

**Institutional Pluralism and Interorganisational Relations**

**in Local Health Care Provision in Uganda:**

**Institutionalised Pathologies or Healing Organisations?**

**Inke Mathauer**

**Thesis submitted in fulfilment of the Doctorate of Philosophy**

**in Development Studies**

**University of London**

**2001**

**Development Studies Institute**

**London School of Economics and Political Science**

UMI Number: U615214

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



UMI U615214

Published by ProQuest LLC 2014. Copyright in the Dissertation held by the Author.  
Microform Edition © ProQuest LLC.

All rights reserved. This work is protected against  
unauthorized copying under Title 17, United States Code.



ProQuest LLC  
789 East Eisenhower Parkway  
P.O. Box 1346  
Ann Arbor, MI 48106-1346



7921

F

THESES

## Abstract

### **Institutional Pluralism and Interorganisational Relations in Local Health Care Provision in Uganda: Institutionalised Pathologies or Healing Organisations?**

This thesis is an examination of health care provision in Uganda by means of a case study in Kamuli District. In Uganda, the response to political and economic breakdown in the 1970s has been the spontaneous, decentralised emergence of a pluralist, but fragmented system made up of public, private and voluntary sector providers. While theorists and policy-makers previously placed almost exclusive emphasis on state health care provision, they now favour a system of institutional pluralism. This approach attempts to use the particular advantages attributed to each type of provider to meet diverse needs and conditions. The thesis undertakes a comparative performance analysis of each sector in relation to access, efficient use of resources and quality of care to determine each provider's relative strengths. While the public sector performs worst, the other two sectors also suffer from performance gaps.

An institutional analysis is used to explain the differences in (mal-)performance. First, the thesis assesses the intraorganisational institutional mechanisms of each provider type and their ability of ensuring accountability, financial responsibility and appropriate staff incentives. Secondly, it examines the nature of interorganisational interactions and the effectiveness of the governance mechanisms for the co-ordination and regulation of the system as a whole and illuminates how these affect organisational performance.

The study demonstrates that the intraorganisational institutional set-up, the governance mechanisms and the interorganisational interactions are characterised by a lack of accountability and therefore are constantly distorted through the operation of perverse incentives. These institutionalised pathologies, especially in the public sector, affect performance negatively. It is argued that a system characterised by institutional pluralism is superior. However, to benefit from its full potential and to heal organisations and put them in a position to heal, it is necessary to manage the intraorganisational and interorganisational dimensions simultaneously and to strengthen accountability mechanisms and the actors' capacities and willingness to co-operate.

## Table of Contents

<b>List of Tables</b>	
<b>List of Figures</b>	
<b>List of Maps</b>	
<b>List of Acronyms</b>	
<b>Acknowledgement</b>	

<b>Chapter 1:</b>	<b>14</b>
<b>Introduction</b>	
<u>1.1. The Ugandan Case: A Pluralistic Health Care System</u>	14
<u>1.2. The Case for Institutional and Organisational Pluralism and the Implications</u>	18
1.2.1. From "Either/Or" to "Both/And" Conceptualisations	18
1.2.2. Potentials and Pitfalls of Institutional Pluralism	21
<u>1.3. Aims and Rationale of the Thesis: Research Questions and Research Focus</u>	25
<u>1.4. Research Methods and Data Collection</u>	28
<u>1.5. Overview</u>	39
<b>Chapter 2:</b>	
<b>Health Care Provision, Institutional Pluralism and Interorganisational Relations</b>	<b>42</b>
<u>2.1. Goods Characteristics of Health Care</u>	42
<u>2.2. Private, Public and Voluntary Sector Organisations: Strengths and Weaknesses in Health Care Provision</u>	45
2.2.1. The Private Sector	46
2.2.2. The Public Sector	48
2.2.3. The Voluntary Sector	50
2.2.4. The Institutional and Context Contingencies of the Sectors' Appropriateness	53
<u>2.3. Interorganisational Relations</u>	54
2.3.1. Governance Mechanisms	55
2.3.1.1. <i>Competition</i>	56
2.3.1.2. <i>Regulation</i>	56
2.3.1.3. <i>Network Co-ordination</i>	59
2.3.1.4. <i>The Institutional and Context Contingencies of the Governance Mechanisms' Appropriateness</i>	61
2.3.2. Interactions and Synergies	62
<u>2.4. Determining Relative Strengths and Performance Criteria</u>	63
2.4.1. A Notion of Relative Strengths	64
2.4.2. Criteria Selection Process	65
2.4.3. Performance Criteria	66
<b>Chapter 3:</b>	
<b>Historical Legacies and the Nature and Structure of Health Care Delivery in Uganda</b>	<b>68</b>
<u>3.1. Local Government During Pre-Independence and Re-centralisation in the 1970s</u>	68
<u>3.2. Post-Independence Organisational Change up to 1986: Service Provision Breakdown and Rehabilitation</u>	70
<u>3.3. Health Policies, Policy Making and the Role of Donors after 1986</u>	76
3.3.1. Reconstruction in the Late 1980s	76

