitated in Pallisa but not quality focused. To understand this apparent analysis, data on the wages of different health staff help to show the basis of this decision by the local government. From the data, one can observe the differences that in 2003 the salary of the nursing aides for example is Uganda shillings 150,000 approximately (£43) a month as compared to the comprehensive nurse who is paid anywhere between Uganda shillings 300,000= and Uganda shillings 400,000= approximately ($145) Although such a decision makes economic sense, the implication is total denial of training opportunities for the health staff in rural areas and consequent reliance on poorly trained manpower to deliver health services in Pallisa. By use of the table 4 below, one can see the impact of such decisions on numbers and type of health staff development in Pallisa since 1997, the year when decentralization in health sector was implemented, to 2003 when this study was conducted.

Table 4 The growth of health manpower in Pallisa 1997-2003



Source: HMIS Pallisa District, 2003

From the table one can observe the steady growth of lower cadres such as the nursing aides, and clinical officers at the expense of almost stagnant growth of the rest of the health staff. Observers here warn that this will affect the quality of health services and that entrusting health services provision to less qualified people directly affects the quality of services. But more so it will lead to what Suzan Newell, (1995) calls the "role overload" a situation where the demands of the jobs will exceed the abilities of the staff, and this endangers the quality of health services delivered to public.

Nursing aides cannot do anything; they know nothing...most of them are those who failed senior four...when you work with them you do most of the work. They keep coming to you for advice...you see there cannot be guess work in the provision of health services because we deal with lives. (Mid Wife, Kibuku Health Centre IV, 18th/April/2004)

Alpo sees the apparent trend of greater attention given to nursing aides in two perspectives. Firstly she recognizes the need for the right skills to do a quality job, which is likely to be affected by the dependence on ill trained nursing aides. Secondly she sees the nursing aides as knowing nothing; hence instead they increase the work burden on the few qualified staff. The assertion by Alpo that 'they keep coming to you for advice' aims to show that nursing aides know nothing hence they depend on her to do their work all time. Alpo therefore sees the skill gap that has developed under decentralization. The obvious analysis is that the 'right' skills to be able to do a good job has been compromised and see this has diluted the quality of services delivered, but even more it is a cause of the increased workload to the few competent staff in Pallisa, hence increasing anxiety.

On the other hand other respondents see the need for training and the lack of it in different ways relating it to a competitive world and a world full of unemployment

You see we need training to keep up to date with the demands of epidemiological changes...it is good to be up to date then you can deliver services with knowledge. It also provides you with an instrument to keep your job secure...I am respected and accorded with due respect because have some training, but if this is lacking then that respect can never be realized...this is what we now face under decentralization. Such opportunities are hard to come by...under decentralization the government is paying much attention to putting in place working norms paying less attention to workers skill development. Working here means you have been cut off from opportunities because of the remoteness (Clinical officer Bulangira health centre)

Training opportunities as viewed by the above respondent are not only an

important aspect of performances and good quality of services provision as it provides up to date skills, but it also provides him with job security and other benefits that goes with it. The staff in the quote is concerned that in a global competitive employment world, lack of skill development means that he will remain uncompetitive in the labor market.

Implicit in the quote therefore is the realisation that it is not enough to develop and implement staffing norms across the country at the time of reform, but that allowances must be made for skill variations based on epidemiological distribution of interventions and provide opportunities for skill advancement. By use of empirical data, I have attempted to show how the health staff see the gap between the training and the actual skills required by the health staff to perform the duties created by the decentralised systems.

5.4 In a dilemma: Self-Preservation, Self-image and survival strategies.

In this section, by use of qualitative evidence, I argue that both the economic and psychological hardship that decentralisation has placed on the health staff as seen in the previous section has motivated the health staff to look for survival outside the public sector. In this section therefore unlike (Mwesigye, 1999, Bennet, et al., 1997; Mwabu, 1992; and Okwi, 2003) who present such activities and actions of the health staff as a cultural givens precipitated by the health staff's desire to make more profits, evidence provided here aims to show the opposite and present the view that whatever action health staff have taken has been an attempt to maintain the life style in order to survive the biting economic crisis felt by all people in Pallisa District under the economic

restructuring of the 1980s and 1990s.

Since the implementation of decentralisation in the health sector in the Ugandan context took place in the overall economic restructuring programme requirements, the social economic hardship experienced by most Ugandans has become part of the experiences also faced by the health staff in Pallisa. The curtailment of spending and the removal of subsidies, which are some of the conditions of SAPS, significantly reduced the buying power of the salaries of the public servants country- wide and plunged many below the poverty line (see for example Mwesigye's analysis of the economy of Uganda under decentralisation). The obvious analysis therefore is that such economic background has made those employing the health staff fail to meet their demands, hence affecting the life style and social position of the previously prestigious profession, creating what Suzan Newell 1995 calls status inconsistencies.

By use of the empirical data therefore, this section attempts to analyse the kind of activities the health staff in Pallisa are engaged in reflects the health staff explanation why they do such activities. My study argues that activities that the health staff have engaged in Pallisa are strategies to survive and therefore contrast with earlier studies that health workers just neglect their work in the health units in search of more profitable opportunities. Mcpake (1999) for example concluded that most health staff in Uganda engage in private practice, drug pilferage, backhanders, and all sorts of business outside the public health sector such as drug shops, mobile drugs sales, etc.

5.4.1 Survival strategies: How health staff make ends meet in Pallisa

This section attempts to provide further elaboration on what sustains health staff and how they survive the unpredictable and adverse conditions that confront them in their work place and daily lives as individual and members of the health profession. It was theorised in Chapter one of this thesis that health workers are engaged in various activities outside the public health sector. While others have regarded this as a cultural given for the health staff in Uganda, it is important to understand that the health staff are not passive to the problems of economic and work environment which has changed during the economic restructuring.

As seen from the preceding sections, the health staff are poorly remunerated, cannot afford to maintain a life style with the wages provided under decentralisation. Secondly there is increased anxiety that the health staff have over the period under decentralisation because of the decreasing social standards, their inability to maintain a life that befits them and factors related to their employment environment.

Going by this analysis therefore is that the declining state support system to the public health workers in the face of declining real wages and increasing cost of living in Pallisa under structural adjustment programmes necessitates their desire to move beyond their expectations from the government. However, the health staff's survival depends on basic resourcefulness, individual abilities and aspirations, which aim to maintain a standard befitting

a professional health staff. This is evident in their survival strategies and for that reason confirms the perception that health staff in such conditions develops their own strategies for survival. Therefore what emanated from their extra work outside the formal health sector are strategies for them to maintain a reasonable life style.

The fundamental issues here therefore to be answered are: what kind of activities do they engage in? How do the health staff see those activities in their social arenas and how do such activities define their social position in the society?

The type of activity engaged by the health staff in Pallisa depends on individual choice, abilities which also entails having money, but inherent in all is the desire to live a fair life of a profession. Such activities range from private practice, which may mean having their own clinics, drug shop or whatever, but others engage in activities that are unrelated to their professions, sometimes turning their workplaces into mini-markets. Bennet et al., 1997, Mwesigye, 1999; Okwi, 2003; the conclusion that most people get from the above literature is that of the market orientation and desire for money precipitated by the economic liberalisation and the introduction of markets in the health services in Uganda. Apparently one can observe the change in attitude by the health staff at work as one consultant observed that,

Before decentralisation, when I entered a ward, nurses asked about the conditions of their patients or some such work related issues, but now when I come in the ward they tell me they are selling vegetables or working in the markets (Interview with the in charge Kadama Health Centre III, 17th/January/2004)

Implicit in this quote is the apparent need by the health staff. Health staff

faced by their needs to survive under such conditions have been conditioned to think more about their survival than perhaps their patients. Self-preservation is the principle of existence but this does not mean that they no longer want their patients as the likes of Mwesigye, 1999 and Okwi have depicted them. Although the staff in the above quote aims to relay how the staff in Pallisa were more concerned about the patients and saving lives in the past and how that perception has been reversed with health staff caring more about their survival, the obvious analysis in this is the declining state support system which in any case has laid bare the health staff with need to maintain a life style: the health staff think more about the vegetables and their work in the markets.

5.4.2 Selling Malwa for survival...

Approximately 14 out of the 19 mid-level health cadres in Pallisa directly or indirectly accepted doing any other activity outside the public health facilities. The activities engaged in by health staff varied depending on the individual health staff and their abilities; critical analysis of the different activities engaged in by individual staff reveals some social characteristics such as position, gender, and seniority of the health staff.

For example 10 nurses (including midwives) told me that at one time in their lives have been engaged in such activities like selling vegetables and brewing Malwa (Local brewed alcohol) as compared to the majority of medical officers who were mostly engaged in more profitable private practices. The sale of malwa is not a prestigious activity as it has in the past

been the work of the unemployed, poor and villager. In fact whoever sold malwa was regarded the poor person. The turn of the health staff to these activities does not only reflect the desperation most health staff have in Pallisa, but it depresses their social status if they engage in activities such as these.

However those who operate such businesses were doing it because they wanted to supplement their earnings as the nurse explains below.

You see the money we get cannot help ...I must get money to get my children to school that is why I sell alcohol... A number of people come and they buy it all. (Interview with a nurse in Kibuku health centre, Pallisa District)

You see for me I cannot afford to do any other business because I do not have the money so I survive on this one...those with money have opened big businesses but I have no way so this is my survival. (interview with the nurse in Budaka health centre]

The nurse's attempt at a universal explanation is steeped in economic inadequacy in the support system that she gets from the government and the pressures she as parent has to endure under decentralization. The nurse here perceptively acknowledges selling 'malwa' as an alternative means to mitigate her daily welfare and meet their daily demands like school fees for their children. The social dynamics here show that the majority of the health staff involved in this kind of petty business are nurses of all cadres. Nurses sell malwa so that they get money to help their families, pay school fees, pay rent and buy food...it is a means of survival. The implication of these activities, however, for the quality of care is that apart from making the

health staff less motivated at work, it reduces their time at the health facility and increases the cases of absenteeism. The nurse in Budaka would wish to do other business to earn more income but she is limited because of her income. She looks at selling malwa as her only way to survive. Asked how much time she spends in these activities, she accepts that she spends a great deal of time although she found it hard to be exact on how much time she spends since this work also includes night activities.

5.4.3 Turning to cultivation as a strategy...

While health staff that have some form of financial capital can engage in the malwa business, some health staff have resorted to peasantry cultivation. As in the previous section, this changes the whole perception of how the health staff are regarded. Farming of peasantry activities is not prestigious; it is the survival of the poor as it provides them with food. The old perception about farming in Pallisa has been that it is for the unemployed rural people but not for the working class. This perception still holds in Pallisa and most rural parts of Uganda (See Kiseka, 1995 cited in New vision, 15 March 1992). However, the data shows that some health staff have resorted to petty farming in order to support their families. The problem here is not the involvement of the health staff in farming since it can provide food for the family and supplementary incomes, but the involvement of the health staff a public workers in such activities has changed his social status and the way they view themselves not as people of high status but reduced to a level of a peasant! As most health staff explained, implicit in the health staff's involvement in these activities is the desire to maintain their families, to be able to provide basic

necessities such as food and take their children back to school.

In order to get more income, I have to cultivate all sorts of crops... sometimes I get the little wage that I get here and hire people to do the work, but most time I have to get up early in the morning so that by the time of going to work, I have done some work on my garden. (Interview with the, Male Nurse, Kadama health centre)

Elements of compulsion, lack of choice and suppression of agency are the issues for the health staff like referred to here. Cultivation may be seen as some health workers' solutions to finding a living in this difficult situation but if health workers do so their level of commitment at the health centre is reduced.

Asked about the impact of such extra activities, most staff noted it as negative. That is the impact of such activities on the health workers performance in the public health services is negative. Those engaged in such activities end up being late at work or abscond from duties as he notes. *The whole thing is negative because doing such activities takes a considerable time to plan and generally to think about it. Even when you have to work sometimes you get there late. The commitment to work as a health worker is destroyed...you either come late or do not come at all...but we have nothing to do...it is beyond our control (Interview with male Nurse, Kadama Health Centre)*

The ensuing consequences of pressure of work both on his *shamba* and in the health centre are an obvious psychological torture to the health staff in this extract, and even more the loss of commitment to public work is very apparent amongst health staff. What appears to annoy the respondent though is the government's propensity to neglect and failure to offer a living to the health staff.

As a worker however, he is virtually powerless in getting the government to honour the obligations to him as health staff. Hence it is right to argue by the use of this quote that the health workers now, unlike before decentralisation, are more motivated to looking for extra incomes because the government cannot offer them the required support. Together with this analysis is that the implication of the health staff's search for survival will continue to derail the quality of care and that unless the needs of the health staff are met the, government effort to promote health services will not produce results.

5.4.4 The clinic and drug shop business

Presently, drug shop and medical services in Uganda are considered very profitable, such that those who engage in it must have the resources. The liberalisation of the medical services in Uganda at the time when the health staff was faced by the need to survive has been received by the health staff in Pallisa as an opportunity to be seized. Earlier studies on the informal activities such as drug shop business, and clinical services reveal that such activities are very profitable. Mesigye for example in his study noted that an average income from such businesses is at the level of the wages for the public servant in western countries (Mwesigye, 1993:27).

It is suspected for example that doctors in the central and western parts of Uganda seek opportunities to sneak out of the public hospitals so as to earn an extra income in the informal sector (Macrae, 1997). Four (4) of the six Doctors interviewed admitted to owning a drug shop or a private clinic in or outside Pallisa. By the same token 4 clinical officers also directly or indirectly acknowledged getting involved in medical service markets in form of drug

shops, clinics or private consultations. The social construction of those who are engaged in medical markets revealed here show that mostly senior staff have the abilities to do so since they have the security for raising some loans from the banks or friends to operate the business as compared to the lower cadres of the health staff. Those who do these activities justify them and do not see them as a crime any more and some feel it is something that has become part of the norms of the community. They justify this by noting that since the state has failed to maintain the public health staff, individual health staff have to look for alternative ways of surviving. Unfortunately the victim of all these activities is the poor of the society who among other things have depended on the public provision in the past, but those engaged in such activities have come to call it a way of life. In an interview with one intern, he summed up much of the feelings of the health staff in Pallisa

Everyone does it...otherwise how we would survive. The principle here is survival for the fittest. Every one has to diversify the sources of income and that is what it requires...if you wait for the salary then you are sleeping because the opportunities are there. I do this business (selling drugs and consultation) so that my family will have food, drink milk and live better. (Doctor intern, Budaka health centre, 2004)

The apparent analysis from the intern is that health staff perception, unlike in the past livelihood cannot be found in the public services alone but rather each individual staff is conditioned to doing some sort of work out side the public sector. His statement that everyone does it reflects the general perception in Pallisa that every health staff member is engaged in some sort of commercial activity. The health worker here lets us know that doing business has made him fulfil his social obligation of buying milk and food for her

children and perceives that she is better off than without this business. But she also makes a general statement that 'everyone does it'. There is a greater feeling that most health workers do some sort of business (Mwesigye, 1999, Kato and others, 2000). Such an assertion reinforces (Olsen and Garung's 1993) conclusions that as a result of decentralisation health workers in most developing countries look for alternative ways of living outside the public sector. This analysis emphasises that the search for such activities is economically motivated and that it is the utmost desire to maintain their families and to keep the standard that influences them to do these activities.

Self –preservation is the first principle of nature. When I come back from work my wife wants this and that, my children want books, I need money to save. I have decided to operate this clinic so that I can get some extra income...one cannot manage on the wages given by the government...it is so meagre (Interview with the in charge Budaka health centre, 2004)

Now it is difficult to depend on wages alone because the prices of things are always going up...even the price of water we buy to drink or sugar has increased...one has to work harder to be able to get some money. In the end you spend the whole of your life that way...? (Nursing Officer, Budaka health centre, 2004)

You have to be creative or else you starve because we are like orphans and that is the principal of life now days. We cannot depend on the government because our District is not the best so start up something and survive on that. We are not supposed to be doing this but what else can we do. (Interview with in charge Kadama health centre, 2004)

Because the state cannot offer an acceptable standard of life, health staff have to develop ways to make a living. The absence of support in terms of housing, school fees and medical care for their children and the unbearable cost of

living drives many to look for alternative means of survival. As noted in Chapter Four, one of the most negative aspects of SAPS was that parents have to pay exorbitant fees at school and medical care. Yet prior to that, he would have been entitled to some of these employment benefits as a health worker and most social services were subsidised. The real test of living as a health staff in Pallisa is the ability to manage these problems against the background of intense competition and dwindling opportunities.

The high cost and the dwindling work opportunities therefore have made it difficult for health workers to realistically pursue their aspirations. In the end there is a simple solution to the necessity that drives them into these apparent activities. In this case, not only are the health workers aware of need to look for alternatives to be able support their families, but they are equally aware of the lack of progress in the economy. When asked if anything could be done to improve the situation, one staff was perceptive but pessimistic in his assessment:

There is nothing that can be done to improve the situation of the health staff because of the way the world is going...it is getting more and more difficult and I don't think things will easily change. I think that more and more health workers will get involved in different activities if they have to support their families. (Clinical office, Budaka health centre)

The assertion that things were "getting more and more difficult" contrasts sharply with earlier claims by the World Bank and IMF about the efficacy of decentralisation in Uganda. Both the health workers' construction of the present economy vis-à-vis their aspiration is quite pessimistic and reflected

the Poverty Assessment Report that put Uganda the 13th poorest country of the world. (World Bank Report, 2002 cited in the Monitor News, Tuesday April 13, 2003). Inability by the government to sustain the health staff, poverty, the increasing cost of living, dwindling opportunities in the health sector and the need to support the family are recurring reasons for the health staff in many areas such as Pallisa to engage in these extra activities to raise extra income.

By this analysis therefore it is right to argue that the underlying impact of these extra activities cannot be taken as a just cultural given of the health staff in Pallisa, but must be seen in the increasing failure of local government to provide acceptable standards of living for the public health staff. The health staff action however does not project just their needs to amass wealth but, the actions project the inconsistencies between the opportunities that they have as public health workers and their aspirations, and resonates Bennett's (1997) argument that working in the public health sector accentuates the 'dissatisfaction' for the health staff. Participating in these businesses broadens their incomes and provides the opportunities to move beyond the traditional life of an average health worker in a decentralised Pallisa.

5.5 Conclusion

This chapter set out to analyze the impact of decentralization of the health staff. Two analytical issues are presented: social status of the health staff and its relationship to the quality of care. The chapter therefore analyzed health staff's perception of the self during decentralization in which they show a falling standard: the unmet aspiration which I term "status incongruity" and

how the health staff attempts to realize those aspirations and the implication for quality of primary health care.

In Pallisa, we have seen that under decentralization, two major themes cross-cut the lives of the health staff inside and outside the decentralized health facilities: professional identity, which entailed recognition for doing quality work from both the health organization and the communities, and the survival strategies which have been necessitated by the desire to maintain a status and life style befitting a professional health staff.

The chapter has argued that the status of the health staff is determined to a certain extent by the structure and the operation of the health sector, the family and personal needs of the staff, and the certainty and career prospects that the organization allows that define the identities of the health staff. The obvious analysis of this chapter however is that the inherent desire to do a quality job, the need to maintain the life style that the staff have enjoyed in the past and the failures to achieve it given the low investment in the health sector faces.

It is clear however that most health staff's choice in Pallisa was mediated by the nature of the flexibility of work practices that allows supporting personal families, adequate and equitable wages and recognition as a professional for doing a good job. However it is right to argue that such aspirations have not been possible to realize hence the health staff in Pallisa live a life inconsistent with their aspirations, what I have termed status inconsistencies (incongruity). The centrality of the desire by the health staff to maintain a life style and the failure of the state to meet their needs is what is presented

here as a driving force behind the much publicized activities by the health staff in Uganda. Private work represents their own pursuit of their own strategies that will mitigate the worst circumstances instead of looking to ineffective government solutions.

There are several factors that have determined the health staff's position; however it is possible to conclude these are mediated by the centrality of poverty and the influence of the background of poverty. The unfavorable conditions are in themselves existing because of the government inabilities at the micro level to organize the health sector in a way that maximizes positive development and promotes the status of the health staff; and the continuing failure of the political economy through critical adjustment policies only serves to underline the hopelessness of families.