3.3.2.	Refinement in the 1990s and the Donors' Dominance	77
3.3.3.	Increased Stakeholder and Provider Co-ordination in the Late 1990s	80
<u>3.4.</u>	<u>Re-decentralisation after 1986 and Today's Local Government Substance</u>	82
3.4.1.	The Establishment of the Resistance Council System	82
3.4.2.	Further Decentralisation after 1993: The Formal-Legal System	84
3.4.3.	The Implementation Status in Kamuli District	88
<u>3.5.</u>	<u>The Nature and Structure of Uganda's Health Care System: Key Features of the Public, Private and Voluntary Sectors</u>	91
3.5.1.	Health Care Financing	91
3.5.2.	The Public Sector	93
3.5.3.	The Private Sector	95
3.5.4.	The Voluntary Sector	97
<u>3.6.</u>	<u>Conclusion</u>	100

#### **Chapter 4:**

#### **The Case Study: Health Care Provision and Utilisation in Kamuli District** **101**

<u>4.1.</u>	<u>Health Care Expenditure and the Role of Donors in Kamuli</u>	102
<u>4.2.</u>	<u>Service Inventory of Curative Health Care Providers</u>	103
<u>4.3.</u>	<u>The Health Care Provider Sample for the Comparative Performance Analysis</u>	105
4.3.1.	Services	108
4.3.2.	Health Unit Management	108
4.3.3.	Financing and Funding	109
4.3.4.	Cost Recovery through User Fee Revenues	111
4.3.5.	Drug Supply	111
<u>4.4.</u>	<u>Promotive and Preventive Health Care Services</u>	113
4.4.1.	Government Services	113
4.4.2.	NGO Services	115
<u>4.5.</u>	<u>Health Care Seeking Behaviour and Utilisation Factors for Curative Services</u>	117
4.5.1.	Medical pluralism	117
4.5.2.	People's Notion of Biomedicine	118
4.5.3.	Health Care Seeking Patterns in the Biomedical Sector	119
4.5.4.	Preferences and Utilisation Factors for Treatment Seeking	124

#### **Chapter 5:**

#### **Unequal Accessibility to Health Care Providers** **127**

<u>5.1.</u>	<u>Household Expenditure on Health Care</u>	129
<u>5.2.</u>	<u>Payment Procedures</u>	130
<u>5.3.</u>	<u>Financial Costs</u>	132
<u>5.4.</u>	<u>Informal Charging and Irregularities</u>	139
<u>5.5.</u>	<u>Exemption Practice</u>	142
<u>5.6.</u>	<u>Deferment: Credit Provision and Partial Payment for Partial Treatment</u>	146
<u>5.7.</u>	<u>Physical Access</u>	153
<u>5.8.</u>	<u>Utilisation Rates and Expenditure Patterns in Relation to Socio-Economic Status</u>	155
<u>5.9.</u>	<u>Conclusion: Restricted Access for the Poorest and Ways Forward</u>	162

<b>Chapter 6:</b>		
<b>Relative Efficiency of Staff Resource Utilisation and Quality of Care</b>		<b>165</b>
<u>6.1.</u>	<u>Efficiency of Staff Resource Utilisation</u>	166
<u>6.2.</u>	<u>Quality of Care</u>	173
6.2.1.	Drug Availability	174
6.2.2.	Staff Behaviour and Commitment	181
6.2.3.	Adequate Provision of Privacy	188
6.2.4.	Waiting Time	189
6.2.5.	Opening Hours and Presence of Qualified Staff	190
6.2.6.	Attendance by Qualified Staff	193
6.2.7.	Quality of Consultation	194
6.2.7.1.	<i>The Provision of a Clinical Examination</i>	194
6.2.7.2.	<i>Quality of Diagnoses</i>	197
6.2.8.	Quality of Treatment and Prescription Patterns	198
6.2.8.1.	<i>Fit Between Diagnosis and Treatment</i>	198
6.2.8.2.	<i>Rational Use of Drugs</i>	200
6.2.8.3.	<i>Use of Clinically Sterilised Syringes</i>	205
6.2.9.	People's Satisfaction with Service Quality	206
<u>6.3.</u>	<u>Conclusion</u>	208
<b>Chapter 7:</b>		
<b>Explaining (Mal-)Performance: Institutional Deficits in Accountability, Financial Responsibility and Staff Equity</b>		<b>212</b>
<u>7.1.</u>	<u>The Theoretical Framework</u>	213
<u>7.2.</u>	<u>The Public Sector: Severe Institutional Deficits</u>	216
7.2.1.	Financial Responsibility	217
7.2.1.1.	<i>Salaries</i>	217
7.2.1.2.	<i>Drugs</i>	218
7.2.1.3.	<i>User Fees</i>	218
7.2.1.4.	<i>Budgeting Versus Actual Expenditure Patterns</i>	219
7.2.2.	Accountability	222
7.2.2.1.	<i>The Health Unit Management and Subcounty Health Committees: Lack of Community Involvement and Community Leverage</i>	224
7.2.2.2.	<i>Inadequate Administrative Control by Subcounty Authorities</i>	228
7.2.2.3.	<i>The Role of the DMO: Supervision Gaps</i>	228
7.2.2.4.	<i>Lack of Political Accountability and Insufficient Local Legitimation</i>	229
7.2.2.5.	<i>Hierarchical Administrative Culture and Suppression of Voice</i>	234
7.2.3.	<i>Incentives and Staff Equity</i>	238
<u>7.3.</u>	<u>The Private Sector: Weakened Exit and Lack of Voice</u>	243
7.3.1.	Financial Responsibility	243
7.3.2.	Accountability	246
7.3.3.	Incentives and Staff Equity	247
<u>7.4.</u>	<u>The Voluntary Sector: Deficits in Participatory Accountability Mechanisms</u>	248
7.4.1.	Financial Responsibility	249
7.4.2.	Accountability	250
7.4.2.1.	<i>Weak Health Unit Management Committees and Voice: Gaps in Community Involvement</i>	252
7.4.2.2.	<i>Adequate Supervision</i>	255
7.4.2.3.	<i>Donor Supervision: The Threat of Exit and Withdrawal</i>	256
7.4.2.4.	<i>Conducive Organisational Culture: Ethical Norms and Loyalty</i>	257
7.4.3.	Incentives and Staff Equity	258
<u>7.5.</u>	<u>Conclusion</u>	260

<b>Chapter 8:</b>		
<b>Deficient Interorganisational Relationships and Their Impact on Organisational and System (Mal-)Performance</b>		<b>263</b>
<u>8.1.</u>	<u>Methodological Considerations</u>	265
<u>8.2.</u>	<u>Regulation and Supervision of Private Clinics</u>	266
8.2.1.	The Formal Regulatory Framework	266
8.2.2.	Regulation in Practice	268
8.2.3.	The Reasons for Inadequate Regulation and Implementation	271
8.2.4.	Ways Forward: Incentive-Based Regulation	273
<u>8.3.</u>	<u>Regulation and Supervision of Drugshops</u>	275
8.3.1.	The Formal Regulatory Framework	275
8.3.2.	Regulation in Practice	277
8.3.3.	The Reasons for Inadequate Regulation and Implementation	279
8.3.4.	Ways Forward: Incentive-Based Regulation	281
<u>8.4.</u>	<u>Regulation and Supervision of NGO Providers</u>	282
8.4.1.	The Formal Regulatory Framework	282
8.4.2.	Regulation and Supervision in Practice	283
<u>8.5.</u>	<u>Network Co-ordination</u>	284
<u>8.6.</u>	<u>The Potential and Pitfalls of Partnerships</u>	286
8.6.1.	Partnership Arrangements	287
8.6.2.	The Benefits of Partnership Arrangements	290
8.6.3.	Face-to-Face Interaction in Practice: The Pitfalls of Partnerships	292
<u>8.7.</u>	<u>Explaining Interaction Patterns: Perverse Incentives and an Impeding Interaction Culture and Structure</u>	295
8.7.1.	The NGOs' Set of Incentives to Co-operate	295
8.7.2.	Perverse Incentives for the Administration Not to Co-operate	297
8.7.3.	Impeding Interaction Culture and Structure	299
8.7.4.	A Weak Civil Society: Lack of Impact upon the Local State	300
<u>8.8.</u>	<u>Interorganisational Relations and their Effect on the Functioning of the Referral System</u>	302
<u>8.9.</u>	<u>Conclusion</u>	304
<b>Chapter 9:</b>		
<b>Conclusion: Institutionalised Pathologies or Healing Organisations?</b>		<b>308</b>
<u>9.1.</u>	<u>The Potential and Pitfalls of Institutional Pluralism</u>	308
<u>9.2.</u>	<u>Wider Implications and Reflections</u>	312
9.2.1.	Weak Intellectual Thrust of Institutional Pluralism? Or: The Importance of Preconditions and Informal Institutions	312
9.2.2.	Which Provider Type to Set On?	315
9.2.3.	Is Institutional Pluralism Superior?	316
<u>9.3.</u>	<u>Making Institutional Pluralism Work: A Multi-Dimensional Approach to Reform</u>	317
<u>9.4.</u>	<u>From Institutionalised Pathologies to Healing Organisations</u>	323
<b>Bibliography</b>		<b>325</b>
<b>Annexes</b>		
Annex 1: Further Methodological Issues		349
Annex 2: List of Interviews		363
Annex 3: Organisational Diagram of the District Medical Office		377
Annex 4: Distribution of Exit Respondents		378
Annex 5: User Charges for Malaria Treatment		379
Annex 6: Distributions and Chi-Square Test Scores		381