Private practices outside the public sector therefore cannot be taken as a cultural given amongst the health staff in Pallisa, but rather be seen as an indicator of the problems that the health sector faces today.

CHAPTER 6: THE QUALITY OF PRIMARY HEALTH CARE UNDER DECENTRALIZATION: THE USERS AND THE PROVIDERS PERCEPTIONS AND EXPERIENCES

6.1 Introduction

The review of the literature in Chapter 2 clearly showed that aspects of the primary health care reforms, such as the impact of such structural changes on the quality of prescriptions, privacy and the confidentiality, proper use of drugs, costs both direct and indirect and transportation facilities which link to the process level of the quality of care are still scanty within the literature domain of the health sector decentralization in most developing societies such as Pallisa. And in most cases, the use of the views of providers and the users of primary health care to construct knowledge about the impact of decentralization have rarely been considered in most studies.

In this chapter, by use of the qualitative data I describe the relationship between the decentralized organizational and financing structure of health services described in Chapter three and the quality of primary health care delivered. The chapter examines the process and the outcomes of health service delivery from the perspectives of the users and providers. This chapter is also based on direct observation of six primary health facilities and clients' interviews between September 2003 and April 2004. Experiences and perceptions of 29 respondents (users and providers), men and women, about the quality of health care they receive and what they used to receive before decentralization are used here to construct knowledge

about decentralization and health service delivery. A comparison is drawn between the services they used to receive before decentralization and what is actually delivered today. Major observations were done on the six primary health centres of Kibuku, Budaka, Kadama, Kabweri, Bulangira and Molokokyomo, all of which are public health centres. Budaka and Kibuku are HSD; while Kadama and Bulangira are health centres three and Molokokyomo and Kabweri are health centre twos at the Parish levels (refer to the structure of primary health care in Chapter four of this thesis). Observations and interviews were convicted on all clients with fever, cough, diarrhoea, while utilization was analyzed from responses of pregnant women during the normal Monday to Friday working hours (8:00 am to 5:00pm). These are top priority conditions because they appear frequently in the outpatient department.

For purposes of understanding the impact of decentralization on the quality of health services, I use various indicators of quality developed by Donabedian (1988) which among others include: availability of modern providers of health services, availability of medication when the rural people want it, quality of prescriptions, and the confidentiality and confidence of the health service consumers, and the cost of treatment both direct and indirect. As noted, client assessment of quality is as important as technical quality assessment because clients will only utilize services they believe are efficacious (Waddington and Enyimayev 1989). Accessibility is also measured in terms of real costs of obtaining services by the users, and the actual opportunities they lose while seeking for medical

care. Although this section makes references to the structural quality of the health services, much emphasis is put on the process and outcomes.

The next sections examine the utilization and demands of services by poor people under decentralization. The focus in this section is on the antenatal services, which is used as a proxy for all public health services. The purpose is to establish the trend in the utilization of public health services under decentralization. The choice of this intervention was because women are the majority users of primary health care in Uganda. These factors therefore can help to point to major factors affecting the use or (non use) of a particular PHC health intervention such as for example antenatal health services. The objective is to show whether decentralization enhances the delivery of primary health care interventions while analyzing how the users perceive the quality of services and how their perceptions influence their utilization of the primary health services under decentralization.

6.2 In their own experience: Quality or quantity of primary care in and out of the public health sector in Uganda

There is a cosmetically positive picture about the quality of the health sector structure under decentralization in Uganda. One such structural quality of care study was conducted by the Uganda Bureau of Statistics which concluded that as compared to the period before decentralization, the structures of health services are qualitatively better countrywide, although on the same note such studies noted that the majority of the facilities still lacked equipment and were under-staffed (UBOS, 2002). Various studies of quality have also argued that most health centres under

decentralization have got no medicine at all. Mwesigye (1999) for example argued that health centres under decentralization cannot offer any quality treatment because of the supply shortages, which have rocked the health sector in the past two decades. The limitation of such a conclusion is that an assessment of the primary health service improvement in Uganda has been focused on the structural quality through which the government and international donors have seen the improvement in health services, in terms of the availability of health centres within walking distance to the users (Hutchison, 1999). While recognizing those observations made above, this section analyses the process which people go through when they seek health services in the new structures and argues that availability of PHC structures has not always translated into the delivery of quality services. The perspective of the users is presented here on how they view the quality of services under decentralization while also drawing on their past and present experiences. For the purpose of the above, four components of quality are considered in this section: drug and other supply availability, accessibility to health services including distance, the direct and indirect cost price of getting treatment, and the quality of prescriptions, confidentiality. And patient satisfaction is addressed under such circumstances. [27] These components are more likely to be affected by the structural changes and consequently can affect the health outcomes and the health seeking behaviours of the health service consumers, which are partly the aims of the

[27] Availability of drugs, accessibility to health services including distance, the direct and indirect cost price of treatment, the quality of prescriptions and confidentiality and confidence of the user's information will affect the quality of care including utilisation behaviours. (Donabedian, 1988).

study.

6.2.1 Health centres are near but services are still far...

The distance that individuals must travel in order to reach a modern health provider is an important determinant of access to and utilization of health services (Hutchison, 1999). There is evidence to conclude that under decentralization the distance the patients travel to reach the health centres in Pallisa has tremendously reduced. Earlier studies indicate that approximately 77% of the population now lives in less than 5km away from the health centres as compared to 1993 when over 80% lived at distance of more than 10 Kilometers (Mwesigye, 1999). Visibly, government effort to reconstruct, and build new health facilities has increased the number of primary health centres in Pallisa from 24 in 1997 to 32 PHC centres in 2003 (HMIS, 2003 Pallisa).

The increase in primary health care structures in Uganda has made the government and international observers conclude that health service delivery has improved but also recognizes that the mortality levels have not improved (Okwi, 2003) which makes it obvious that such assertions of improved health services are based on the assumptions that availability of health service facilities would translate into service accessibility and availability of primary health services used in this work as a measure of quality.

By use of the data in this study, the picture depicted is quite opposite at best, the majority of primary health service consumers, for example noted that while the health structures have come closer to them under

decentralization, health services have continued to go further as noted

I come here because it is near my home...I am happy the facilities are within a walking distance and if there were drugs and medication that would be ok. But we come here not to get the actual treatment but rather to get advices and prescriptions and we look for treatment elsewhere normally, in the shops 10 kilometers away or in Mbale, which is still a long way. Getting medication (drugs, health staff, care) in these centres is by chance. You see, perhaps you were young but health centres used to have drugs...it is true they were very far Budaka... but the distance you walked was worthy for the treatment you would get but it is different...having these houses here does not help me because they in themselves will not give us treatment... (Unstructured Interview with Norah, health user Kibuku health centre, 04/02/04)

We have very good facilities...surely these are better than what we used to have (dispensary in Kibuku), but if there was medicine and health workers, there it would be better so that one does not have to go anywhere for treatment... For me I have walked from Molokokyomo to here...it is about 15 kilometers but there are health centres all the way but there was no medicine so I came here because I was told that they have treatment (Unstructured interview with Jessica, Health user, Kibuku health centre 06/02/04)

I don't think the planners thought about this... but if we had few centres...for example if we had only one health centre in Kadama sub county such that the resources are put there, with a doctor and good equipment, it would be better than having all these ones which some of them open half days. I think the planners thought of impressing the electorate with this massive program without looking into the available resources to run them. See we are told to clean...is this the way? We come here because we are sick and we should be treated like sick people, not again being told do this and that... (Gimbo, Health user Kadama health centre, 17/02/04)

There is an overall appreciation and acceptance that decentralization has brought health facilities closer to the household in Uganda. This

is one of the positive results in as far as the decentralization under the NRM[28] government is concerned. The government efforts to construct and refurbish the health facilities have brought health facilities closer to the population such that facilities are spread all over the surrounding villages as seen in Chapter four. This was in response to a household survey in 1988 that concluded that distance was one of the biggest deterrents to health service consumption in Uganda (UBOS, 1997-98). Such structural studies also concluded that the structures of the health sector which included the houses and wards were improving (See Hutchison, 1999, Okwi, 2003). Whereas this is true, this study noted that within the health structures, there are rarely treatment and medication, which is the main concern of most consumers such as Gimbo, Jessica and Norah. Major complaints of health seekers were the drug unavailability at the facility, of frequently being asked to buy drugs elsewhere, or under dosing due to limited medical supply. Getting treatment by chance which the respondent refers to here support the conclusion that sometimes but not always drugs are available at the health centre. The records show that on rare occasions some drugs are available at the health centre, especially during the first 6 weeks of quota of kit supply. Although most respondents did not refer to the period before decentralization, the fact that some respondents, such as Gimbo and Norah, talked about the past in reference to drug and treatment availability in the public health centres suggests that they were aware that there were more drugs and better treatment than what they were getting under

[28] National Resistance Movement is the ruling government, which came to power under the leadership of President Yoweri Kaguta Museveni.

decentralization. In most cases as a result of shortages, most times patients are written prescriptions and asked to go and buy medication elsewhere. Certainly this was a feeling of most respondents who said that if by chance you get some treatment it will be half, and the other half you have to find by your self as noted

It may take more than one-month health workers tell patients that there are no drugs. They tell patients to go and buy drugs from shops. But I personally have never bought; other people buy most of the time (Unstructured interview, with Talisuna, 58 health service users, Kadama health centre, 13/03/04

"I was given some treatment, but most of the drugs that were written in my 'book' medical form were not there...but I was given some panadol and I had to buy the rest..."(Unstructured interviews, Kadama health centre, 15/03/04

The drugs stocke cards seen showed that drugs were out frequently for the whole 8 months during the study. Drugs are supplied through drug kit system quarterly from the national medical stores unfortunately the quarterly supply according to the study lasts less than six weeks of the intended 12 weeks of the quarter. There is little evidence however, to show that drug absences in the health centres are related to drug leakages, but rather the shortages are inherent in the supply chain from the centre which many attributed to shortages of funds to secure enough supplies from the importers of pharmaceuticals. Evidence in this study therefore contrasts that of the earlier studies, which had attributed these chronic shortages of medical supplies to leakages (Bennet, 1997; Mwesigye 1999 and Okwi's 2003, Mcpake, 1999) and assertions that health workers were responsible for these shortages. Even when drugs were in stock, the study noted that

between 7 in every 10 patients per day were asked to buy some sort of medication indicating that most types of drugs (expensive ones such as the syringes, antibiotics) were not there with most patients being given panadol and aspirin which did not cure the intended diseases.

Experiences of being asked to buy drugs were very severe within the maternity section; in outpatient centres the main other supply item often mentioned by either health workers or health users being asked to buy gloves. Gloves for example appeared to be invariably sold rather than given to maternity patients, and many patients brought their own in order to avoid time wasting in going back to buy (they knew that if they came they would be told to go back and buy). A number of mothers narrated that health workers refused to undertake delivery or check ups without gloves, citing HIV/Aids risks. This was one of the predicaments mentioned by the health staff in Chapter five in which health staff resorted to keeping a pair of gloves for sale so that the eventuality of having to deliver without gloves can easily be avoided.

A count of the available gloves for example showed that there were in Kibuku health centre sixty pairs of gloves in the five basic and two complementary kits supplied to this units. This is the biggest referral unit with an estimated catchments population of 100,000 plus. This meant that there were fifteen pairs available monthly to deal with an estimated average of 40 deliveries, which clearly was insufficient. What really is clear is that the policies have alienated the government from the needs of the people, throwing them into an abyss of suffering and hopelessness in which health

seekers have found themselves in the past two decades.

Me I think the government does not have the money...you see nobody can understand what is happening. Where did the previous government get the money that they used to provide the treatment? Everything was free such that it was you the patient who would refuse to go the hospital but now it is the opposite. You have to reach for your pocket all the time...if the government cannot assist then we are all going to die because people like me cannot manage even to buy a full dose of panadol. Things are getting worse every day...things that used to be free are now sold to us...the situation is not getting better...Kadondi... (Unstructured interview, Budaka health centre, 2004)

I don't think things will improve...it has been like this for a long time. I think things are getting worse every time...I am sure about this... (Tadewo, health users, Kabweri health centre, November 2003)

The respondents' assertion for example that things were "getting more and more difficult" contrasted sharply with the earlier claims by the government and international donors about the efficacy of decentralization and its ability to bring services closer to the needy in poor areas such as Pallisa (Hutchison, 1999, Government of Uganda, 2003). Alpo, Kadondi and Tadewo's construction of the present economy vis-ă- vis their health needs was quite pessimistic and reflected the hardship primary health users face in Pallisa. This pessimism shows that health outcomes had deteriorated in Uganda in spite of several years of reform efforts under SAP. The reasons cited by most participants include – absence of medication, being told to buy their own drugs, poverty which when summed up led to increased difficulty for the ordinary families. The critical role of government and its inability to provide free health services and its multi-faceted implication in the use and delivery of quality primary health care is well articulated and represents an

experience to those who seek the services when in pain.

6.2.2 It is even very difficult to manage diseases...

In a situation where individuals are responsible for buying and determining their treatment, it becomes very difficult to manage and control the spread, or even reduce pain for those deemed poor in the society. This was the feeling among the majority of the respondents, especially the health staff. For example almost all the health staff in one way or the other mentioned this issue as being one of the problems many health service promoters are facing under decentralisation as noted:

You see the majority of the people in Pallisa are poor people...they expect to get free treatment but when they come here even with pain, we tell them to go and buy drugs in the shops. Some of them buy but those without money return to their homes and suffer in silence. But even those who buy may not have enough money to buy a full dose, so they may opt to buy what will reduce the pain for the time being and this is more dangerous (Personal communication with Health worker, Kibuku health centre, 20th /02/04)

When you come here, the health worker will tell you go and buy the drugs...I think they assume that we have the money but sometimes we don't have the money...and it is expensive. When my child fell sick I decided to go direct to the shop and bought some quinine but the child was getting worse and worse, so I have now brought him here but even here I am told to go and buy...I cannot manage to buy the whole dose so I will buy what my money can afford (Unstructured interview with a patient, Kibuku health centre, 17th 02/04)

I am sure that people don't buy full doses... they buy what will reduce the pain and when the pain gets worse then they come to the health centre...so you find that the patient spends more than what he/she would have spent. But this is because they are poor and cannot afford...where can some one like that woman (one with a child) get the three thousand shillings to buy the full dose? The other issue is that

most of the drug sellers are after money...they give any type of drugs, even the one which has expired...these are not medical professionals and they are after money, so you find that they give a cocktail of drugs to the patients. These days the previously very effective chloroquine does not work with malaria because the malaria is becoming resistant to the drugs because of poly-pharmacy (interview, Health staff, Budaka health centre, (15/03/04)

Implicit in these quotes are a number of fundamental policy issues, which reflect the experiences of the primary health users in Pallisa. In the quotes are very fundamental policy issues of quality of care; management of patient when they get ill; and the resulting resistance of diseases to the medicine because of poly-pharmacy and poor utilization of medication, which they buy from the private drug outlet. There is an overall acceptance first by the health staff that the managing of disease has become more complicated due to public health inefficiencies and the health staff's inability to follow the way patients use the medicine they buy effectively.

The health staff noted that the inability by the patients to afford the full doses drives them to buy half doses of the required medication, which provides no cure to their illness but rather promotes the period of illness. The respondents in abilities to buy a full dose of treatment is rooted in their economic inadequacies and poverty which has characterized many in the past two decades of Structural Adjustment Programme at the time of ever increasing cost of medical care.

From the data, the respondents also recognize the irresponsible behaviour of the drug dealers, who some respondents noted give any type of drugs irrespective of what has been written on the prescription notes. Self-medication is well documented in Uganda (Mesigye, 1999; Bennet

1997 and Benna, 2003).[29]

Accordingly, some health staff concluded that it would be difficult to manage the way patients take treatment because the health staff do not control the quantity and the process of how the patient takes the medication, hence one cannot say that quality services are being delivered. Although most respondents did not refer to the period before decentralization, the fact that they were aware that in the past medicine was given by the dispenser, confirms their knowledge of the differences in quality of medical services and how they feel about it.

Elderly patients such as Nsenye, for example, noted that in the past most drugs were given in the health centres at the dispensary and the nurse supervised the way patients took drug, which is no longer possible since patients now determine how many drugs they want to take or buy at any one time. This is the opposite: with the absence of the medication in the public health facilities, most drugs are now a tradable commodity; some are offered by the professional health workers, but the majority by the ordinary person as long as he/she has had capital to start a drug shop or a clinic. The respondents noted that the private drug seller has no concern about the plight of the patient, has no ethical concern and are more troubled by how much money they can make, hence they give any type of drugs without proper prescription (cocktail) even any type which is not meant for that

[29] In Uganda the majority of the people buy their own drugs. This ranges from buying in the shop, in the market, drug shops and pharmacies. There is massive poly pharmacy in Uganda with some people who sell drug being non health staff, as long as they have the money to start the "business" (Assimwe 1999) This is because most health facilities do not have drugs most of the time and the patient in Pallisa depends on out of pocket purchases of drugs from the drug shops who are now the middlemen between the pharmaceutical importers and the consumers.

particular illness. Respondents noted that people come to see the health workers after they have taken various half doses of medication hence there is an overall recognition by several respondents that the disease that used to be simple to treat and manage has become resistant to the usual chloroquine and quinine tablets because of the poly-pharmacy hence the quality of health care measured in terms of well-ness of the patient and the level of disability and loss of time the person takes to recover when sick. So the conclusion at this stage of study suggests that in poor districts such as Pallisa where medical supply is insufficient in public facilities and the treatment is the responsibility of the sick person, then the provision of quality care is far than being achieved.

Poor management of drugs and the inability of the health staff to manage and supervise the patient treatment, the inability of the patient to buy complete doses and the irresponsible behaviors of the drug sellers who are the results of economic liberalization of the late 1980s and 1990s are some of the reasons given for the above conclusion. The study noted that SAP programs such as decentralization which has encouraged a situation which necessitated the individuals to be responsible for their own social needs such as health services, and reduced the public funding for social services, has put more people in untold suffering and increased poverty. The next section examines the prescription dilemmas under decentralization under the situation mentioned above.

6.2.3 Prescription in form but not in content...

Prescription is adopted here as a measure of quality of health services because it determines the type of illness and it directs to the patients the kind of treatment they are supposed to have. Three major important issues of quality of prescription emerged from the respondents: Absence of prescription materials so people are asked to buy their own books; not being given medicine after examination; patients being not well checked because of many patients and inexperienced health workers.

6.2.4 Prescription or advice on where to buy drugs...?

The majority of health users interviewed noted that what used to be medical prescription has become a "medical advice" on where you can find which drug, implying that the health users in Pallisa get the prescriptions at the health facility, but are told to buy drugs elsewhere, as some health users noted,

You see in the past when you went to the hospital...it was a must that you will be checked properly by the health staff, and given the medical form to go to the dispensary to get free medication, but now we get notes in our books directing us to what kind of drugs to buy not to be given at the dispensary...I have seen the dispenser most of the time but rarely do people go there...after you have seen the doctor...you have to go elsewhere to buy drugs (Personal interview with Gimbo, Kibuku health centre, 2004)

Implicit in this quote is an expression of frustration by the patient's interpretation of the current delivery of primary health care. The inefficiencies in the health sector in Uganda are such that while prescription can be done at the public health centre, rarely do patients get the prescribed treatment, rather patients such Gimbo are instead asked to go and buy the

medicine from other outlets such as drug shops, markets and pharmacies. This condition is now universally adopted in Uganda's public health centres as a measure of cost sharing where patients now know that they have to improvise when the need for treatment arises. Although the majority of respondents did not refer to the past, some patients such as Gimbo noted that in the past after prescription, the patient was given medication. While also recognizing this situation, Musana for example in his attempt to refer to the past noted that medication in the past was given as soon as the prescription had been completed:

It was different because when the nurse or the Doctor had finished seeing you, the next step was the dispensary...drugs were given to you free. It was prescription and medication, not again being told to ride your bicycle to go and buy medication elsewhere...that is really frustrating when you're ill or you have a sick person because what you want is medical attention from the centre... (Personal interview with Musana, 56 Kadama health centre, 2004)

Just like the earlier respondents, Musana noted the difficulty in prescription and the dwindling quality of it. The difference he sees here is in terms of being prescribed the treatment and actually getting it, which is not possible today in Uganda due to the financial difficulties most decentralized districts such as Pallisa have found themselves under devolution, which dictates the quality of treatment to be availed at these centres.

6.2.5 Buying the prescription forms...

Although direct cost sharing was abolished in public health centres in Uganda after it was found to be counter-productive (Mwesigye, 2003; Okwi, 2003) indirect cost sharing in the form of buying prescription materials is still going on in most health centres in rural areas. In all the health centres

visited the patients noted that they are now asked to buy their prescription books which replaced the medical form five that used to be given free to any out-patients or in-patients, as one respondent noted

Even the prescription forms are not there, such that we have now been asked to come with our own books where the information about our sickness and treatment is written, then you go and buy (Personal interview with the patient in Kadama health centre, 21/03/04)

I remember when you went to the dispensary in the past the nurse gave you a medical card, it was free and you did not have to pay for it, but now we carry books like school children. See everyone has one...it is difficult some times when you don't have money, however little it might appear (personal interview with Nsenye, health user Kibuku, 2004)

For me I don't work...I know some people who have the money will say that a hundred shillings is nothing, but for me that is not little because I don't work, I have no source of money so it is difficult...(Personal interview wit, Patients Budak a health centre, 2004)

The current state of health services in terms of prescription in Pallisa is that patients are asked to come with their own books which are now used as a prescription form, replacing the medical form five which was used before the decentralization reform. Although not many patients referred to the past experiences where prescription forms were given free, their knowledge of such existence means that this is a big difference in their livelihood. The inability of the local government to provide stationery is rooted in the absolute local government lack of funds to be able to purchase the stationery, hence patients are now asked to improvise themselves. Although some respondents have seen the cost of the book as being not expensive (UG 100)

the fact that some respondents found it had to be purchased also means that it was causing difficulty to some disadvantaged people who have no source of income such as Naula. The overall observation at each of the health centres visited was that each patient had a book in his or her hand. The nearest picture was that of the primary school where pupils carry their books in their hands.

6.2.6 Even the nurses just touch you and that is all...

Notwithstanding issues such as lack of prescription materials mentioned above, respondents also noted that under decentralized settings there are the poor prescription procedures because of the lack of well qualified health staff.

These so called nurses now days are not well educated. A person who failed senior four or whose education stopped after finishing P7 is recruited as a nurse. Such people, what do you think they will tell if you come...won't she only touch you, look at your pregnancy and you go home? Yet in the private clinic if you pay, the nurse will examine you properly and tell you how your pregnancy is and even get you some tablets and other drugs...(Unstructured interview with health user, Bulangira health centre, 22/03/04

I don't know but I think that these nurses even don't know anything...they just look at you, ask questions...there is no proper examination. You see Doctor Okello was so good... he had very good nurses, they could check you properly but I think that these ones even don't know what they are doing... (Unstructured interview with Kadondi, Kibuku health centre, 2004)

I don't think these young girls know what they are doing...they touch you here and there and tell you to go...they keep asking you questions without telling you the cause of the pain. I think they are not well qualified to do the job... I have not seen it in the past but we are told that health staff in the past properly examined you and

told you what you were suffering from, but these ones, some of them are just like me...they don't know any thing...(Unstructured interview with Namajja, 38 Patient Kibuku health centre, 22/03/02)

We cannot afford to entrust prescription to people who are supposed to be dressers...in medicine there is no guessing because we deal with life but it appears that is where we have reached...the prescription must be done with a competent person who knows about medicine, not anyone... but the tendencies are that we are increasingly seeing the semi qualified people being recruited and taking on the work which they have no knowledge...it is dangerous... (Personal interviews with Alpo, senior midwife, Kibuku healths centre).

The staffing problem in Pallisa has already been described in Chapter four in which the most important factor for the quality of care was the limited presence of qualified staff and the presence of nursing aides. There is an apparent feeling amongst the health users such as the one above that the health staff in the past was more efficient than of today. *"These health staff are not well trained",* indicates that health users are aware of the inabilities of the nursing aides, but this is also related to the shortages of qualified medical staff.

What is clear therefore from the data is that decentralization promotes services in form but not in content with nursing aides going through the motions of what they have seen their seniors do without the knowledge to render it meaningfully. The situation explained above is certainly the impression of the majority of health users in the antenatal care and out-patient department.

Nursing aides, possibly with limited qualification, essentially ran most facilities visited. This has clear implications for the quality of services. For

example the visits to different facilities provides such conclusions in that most health units were staffed by under-qualified staff of the likes of nursing aides and general nurses with the exception of the health centre 1Vs, where there was a professional midwife and a medical officer. But even then the medical officer was rarely there, which means that the majority of work such as prescriptions and treatment rested on the lower cadres of the health staff of the likes of nursing aides who, provided services for which they themselves had little knowledge.

The issue of having a medical officer at the health III has been recognized by the Ministry of Health and it appears in the government proposals on health service improvements and strategic plans (Ministry of Health, 2003). The study noted that understaffing and using unqualified staff in Pallisa had led to under-treatment and irrational drug use where providers provide totally ineffective or palliative treatment for conditions with which they are not qualified to deal with.

If quality services are measured in terms of the quality of those who prescribe, and the information that they give which in many cases is very important as the primary source of treatment, then the quality of services under decentralization in many areas with similar social economic characteristics such as Pallisa would never claim to have improved. The conclusion given here is certainly the opposite to that given by the government and the international communities who see quality services in terms of structural development (Okwi, 2003) but this conclusion stresses the importance of the medical examination that a patient gets in the process

of treatment and its importance in healing. Absence of prescription forms and poor quality staff, which translates into poor information, are some of the reasons given for the above conclusion.

The study noted that quality of prescription is worsened by the fact that health staff, given their levels of workloads as seen in chapter four, spend less time with an individual patient in an attempt to see as many as possible amidst increasing pressure. The implication of this increasing pressure for the quality of prescription is that it means that proper examination is not done, as health staff struggle to see at least as many patients as possible under increasing pressure.

Abel like others sees the threat to the quality of prescription in form of incomplete patient examination. In his capacity as a health worker he perceptively mentions the limitation to do so, rooted in the limited number of staff and the increasing patient loads. Abel sees this as a failure of the local government to increase the number of qualified health staff to reduce workloads for individual health staff so to permit them carry out proper patient examination. In an attempt to hurry to see every one, the respondents noted that prescription is in form but not in content, as complete examination is not done because of the pressure of many patients waiting to be seen:

Patients wait longer...see I am alone here and have to see all those patients. It is now coming to 5:00 pm but some of those patients came in the morning. As a health staff you are driven by consciousness to rush through so as to ensure that you at least see as many as possible. This certainly means that you have to skip some stages so as to cover as many as possible. We are supposed to spend some time with patients, to properly examine them but that would be more painful for

those outside because they don't understand this, all they want is to be seen...it is getting worse because of the staff shortages and an ever increasing patients...(Personal interview with Dr Malo, Budaka health centre, 2004)

Clearly, in all health centres studied, patients waited longer hours to be seen by either the nurse or any health staff, which according to Malo has resulted from the health staff shortages in Pallisa. He like others admits that there are more patients now than ever before and therefore they wait longer time than has been in the past. The study noted that patients who wanted to see the doctor waited longer because the doctor was most times not available. This was the same experience even at lower levels such as health centre three where the clinical officer who served both as a main medical personnel was also most of the time involved in administrative activities such as meetings and workshops such that they were rarely there and the few health staff who remain at the health centres hurried through to ensure that all patients are seen without necessarily doing a proper examination. This was the case in most health centre and was mentioned by a number of respondents who thought examination of patients was not well done.

6.2.7 We spend more time running up and down and at the end you get nothing...

While the referral system looks very impressive from lower levels to the higher levels all throughout the five levels of primary health care, the absence of medical care at the lower levels means that patients in Pallisa move from one facility to another in search of treatment, which many related patients saw as another burden. This certainly overshadows the earlier achievements of bringing primary health care facilities closer to the

users, which most commentators have referred to as the sources for increased quality of care in Uganda. Most patients noted that despite the nearness of the health centres, the treatment is not most of the time there, such that they still have to walk distances to look for treatment. These circumstances made some patients see the social effects of moving up and down in search of treatment when they get ill, which makes them lose their valuable time for their domestic activities such as cultivation, which according to patient increases their level of vulnerability to hunger and poverty and ill health:

The problem is not the centres really...they are there but they are empty. When you go there they will tell you to go to Kadama and you're not lucky, even there you will be told to Budaka. I find it time wasting because while your busy moving today and tomorrow, the stomach will not stop from demanding. By the time you get well the time you have wasted is just too much...personal Interview with the user.

My son, may be you don't know but it is very annoying to come here in the morning and sit the whole day doing nothing and yet the stomach is demanding...it is now coming to 5:00 o'clock but the nurse has not yet seen me. I think I will go back home and come back tomorrow... You know we walked from Buseta to come here because we were told that the nurses here are good but we have not been able to see anyone... Personal interview with Naima, Kibuku health centre, 29/03.04)

I first went to Kabweri but there I was told that there were no treatment, then I went to Kadama but still the 'Musawo' nurse told me that I have to go to Kibuku to see the doctor. I have been coming here this is the third day but have not had the chance. Sometimes I go and buy drugs from the shop to give my sick child but I don't know...You see when your busy moving like this the weed is growing in my garden...no body is helping me there...(Unstructured interview, health user, Kibuku health centre 19th/02/04).

Some times when you think of the time you're going to lose...you decide to go to the shop and buy panadol...it is all the same, you will come back there. When my daughter was ill (she died) I was moving every day from one place to another hoping that I will get some kind of treatment...When I went to Kadama, some people said Kibuku was better so I went there but was all the same, I got nothing so I decided to go to Mbale...it was very difficult for us... (Unstructured interview with Namudaka, in Budaka health center on the 21st/02/04).

A number of issues are raised by the respondents in the above quotes: Time lost while waiting to see the nurse, time lost while walking from one health centre to another in search of the one with treatment and the opportunity cost it brings in terms of household activities, which accordingly makes them vulnerable to poverty and hunger at the individual levels. The study noted that the lack of medical supplies in most health centres means that those at lower levels are referred to higher levels, which are supposed to be well stocked. The inefficiency level described by the users clearly contrasts the government assertions that as a result of decentralization there is efficiency and certainly undermines the reformist's advocates such as Okwi, (2003) and the World Bank's assertion that decentralization would lead to efficiency in service delivery. Inefficiency here is seen by the respondents in terms of the time spent when seeking medical attention, which accordingly keeps them from their productive work. There is a strong feeling by the respondents that the time people lose before getting treatment now is higher than it was before decentralization even when primary health structures are planted every inch of the village in Pallisa, which again undermines the central government assertion that decentralization has brought about

efficiency by bringing services nearer the population. Time lost when patient are rotated from centre to centre in search of treatment was seen as an experience by users of primary health care:

When you think of the time you will spend running up and down, you don't wish anyone in your family should fall sick...it is all about money and time...I personally think that people now waste more time before they get meaningful treatment. Some one begins by going to Kabweri (HC11) and then to Kadama (HCIII) but it is all the same there is nothing, so that time is what I am talking about... (Personal interview with Namaja, Kadama health centre, 31/02/04)

I don't remember very well because I was young, but those who lived then tell us that it was not like this. Yes they say that health centres were very far but when you went there you could get treatment... You can go to more than three centres but you will not find the nurse until when you go to Kibuku or Budaka and it is by chance that you get treatment...treatment is rarely there" (Naula, patient, Budaka health centre, 13/04/2004)

Unlike the British experience where some one waits for months to see a GP, the Ugandan past experiences has been that drop in centres such as dispensaries were quick and patients who visited spent less time than it is now. One of the fundamental factors are the readily available medicine at each level of primary health service delivery, be it clinic or dispensary. Secondly the readily available well-qualified health staff that are able to do their work so efficiently is referred to by Namaja and Naula for example. The inefficiencies in the decentralized health sector in Uganda is rooted in the social economic inabilities, and the health sector funding shortages which makes more health centres docile, empty and inactive due to supply shortages. The study noted that attempts by the district to recruit qualified staff fell short of resources to retain and motivate them and the attempt to

equip and provide medical supply is met with budgetary deficits. This finding corroborates a study which examines the waiting time as a measure of quality of care in the hospital environment (Benna, 2001), which suggests that the problem in the health care delivery is the same, be it primary, secondary or tertiary, since the cause of it is the financial limitation which makes more health centres inactive. Time wasting while moving from one provider to another, waiting to see the only health staff available, are some of the recurring reasons for this conclusion.

6.2.8 Paying with their feet: Money is now your "brother"...

Not only has the opportunity cost of getting treatment by the patients increased as seen in the previous section, but under decentralization there is evidence to show that the financial requirements of getting meaningful treatment have actually taken a new shape, which has changed the way people see money. The perception of the majority of health users in Pallisa was that their household expenditure on health has more than doubled in the past decade as one respondent summed it up:

Money is now your brother...if you don't have it even when you produce all your biological brothers you will die...it is money because if you have it, even the nurses will look at you and you will get "good" treatment...this is what is happening so when you get ill you now think of money, how to get it and where to get it. It is a very difficult moment because if you don't have what can you do...? (Personal interview with Kanyago, health user, Pallisa, 2004)

I am sure I pay more than I have ever paid in my whole life, the government catered for our medication, and education was subsidized. Now we are carrying a very big load because we have to ensure our survival. In the past we paid the tax

and the services were there ...but now we still pay the tax and also pay for the treatment...have you not heard about your brother? It is money now or else no one will care about you. I have already paid so much that I don't know where I will get more to complete the treatment... (Personal interview with Musana,in Budaka health centre, 2004).

Akin and others' (1998; Hutchison 1999; Mwabu and others 1994) studies of the determinants of health service consumptions noted that more than anything else, financial costs are a hindrance to health service consumption in many African countries. The experiences by the majority of health consumers in Pallisa such as Musana for example suggest that the ever-increasing costs affect their health service consumption. Musana's perception is that payments for health services have increased over time which he attributes to the purchase of medical treatment, transport costs, and other medical examination such as prescription books and laboratories in case one had to undertake one which is all the work of money. This perception is shared by others health seekers:

You see now these centres have got nothing...they are like churches and treatment really is not there so we have to buy our treatment...See I bought this book it is the first step in getting to see a health staff...these are not provided as we used to. You have to buy the book by yourself...it is my 'ticket' where the 'Musawo' health staff will write the treatment...you don't expect to be given anything free...everything you have to buy by yourself nowadays (Unstructured interviews with health seeker, Bulangira health centre, 11th March/ 2004).

In the past we were given the cards...we were not asked to pay for anything...Medical cards and treatment were in the hospital and were given free. I cannot understand how things have changed that we now have to buy the book for your child and also buy one for yourself in case you fall sick. It is certainly expensive...you people with money may think a hundred shillings for the book is small but we cannot have it ...we cannot know why this is happening...

(Unstructured interview with, patient Kibuku health centre, 2004)

I came to see the doctor but he asked me to buy a book... then later the "Musawo" nurse wrote for me the type of drugs I had to buy in the book...I had not carried any money so I went a round begging other people who had brought their children to lend me a hundred shillings and buy the book. I felt more pain because if I was not going to have it then the child was not going to be seen by the doctor...it is money now everywhere...(Unstructured interview with Kanyago, 56, health seeker, Molokokyomo health centre, 3rd/03/04).

Authorities on quality assessments note that quality care must not be expensive according to the work of (Donabedian 1988). The study noted that out of pocket expenditures on health had increased with the majority of patients buying their treatment from private sellers such as drug shops, and private clinics by the patients. The estimated cost of the dose of chroloquine is approximately Uganda shillings 3000 (£1) while that of antibiotics is Uganda shillings 4000 (£1.25). This means for example that a patient who has been prescribed both drugs will have to raise Uganda shillings 7000 (2.50) at minimum to get a full treatment. This cost does not include transport or accommodation type of health care. The study noted that while the amount can be seen to be small, in the case of the majority of the people in Pallisa who have no source of income, it has put a tremendous pressure on them. The conclusion reached here corroborates what Mandan (2006) called the "Marketization" of public goods in which he concluded that household expenditures on health was more than 70% over and above what used to be before structural adjustment programs were implemented in Uganda.

This study noted that expenses, which have now been routinely introduced

at all levels of health service delivery, amidst dwindling economic opportunities, have put financial pressure on the service seekers. This conclusion falls in the literature domain of the critics of SAP which argue that, because of the global wide policy of cost containment within the public sector, pursued by the World Bank, the funding for social services has been curtailed, leaving most interventions such as primary health care under-funded (Mwesigye, 1999). What clearly is observable analytically is that these additional costs mentioned above have not only led to tremendous increases in the demands on the household to increase their expenditures on health but have put such pressures on the poor families to do so if they are to get meaningful treatment.

Many respondents mentioned the increased requirement for money which is now being interpreted here as "Mugandawo", meaning money has become the real brother because it is now money not the blood relative who can help when you get sick, a comparison most respondents drew in relationship with the past when you only needed someone to take you to the health centre when you fell sick, unlike to day where even with so many relatives, without money you wouldn't be able to get any treatment.

The question that many studies have ignored is how do they buy the drugs, where do they get the money to buy treatment? These issues are explored in the next section.

6.2.9 The question of paying: We now sell anything in the house to get treatment...

The literature on the patient's dilemmas in getting money to pay medication

indicates that some patients borrow the money to go to hospitals (Spar, 1994). For this reason alone, Spar concluded that SAPS (structural adjustment programs) had drawn the poor into debt (See also Mwesigye, 1999). While this applies to many wealthy areas, the opposite here is true since given the poverty levels, borrowing is at best not well conceived, but rather of most respondents interviewed, the majority noted that they have sold some kind of property before they came or bought the treatment. Properties commonly mentioned included food items, chicken, goats, cattle and household properties such as bicycles. Selling of properties and household items was very diverse as noted in the quotes below.

When my child fell sick I cried to myself because where can I get the money...I don't have a husband to pay for me, I am a poor woman, where will I get the money to buy this and the other...I thought my child was going to die. I have never sold food before but this time I had to do it because what can we do? The ideas that selling food was a taboo seem to be no longer working because we only have food and can only sell food in cases such as this... (Personal interview with a user 46, Kibuku health centre, 11/02/04)

I am here but when I go back home, I don't know what I will eat because everything was sold...my son sold the cassava garden...it was not yet ready but some one bought it so that I could be brought the health centre ... In the past who sold food or any thing to go to the hospital? Things were good because even in the hospital you could be given food such that sometimes one would want to stay there fore ever...but now, hunger sickness and pressure for money are on us all the time... (Unstructured interview with Nsenye, in patient department, Kibuku health centre 16/02/04)

Adjustment programs have been criticized a great deal for contributing to increased poverty and food shortages (Cornia, John and Stewart, 1987). Much of the early criticism of the human consequences of adjustment was

based on Asia and Latin America's experiences, and many assumed that the same experiences were being felt in Africa. Indeed less connection had been made with regards to how people struggling to get social services such as health have turned to selling the household properties, hence plunging themselves in untold suffering such as hunger, landlessness and absolute poverty etc.[30]

Universally, almost all the respondents of the likes of Wenene in the above extracts accepted that food selling and other household properties to pay house hold health bills are more common now, and viewed it as an activity that started in the recent past, which indicates that it was not the case in the past. Millet and Casaava tubers mentioned in the quotes are the staple foodstuffs for the people of Pallisa.

Selling food and household items are things that have just come when we are old...nobody sold land or food for what? If you got sick the missionary hospitals or government dispensaries were free of charge so you could not find any reason to sell your chicken or goat... , Patient Budaka health centre)

The respondent above sees the sale of properties or land as an attempt to get money to buy treatment, or transport their siblings to the health centre, which show compulsion of agency and lack of alternative by the respondents in the three extracts. There is an apparent expression of pain by the second respondent here "when my child fell sick, I cried to my self". Her lack of support from anybody like husband makes her more vulnerable

[30] Because there is no public treatment, the patient has resorted to selling some of their food items to get treatment. The majority of the people, almost eight in every ten, accepted that they have sold food and recognised the threat this has had on their food security in their homesteads. This though seems a new social direction because food selling (goats, millet, chicken, bananas, etc) seems to have been unacceptable in these societies as it was seen as taboo...Causing hunger.

in this case, which confirms the conclusions by many studies on Structural Adjustment that such reforms have pressed on the vulnerable groups such as women, widows and children (Idemudia, 1994 cited in Spar, 1994). The study therefore notes that selling food and household items is therefore not a choice but a compulsion if they are to get money to buy medication for her child.