## List of Tables

Table 1.1:	Health indicators	15
Table 1.2:	Research methods and research aspects	29
Table 3.1:	Central and local government tasks	85
Table 4.1:	Inventory of health care facilities in Kamuli District	103
Table 4.2:	Health care providers in Kamuli town	104
Table 4.3:	Organisational inventory in selected areas	107
Table 4.4:	HUMC composition	109
Table 4.5:	Funding and financing sources	110
Table 4.6:	Cost recovery rates	111
Table 4.7:	PPHC activities of local NGOs in Kamuli	116
Table 5.1:	Official payment procedures for outpatient curative care	131
Table 5.2:	User fee rates at rural government clinics	133
Table 5.3:	Additional costs incurred at government clinics	134
Table 5.4:	User fee rates at urban health care providers	138
Table 5.5:	Additional costs incurred at the urban government clinic	138
Table 5.6:	Exemption policy and practice	143
Table 5.7:	Transport costs	154
Table 6.1:	Staff presence at rural providers	191
Table 6.2:	Staff presence at urban providers	191
Table 6.3:	Treatment quality	199
Table 6.4:	Rational use of drugs	200
Table 6.5:	Use of home-sterilised syringes	205
Table 7.1:	Respondents' knowledge of and interaction with government HUMCs	227
Table 7.2:	Monthly staff salaries/incomes earned in the public, private and NGO sectors	239
Table 7.3:	Allowances paid in government clinics	241
Table 7.4:	Knowledge of and interaction with HUMCs of NGO clinics	253
Table 8.1:	Agreed financial and technical support for NGO clinics	288
A1, Table 1:	Distribution: Poor vs. better-off household respondents	362
A1, Table 2:	Distribution: Female and male household respondents	362
A1, Table 3:	Distribution: Poor vs. better-off exit respondents	362
A4, Table 1:	Distribution of exit interview respondents	378
A5, Table 1:	User charges for oral malaria adult treatment at rural health care providers	379
A5, Table 2:	User charges for oral malaria adult treatment at urban health care Providers	379
A6, Table 1-17:	Distributions and Chi Square test scores for Chapters 5.6. and 5.8.	381

## List of Figures

Figure 2.1:	The sector poles	45
Figure 3.1:	Donor funds by source for 1991/92	78
Figure 3.2:	Government and donor contribution to recurrent and development funds	78
Figure 3.3:	Health expenditure channelled to the Primary Health Care level	79
Figure 3.4:	The LC-system in rural areas	87
Figure 3.5:	Health care expenditure sources	92
Figure 3.6:	Per capita expenditure	92
Figure 4.1:	Treatment seeking decisions	120
Figure 4.2:	Utilisation pattern of the household sample	121
Figure 4.3:	Utilisation of urban and peri-urban household respondents	122
Figure 4.4:	Utilisation rates in the formal sector	122
Figure 5.1:	Household out-of-pocket expenditure at the health care providers	130
Figure 5.2:	Costs at rural health care providers	133
Figure 5.3:	Cost comparisons within Subcounties	136
Figure 5.4:	Costs at urban health care providers	137
Figure 5.5:	Extent of bribing	139
Figure 5.6:	Percentage of patients with credit provision at rural providers	147
Figure 5.7:	Percentage of patients with deferred payment at urban providers	150
Figure 6.1:	Average monthly outpatient throughput per (qualified) staff at rural providers	169
Figure 6.2:	Average monthly case throughput per (qualified) staff at rural providers	170
Figure 6.3:	Average staff salary costs per patient at rural providers	170
Figure 6.4:	Average monthly patient throughput at rural government health units	171
Figure 6.5:	Average monthly patient throughput per (qualified) staff at urban providers	172
Figure 6.6:	Average staff salary costs per patient at urban providers	172
Figure 6.7:	Percentage of patients that received (all) drugs at rural providers	175
Figure 6.8:	Percentage of patients that received (all) drugs at urban providers	176
Figure 6.9:	Satisfaction with staff behaviour at rural providers	182
Figure 6.10:	Satisfaction with staff behaviour at urban providers	182
Figure 6.11:	Average waiting time until registration/attendance	189
Figure 6.12:	Qualification of attending staff at rural health care providers	194
Figure 6.13:	Qualification of attending staff at urban health care providers	194
Figure 6.14:	Percentage of patients being examined, patient's perception	195
Figure 6.15:	Relative examination quality	197
Figure 6.16:	Average number of drugs prescribed	201
Figure 6.17:	Patient satisfaction with the service quality at rural providers	207
Figure 6.18:	Patient satisfaction with the service quality at urban providers	208
Figure 7.1:	Formal accountability chains in the public sector	223
Figure 7.2:	Formal accountability chains of rural clinics in the NGO sector	251
Figure 8.1:	The formal regulatory and supervisory system of private clinics	267
Figure 8.2:	The formal regulatory and supervisory system of drugshops	276
A3, Figure 1	Organigram of the District Medical Office	377
A5, Figure 1	Costs for malaria treatment	380

## List of Maps

Map 1:	Uganda	12
Map 2:	Kamuli	13

## Acronyms

ADI	Assistant Drug Inspector
approx.	approximately
CAO	Chief Administrative Officer
CFO	Chief Finance Officer
CBHC	Community Based Health Care
CBO	Community Based Organisation
CIDA	Canadian International Development Agency
DALE	Disability Adjusted Life Expectancy
DALY	Disability Adjusted Life Years
DANIDA	Danish International Development Assistance
DDHS	District Director of Health Services
DED	German Development Service
DENIVA	Development Network of Indigenous Voluntary Associations
DFID	Department for International Development
DHE	District Health Educator
DHI	District Health Inspector
DHSP	District Health Service Pilot and Demonstration Project
DHV	District Health Visitor
DISH	Delivery of Improved Services for Health (USAID program)
DMO	District Medical Office
DMU	Dispensary and Maternity Unit
DNO	District Nursing Officer
Dr.	Doctor
EC	European Community
EDK	Essential drug kit
e.g.	for example
FGD	Focus group discussion
FP	Family Planning
GDP	Gross Domestic Product
GTZ	German Agency for Technical Co-operation
HA	Health Assistant
HC	Health Centre
HDI	Human Development Index
HU	Health Unit
HUMC	Health Unit Management Committee
I/C	In-charge
i.e.	that is
IEC	Information, Education, Communication
JMS	Joint Medical Store
KDA	Kamuli District Administration
KfW	Kreditanstalt für Wiederaufbau
km	kilometre
LC	Local Council