An overwhelming majority of respondents 27/ 29 accepted having sold some item to pay for some kind of treatment. Food was mostly sold 26; respondents said they have sold food; this number includes those who have sold chicken goats and cattle.

A number of respondents noted that they have sold land while two men said they had sold their bicycles when the need arose. What is clear in all these respondents is that selling of whatever property was not a choice they had to make, but had to do it no matter the consequences! As a result some patients, expressed anxieties: first, the worry by the respondent is that after selling all the food to be able to go to the hospital, when she returns there is no food for her to eat, which means hunger in the family. Certainly this is a feeling was often mentioned by almost all respondents and appeared very much recognized by the majority of health users in Pallisa who admitted to selling food stuff such as millet, cassava and other cereals. They also recognized the fact that this practice has drastically reduced their food at the household levels and had plunged them into food shortages at the household. The reference to selling food and taboo is a widely conceived concept among the population in Pallisa, especially the older people, but even

relatively young people have come to accept that social economic hardships such as getting treatment has forced them to abandon such an old tradition so important for the protection and security of food at the household level. Selling of these food items is rooted in the economic inadequacies of the district and its inability to provide treatment free of charge to the needy. Medical supply shortages which have rocked the health sector in Pallisa in the past decade have put a stringent requirement on the part of the local community to "cost share" that has necessitated the sale of whatever property is available in the household if they are to access treatment hence, increasing suffering and psychological pain for those who have done so. But certainly, what is clear is that, in all aspects, the state, which reduced its roles and increased responsibilities to the local government without ensuring proper funding is responsible for these untold consequences, and if these policies as always have been depicted as aimed to improving the quality of life and reducing poverty, then this study points to another direction because it has not and like other studies which have showed that SAPS have increased suffering and made people poor, the conclusions in this study are not different because at best the people of Pallisa sell anything that they put their hands on to reduce vulnerability caused by fluctuating state provisioning of primary health care. The study noted that food items commonly sold ranged from goats, cows, land and any thing that would bring money to self improvise, and if poverty and quality of life is measured in terms of wellbeing, food availability, and household properties then these people in Pallisa still live at the margin because they have to sell everything

when they get ill, which has made more of them poorer and without food which increases malnutrition. Perhaps this is why Ken's study of dietary deficiencies found that many people in Uganda now have less than three meals a day as compared to 1989 (Ken, 2000). This study therefore at this stage concludes that in pursuance of economic growth, the government of Uganda ignored the social services such as primary health, hence promoting a flawed policy, which only has promoted sufferings and vulnerability.

6.3 Under decentralization, confidentiality and privacy is compromised...

The arguments in this section follows Corte's prediction in his study of the effect of confidentiality on the behaviors of health users in the Central African Republic where he noted that if there is no assurance of secrecy, patients would be reluctant to seek medical advice or treatment or would be less than frank when talking to their health care providers, and this would, he argued, have an adverse effect on the health of the society (Corte, 2001). In the previous sections of this chapter by use of qualitative data, the study has concluded that the public sector is weak, such that the majority of health seekers get their treatment outside the public sector. Evidence from this study shows that people in Pallisa shop around for treatment between different primary health providers; traditional, private and public allopathetic, unfortunately the issue of privacy and confidentiality, which affects the confidence and integrity of the users, have not been considered in most studies which have looked at the elements of quality of primary health care in Uganda. Studies on the quality of care in Uganda have focused

more on the structural quality of primary care, which only pays much attention to the organization, and delivery systems of primary health care, but less on what the structures produces. For example Hutchison's conclusion that there is improved quality was based on such premises (Hutchison 1999). Even UBOS, National Survey Coordinating Group has always made such conclusion without analyzing most components such as confidentiality and privacy, which are so important for clinical governance (UBOS, 2002). And yet society always recognizes the individual needs for privacy. Even in the Ugandan constitution self-incrimination and stigmatization is not permitted (The 1995 constitution of Uganda, Pages 21-33). The Data Protection Act 1998 provides for the protection for personal data, these include information that can jeopardize the privacy of the person and the subsequent violation of human rights.

Whereas those in the western world are confronted with how to protect the health users' information and confidentiality and privacy in the 21st century era of information technology and use of electronics to keep health records, this preoccupation, commitment and obligation admits to several exceptions and lack of clarity: for example, how confidentiality is maintained under the plurality and fragmentation of health provision witnessed in many developing societies such as Pallisa. This section argues that because of the inability of the state to provide health services, and the increased plurality and fragmentation of primary health services delivery, confidentiality and confidence has been compromised, hence quality of services along this very important premises have negatively been affected. Confidentiality is an

integral part of clinical governance because the systems and process are founded upon the principles of effective communication and the way information is collected and monitored, therefore this study by use of the data argues that confidentiality can no longer be viewed in isolation but is seen here as an integral part in maintaining and in improving the quality of care.

By use of the data and observation from the field, there is evidence to show that the confidentiality of the patient information has been compromised under decentralization as noted by respondents,

You see because of the lack of stationery, the government required that each patient comes with the book...which is now used as a prescription form. The book is a property of the patient and you can see that each patient is carrying one. In those books we write the illness history, the type of drugs ...But the patients takes the book home. Some of them because of the ignorance, they expose the book to anyone... I think that people need to be protected especially now (personal interview with Kairania, Health worker Bulangira health centre)

When I have seen the (Musawo) nurse, she writes everything in my book and then I go to the shop with my book and buy the drugs...for us we don't know so the drug seller tell us which medicine the doctor has recommended and when we are given we go away...(Unstructured interview with Tadewo, 44, Health user, Kibuku health centre 26/02/04

6.3.1 Loss of confidence: Patients cannot fully express themselves

The study noted that some patients have lost confidence in themselves and in their health staff, hence they cannot speak out freely. This was attributed to lack of space, confidential issues being rumoured, which makes some patients, even fear now to go to the health centre for treatment or to speak

freely to their health staff. The study noted that as a result of this compromise in confidentiality, there is increasing stigmatization especially to those with HIV/AIDS whose privacy about their health status has become the topic of everyone.

Some patients talked of the problem without knowing where it was coming from. But it was clear that privacy is compromised during prescription time because the patients are squeezed up all waiting to see the health staff so they can hear what others are saying and during the time when they are buying medicine from the drug shops. It is very common that among the patients, almost all those interviewed had a book in his or her hand. These were not properly guarded and given their levels of ignorance about what is contained in the book, care for the book was minimal.

I don't want when people hear about my pain...when you go to the health centre there is no way you can talk what you want to say because every one is hearing. I get shy to say everything. If you say, that is going to be the rumours around and you know people talk anything. In the past there was a small room for meeting with the nurse or the doctor...it was really very good because no one could hear what you discuss with the (Musawo) but look everyone can see and hear whatever the other is saying... (Un structured interview with Kadondi, health user, Kibuku, 2004)

Me I am concerned about the social impacts of exposing the information about the patients. In fact it is now easy to know who is suffering from what because the information is readily available. The problem is that most patients now move with their data in their hands and it goes to anybody, not necessarily a health worker but what I can call quacks...these people lack the ethical conduct so they do anything and can go telling anybody about anything they have read... (Personal communication with Amos, senior health worker, Budaka health centre, Feburay/2004

The person might just have symptoms such as diarrhoea, cough and when the quacks read, they begin telling every one that so and so is suffering from AIDS. Such patients stop even to come for further treatment. People have lost confidence in us and in themselves because they think we give out their information but a professional health staff unless he/she never went to a medical school will not do that because it is against the medical ethics, but people are breaking the medical ethics unknowingly (Personal correspondent with Abel, in charge Kibuku health centre)

Two very important aspects of quality of care are mentioned in the above extracts; the growing suspicion, loss of trust by the patients about the ability of the health staff to keep the information they are told by the patients, and the loss of confidence in the patient to freely express him/her self when ill for fear that some one else will know. My feeling as a researcher was that less difference is made between the private/ drug shop attendant and the professional health staff, as all of them are referred to as "doctors" Hence they are seen in the same way. The study noted that patients expect a certain level of privacy in public health centres, which has increasingly become so difficult given the plurality of primary health providers. However, despite this requirement, the study noted that in an increasingly intrusive society, patient's privacy has come under threat. There is no literature in Uganda to show whether under decentralization patients' confidentiality which is an integral part of clinical governance as observed by many respondents of whom the majority are health workers, has been affected by decentralization, and much often has not been included when evaluating the quality of care provided, although it is part of the quality assurance measures.

Citing difficulties in providing treatment and referring the patients to buy medication outside the public sector, requiring the patients to move with their prescriptions (book) and the fact that the majority of health providers are not medical professionals, with no knowledge about medical ethics, are some of the reasons given for this compromise by the majority of the respondents most of whom are medical professions. The study noted that the lack of privacy at the facilities is disrupting some patients' ability to maintain significant relationships that define their personalities as seen from the two quotes:

Namaja ...When you go to fetch water you hear women whispering about you...I had a miscarriage and the rumour was everywhere...women talked about me, later I realized the rumour was coming from the wife of the drug shop owner...I felt so bad that I confronted her...I don't want people to talk about me like that...

Qn. So how did you know who had talked?

I just remembered that it was only that shop where I went to buy the medicine...she kept looking at me and reading my book, then later I heard people talk about it...it is bad because now everyone when I pass talks about me and you see women have rumours here...

Qn What had she said about you?

Namaja...That I had aborted...many things some of them were not true but people believed her because of what she told them...that is not good... sometimes you ask yourself who is talking and it pains to hear such things are being said about you...this is happening and no one will talk about it"

Patients such as Namaja were not happy that they are talked about in public that they have aborted. Abortion in the Pallisa community would demean the woman who has aborted and she would be looked at with contempt and ridicule by all those who come to know about it, so if that happens the

victim such as Namaja would suffer the same and would make the patient less inclined to speak or seek same medical attention for fear of the outsiders knowing. The study noted that major issues of quality of care here are surely that of stigmatization, loss of integrity and the effect on the confidence of the patient. As Lubbaale (2002) puts, "Confidentiality provides patients with health care of the outside influence; it empowers patients by giving them control over who will have influence about their health conditions and it enables them to seek help without fear of the public knowing, and once this is absent then the outside healing disappears… Patients such as Namaja felt their integrity threatened when people came to know of her miscarriage. In societies where illiteracy and diseases such as AIDS are very prevalent, and with AIDS still seen as a personal failure and bad behaviur connected to promiscuity, the respondents noted that mechanisms to protect them and the information about them are more than necessary to maintain their confidence in them and their position in their societies, which is increasingly becoming difficult due to the public sector failures as noted by the health worker

I don't know what is going to be seen in the next future...people need to be protected but how can I do that now? I have no control over who reads that book...Patients carry with them these books...most of them don't know how to read so they take the books to the shops where they get the medication...and that is the point where it all spreads...(Unstructured interviews with Katoko, Kadama health centre, 2004)

The study noted that most of those whose privacy has been compromised now fear to go to see their health workers. The patients have lost confidence in themselves and in their health staff, hence they cannot speak out freely. There

are also signs of stigmatisation especially to those with HIV/Aids, whose privacy about their health status has become the topic of every one. Some patients talked of the problem without knowing where it was coming from. But it was clear that privacy is compromised during prescription time because the patients are squeezed up all waiting to see the health staff so they can hear what others are saying and during the time when they are buying medicine from the drug shops. It is very common that patients, almost all those interviewed, had a book in his or her hand. These were not properly guarded and given their levels of ignorance about what is contained in the book, care for the book was minimal.

Although there was no reference by the majority of the respondents to the period before decentralization, and how confidentiality was ensured then, in all the extracts the respondents' references to the use of books as prescription materials and space between patients at the time of examination show that they are aware that in the past medical records were kept at the health facility and patient consultation room was available which ensured confidentiality and privacy unlike today where patient consultation takes place under the tree because of lack of space amidst increased consumers of primary health services. And the reference to the practice of the plurality of medical providers of health services in Pallisa shows that they are aware that in the past the disadvantaged groups of the public depended solely on the public sector with medical professionals who were bound by the medical ethics of keeping confidentiality unlike the quack "bogus doctors" who now operate most drugs shops as businesses in Pallisa. It is not known, however,

how much this exposure in the patient information affects the confidence of the health users and their responses in their utilization of services. But certainly the experience from the pregnant woman for example can summarizes it all:

Before you have told your husband that you're pregnant, the whole village knows. This is not good; you begin feeling so shy to go back and even to walk in public. I went to the clinic when I started feeling weak, the nurse told me that I was pregnant and I needed to buy some folic acid, so I went to buy, but I tell you the following day I heard people talking about how I was pregnant...and the rumour goes so fast it is so annoying... (Unstructured interview, with Katoko, Kadama health centre, March 2004)

The quotes however show that not only is confidentiality compromised, but it has generated the loss of confidence among the consumers of PHC services. This compromise in confidentiality is not only outside the public health sector, but even within the public sector too. The latter was attributed to shortages in space for consultation where as a result consultation takes place in the open, where other patients are able to hear what the other is telling the health staff.

Among both women and men who were interviewed, the issue of confidentiality was mentioned several times, and that suggest the importance the patients in Uganda attach to confidentiality. The study points to the already known inefficiencies in the public health sector in many countries implementing decentralization, which include shortages of space. The lack of economic strength of Pallisa, for example, does not permit the

authority to construct more health centres, which would include bigger space even when they regard it as important. The abilities of the local governments are further constrained by the fact that much of the health sector funds come from the central government and donors as a conditional grant with less flexibility for manoeuvre. (See chapter three on the funding mechanism of local government).

In reference to confidentiality, the respondent sees the lack of space as having reduced the confidence of the users, as such intimate conversation, so important for health services to be delivered, is not possible because everyone is hearing what is being said. Although this study did not document cases of stigmatization and incrimination, the data shows that without doubt it is happening. More studies are needed on this issue to establish more social implications of the breach of patient confidentiality on individual's integrity, respect and confidence.

In conclusion, one can note that the patient in Pallisa recognizes the individual's need for a person with whom private things may be shared without dangers of being incriminated. The study however, shows that under decentralization, the critical requirement of confidentiality is not available. Under centralization, the decision to give information to others was upon the patients, who would choose what to share with whom, and under what conditions, but under decentralization, although it still requires that patients to keep private what others know about them, it is proving difficult under such a sensation of the multiplicity of health service providers, whose interests are beyond the patient's wellbeing, but how to exploit them and

make the best out of their suffering.

At this stage, the study concludes that it is vital emotionally and socially for individuals to have a sense of personal identity. The study notes that the identity feeling requires some control over what others know about the patients, without which it has become difficult to reassure the patient. It has also been noted that the threat to confidentiality of the patient's relationships with others, more so when the person's secrecy has been compromised makes some patients lose respect and confidence and hence suffer stigma and loss of personal integrity, which accordingly is happening in Uganda. These scenarios more so could have had a negative impact on the utilization behaviours. The next section explores the implication of the structural changes for the utilization of health services.

6.4 "In the mother's wing" What is the state of antenatal care under decentralization in Pallisa?

6.4.1 The state of antenatal services in Uganda

Antenatal services are important because they help to identify and treat complications during pregnancy such as anaemia and other infections, which could lead to death of the new born child or the mother, therefore antenatal services, are used here because of their importance and the readily available data over time that can be used to measure the effects. Besides, since most patients who use these centres are mothers, it would generate a broader picture in educating about how decentralization impacts on the health services. In Uganda the Ministry of Health recommends that a woman attend antenatal care at least four times during pregnancy. It further

recommends that a woman attend antenatal care monthly during the first seven months, every two months in the eight months and then weekly until birth (UBOS, 2002; Safe Motherhood, 2002). In this section I recorded the source of antenatal services and the person who provided that care for the women's most recent births (3 years) preceding the study. The aim is to examine whether decentralization has led to improved attendances and utilization of health services such as antenatal services, while also examining the factors that have hindered or facilitated that trend. Both qualitative and quantitative data were used.

Quantitative data used here were obtained from the Health Management Information Services for Pallisa between 1997 and 2003 and was supported by interviews of 19 mothers. Three variables of antenatal services are explored: Times of antenatal visits by mother which aimed to find out whether mothers actually complete the schedule as envisaged in the Minimum Health Care package; the place of delivery, in which deliveries in the health facilities were compared to that of outside the facilities, including those recorded by Traditional Birth Attendants since 1997 to 2003; and the timing of their first visit. This section argues that an increased number of users of antenatal services complete antenatal services and increased deliveries by mothers in the health facilities would signal improved quality of services and vice versa. The study noted that the place where the mothers receive antenatal care is important because it influences the frequency and the quality of care received. The choice of antenatal to represent the public good is because the majority of users of primary health services in Uganda

are mothers and children so I am sure that the lesson leant from the utilization trend and the way users describe their experiences will give an insight in the rest of public good utilization under decentralization. The next section asks whether mothers complete the schedule or not and why.

Table 5. Antenatal Care Visits and the timing of the visits in Pallisa 2003

Number of antenatal care visits and the timing of the visits. Percentage distribution of mothers who had a live birth in the three years preceding the study by number of ANC visits, and by timing of the first visits, Pallisa District, 2003	
Number of ANC visits	Percentage
None	2
2-3	12
4+	4
Don't know	1
Total	100=19%
Number of month pregnant at first ANC visit	
No antenatal care	0
Less 4 months	3
4-5 months	3
6-7	10
8+	2
Don't know	0
Total	100=19%
Medium months pregnant at first visit	6.5

More often, studies on the quality of antenatal care have ignored the aspect of the frequency of the visit by mothers for antenatal services and have looked at absolute numbers of those who attend, from which conclusions have been drawn that there is an improvement in ANC in Uganda (Ndiomugenyi, 2002) while Safe Motherhood, (2002) based on the presence of antenatal health facilities concluded that antenatal services in Uganda have improved. This assumption suffers from a lack of reality and clarity, and assumes that the presence of health facilities automatically leads to quality service delivery, which may not be the case according to this study.

This study argues that while the absolute number of attendances has increased as seen in the graph, the number of women who actually complete the recommended visits is so minimal. The data indicates that only (4) out of the 19 mothers who were interviewed had completed all the courses. By social characteristics, however, most of those who completed the schedule were middle-income women who either had some kind of business, or their husbands were working and had some kind of education. Age was insignificant such that only 2 mothers of the six who completed the schedule were young mothers between 17-30 years of age indicating that age was not a factor in the utilization behaviors and attendances as had earlier been noted by DISH (1999). On the other hand 12 of the 19 mothers noted that they did not complete the schedule with almost all saying that they only attend when in the second and third trimester of their pregnancies.

Another point to consider was that consultation tended to start late with an average of (6.5) months of gestation, which clearly is too late. The attendance picture in this study however, shows the same picture as that of the DHS survey (1995-2001), which made similar conclusion about antenatal utilization trends. The social characteristics of those who did not complete indicate that they were the very poor with no source of income; most of them noted that their husbands were not employed but worked on the small plots (Shanbas) growing food. I asked mothers why they did not complete the antenatal schedule in order to understand this trend.

6.4.2 Why mothers do not complete the schedule

The reasons given by different mothers why they do not complete the

schedule in one way or the other is connected to the health sector deficiencies and the requirement of money on the part of the pregnant patients to have treatment, which money was hard to come by, hence lack of money and costs were involved and loss of time for production:

I went there only twice when my pregnancy was 6 months ...I come here because I want to get the ticket so that in case of any problem the Basawo will know that I have ever come here...but there is no need for me to come every other time. I produced my first three children without coming to the health centre...I never had a problem but ever since I had the complication with the third child, I was taken to the hospital and I did not have the card...the nurses really were harsh on me so I have now come although I don't complete the schedule. It is also expensive to come here because every visit you have to pay Uganda shillings 500, it is very dear because my husband does not work and has no money (Unstructured interview with Naula, Kadama health centre, 2004)

The tradition of delivering at home is an old tradition in Uganda since time immemorial so it cannot be attributed to decentralization, however the fact that Naula goes to the antenatal clinic to get the medical card indicates that she is aware of the dangers of delivering at home. Coming to the health centre to get antenatal medical cards is a security measure most women in Pallisa have adopted just in case of complications. More than 16 women repeatedly talked about going to the health centre so that in case of complications, they have a reference. The study noted that the woman with a card would be likelier to get attention in case of danger than the one without. However, for women such as Naula, costs involved in the visits appeared a constraint in completing the schedule, which suggests that many would have come if the services were cost free.

Gimbo on the other hand failed to complete the visits because of the

inefficiencies in the health centre. She found the process time wasting and unbearable. On average she said that she would need 7 hours every time she has to visit the health centre for antenatal care and yet as a producer of food, she has to be in the garden. This clearly shows that waiting time is one of the factors affecting the decentralized health sector Surely her reasoning is credible because the attendance levels in Kibuku health centre for example tended to fall in April and October (Abel, 2003) when it is the time for planting and cultivation in Uganda. Most reasons given by patients such as Gimbo was that sometimes the nurses are not there or there is only one nurse and waiting becomes a burden so she finds it so difficult to come even when she finds it important. The implication of this quote is that as a result of inefficiencies, the economic cost of getting treatment has not only increased in monetary terms but equally the loss of productive time is experienced and respondents have found it as one of the reasons why they drop out, as noted:

I think that most mothers do not complete. The nurses tell us that you have to come more than four times...For me I find it hard to come because of what is its use? My last child, I went there twice when I think I was five months... The problem is that you waste a lot of time waiting to see the nurse...you see that is not good because sometimes you have to do your work. See now it is raining and when you think of wasting the whole day seated here sometimes the nurse is not around so we remain at home. I have never delivered in the hospital. (Unstructured interview with Kadondi, Budaka health centre)

On the other hand while also mentioning the fact that health users in Pallisa have been educated as to the value and importance of antenatal care, which is one of the positive, attributes of decentralization in Uganda, Women such

as Kadondi (11 women) noted that things such as lack of money and time made her not complete. A number of women noted that they could not complete because of their lack of money for transport during the visit, as noted:

You see my husband does not have a bicycle...if I had money I would have paid for boda boda (commercial bicycle) but I don't have...sometimes when I asked my husband to give me he tells me he does not have and I decide to remain. He tells you go to the traditional attendants...these one can take a chicken and then will give you the herbs. (Unstructured interview with Kanyago, Kibuku health centre)

The study noted that in the case of women such as Kanyago, Gimbo, their inability to complete the schedule is rooted in the economic inadequacies that most people in Pallisa have found themselves during the SAP period. Her lack of money to pay for *boda boda* (commercial bicycle) is what makes her not attend. This clearly corroborates the HDS, 2002 survey which indicated that women in Uganda still lacked control over money, which has been found to be a factor inhibiting their health care seeking behaviour. Most husbands in Uganda take their wives to the health centres on a bicycle such that those who do not have the bicycle, such as Kanyago, find transport so difficult, and are hence inhibited from completing the schedule even when they wished to do so. However, although women such as Kanyago, Gimbo and Kadondi did not mention about patient transport in the health centres, the absence of it makes it worse for the majority of women who would have wished to attend more frequently. Some users such as Katoko noted some concerns regarding the quality of staff in the health centres

"These girls what do they know...if you're lucky and you find a midwife then you come back when you're happy...the problem is that sometimes it is the nursing

assistance...these girls are known here and some of them failed their exams but now they are there as nurses...I don't think they know what they are doing...so if some one tells me that the midwife will not be there, then I don't go, I will wait" (Personal unstructured interview with Katoko, Molokoyomo health centre, 2004)

Women such as Katoko thought that there was no need for them to go to the health centre if they knew that the midwife would not be there. The nursing aides, whom most mothers think are not well educated and lack the knowledge to handle pregnancies, are the majority of the health staff in the decentralised health centres in Pallisa. The relationship to the number of times women visit therefore is that women in Pallisa tend to visit the health centres only if they are aware that the midwife or senior nurse is going to be there. This to a certain extent determined the number of times the women visited while pregnant, hence in the process, quality antenatal care was compromised simply because of the staff shortages and the way the health users in Pallisa rate the nursing aides. The health staff shortages in the decentralised structure has been high lightened in Chapter five of this thesis, in which it was concluded that over 70% of health staff are either nursing aides, with reducing numbers of professional staff such as midwives and nurses.

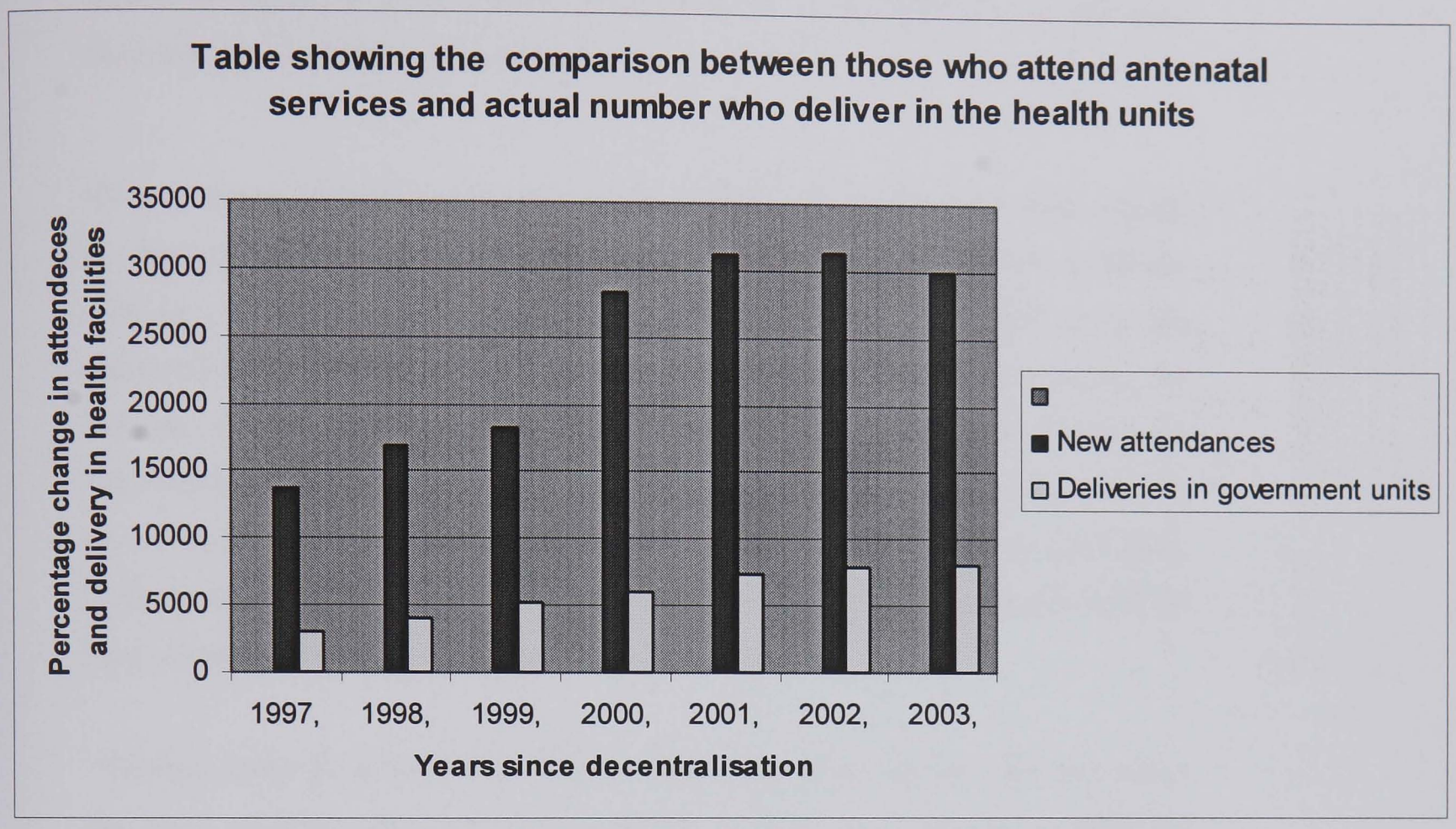
What can be concluded in this section is that although the cumulative numbers of mothers who attend antenatal services is more than 90% (HIMS, 2003) the numbers of the mothers who complete the schedule is still below the one recommended by the Ministry of Health. This picture clearly has implications for the quality of health services: firstly, since the majority make their first visit when the pregnancy is over five months, it is sometimes too late to identify complications and to refer the women

appropriately, which results in some cases of maternal death in Pallisa. The fourth factor is associated with the shortages of professional medical staff which all are compounded in the background of poverty. The above factors are some of the factor that most mothers see as a cause of drop out of antenatal care seekers in Pallisa. This conclusion contrasts sharply with studies such as that of Nema (1994) which have in the past singled out traditional beliefs and cultural givens as factors hindering antenatal services in Uganda.

6.4.3 Place of antenatal and delivery of mothers ...

While still presenting the distribution of women who delivered in the three years preceding this study, tabulated by the place of ANC and background characteristics of the mother, it was noted that overall 90% of mothers use a public facility for antenatal care at any one time when pregnant.

Table 6: Comparison between general attendances for antenatal and the actual deliveries in the health units in Pallisa, 2003



Sources: HIMS Pallisa, 2003

The obvious conclusion from the data and the graph above is that there is a marked increase in the absolute numbers of antenatal attendances in Pallisa. This corresponds with the majority (19) of women who said that they have used the centres for their antenatal or while pregnant. In Uganda, it is estimated that 57% of the public health facility can provide antenatal services. The most common components of antenatal care include the administration of tetanus toxoid, weight measurement, blood pressure measurement, provision of iron tablets, height, and pregnancy complication and provision of anti- malarial drugs (Reproductive health Uganda, 2003). This study noted that 7 in every 10 women who attend antenatal care deliver

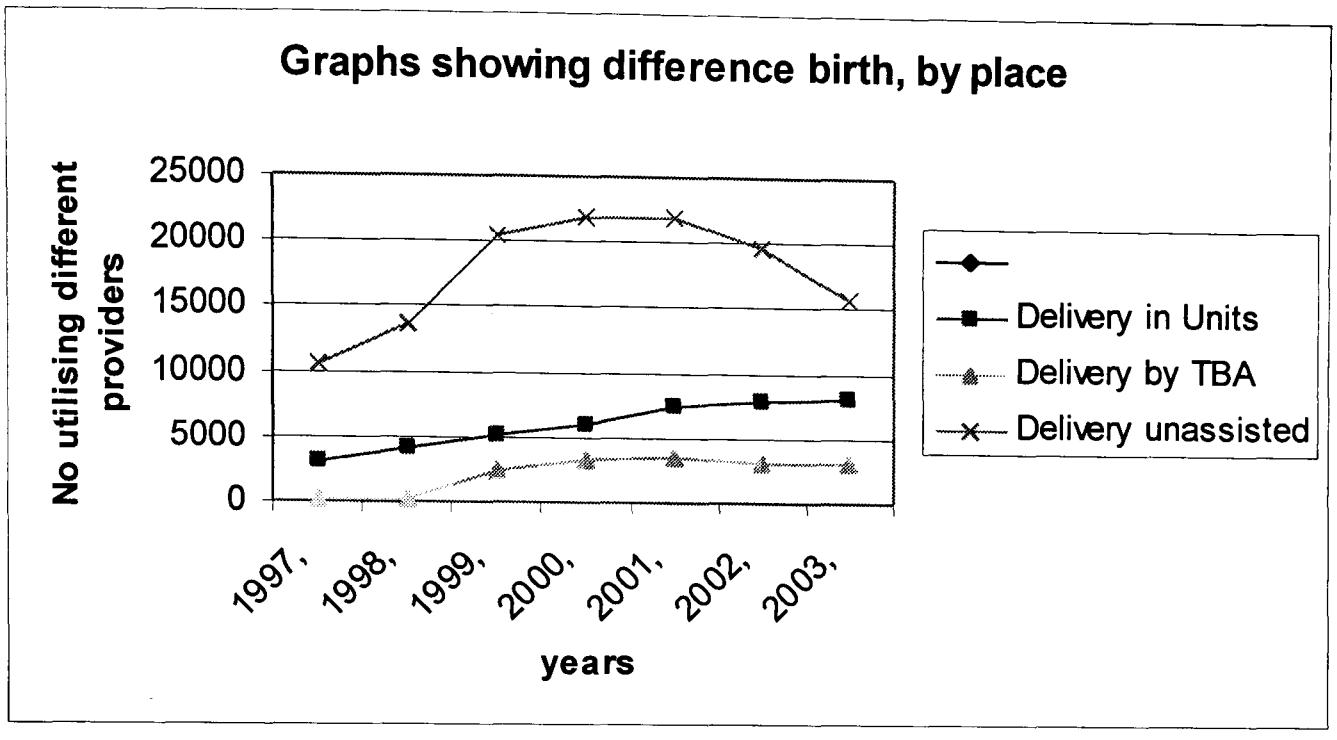
outside the public centres. As noted by Dr Abel and Alpo

I find it difficult to explain because we actually get big numbers of women who come to attend antenatal...although the majority do not complete the schedules, but at least we registered many of them...I realize the increase in attendances (Personal interview Alpo, Midwife, Kibuku health centre, 2003)

When it comes to delivery you look at the records and you discover that actually the majority of those who attend antenatal care during pregnancies do not deliver with us...we don't know what happens to them after that...I think some are delivered by the traditional birth attendants, while others just by their relatives. No one can tell but some prefer to be delivered near their homes...But I think some costs involved could be one reason and that is not a good indicator because some are brought when complications arise and you don't know where to start from. Actually most of such cases rarely survive..." (Personal communication with Dr Abel, Kibuku health centre, 2004)

"Mothers prefer to deliver from villages...they bring some of them when they are at the point of death and you have nowhere to start from...every one must be concerned with this trend. This practice has led to increased maternal death...in fact the rate of death is very rapidly increasing between 4 to 7%... (Personal interview with DDHS, Pallisa, 23/02/04)

Table 7: Graph showing different births by place in Pallisa District 1997-2003



Source: HIMS Pallisa District, 2003

According to the study, there is an increase in the number of women seeking antenatal services when they are pregnant, however, despite the increase in attendances institutional delivery is still less than 30%. Most women (15/19) interviewed noted that they attended antenatal at least twice during their pregnancies but reiterated that they delivered either by the help of their mothers in law or anyone in the village. According to other studies it is a general trend in a far as antenatal services are concerned in Uganda. Cases such as these are reported in other districts such as Bundibugyo where more than 8 in every 10 pregnant woman who attend antenatal services, deliver elsewhere.

Data from Mbarara districts corroborates this finding that 90% of women in Mbarara (western Uganda) attend antenatal services of some sort but more than 78% deliver outside the public health facilities (Nema, 2001).

Reviewed studies have showed that expecting mothers face difficulties if they attempt to deliver in the health units without providing evidence from antenatal users (Dr Mdyomugenyi, Bundibujo hospital, quoted in the Monitor Newspaper, Tuesday, 22 February, 2005 P.17). There seem to be increases in the use of the TBAs, which suggests that some have opted for Traditional Birth Attendants. While Dr Edrisa, Musisi quoted in the Monitor News, 23 April 2005 pp.1.4, noted that in Kayunga district 75% of mothers give birth from the villages despite centres being near. However, even with this number of those who attend Traditional Birth Attendants, the attendance levels for those delivered by any kind of assistance is still small, which means that the majority still deliver unassisted since the possibility of using the private provider is ruled out given their financial shortfalls.

Analytically, the data and the graph above shows that most health mothers delivered unassisted between 1997 and 2001.This increase coincides with the time when health centres were charging formal cost sharing. However the number of unassisted deliveries began to fall between 2001 and 2003, bringing a reasonable increase in the deliveries in the health facilities. This change in trend is also attributed to the increased number of health facilities, the abolition of formal cost sharing and the role of the mass media and community organization in the form of women clubs and self-help groups. This issue has been also highlighted in the MOH report on Utilization (2001), and WHO report on the effect of the abolition of user fees in Uganda. However this study found no relationship between the relative increases in the use of modern providers and the availability of medicine such as drugs

and gloves, as most supplies were irregular, which suggests that an increase in attendances was not related to improvement in the quality of services. Thus the study at this stage provides similar conclusions to that of Acaye (2001) that an increased utilization in services lead to reduced quality measured in terms of availability of medication while also noting that user fees are disincentives to public health deliveries.

It has also been argued that the increase in the TBAs from 1999 to 2001 coincides with the period of the training of Traditional Birth Attendants in Pallisa. DISH international (Delivery of improved services for health) under the Safe Motherhood carried out training exercise for Traditional Birth Attendants which could have boosted their presence in Pallisa, hence attracting some reasonable numbers of women (Safe-Motherhood, 2002).

6.5 Why do most mothers deliver outside the public health centres...?

The reduction in the number of mothers delivering in health units has been attributed by most researchers and reports such as Safe Motherhood (2002) to the presence of TBAs and that most mothers use the private providers. This study clearly contrasts with such a conclusion, and it argues that where there is an increase in the number of mothers using TBAs and delivering outside the public health sector, it is not by choice, but the reasons given for this trend, as given above for not completing antenatal visits, ranges from public sector inefficiencies and the public perception of the quality of services under decentralization, which has generated gradual loss of confidence by the users of the substandard state of the services as noted by

the health users represented in the quotes

In the past when you went to the hospital to deliver or when you were not feeling well the nurses would check you properly and really provide you with good treatment...they could give you all the things to use such as basin, blanket, water Jeri cans, a bed and food. For the pregnant woman that was really good...that made most women want to go there when they were pregnant...But now when you go there as soon as you arrive the (musawo) health staff will ask you for the book and have this and that...you have to buy all those things and on top of it pay a delivery fee. I am sure some women just decide to remain and deliver at home maybe because they don't have the money...It is easy to go for antenatal check up if one has time because it does not cost a lot of money but delivery requires a lot of money, you have now to buy your own gloves, a basin, a polythene bag to deliver on because the health centre does not have them...if you have a poor husband like mine then you have no choice but you remain at home or call your neighbour to assist you...that is what I do and in fact most women do that in this village because where can one get the money...? Some few with money go, but I don't think many. (Unstructured interview with Alice, 28 Kibuku health centre, 2004)

We are told that long ago things were better than today...my mother told us that when she delivered us the ambulance picked her from home...my father went there and informed the hospital and an ambulance was sent to pick her...she would have not gone if it was today because there are no such services. When you're pregnant you don't want to walk...and you would rather be in one place.... it is all money if you need to go to the hospital...if you want to use boda boda (commercial bicycle) you need 1000 shillings (£0.40) and it is more expensive if your to use a car. My last child...this one I felt pain and my husband got worried because we had no money and if we came to the health centre it would have required us to pay for transport, buy this and the other and then pay five thousand shillings...when we

saw that this was not possible, my husband went and called the neighbour...she has been delivering other people so she is well known...it is actually God who helps us because if you get complications you die" (Unstructured interview with Gimbo, mother Kadama health centre, 2004).