LDCs	Least Developed Countries
LGA	Local Government Act
MA	Medical Assistant
MFEP	Ministry of Finance and Economic Planning
min.	minutes
MoA	Ministry of Agriculture
MoH	Ministry of Health
MoLG	Ministry of Local Government
N	Number
N/A	not available
NDA	National Drug Authority
NDPA	National Drug Policy and Authority
NGO	Non-Governmental Organisation
NRM	National Resistance Movement
ODA	Overseas Development Aid
OPD	Outpatient department
PHC	Primary Health Care
PPHC	Preventive and Promotive Health Care
PRSP	Poverty Reduction Strategy Paper
PU	Planning Unit
PWAs	People Living with AIDS
RC	Resistance Council
RDC	Resident District Commissioner
RH	Reproductive Health
SAA	Sub-Saharan Africa
SC	Subcounty
SCHC	Subcounty Health Committee
Shs	Shillings
STD	Sexually Transmitted Disease
STIP	Sexually Transmitted Infections Programme
SWAP	Sector Wide Approach
TBA	Traditional Birth Attendant
T.C.	Trading Centre
UCBHCA	Uganda Community Based Health Care Association
UCMB	Uganda Catholic Medical Bureau
UCR	User charge revenues
UECP	Uganda Early Childhood Program
UEDMP	Uganda Essential Drug Management Programme
UMDPC	Uganda Medical and Dental Practitioners Council
UMDPS	Uganda Medical and Dental Practitioners Statute
UNDP	United Nations Development Program
UNEPI	Uganda National Extended Program of Immunisation
UPMB	Ugandan Protestant Medical Bureau
USh	Ugandan Shillings
WHO	World Health Organisation

### **Facility code**

D	Drugshop
uG	Urban government clinic
rG	Rural government clinic
uN	Urban NGO clinic
rN	Rural NGO clinic
P	Private clinic

### **Local NGOs in Kamuli**

AEGY	AIDS Education Group for Youth
CCF	Christian Children Fund
FFWP	Family Federation for World Peace
IMAU	Islamic Medical Association of Uganda
KAASFA	Kamuli AIDS Alleviation Support for Families Association
KADIWODA	Kamuli District Women's Development Association
KAEA	Kamuli Adult Education Association
KAMASO	Kamuli Mission AIDS Support Organisation
KREDA	Kamuli Rural Economic Development Association
NACWOLA	National Council for Women Living with AIDS
NASCRUD	Numerous Actions and Solutions for Community and Rural Development
UCOBAC	Ugandan Community Based Association for Child Care
UNFA	Ugandan National Farmers' Association
USSIA	Ugandan Small Scale Industry Association
UTHA	Ugandan Traditional Healers' Association
UWFCT	Ugandan Women's Finance and Credit Trust

## **Acknowledgement**

This research benefited from the intellectual input and support of many people.

First of all, at the London School of Economics, my greatest thanks go to Dr. Teddy Brett, to whom I am greatly indebted through his valuable input as well as his generous time for discussions, which have shaped my thesis and my thinking. I am also very grateful to Dr. Elizabeth Francis for her supervision, support and feedback.

My interest in institutional pluralism and interorganisational relations developed during the action research project "Entry points for the promotion of subsidiarity by the German Development Service". This project was funded by and carried out under the auspices of the German Development Service (DED) in co-operation with the Faculty of Administrative and Political Science (University of Konstanz) and was directed by Prof. Dr. Klaus Simon. I am grateful to him for his guidance, support and the many discussions.

I owe special thanks to Klaus-Dieter Seidel, the Country Director of DED Uganda, who was very supportive to this project, not only in his capacity as the director, but also in his personal capacity by facilitating my mobility during my third stay in Uganda. The DED-office team was always very supportive, and particular thanks go to Janet Etuket. I also benefited from the discussions with Jochen Becker, Nenad Kostansjek, Dr. Georg Kopf, Dr. Koppenleitner and Cornelia Grade, and many other DED professionals.

Likewise, the DED health professionals in Kamuli District shared a lot of time for many discussions and talks, without which I would not have gained the same insights into the happenings of Kamuli District. I owe a great debt of gratitude particularly to Hannelore Christen, Bernhard Krötz, Irmela Müller-Stöver and Annerose Beer. The former three carried out a medical-professional assessment of some aspects under study. They were all very supportive not only with logistical and practical issues, but above all in terms of their moral support and friendship.

I sincerely thank my team of research assistants, translators and facilitators in Uganda: Monica Nayenga, Florence Ifuba, Annie Alimuwa, Patrick Mwigo, Andrew Mukembo and James Menya, who worked long hours with much dedication. I owe very special thanks to Monica Nayenga and Florence Ifuba, who accompanied me throughout my research from 1997-1999 and who were extremely committed. They assisted me developing and bouncing ideas. Through their long work experience at the community level, with their admirable personality, and with respect and authority, they quickly gained the trust of respondents. Without them, I could not have gained the access to household and focus group respondents and receive the deep insights into the local level that I managed to get. I also thank them for having gone through the hard times of this process, and I value them as work colleagues, but above all as friends.

Thanks also go to the Executive Committee of Kamuli District Women's Development Association that enabled me to get access to the communities. I would also like to thank all the respondents from the public, private and NGO sector for their time and for their trust, in that they provided key information about some highly sensitive matters.

I feel enormously privileged to have been able to meet the many women and men in the villages in Kamuli. The interviews and focus group discussions with them provide the basis for this research. I am very grateful to them for sharing with me their time as well as personal and delicate information about their health and their daily struggles. It was their spirits and perseverance in a context of adversity that gave me the dedication to what I was doing.

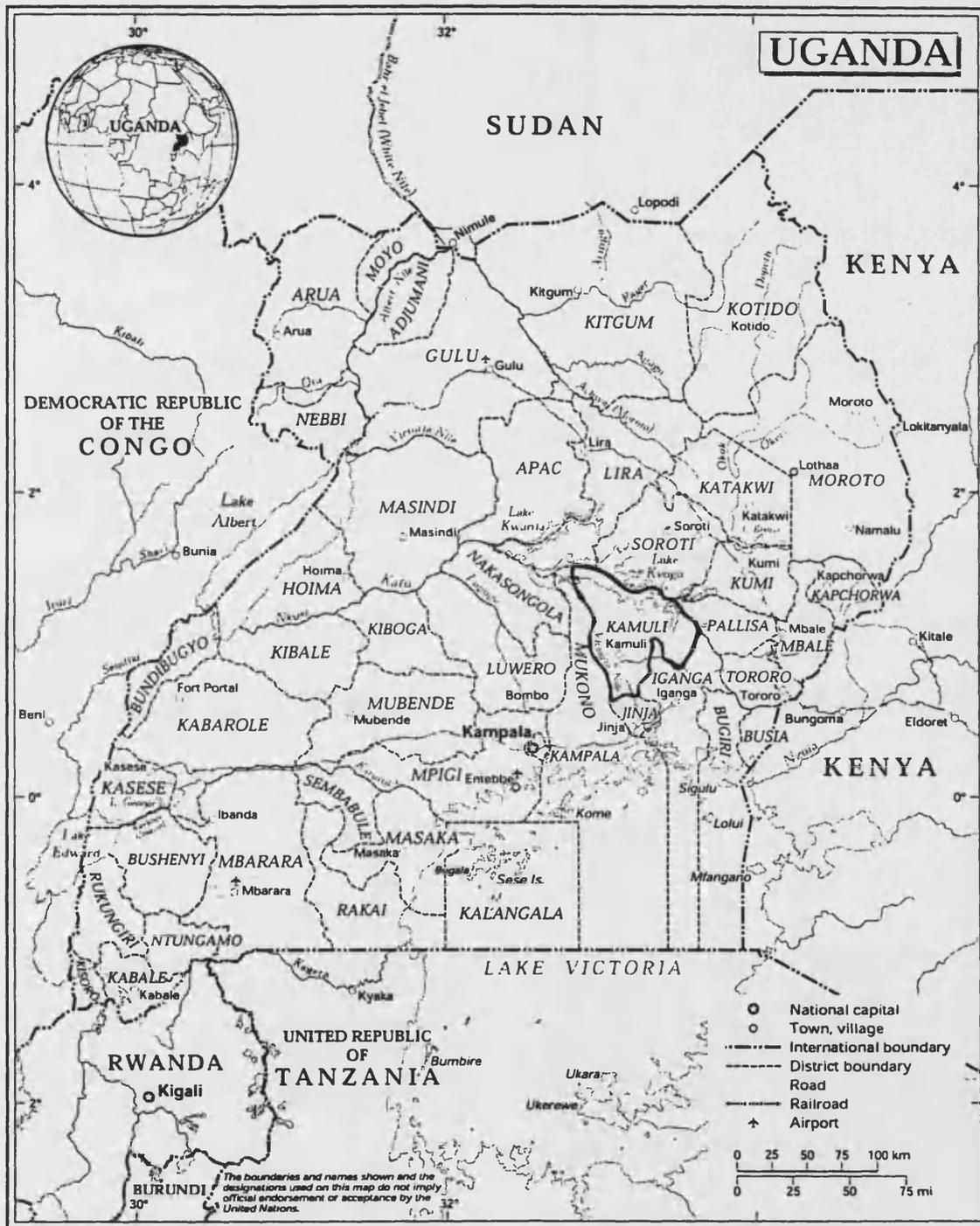
Further, I would like to thank Betty Kwagala, Rebecca Mukyala and Lynn Kadhiagala (Makerere Institute of Social Research) for the discussions with them. Likewise, Paul Bukuluki and Fredrick Ssali (Makerere University) provided helpful feedback during their two week participation in the initial stage of the research in Kamuli.