Why go there? Only when I have complications but I am lucky I have never had one. Going there requires money and yet you don't have it. You see such services used to be free, there were benefits of going there but there are not there any more. When you reach the nurse tells you to buy the book, then a polythene bag...you have to buy your own pain killer so when you think about this, you decide to deliver at home. It is very dangerous in case you had some complications...but that is the fashion. My neighbour who just gave birth told me that she was asked to pay 5000 shillings and I said where would I have got that poor me...If I was the one I would have not gone there (Unstructured interview with a patient, Kibuku health centre, 2004)

The health centres are near... sometimes the nurses are there but I tell you to get assistance there it is by chance...some people say that they have got it but me I have never got anything, so I find no motivation to go back...I am better off here than wasting all that time...I remain here and wait for my day...if it your time you go ...what can you do...I don't find any reason to go and spend my only money when I will get nothing...in fact people now say that when you go to the hospital you go to get diseases not to cure. The place is very dirty especially in the maternity...it is all smelly...I comfortably delivered at home because of the fact that it is my home...no body would charge me for anything...we are told that it is dangerous when we go for antenatal but I am still lucky... My mother in law is always there to deliver us. You see she has so far delivered 11 grand children so we rely on her for help... (Unstructured interview with Health User, Pallisa, 2004)

When I took my daughter last year I said I will never bring her again...there is no privacy the place is open...you can cry when every one is seeing you...some begin to laugh at you when your grinding your tooth in pain...When you come back you hear people heckling you then you realize that I think they saw me in the hospital...it makes you feel so bad (Personal interview with Deborah, Budaka health centre,

2004)

At least if there was a special room for that time when you need even to be naked, but it is not there. When I arrived to deliver second child, there was a woman sleeping naked and you could see the misery, I don't know how she feels now but I don't think she will ever come back...you see there is no privacy whatsoever in the facilities so most women fear and stay away. I don't know how it was in the past but I am sure it was not like this because (Tabitha, Kadama health centre, Budak health centre, 2004)

But sometimes you don't have any money and that is when you get ill...I tell you it is a very difficult time.... you begin thinking how to go to the hospital and yet your pocket tells you there is nothing. You have to buy everything from the gloves to painkiller so because I don't have it, I don't come here...it is poverty but those who have go to private clinics where they are well treated. In fact it is God who helps but at that time if you have the complications how you would reach the hospital. Our neighbor lost his wife...she had a complication when delivering (Unstructured interview Kanyago, health user, Kadama health centre, 2004)

The issues in the primary health sector in Uganda zeros around the costs, and inefficiencies as can be seen below.

6.5.1 Avoiding the costs: When you reach the centre, they tell you to buy this and that...

Although there is an overall acceptance that in most villages, there are health centres in every village, [31] when I asked the respondents why they do not go to deliver in the public health facilities, most respondents such as Alice for example saw the costs involved in delivering in the public health facility as something she cannot afford. At 28 years, she sees her decision to stay and deliver in the village as being precipitated by her inability for

[31] Traditional Birth Attendants are women who help to deliver in the communities. Some have been trained in delivering, but the majority use their wisdom.

example to buy a basin, pay for delivery fee of 5000 Uganda shillings, buy the polythene bag to deliver on, buy blanket etc, variables when computed amounted to 30,000 shillings, which would be extravagantly expensive for an average person in Pallisa. This was certainly the feeling shared by the majority (17/19) of other mothers such as Gimbo, Jane, Kadondi and others. The issue of costs in the public health facility in Uganda has become a major topic of debate. This explains why the formal cost sharing was abolished in 2001 after it was found to be counter-productive (See Okwi, 2003; Mwesigye, 2003 and Mbonye, 2002). An obvious conclusion that can be drawn here is that anticipated costs to be incurred in case of delivering in the health facility are one of the factors that de-motivate the would be patients and hence make them remain at home or seek traditional birth attendants who are considered cost free.

6.5.2 Protecting their privacy and confidentiality...

Rated according to frequency with which the issue was raised, another major issue that the respondents mentioned again and again was the issue of confidentiality at the time of delivery. A significant number of mothers, 16 of the 19 respondents, in one way or the other noted that it was because of the fear of the lack of confidentiality and privacy in the health centres. Kadondi for example, noted that the lack of privacy among other things is what makes her not deliver in the public centres. Confidentiality therefore becomes a major quality issue for policy makers in Pallisa to look at as an issue that affects quality of services and consequently would affect the government efforts to improve health outcomes through utilization.

Observation in the health facilities of Budaka, Kibuku and Kadama confirmed the patient's fear of lack of privacy, which made them, either go to the traditional birth attendants or deliver an assisted in their homes. In Kadama for example, there was only one bed, which was being occupied by one expectant mother, at the same time another woman was lying on the floor helplessly. By the time I left at 4:00, O'clock there were three mothers in the same small room with the two expecting mothers who came later lying on the (Kapali) mat on the floor. It was therefore visible that there was no privacy in the place. Clearly as regards decentralized structures, however modern and nearer to the public they have become, this study shows that confidentiality and privacy of mothers is compromised. Studies elsewhere about confidentiality have shown that lack of it will make patients shy away (lose confidence in themselves) and may not be as free with the health provider (Tamu, 1999). And yet concerns have been also shown where women fear to be delivered by men health workers (ibid, 23). Hence the fear of stigmatization, lack of privacy among other things is what de-motivates the majority of health users to go into public health centres at the time of delivery. Although elements of stigmatization were not recorded in this study, the attempt by some mothers to talk about the importance of privacy and confidentiality suggests that it may be happening on a scale not yet known. Further studies are required to establish the extent of this problem.

6.5.3 The health centres are hygienically dirty...

Thirdly, another issue that was mentioned by the majority of health users that makes them decide to deliver at home was the fact that the hygiene

situation in the public health centre was near disaster. Mother such as Kadondi noted that in the public health facility, the place is very dirty and there is an apparent fear by many mothers to use the services. 14 mothers perceptively viewed this issue as very important just as much as the earlier issues in 1 and 2 above. The fear of catching diseases is very instrumental in making the mothers decide to use traditional birth attendants or deliver unassisted as a measure of avoiding the unhygienic places. Implicit in the quotes by Jane, Kadondi, Gimbo and others is the expression of the falling standards of the public health services in Uganda.

Hygiene concerns have also been raised in some studies in Uganda, mostly in the hospital wards (Kaadu, 1999). This study shows that like the appalling hygiene situation noted by Kaadu above, the situation in most primary health centres is no different. Some centres took three days to be cleaned, the weed was everywhere and the smell in the maternity ward could chase away any normal person. The study noted that the poor hygiene was caused by the inability of the centres to employ ground workers coupled with the lack of cleaning materials such as washing detergents. The study observed in Kadama and Kibuku health centres that patients were responsible for cleaning where they are, or the carers were responsible for that. These shortcomings mentioned here are rooted in the economic inabilities of the districts to provide a budget for it which has meant that centres have become in every way disease transmitting centre but not necessarily offering treatment, which makes some patients reject going to them when it is required.

Quality concerns therefore are some of the major reasons why even when services have been taken nearer the public, the public response to using those services remains skeptical, or at best services are rejected.

The fact that the State retreats from the provision of public goods such as health, which is one of the many conditions of Structural Adjustment, has to a certain extent greater bearing on the quality of care that can be delivered. Although many respondents did not refer to the past in reference to the issues raised here, the fact that some respondents such as Gimbo, Kadondi and Takali among others mentioned about the past in one way or the other means that most respondents think that the quality of services measured in the same variables were better under centralization. For example, the repeated reference to being lucky by most respondents such as Kadondi also means that they are aware of the dangers of not using the modern provider for treatment. They are aware of death in case of complication, so it is not by choice that they do not go to deliver in the health centres, but rather they are compelled not to go because of the evident factors such as costs, hygiene, and confidentiality dilemmas among others.

The above conclusion is certainly the opposite of what is known in Uganda as better quality services that everyone is made to believe (Safe Motherhood, 2002; Ministry of Health Report on maternal health, 2003a). If the use of traditional medicines has been found to be dangerous, with highly toxic elements (Ssengoba, 2000) and yet the majority of the people in the villages increasingly use them, then we can see the causes of increased mortalities for both mothers and children reported by the World Health Organization, in

which Uganda is number 6 in the world among countries with the highest morbidity levels (WHO, 2003). But most and perhaps more challenging in the same conclusion, one can note that as the state retreats, the burden of the delivery of health services increasingly becomes an individual responsibility, but for this case the older women and elders are facing the hitch since they are confronted with the responsibility of providing such services that are supposed to be delivered by the state in an attempt to save their relatives or members of their families or communities.

A number of issues are raised by the respondents in the previous quotes: costs involved in going to the health facility which includes transport, buying your own food, beds and other necessary things to use; confidentiality and confidence; and the dilemma of health hygiene which characterizes the health units in many decentralizing countries, such as in Pallisa. This conclusion suggests that, the government's efforts in constructing health units may be rendered useless if the services offered are perceived to be of poor quality and most people will reject them, as seen in Pallisa. Significantly, these health behaviours seen in Pallisa must be having a greater bearing on the mortalities and morbidity situation in Uganda. Due to limited time and data, this study was not able to investigate these very important indicators of health service; hence this study recommends that a study to ascertain the extent to which mothers and their children are dying because of these circumstance would inform us of the underlying implication for this trend in service utilization in Pallisa and many areas that are experiencing these changes.

6.6 Conclusion

In order to unravel the impact of decentralization and its contribution to the state of health services in many developing societies such as Pallisa, this chapter set out to examine the lived experiences of those who use primary health services in Pallisa. This chapter has attempted to access the 'hidden' aspect of quality of health care delivery in Pallisa from their perspectives. Most of the studies done in Uganda stop at what is officially acknowledged and accept the accounts of those within the system at face value without finding out the perception of the users themselves. Based on the evidence from various health centres and respondents therefore, it can be concluded that quality health service delivery in Pallisa is not just uncertain and difficult to get but also represents a difficult experience for them. The pressures they encounter when they fall sick exacerbate the difficulties, while the unpredictable public service provision also sustains their increased sufferings. There are several factors to these difficulties in service delivery at local levels; however it is possible to conclude that these are mediated by the centrality of poverty and the influences in the background of SAPS. The unfavourable conditions are in themselves existing because of the state's inability at both macro and micro levels to deliver services in a way that maximizes quality service delivery, and the continuing failure of the political economy through critical adjustment policies only serves to underline the hopelessness of major health service users.

This does not demean the success decentralization has brought in structural development of the health sector in Uganda and Pallisa as a district. Quality

of care measured in terms of the distance people move to go to the health facilities as a result has improved, but on the same note, the study noted that on the contrary, other indicators of quality of care are still of greater concern to those who use the services and to a certain extent the health staff who are faced with the challenge of delivering the services. The conclusion that is easily drawn is that while the facilities have come closer, the services continue to be difficult and the patients still have to travel distances to buy their own drugs in the private outlets such as drug shops, pharmacies and markets.

Issues such as cost price both direct and indirect cost of health services, the availability of medical supplies, confidentiality and privacy and the hygienic conditions are of greater experiential importance to the users of health services in Pallisa. By these measures, it is possible to conclude that the quality of care has not only reduced in terms of access, but even the little accessibility that people have is regarded as not good enough. There is evidence therefore to suggest that given these perceptions by the users about the quality of care under decentralization, the government effort of putting in place many health facilities without necessarily improving the quality of it will be rendered useless, because at best, people will reject the services as seen in some cases with pregnant mothers. It is also possible to conclude that a decentralized system unless well planned and with financial autonomy, will not achieve the stated goals of quality health care for all and efficiency will remain a dream and will not achieve the always promised gains such as improving quality of care.

The government reduction in public expenditure has resulted in the reduction of public health. Under funding has resulted in dysfunctional health systems, which are characterized by drug shortages, overworked and de-motivated staff. Utilization, access and quality of care are compromised as escalating cost recovery measures are introduced. There is evidence to show that the introduction of markets in public health as a measure of funding has engendered the epic of human suffering and has reinforced poverty by severely restricting poor people's access to essential quality services such as antenatal and outpatient treatment. In Pallisa, consumers of health services have become the source of health financing as an out of pocket spending has overtaken the Ministry of Health as a major source of health financing (MOH, 2003). Those who cannot afford such payments have resorted to other means of treating themselves, including traditional medicine. The example is shown when women unable to pay for costs involved in the delivery in the health facilities have resorted to the use of Traditional Birth Attendants as a last resort and this should not be misinterpreted as a means to an end but rather, an indication of the problems that needs to be addressed within the health sector.

What is clearly shown in this chapter is that as the state retreats in the name of devolution of powers without necessarily providing enough resources to local government, the impact of this devolution is felt by the majority of the marginalised and deprived citizens. The system destroys the 'social contract' between the state and its people. Unfortunately, the impact has been forced upon the marginalised and deprived citizens who in the past enjoyed a degree

of government protection and social services, hence poor quality services are consumed instead.

CHAPTER 7. CONCLUSION: DECENTRALIZATION AND POLICY IMPLICATIONS.

In this concluding chapter, I will show how the primary care service users and providers perceive health services and how they negotiate the sense of self in relationship to decentralization, which has been presented as the means for service delivery in Uganda in the last two decades. This study provides an evaluation of the structures of primary health care delivery under decentralization and to a certain extent the performance of it in Pallisa. Understanding the impact of decentralization on the health care of the poor provides a basis upon which government can reform health policy. This is particularly important in poor countries, such as Uganda, where large proportions of household are below the poverty line and policy changes such as decentralization can have a huge impact on the way people use health services.

A qualitative exploratory approach enabled the study to assess the users and providers' own experiences with the current structures of primary health care delivery, the quality of services delivered in them and the implications for the general health of the public who use the services. The study therefore provides an intermediate evaluation of the on-going decentralization process and its impact on the primary health care in one of the poorest districts of Uganda. The stories of the respondents reveal countless difficulties, deeply courageous attempts to survive, and how they offer mutual support to each other amidst dwindling state service provision. The daily enactment of the

debased exclusion imposed on them, as we will see, constitutes a powerful assault on the sense of self in relationship to others. Their attempt to maintain their self-respect in the face of these difficulties is partially undermined from within, by the ever-increasing poverty. The testimonies of users and providers reveal a strong sense of falling standards of primary health care services in terms of quality. To a degree, it seems as though the respondents themselves judge what decentralization of service delivery has forced them to become, by the standards of the localization, which was meant to bring service delivery closer to the users, which only serve to exacerbate the difficulties.

However, based on the summaries of the discussions in Chapters one, Two and Three, I will argue in this first concluding section that health service is a development problem, which will eventually get better with sustained economic and social development when the policy of decentralization eventually becomes rooted. But because of the dismal nature of the Ugandan economy, health service delivery may need redesigning.

Throughout this thesis, we have seen that decentralization has altered the role of the Ministry of Health, which now focuses on developing policies and guidelines and setting standards to be followed by districts. On the other hand, the study has also showed that districts are no longer passive recipients of plans and financing and are actively involved in assessing the needs, allocating resources and implementing activities. The literature review in Chapter two revealed that decentralization is well accepted in Uganda. Most of the literature on decentralization is focused on how to

carry it out rather than on whether it increases social welfare. I have discussed and formalized a conceptual model in Chapter two that leads to the questioning of the widely held assumptions that decentralization necessarily increases and improves primary health services delivery.

The study noted that most studies that have attempted to analyze the impacts of decentralization through a quantitative approach that accordingly inhibits some social and real life experiences of the health users and the health staff. This became the focus of this study. The study therefore developed a methodology in a qualitative tradition that allows the views of the users and providers to be heard as a means to understanding the impact of decentralization on the quality of primary health care. Throughout the study therefore, the users and the providers are treated as major actors and at most, best evaluators of the success and failures of the decentralization policies based on their daily interface with health services. One of the study's special contributions to knowledge is that we can evaluate primary services in relationship to new policies by use of experiences and perceptions of the users and providers, a step away from a purely quantitative tradition, which tends to treat actors as numbers.

7.1 Breaking the silence: The Perception of users and providers on the structure and organization of primary health care

The structure of primary care service delivery drew as we have seen in Chapter four upon the proposition found in the decentralization literature that proposes that decentralization brings service delivery closer and

therefore improves service delivery.

District leaders noted that decentralization has had a positive development impact on the structural development of primary health care in Pallisa. The structures of primary health care have expanded both in the numbers and services offered in them, which reflected well on the side of decentralization. The study noted that throughout the district, there were various levels of health services ranging from lower levels at the parish to the HSD, which are the current vehicles for the delivery of primary health care. In each of these centres, there was a Health Management Team for management purposes. Community participation is taking place through the elected health committees. The communities therefore to a certain extent have assumed the responsibilities for planning, budgeting and even mobilization for health related activities and the communities now have a sense of "ownership" of their local health unit.

7.2 Power without authority: tension between vertical and horizontal integration

The question as to whether decentralization has created autonomy in funding and allocation decisions by the district was raised in the study. The study showed that districts are still dependent on external sources of funds for most of their health activities. This is likely to continue into a foreseeable future since local revenue- generating capacities are likely to remain low, at least in the short term. However dependence on external financing did not appear to be an inherent problem, assuming that funding is not abruptly withdrawn and the funds are released in time to allow planning

and implementation, which is still the problem. The study showed that the districts such as Pallisa are still not free to allocate resources to priority areas as per their needs because of the conditions that follow funding. The district administrators were concerned that if the donors (central government and the international donors) continue to influence budgets and plans, the district priority plans are left out. This was the case. In fact the study showed that the district has flexibility in spending in less than 50% of all the funds that the districts receive from the donors and the central government. The study noted that if local health services consist mainly of a collection of vertical programmes funded by donors and central governments, local decision-making discretion remains quite low and decentralization will be limited at best to deconcentration. Delegation and/or devolution to achieve integrated service delivery need to offset the effects of these vertical lines of control to allow more community and local government roles in planning and implementation of major projects that affects the communities. The establishment of Health Unit Management Committees and the District Health Committees to carry out planning, management and financial oversight functions is a classic organizational response to this issue. Evidence on the effectiveness of this response is, however, mixed, given the lack of skills for various functions (the capacity gap). A classic issue that was noted at the local government however was the lack of capacity. In fact most of the health units are technically and administratively weak. It was also noted that local government level lacked the capacity to plan, and at other health units budgeting skills were not up to standard. This would

benefit from vigorous training through workshops and seminars that certainly look to be happening on a small scale.

The study however showed that the reason why the district currently controls a minority of health resources is largely due to the intermediate state of decentralization in Uganda. There is hope that flexibility in both planning and allocation of funds will increase with devolution to the district of funds for health interventions (fiscal) and the development budgets incorporated in the sector wide approach, which appears likely to take place within the next couple of years.

In the administrative structure, however, one issue that did not appear to be adequately addressed by the decentralization is the technical efficiency of the health unit management committees. Community oversight does not appear to have had much effect on corruption and accountability generally, as the opposite is true. Additional mechanisms for enforcing accountability may be necessary. This can be done through better health sector monitoring system as opposed to reliance on the health management committees. The study noted that Uganda has a political commitment to public participation in decision-making and the structures are in place to facilitate this commitment. However, like many other studies done in Uganda, the study noted poor public participation. One reason according to the study incorporates the former tradition where health care was provided by the state. But as seen in Chapter four, a lack of individual and community empowerment, the failure of the state to operationalize the policy of participation in health and the lack of commitments and time are some of

the barriers to effective participation. These can be summed up as social, economic, and cultural barriers.

However, the study noted that many of these negative effects noted here are intermediate, and the government is somehow set on tackling them. Training and capacity building at the district level will go a long way towards resolving some of the manpower problems and the weak operation of the Health Units Management Committees and it is hoped that fiscal decentralization and the on-going implementation of the sector wide approach will alleviate some of management gaps noted in this study.

7.3 Users' experiences and perception of the services

While the previous section of this conclusion was more concerned about the structural changes and their impact so far, the users of primary health care on the other hand were more concerned about the quality of care that the decentralized structures produces. Unlike the previous studies, the aim was to make the users evaluate the system of decentralization through the way they feel and perceive the services and to reveal the "hidden" aspects of quality of care which policy makers rarely talk about. The question was a general one: has decentralization improved the quality of care? The study showed that decentralization has not yet eased the difficulties in primary health care delivery that most people experienced under centralization. In fact, to some respondents, the situation is worse than it had been before decentralization. Quality primary health care is not only uncertain and difficult to get, but it represents a difficult experience for most health users in Pallisa. The pressures they encounter when they fall ill exacerbate the

difficulties, while the actual unpredictability of public health care under decentralization sustains their increased sufferings.

The most severe quality concern of the health users was the chronic absence of drugs and being asked to buy medication every time they reached the health centre. The user's experience of being told that there was no medication every time they visited the health units and being asked to pay for some services was interpreted as a falling standard of health care, which neither catered for their needs nor provided treatment that they sought in these health units. Although there was a general appreciation of the health sector development which resulted from the construction and renovation of the primary health units which improved the geographical access to health care, however, on the same note, the users noted that bringing of health centres near has not solved the chronic barriers to health service accessibility which had been promised by the advocates of decentralization. The study showed that there is a tremendous growth in health units since decentralization and the distance to the facility from an average household had reduced from 15 kms in 1997 to 5km in 2003, which clearly shows an effort on the part of government; however, most of these centres are not functional due to resource constraints. The difficulties in primary service delivery that most users and providers experience in Pallisa district are attributed to the centrality of poverty and the influence in the background of Structural Adjustment Programs. Most respondents understanding is that these unfavorable conditions are in themselves existing because of the local government's inability on both micro and macro levels to deliver services in

a way that satisfies the consumers, and the continuing failure of the political economy through what is commonly referred to as critical adjustment policies, which only serves to underlie the hopelessness of primary health service delivery.