My thanks are extended to the staff at the Development Studies Institute, particularly Dr. James Putzel and Dr. Tim Allen, as well as my Ph.D. colleagues, who gave valuable comments on my work during the research seminars.

This Ph.D. was financed by the Economic and Social Research Council, the Studienstiftung des deutschen Volkes and a University of London Central Research Grant (field research), all of whose support is gratefully acknowledged.

I would like to express a personal debt of thanks to my friends and family who accompanied me through these years. Finally, my greatest thanks go to my parents for their constant encouragement and support throughout this process.

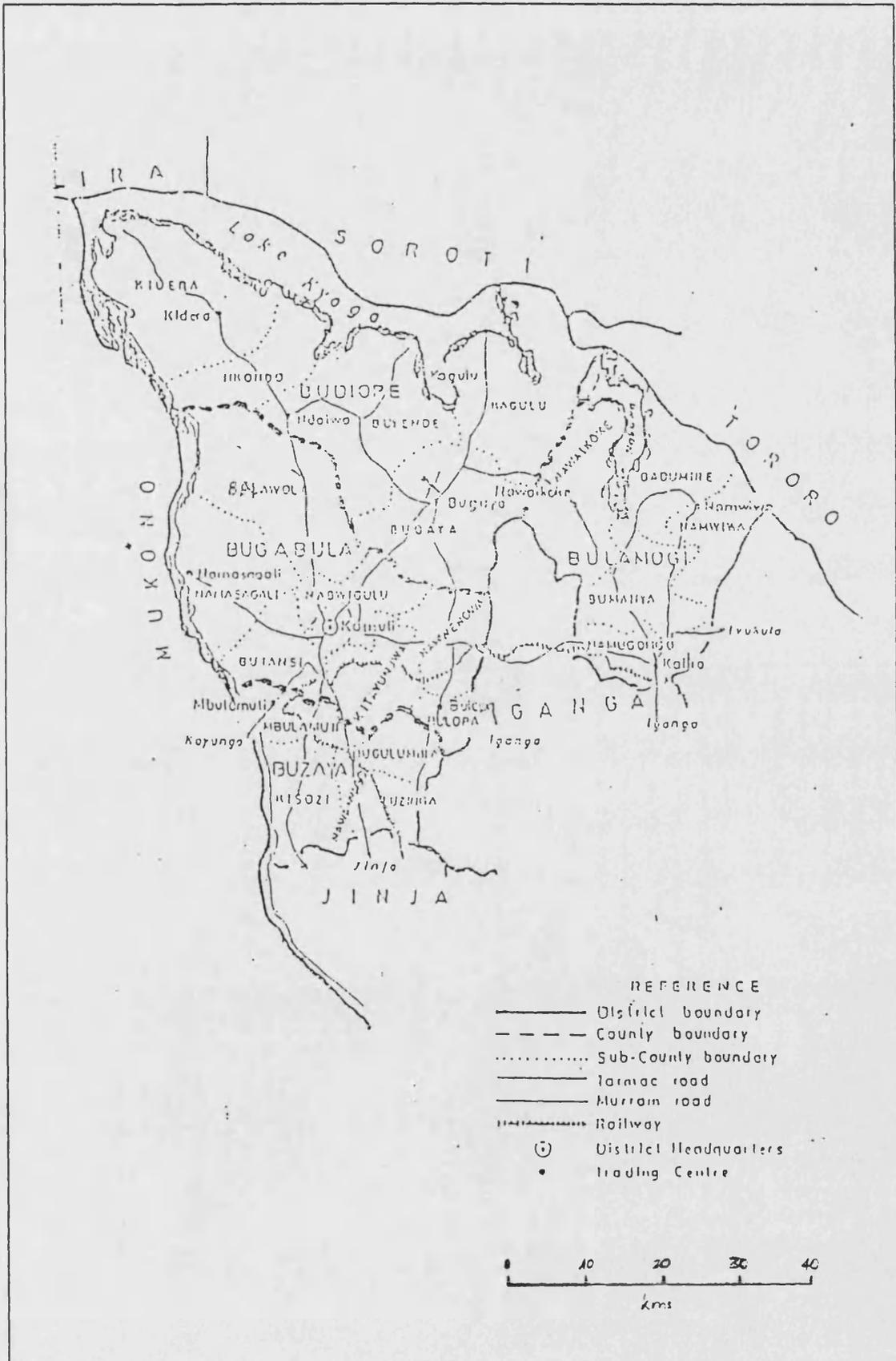
# Map of Uganda



Map No. 3882 Rev. 2 UNITED NATIONS  
December 1958

Department of Public Information  
Cartographic Section

# Map of Kamuli District



## Chapter 1

### Introduction

#### **1.1. The Ugandan Case: A Pluralistic Health Care System**

During the 1950s and 1960s, Uganda was called the pearl of Africa. At Independence in 1960, it had one of the best developed health services in Africa. A few years later, however, Uganda began to move into political turmoil, which resulted in a predatory state, in chaos and repression, and eventually civil war. This also led to the breakdown of social services, and particularly in the health care system (Dodge 1987). The decline of government health services provided a boost to informal private activities and increased the relevance of mission church health care services. Voluntary sector organisations also began to run their own health services, especially from the 1980 onwards. Because of the breakdown of health care services and the negative impacts the civil war had on the country's epidemiological profile, Uganda's health situation suffered serious deterioration.