While the government instituted cost recovery measures such as cost sharing, popularly known as users' fees, as a means to raise local revenue, most respondents noted that under decentralization the requirement for money has increased, as most patients have to buy their own treatment or go home without treatment and suffer with pain in silence. The experiences of the users was that the requirement for money in the heath sector in Uganda has been worsened by the general medical supply shortages, which makes them potential financiers of the health services amidst poverty.

On the other hand, the health managers attributed this phenomenon to low investments in the public health sector and the state of the economy of Pallisa district that is not yet developed to provide resources necessary for social services such as health. The problem as noted by the study is that most of the health users who cannot afford to buy treatment resort to other means of treating themselves; these included the use of traditional medicine, buying half doses to relieve the pain, which also increases their disability. For the pregnant women who failed to get public care, some have opted for the services of the Traditional Birth Attendants, who have been accepted as partners in primary care service delivery in Uganda. However, the study also noted that this action by the health users especially should not be treated as a means to an end, but rather, an indication of the problems within the health

sector that need to be addressed.

Another issue that the study noted was that of the waiting time price for health services. Under decentralization, the waiting time increased. This was attributed to increased patients at all levels, the shortages of health staff at some health centres where one staff member had to deal more than 70 patients a day, and the fact that most staff lacked experience given their levels of training, which made them repeat what their seniors do with less speed and accuracy. Many health users complained about the loss of time due to waiting and the effect on their domestic work.

To compare with the past, for most respondents in the past waiting was limited to certain acceptable hours unlike today where they have to wait for hours and move from one centre to another looking for treatment. The latter, it was noted, was because of the lack of treatment in some centres, so the patients have to move from one centre to another in search of where they can find treatment, in the process the indirect cost price was found to be larger than they have ever experienced.

Issues such as cost price both direct and indirect for services, the availability of medical supplies, confidentiality and privacy, and hygiene conditions are increased experiences for both users and providers of primary health care in Pallisa during the last 10 years of decentralization. Using these as standards of quality of primary care as experienced by the respondents, the study at this stage concludes that the quality of primary health care has not only reduced in terms of accessibility, but as noted earlier, even the little accessibility that people have is regarded not good enough by the

respondents and it constitutes an experience. This study also demonstrated that users could reject the use of poor quality services, especially if they perceive it to be so as demonstrated by the users, especially the pregnant women. The implication for the policy makers in Uganda is that given this perception by the users about the quality of primary care, efforts by the government to put up the infrastructure without equipping them and improving the delivery of services in the primary care structures will be rendered useless, because as demonstrated, at most consumers will reject them and the problem of poor health will continue despite such efforts.

7.4 Confidentiality and privacy concerns

The importance of patient's privacy and confidentiality during and after treatment cannot be under estimated. The study noted that some respondents were concerned about the way privacy is ensured under decentralization. Others concluded that confidentiality and privacy is compromised. The health users noted confidentiality issues during and after treatment as a major concern. This, it was noted, has worsened under decentralization because health staff both private and public cannot control the flow of information. The study therefore noted two ways in which confidentiality is compromised: firstly it is compromised as the patients move around with their books (prescription books) which make them expose the information especially to the "quack doctor" in the markets and drug shops, and even in clinics. This seemed to be the case because many patients walked with their prescription books from one provider to another. The study noted that decentralization changed the prescription procedure. For example patients

have to buy their own medical card on which the information is written, and secondly they have to carry these cards with them. The implication for quality of care is that given the illiteracy of most primary health care consumers, they do not guard the information at all, such that the information is exposed.

"The problem is that there are many providers of primary health care (drug shop, clinics, markets, traditional medicine, pharmaceuticals and other primary health care providers) and yet there is no effective means of monitoring to ensure that medical standards are followed"

In the first place the study noted that there are more consumers of health than at any period in Uganda's history (UBOS, 2002; HDS, 2002). This was attributed to the reduced distance to the facility and to a certain extent the flow of information to the communities (fm radios and mobilization). This can also be attributed to increased population of Uganda, which grows at 2.5% on average (Uganda census, 2002). However, this increase has not been matched with the required resources. At most centres the study noted that as a result of the increased attendances there was lack of adequate space, such that most health centres did not have consultation rooms so that consultation between the staff and the patient took place in the open, but most of the time this was done under the trees where all the patients surrounded the health staff and could see and hear any discussion between the staff and other patients. The study noted that this did not only make the patients apprehensive in talking about their health, but also made them less frank in expressing themselves before the health staff.

To the users this was tantamount to a compromise in good practice in medical provision, as confidential issues cannot be maintained under such

situation. This was the case in the maternal wards, which according to the study, is one of the reasons why some expecting mothers did not want to deliver in the centres, and therefore opted out for other alternatives, hoping to preserve their privacy. Although the study did not document cases of stigmatization, there were cases where patients complained of the "rumours" about them resulting from the failure of the health service delivery to ensure confidential matters are well preserved, which is not possible under such circumstances. While this can be attributed to the liberalization policy and the unending roles of the private providers, some of them lacked medical qualification and therefore had no knowledge about medical ethics. The problem is that of delegation of responsibilities without adequate resources. Most respondents related these problems to the inefficiencies in the public system, which creates markets for health care outside the public sector system, but more so to the lack of capacity by the public health sector to absorb the ever increasing patients.

7.5 Prescription is compromised

While, the study noted that most patients were asked to come with their own "prescription books" which replaced the medical form five that used to be given in the hospital, the study also noted that prescriptions and medical examinations were not done according to proper standards. The users and the providers noted that because of the shortages of the health staff and the increasing numbers of patients, the health staff is not in position to examine the patients as required. Many patients complained of just being touched and not well-examined, other users complained of being examined by junior

staff who lacked experience and were assumed to know nothing. This was attributed to the inability of the local government to recruit and retain well-qualified staff, which makes them depend more on the junior staff such as the nursing aides for most of the work.

7.6 The perception of the health staff: fighting for identity

The study noted that the responsibility for recruitment, retention and remuneration of the health staff was like many other responsibilities devolved to the local government. This study aimed to know how this has been experienced by the primary health staff in Pallisa and its implications for the quality of primary health care that the health staff deliver. Major issues that were captured in the study relate to the social status and the self, which I termed "status incongruity" and its relationship to the behaviours of the health staff and their relationship to the delivery of quality primary health care. The study however noted that under decentralization, two major themes cross-cut the lives of the health staff inside and outside the decentralized health facilities: professional identity which entails recognition for doing quality work, and that of how to survive and maintain a status and a life style befitting a member of the health staff amidst dwindling opportunities.

The status of the health staff is determined to a certain extent by the structure and the operation of their work place (health institutions), their families and the extent to which they satisfy their personal needs and how certain are their career prospects that the organization offers. The study noted that neither is offered by decentralization. The desire to do quality

jobs, the need to maintain the life style that the staff has enjoyed in the past, and the failure to achieve is deemed greater experiences. This conclusion drives the debate to a further degree by arguing that decentralization has affected the morale of the primary care providers negatively, since it does not offer opportunities and therefore does not satisfy their aspirations. And more importantly, is that any choice of action that the medical staff take are mediated by the nature of the needs.

The study noted that such aspirations have not been possible; hence the health staff in Pallisa live a life inconsistent with their aspirations, what I have termed status inconsistencies. The centrality of the desire by the health staff to maintain a life style and the inability of the local government to meet the health staff's needs is what is presented here as a driving force behind the much publicized bad practices by the health staff in Uganda. This conclusion therefore contrasts sharply to that of Mcpake (1999) in which the health staff are presented as irresponsible only profit seekers who cared less about their patients but aimed to get money out of the unfortunate circumstances of the health seekers. While this could be happening else where, in Pallisa the study did not find any relationship between medical supply shortages and the health staff but the medical shortages were found to be originating from the central medical supply in Kampala. The study also noted that the health staff are willing to work to help their communities, but were constrained by the health organization which is characterized by medical supply shortages. Therefore the study noted that private work represents their own pursuit of their own strategies that they hope will

mitigate the worst circumstances.

The study showed that unfavorable conditions are in themselves existing because of the government inabilities, and low investments in the health sector, and the inability of the local government to maintain the status of the health staff as it had been before decentralization. Therefore, private practice outside the public sector cannot be taken as a cultural given among the health staff in Pallisa, rather it should be seen as an indicator of the problems that the health sector managers have to address.

The relationship of the above to the quality of care delivered is devastating. These private practices take away the public health staff. In some incidences, some health staff prefers to stay on their private activities rather than coming to work in the public primary centres. The consequences are that the health units are left without the staff most of the time, while those who come to the health sector are less motivated to do quality work. Although most of the problems identified by the staff were lack of supplies such as medical equipments, drugs, gloves, and many other medical requirements that rendered them less effective in their work place, personal concerns of the health staff included the low and inequitable wages, poor living standard, job insecurity and uncertainty which accordingly make them demoralized in their work place and their communities where they live. These were some of the exacerbating factors in their circumstances. Because of the supply shortages and the ineffectiveness of the health organization most health staff regard themselves as less effective and therefore less respected by the communities because of their failure to provide health services whenever

approached by the patients.

Generally, decentralization has caused a status incongruity amongst the health staff. Even those who attempt to do work outside the public health sector have not been able to regain their status; instead it has continued to fall. The problem is that under such confusion of how to survive, the way health staff react and deliver services is negatively affected. It is learnt from this study that while decentralization increases the management powers of the health staff by offering them administrative roles, in the same way it undermines their clinical powers and how they are seen by the ordinary service users.

7.7 Recommendations based on the study

Although this study does not recommend a return to centralization; it does however, points to implementation requirements that have made it less successful in Pallisa. The study concludes that one approach to (re) building public service provision is to establish mechanism for popular participation, with a view to enhancing accountability of service providers to the general public. Strengthening participation and accountability are often, at least on paper, taken as integral components of decentralization programmes in Uganda. The findings of this study presented here, however, highlight the considerable challenges faced in implementing such a strategy in poor areas such as Pallisa. The finding suggest that the assumption that participation and decentralization are likely to be effective as a tool for improving health service delivery and enhancing quality services must be questioned. The study makes it clear that the success of efforts to encourage decentralization is influenced by the broader context of institutional and financial capacity in

which they are implemented. The study noted that decentralization imposes heavy demands on the state's resources and demands strong capacity for over sight, advice, direction and co-ordination. Popular participation can only serve as a supplement to such capacity, and requires both a context of user's dependence on public provision and participatory political culture. The study also noted that even then, participation does not come out simply because opportunities for it exist.

The difficulties highlighted by this study also points to three particular lessons for efforts to deliver high-quality services by strengthening popular participation and decentralization. First, health workers must be paid adequately, and resources for technical supervision made available. Secondly, a careful balance of local and extra-local oversight mechanisms is required. Thirdly, efforts to improve health services quality must be made and publicized, thereby providing the foundation for public interest in exercising voice in the decision- making.

2 APPENDIX

APPENDIX I

GUIDE FOR INTERVIEWING BOTH USERS AND STAFF

The aim was to gather in-depth information from both the users and the providers so that we can understand the impact of decentralization on the primary health service delivery and to relate that to the orthodox positions of the health service consumers and the health staff on the one hand and the health managers on the other. To do this, the interview process treated both respondents as social actors who have constructed their own ideas and interpretations in the social and economic world in which their experiences are formed.

The interview guide was designed around the two main research questions raised in Chapter two. The questions on their personal background were asked in a routine manner. There was no sequence to the rest, but were asked in relation to the process and trend of the conversation with each individual respondent. The guide was:

1. Personal and family background
Age
Gender
Treatment sought
Occupation
Origin
2. Perception of the quality of primary care
Quality of the facilities
Availability of drugs
Availability and quality of the staff
Waiting time
Cost of treatment
Level of involvement, who and why
Sources of treatment
3. Utilization of care
How they use the services
Why they use or don't use
Factors affecting the use and none use
Their interpretation of the economy
4. The structure and delivery of primary care
Levels of primary care delivery
Funding and sources of funds
Levels of autonomy on planning and use of funds

Role of the communities

5. The health staff and Managers.

5.1 Responsibility and power

Position of responsibility

Age

Gender

Time spent at the facility

Cadre ship

5.2 Their views on work conditions and job satisfaction.

Job security

Workloads

Wages and salary

Performance at work

View on the economy

5.3 Survival strategies

What do they do?

Why do they do that?

What does it mean to them to do these activities?

How does it affect them?

APPENDIX II

Map of Uganda

APPENDIX III

Representatives of the Participants

Because of ethical reasons, I have not given the names of the participants. I have instead provided the number of participants by sex with regards to the users. With regards to the health staff, I have provided the number of staff interviewed and the cadre ship. Lastly, the representative health centres are shown below to indicate the distribution of my representatives.

Users and providers of primary care interviewed in Pallisa	
Women	21
Men	8
Total men and women users	29
Health staff interviewed	
Doctor	6
Clinical officers	4
Midwives/nurses	7
Other managers and administrators	6
Total health staff and managers interviewed	23
Total respondents staff + users	**52**
Health centres that participated in the study	
Kadama health centre	HCIII
Budaka health centre	HC1V
Bulanagira health centre	HCIII
Molokokyomo health centre	HCII
Budaka health centre	HC1V
Naboa health centre	HCIII
Kabweri health centre	HCII

3 BIBILIOGRAPHY

Abel, J. (2003) 'The Face of our Health Care'. The Quality of Health Care in Uganda. Unpublished.

Acaya G. (2001) "Increased Utilization, Reduced Quality: The Result of Cost Sharing in Busia" *Uganda Health Bulletin* 7 (3): 49-53.

Agrawal, A. and Ribbot, J., (1999) "Accountability in Decentralization: A Framework for South Asia and West Africa Cases". *Journal of Development Areas* (33): 493-502.

Aitken I. (1999) Decentralization and the Reproductive Health in Kolehmanen-Aitken (3rd edition). "Myths and Realities about the Decentralization of Health Systems" *Management Science for Health*, Boston.

Akin, J. et al., (2000) "Decentralization and Government Provision of Public Goods: The Public Health Sector in Uganda," *MEA Evaluation*, The University of North Carolina at Chapel Hill.

Araujo, J (1997) "Attempts to Decentralize in Recent Brazilian Health Policy Issues and Problems, 1988-1994" *International Journal of Health Services* 27 (1): 109-24.

Asiimwe, D. (1996). *"Informal Markets and Formal Health financing policy" Makerere Institute of Social Research*, Kampala, and Uganda Ministry of Health Entebbe.

Assiimwe D. et al., (1997) The Private Sector Activities of Public Sector Health Workers in Uganda', in S. Bennet, B. Mcpake and A. Mills (eds.), "*Private Health Providers in Developing Countries: Serving the Public Interest*"? *London and Atlantic Height*, NJ: Zed Books.

Assiimwe, D. et al., (2002) *"Copying Strategies of Health Workers in Uganda. Personnel Performance and Providing Health Care under Adverse Conditions: individual copying strategies" Studies in Health Service Organization and Policy, Antwerp*: ITG Press, 157-162.

Atkinson, S. et al. (2000) *"Going Down to the Local: Incorporating Social Organization and Political Culture into Assessment of Decentralized Health Care". Social Science and Medicine* 51:619-36.

Azfar, O. et al. (2001) Conditions for effective decentralized governance: a synthesis of research findings. *College Park, University of Maryland, Centre for Institutional Reform and the Informal Sector.*

Background to the District Budget, Pallisa District, 2000

Badham. P & Mookherjee, D. (1998). *Expenditure under Decentralization and the Delivery of Public Services in the Developing Countries.* Department of Economics, University of Berkeley.

Bennet S, et al., (2000) *Health Workers Motivation and the Health Sector Reform.* PHR Premier for Policy Makers. Washington D.C.

Bennet, S. et al., (2001) *Health Financing: Designs and Implementing Pro-poor Policies.* London: DFID Health System Resource Centre.

Besley, T., and S. Coate (1999) "Centralized Vs Decentralized provision public goods: a political economy analysis" Working Paper 7084. *National Bureau for Economic Research, Cambridge, Mass.*

Bird, R. et al. (1995) *Decentralization of the Socialist State: Inter-governmental* Finance in Transition Economies. Washington D.C. World Bank.

Birungi H. (1998) '"Injections and Self help: Risk and Trust in Ugandan

Health Care". *Social Science and Medicine* 47(10): 1455-62.

Birungi H, et al., (1998) "The Policy on Public-Private Mix in the Ugandan Health Sector: Catching up with Reality" *Health Policy and Planning* 16 (Supplement 2):79-86. Kampala Uganda.

Blackie, N. (1993) *Approaches to Social Enquiry, Cambridge*: Polity Press.

Blaxter, L., Hughes, C. and Tight, M. (1996) *How to Research*: Buckingham, Open University Press.

Bloor K. et al., (2003) Planning Human Resources in Health Care. Towards Economic Approach. An International Comparative Review Ottawa. Canadian Health Service Research Foundation.

Bossert T. Beuvais J. C (2002) "Decentralization of the Health System in Ghana, Zambia, Uganda and the Philippines" A Comparative Analysis of Decision Space in *Health Policy and Planning* 17(1): 14-31.

Bossert, T et al., (2000) *Decentralization of Health Systems: Preliminary Review of Four Country Case Studies. Major Applied Research 6, Technical Report No.1. Partnership for Health Reform Project. Associates Inc.*, Bethesda, Md.

Bossert, T. (1998) "Analyzing the Decentralization of Health Systems in Developing Countries: Decision Space, Innovation and Performance," *Social Science and Medicine*, 47 (10) pp.1513-1527.

Bulmenthal, D. et al., (1998) "A report Card and Continuous Quality Improvement." *The Milbank Quarterly*, 76 (4): 625-647.

Brijlal, V. et al., (1998) Health Sector and Financing: Key issues in Decentralization" *Background Paper Commissioned by the Education Development Institute of the World Bank for Flagship Course*, University of

Cape Town and the University of the Witwatersrand.

Campos-Outcalt, D. et al. (1995) "Decentralization of Health Services in Western Highland Province, Papwa New Guinea: An attempt to Administer Health Service at Sub district Level" *Social Science and Medicine* 40(8): 1091-98.

Campos-Outcalt, D., and W. Newbrander (1989) "Decentralization of Health Services in Papwa New Gunea" *Health Policy and Planning* 4(4):347-53.

Cockroft, A. (1997) "Performance and Decentralization of the Health and Agricultural Services in Uganda: A Report Based on Findings of Baseline Services Delivery Survey" *World Bank, Washington, D.C*

Cooper and Marshall, (1999) "Occupational Sources of Stress: A review of the Recent Literature Related to Job Distress: Recent Research and the Emerging Roles of Clinical Occupational Psychologists" *Bulletin of British Psychological Society,* 39,325-331.

Creswell, J.W. (1994) Research Design: Qualitative and Quantitative Approaches: *London:* SAGE Publications.

Crook,& Manor, J. (1998) *Democracy and Decentralization in South Asia and West Africa: Participation, Accountability and Performance.* Cambridge University Press.

Crotty, M. (1998) *The Foundation of Social Research*: *Meaning and Perspectives in the Research Process*, London: SAGE Publication.

Daba, A. (1998) *Status of the Process of Decentralization in Uganda.* World Bank, Washington D.C.

Danish International Development Assistance (2001) *Uganda Health Sector Support Program*. Copenhagen: DANIDA/Ministry of Foreign Affairs.

David, S (1985). *A. Qualitative Methodology and Sociology*. Biddles Ltd, UK.

David, S (1993) *Interpreting Qualitative Data. Methods for Analyzing Talks, Text and Interactions*. Sage Publication, London.

Donabedian, A. (1988) "The quality of care: How can it be assessed?" *Journal of the American Medical Association* 260(12): 1743-8.

Dusult, G and Dubois (2003) "Human Resources for Health Policies: A critical Component in Health Policies". *Human Resources for Health* (1): 1-25.

Enemu, F. (2000) "Problems and Perspectives of Local Governments" pp.181-204 (chapter7) in G. Hyden, D. Olowu & H.Ogendo (eds.) African Perspectives of Governance, Trenton Asmara: Africa World Press.

England, S. et al., (2001) *Practices and Policies on User Fees for Immunization in Developing Countries."* WHO, Geneva.

Francis, P. and James (2003), "Balancing Rural Poverty Reduction and Citizen Participation: The Contradiction of Uganda's Decentralization Program", *World Development,* Vol. 31, No.2, pp. 325-337.

Fukasaku, K. & de Mello, L. (eds.) (1999) *Fiscal Decentralization in Emerging Economies: Governance Issues. Paris*: OECD, Development Centre.

Gilson, L. and Travis P. (1997) *Health System Decentralization in Africa: An overview of Experiences in 8 Countries*. Background Document Prepared for the Regional Meeting on Decentralization in the Context of

Health Sector Reform in Africa. World Health Organization

Gilson, L., P. Kilma, and M. Tanner (1994) "Local Government decentralization and the health sector in Tanzania" Public *Administration and Development* 14.451-77.

Golooba–Mutebi, F. (1999) "Decentralization, Democracy and Development Administration in Uganda: Limits to Popular Participation" (DPhil Thesis: London School of Economics.

Government of Uganda (1999) The National health policy.

Government of Uganda, (1995) The Civil Service Reform Programme: Restructuring Report, Ministry Of Health, Kampala.

Government of Uganda (2004), Background to the Budget 2004-2003. Kampala: Ministry of Finance, *Planning and Economic Development.*

Government of Uganda, (1994) *"Decentralization in Uganda: The Policy and its Implications". Kampala*: Ministry of Local Government.

Government of Uganda, (2003) "Health Sector Review Report". Kampala. Ministry of Health.

Gyapong M. et al., (1995) "Risk Factors for Child Mortality in Ghana: A case Control Study" *International Journal of Epidemiology.* 24(1): 127-135)

Hakim, C. (1987) *Research Design: Strategies and Choices in the Design of Social Research.* London, Rutledge.

Hay, R., (1998) "*Health Services in Uganda*" World Bank, Ministry of Finance, Public Expenditure Review, 1997.

Herman, S. et al, (1982) *Confidentiality of Health Records: The Meeting of Law, Ethics and Clinical Issues.* Gardener Press, Inc, New York.

HIMS, 2003, Pallisa District, Uganda

Hirschman, A. (1970) *Exit, Voice and Loyalty.* Cambridge, Mass.: Harvard University Press.

Hughes, J.A. (1990) *The Philosophy of Social Research.* New York, Longman Inc.

Hutchison P (1999) *"Decentralization of Health Services in Uganda: Moving Improved Delivery Services."* in P.Hutchison, *"Health Care in Uganda: Selected Issues"*. World Bank Discussion Paper. Washington D.C.

Hutchison Paul (1999) *Health Care in Uganda. Selected Issues*: World Bank Discussion Paper, No.404.

Hutchison, P. (1998a) *"Equity and Access of Health Care: The Effects of Income, Access and Gender"* World Bank, Uganda Resident Mission, Kampala.

Hutchison, P. (1998b), *"The Survey of District Directors of Health Services"*. World Bank. Uganda Resident Mission, Kampala.

International Labor Organization (1998) *Terms of Employment and Working Conditions in the Health Sector Reforms.* Report for Discussion at the Joint Meeting on the Terms of Employment and Working Conditions in Health Sector Reform, Geneva

Jakarta Declaration (1997) *Extract from the 4th International Conference on Health Promotion*: New Players for A new Era, and the Jakarta Declaration on Leading Health Promotions into the 21st Century, Jakarta, Indonesia.

Jepson, A. et al., (2000) "Vertical and Holistic Decentralization of the Health Sector: Experiences from Zambia and Uganda" *International Journal of Health Planning and Management.* (15) (2001), pp.273-289.

Jepson A. (2001), "Financial Priorities under Decentralization in Uganda" *Health Policy and Planning* 16:187-92.

Jita, J. (1998) "Quality of health care services in health care Systems in Africa" Copenhagen" University of Copenhagen, *Erica Health Network.* 35-47.

Jita, J. et al, (1993) "Economic Survival Strategies of Health Workers in Uganda: Study Report" December. *Child Health and Development Centre.* Makerere University, Kampala.

Kanu, F (2003) "*The Health Staff's Image among the Antenatal Users in Uganda*" Unpublished

Kapiriri L. (1994) "Towards a Healthier Kampala through urban primary health care" master's degree thesis. Royal Tropical Institute, Amsterdam.

Kato R, (2000) "Uganda Private Midwives Association Annual Report". *Uganda Private Association*, DISH Project, Kampala.

Ken, F. (2002) "Health Care under the New Management: The Retreat of the State and the Falling Standard of Care in Uganda". *Uganda Medial Journal*, 29 (12-34).

Kiing, S. (2003) "What Decentralization Can do and cannot do: The Retreating State and the Worsening Quality of Care", *Uganda Medical Journal*, (21): 223-312.

Kiseka, J. Quoted in *The New Vision*, 15 March, 1995, Kampala Uganda

Kolehmainen, A. et al., (1997) *Decentralizing the Management of Health and Family Planning Programmes*. Management Science for Health. Boston USA.

Kolyangha, S. quoted in *The New Vision*, 21/May/2003 ,Kampala

Uganda

L. C. Moler, (2002) "Infant mortality in Uganda 1995-2000: Why Non Improvement"? *Uganda Health Bulletin*, (8) pp.211-214.

L.O. Gostin, (1999) "Privacy and the Law: An End to Genetic Exceptionalism". *Jurimetrics Journal* 40:21-58)

Langaseth, P. (1996a) "Civil Service Reform: A General Overview" in S.Villadsen and F. Lubega, (Ed). *Democratization in Uganda*: *A new Approach to Local Governance. Kampala*: Fountain Publishers.

Litivac, A. et al., (1998), *Rethinking Decentralization in Developing Countries.* Washington, D.C.: World Bank.

Livingston, I. and Charlton, R. (1998) "Raising local authority and district revenue through direct taxation in a low–income developing country" Evaluating Uganda's GPT.' *Public Administration and Development.* Volume,18. pp.499-517.

Lubaale T. (2001) "User Fees, Health Staff Incentives, and the Service Utilization in Kabarole District in Uganda". *Bulletin of the World Health Organization* (77) 200-243.

Lubowa M. (1995) *The Health Sector Infrastructure Development in Uganda*: *towards progress*. Kampala Publishers Inc.

Macrae, J et al., (1995) "A Healthy Peace" Rehabilitation and Development of the Health Sector in a 'Post'-conflict Situation. The Case of Uganda. *PHP Departmental Publication* No. 14, London School of Hygiene and Tropical Medicine.

Makerere Institute of Social Research (1997) Study of the Effect of the Decentralisation Reform in Uganda, *Report Prepared for DANIDA.*

Makumbi, I., (1994) "Basics of Decentralization and its Implication to the Health Sector in Uganda" *Uganda Medical Bulletin* (MOH) 1(2): 28-30.

Mamdani M. (1996) *Citizen and Subjects: Contemporary Africa and the Legacy of Late Colonialism*: Princeton University Press, pp.111, 287.

Manor J. (1997a) *Explaining the Popularity of Decentralization.* Washington DC. World Bank.

Manor, J. (1997b) *The Promise and Limitations of Decentralization,* Washington D.C. World Bank.

Manor, J. (1999) *The Political Economy of Democratic Decentralization.* Washington D.C.: The World Bank.

May, T (1993) *Social Research: Issues, Methods and Process.* Buckingham: Open University.

McPake B. et al., (1999) "Informal Economic Activities of Public Health Workers in Uganda: Implication for Quality and Accessibility of Care". *Social Science and Medicine* (49) pp 849-865)

Meads G., Wakida P. (2005) How Uganda's decentralization has shifted the balance: PCT Abroad, Article, Volume 7, Issue 2, pages (14-17)

Merriam, S. B. (1988) *Case Study Research in Education: Qualitative Approach*, San Francisco: Jossey-Bass.

Michael A. and Angela.,B. (1998) *Performance Management. The New Realities*. Institute of Personnel and Development. IPD House, Camp Road, London.

Mike, O. and Richard S. Wellins (1995), Re-*engineering Missing Ingredients. The Human Factor*: Institute of Personnel and Development, IPD House, Camp Road, London.

Mills et al., (1990) '*Health system decentralization: Concepts, Issues and Country Experiences*, Geneva'. World Health Organization.

Ministry of Finance and Macro International (1989) "Uganda Demographic and Health Survey" Kampala.

Ministry of Gender and Community Development, (1997) "The National Gender Policy," Kampala, Uganda

Ministry of Health (2000a) "Draft Health Sector Strategic Plan" (May) Kampala Uganda.

Ministry of Health (2001) "The paradox of Uganda's Poor and Worsening Health Indicators in the Areas of Economic Growth, Poverty Reduction and the Health Sector Reform" *Uganda health Bulletin* (17) pp 3-4.

Ministry of Health (2001) "Utilization of Health Services. Report Circulated at the 5th Joint Review Mission," Nile Conference Centre, Kampala Uganda.

Ministry of Health and WHO, (1996)" Safe Motherhood Needs Assessment Survey" Kampala, Uganda.

Ministry of Health Annual Health Sector Performance Report Financial Year, 2000/2001

Ministry of Health, (1999) "Concept Paper: Uganda Health Sub-district". Kampala, Uganda.

Ministry of Health, (2001) "Health Infrastructure Development and Maintenance Plan" Engineering Department. Kampala Uganda

Ministry of Health, (2002) Ministry of Health Statistical Abstract: Ministry

of Health Kampala, Uganda.

Ministry of Public Services (1998) "National Service Delivery Survey" Kampala, Uganda.

Moler, C. (2002) "Infant Mortality in Uganda 1995-2000: Why the Non Improvement"? *Uganda Health Bulletin* (8) pp. 211-214.

Mookhejee, D. (2001) "Combating the Crisis in Government Accountability" Discussion Paper, No.117. *Boston University Institute for Economic Development.*

Museveni, Y., *Monitor Newspaper*,23 November 1999,pp.4-5,Kampala, Uganda

Muwhezi quoted in the New Vision, Uganda June 23/2003.

Mwabu, G. et al., (1995) "The effect of Prices, Service Quality, and Availability on the Demand for Medical Care, Insights from Kenya". In R.P. Shaw and C.C. Griffin, ed., *Financing Health Care in Sub-Saharan Africa Through User Fees and In insurance*. World Bank, Washington, D.C

Mwabu, G. et al., (2001) in J. Whyte (ed.) (2001) *Social Provision in Low–Income Countries: New Patterns and Emerging Trends*, Oxford: Oxford University Press.

Mwesigye, F. et al (1999) "Priority Service Provision under Decentralization: a case Study of Maternal and Child Health Care in Uganda" *Small-Applied Research Paper*, No.10. Bethesda, Md.: Partnerships for Health Reform Project, At Associates Inc.

Ndomugenyi R. et al., (1998) The Use of Formal and Informal Services for Antenatal Care and Malaria Treatment in Rural Uganda: *Health Policy and Planning* 13(1):94-102 Uganda Kampala.

Nema S. (1994) "Mothers and Midwives: Maternity care in Ankole South Western Uganda." PhD Thesis Submitted to the Institute of Anthropology, University of Copenhagen, Denmark.

Nema S. (2001) "What Traditional Birth Attendants Know and Prescribe for Malaria in Pregnancy?" Uganda Workshop Paper No 41, Lake View Regency Hotel, Mbarara Uganda. Unpublished.

NRM (1986) *The Ten Point Programs.* NRM Secretariat, Kampala Uganda.

Oetes, W.E. (1972) *Fiscal Federalism, Harcourt Brace Jovanovich*: New York.

Okwi, M. (2003) "Widening Choices in Health Care." The Gains From Decentralization in the Health Sector: Unpublished.

Okwi, O (1997) "Sustainability of Health Structures and Systems in Sub-Saharan Africa: Uganda Case Study." *UNICEF, Office of the Evaluation, Policy and Planning*. New York.

Okwonzi SA. (2001) "Uganda's Worsening Health Indicators During Economic Growth: What is Not Right"? *Uganda Health Bulletin* 7(4): pp. 17-23.

Okwonzi, A. and J. Macrae (1995) "Whose Policy is it Any Way? International Influences on Health Policy Development in Uganda" *Health Policy and Planning* (10) pp.122-132. Abstract-EMBASE/MEDLINE.

Okwonzi, S. et al., (1997) *Decentralization and Health System Changes in Uganda:* Ministry of Health and Ministry of Local Government, Entebbe, Uganda.

Olowu D. (2001) *Local Political and Institutional Structures and Processes*, (UNCDF, 2001)

Olsen, I. et al., (1997) " Sustainability of Health Structures and Systems in Sub- Saharan Africa. Uganda Case Studies" Organisation Options. *Public Administration and Development*. 17. pp.399-412.

Olsen, I.T, et al. (1996) *"Sustainability of Health Structures and Systems in Sub-Saharan Africa"*. Uganda Case Study. Geneva. *World Health Organization.*

Pallisa District Background to the Budget, (2002)

Sparr, P, ed. (1994) *Mortgaging Women's Lives: A feminist Critique of Structural Adjustment*, Zed Books Ltd, London and New Jersey

Patience, E. Idemudia, (1994) "Agricultural Exports and Compensatory Schemes- Rural Women's Production Resources and Quality of Life" in Sparr Pammella, (ed) (1994) *Mortgaging Women's Lives: A feminist Critiques of Structural Adjustment*, Zed Books Ltd, London and New Jersey.

Prud'homme, R. (1995) "The Dangers of Decentralization" *The World Bank Research Obsever*.10 (2): 201-20.

Putnum, R. et al., (1993) *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton, NJ: Princeton University Press.

Qadeer, I. et al. eds. (2000) *Public Health and the Poverty of Reforms*, New Delhi: Sage.

Republic of Uganda, Decentralization Secretariat (1994) *Decentralization in Uganda: The Policy and its Implication*. Decentralization Secretariat, Kampala Uganda.

Rondinelli D.et al., (1989) "Analyzing Decentralized Policies in Developing Countries: a Political-Economy Framework" *Development and Change*, 20:50-87.

Ronineli, D et al., (eds.) (1983) *Decentralization and Development: Policy Implementation in Developing Countries*. Beverley Hills, CA, London and New Delhi: Sage.

Safe Motherhood (2002) *Maternal Health around the World*: Kampala Uganda.

Shah, A. (1998) "Fostering Fiscally Responsive and Accountable Governance: Lessons from Decentralization" (pp. 83-96) in R. Piccotto and E.Wiesner (eds.) *Evaluation and Development*: The Institutional Dimension. New Brunswick/London.

Silverman D., (1998) "Qualitative Research: Meaning or Practices?" *Information System Journal* (8): 3-20.

Smith, B. (1997) "Decentralization of Health Care in Developing countries. Organization Options". *Public Administration and Development*, 17, pp.399-412.

Smoke, P. (1994) *Local Government Finances in Developing Countries. The Case* of *Kenya, Nairobi*: Oxford University Press.

Soerajo, W. et al., (2001) *Decentralization and Immunization Services in Indonesia.* Consultant Report Prepared for East Asia and Pacific Division. World Bank, Washington, D.C.

Soren,V. Francis. L. (1996) *Democratic Decentralization in Uganda: a New Approach to Local Governance*. Fountain Publishers Ltd, Kampala-Uganda.

Ssengoba, F (1999) "Implementation Cost-effectiveness of Decentralization in Uganda". Unpublished.

Standing, H. (1997) "Gender and Equity in Health Sector Reform Programs:

A review" *Health Policy and Planning* 12 (1) 1-8.

Standing, H. (2002) "Gender Impacts of Health Sector Reforms: The Current State of Policy and Implementation," *ALAMES meeting, Havana*, Cuba.

Sundar, N. (2001) "Is Devolution Decentralization"? *World Development* 29(12): 2007-23.

Susan Newell, (1995) *The Health Organization, Fairness, Ethics and Effective Management*. New Fetter Lane: London.

Tawfic and, L. et al., (2001) *The Impact of HIV/AIDS in Sub-Saharan Africa: The Issue of Human Resources*. SARA Project.

The Republic of Uganda. The 1995 Constitution, Uganda.

Uganda Bureau of Statistics (2002) *Statistical Abstract:* Entebbe/ Kampala.

Uganda Bureau of Statistics and Macro International, 2000-2001. Calverton, MD, USA: UBOS and ORC Macro, 2001.

Uganda Demographic and Health Survey (2000-2001) Entebbe Uganda, Calverton, Maryland, USA.

Uganda Government (1999) "National Health Policy" Ministry of Health. Kampala, Uganda.

Viladsen, S. (1996a) "Decentralization of Governance" in S. Viladsen and F. Lumbaga (eds.,) *Democratic Decentralization in Uganda: a new approach to local governance.* Kampala: Fountain Publishers.

Waddington C, and Enyimayev E. (1989) "A price to Pay: The Impact of User Charges in Ghana." *International Journal for Health Planning and Management*, (1989) (4) 17-49.

Wanda, G. (2003) "The New Move in the Health Sector: Increasing the Problem or Solution"? Unpublished.

WHO, (1996) *Revised 1990 Estimates of Maternal Mortality: a New Approach by WHO/UNICEF*, WHO, Geneva, (1996)

WHO, 2001) "Report on the Commission of Macro-economics and Health" Geneva: WHO.

Whyte, S (1997) *Questioning Misfortune: The Pragmatics of Uncertainties in Eastern Uganda*. Cambridge University Press.

World Bank (2002) *Poverty and Democracy in Africa*: World Bank, Washington D.C.

World Bank (1999) *World Development Report 1999/2000: Entering the 21st Century. The Changing Development Landscape*, London/New York: Oxford University Press.

World Bank (2000) "Decentralization and Health Care" Decentralization *Thematic Group*. Washington, D.C. (Retrieved on April 10, 2002 from http:// www1.worldbank.org/publicsector/decentralisation/healthcare.htm)

World Bank (2001b) "World Development Indicators", Washington D.C.

World Bank, (1994) *Better Health in Africa.* World Bank, Washington D.C.

World Bank, (1996b) "District Service and Decentralization: Staff Appraisal Report". Washington D.C.

World Bank, (1997) *World Development Reports: The State in a Changing World*. New York, Oxford University press.

World Bank, (1999) *Beyond the Centre: Decentralizing the State,* Washington D.C.

World Bank, (2001c) "Classification of Economies, Development Data Group". *Accessed at http:// www.worldbank.org/data/databytopic/class.htm November, 30th, 2001.*

World Bank, (2002) *World Development Report. Building Institutions for Markets*. Washington D.C.

World Bank, (1993) *World Development Deport: Investing in Health.* New York: Oxford University Press.

World Bank (200b1) "Decentralization and Governance: Does Decentralization Improve Public Service Delivery"? *The World Bank. PREM Notes,* No. 55,

World Health Organization (1978) *Report of the International Conference on Primary Health Care*: Alma- Ata, USSR, Health for All Series No.1 WHO, Geneva.

World Health Organization (1999) "Report of a Meeting of Health Sector Reforms and Priority Health Interventions: The Case of Immunization Services." November 15-16, (1999) Washington, D.C. Geneva.

World Health Organization (2000) *The World Health Report 2000. Health Systems: Improving Performance.* World Health Organization. Geneva.

World Health Organization (2001) *Report on the Effect of Abolition of User Fees*: WHO Uganda Country Office.

World Health Organization and Uganda Ministry of Health, (2002) "The Effects of Abolition of Cost-sharing in Uganda": *World Health Organization and Uganda Ministry of Health; 2002.*

World Health Organization, (2003) *The World Health Report: Shaping the Future*. Ministry of Health, Kampala.

World Health Report (2000). *Health Systems: Improving Performance*, Geneva.

Wunsch, J. (2001) "Decentralization, Local Governance and 'Recentralization' in Africa". *Public Administration and Development*, Vol.21, No.4, pp.277-88.