The National Resistance Movement (NRM), which took over in 1986, must be credited for its enormous efforts at engaging in political and economic reconstruction, namely democratisation, decentralisation, liberalisation, and privatisation. Nevertheless, Uganda shows the features typical of least developed countries (LDCs), i.e., weak state institutions and capacity as a result of prolonged institutional decay, patronage and patrimonial relationships deeply embedded in social structure, high levels of corruption, and systemic problems in the government's revenue and expenditure management (cf. Brett 1998b, Kjaer 1999). Access to the state is still one of the principal means of acquiring wealth (Watt et al. 1999). Democratisation is incomplete, as Uganda can be considered as a single-party state. Further, Uganda's legal system is under-resourced and underdeveloped, and human rights abuses still occur (Oloka-Onyango 2000, HRW 1999). All of these factors – coupled with the civil war in the northern part of the country that devours enormous amounts of resources – constrain the alleviation of poverty and maintain the high levels of deprivation, scarcity and insecurity. Although economic growth rates average nearly 6 percent per annum for the last decade, real poverty has increased. In 1993, 55 percent of the total population is categorised as "poor", and in

1999, per capita GDP was only US\$ 300 (Oloka-Onyango 2000: 44). The human development outturn places Uganda among the bottom 10 percent of all countries.<sup>1</sup>

Despite 15 years of rehabilitation (attempts) and large donor support since the early 1980s, the health status of the Ugandan population, as measured by DALE<sup>2</sup>, is one of the worst five of the 191 WHO member states (estimates for 1997, WHO 2000). Equally problematic are the very unequal health outcomes among Ugandans (Gwatkin et al. 2000). AIDS is also a severe problem, as every sixth to seventh adult over 15 years is infected with HIV (World Bank 1994). This increases the burden of disease and the need and demand for health care services. Table 1.1 further illustrates Uganda's lagging behind.

Table 1.1: Health indicators

	Uganda	All LDCs
Life expectancy (years)	43	62
Crude death rate per 1000	20	10
Total fertility rate	7.2	3.8
Malnutrition among children (%)	45	28 (for SSA)
Births considered high risk (%)	65.9	

Source: World Bank 1993: 2 in Brett 1998b, Bigsten et al. 1999, and Hutchinson 1999.

The NRM inherited a pluralistic, but fragmented health care system<sup>3</sup>, comprising public, private and voluntary sector health care providers, including home care.<sup>4</sup> This health care system is characterised by growing diversity, dynamics and complexity, but it is troubled with organisational-institutional deficits and funding gaps. As the WHO emphasises, apart from other determinants, such as education, income and sanitation, health care systems do make a large difference to health through their core functions of financing, generating inputs and the provision of services (WHO 2000: 9). The lengthy period of conflict that Uganda has seen posed particular challenges, but also opportunities

<sup>1</sup> Uganda is at the 158<sup>th</sup> position in 1999 out of 175 countries (Oloka-Onyango 2000).

<sup>2</sup> Disability adjusted life expectancy

<sup>3</sup> A health care system includes "all activities whose primary purpose is to promote, restore and maintain health" (WHO 2000: 5).

<sup>4</sup> Pluralistic and fragmented systems are not a phenomenon restricted to health care, but also found in education, solid waste management and transport. This is equally the case for other poor countries (Batley 1996: 733; cf. Chapter 3.3).

for the post-conflict era.<sup>5</sup> Nevertheless, Uganda's decentralised and pluralistic health care system and the problems related thereto are not unique; rather, they are typical of many African and developing countries (cf. World Bank 1993, 1997a, Green 1992, WHO 2000, Zwi/Mills 1995, Bennett et al. 1997, Bennett et al. 1999, Leonard/Leonard 2000<sup>6</sup>).

The problems of African systems comprise financial shortcomings, low efficiency and sustainability, quality concerns and unequal health outcomes. Service provision of the public sector is inadequate and fails in terms of allocation (such as insufficient spending on cost-effective programs), in terms of internal, technical efficiency (wasteful public programs of poor quality), unsuccessful user fee schemes and equity (due to inequitable distribution of the benefits of health services) (World Bank 1993, Bennett et al. 1995, Russell/Gilson 1995). Inadequate drug availability, rude staff behaviour and inefficient use of staff resources in the public sector are problems found in many of the poorest countries in both Africa and Asia. Governments are increasingly liberalising and encouraging the entry of private and NGO sector providers (Mackintosh 1999). Moreover, public health services have been de facto marketised through widespread private practice, drug sales and informal charging (Cornwall et al. 2000). The existence of a large (partly informal) private sector in many of these countries constitutes a challenge. Reviewing the evidence indicates that the regulatory systems generally do not operate well in developing countries (Bennett et al. 1994, Kumaranayake 1998; Mackintosh 1999); nor is there clear evidence whether the private sector performs better than the public sector (Bitrán 1995, Mills 1997b). Another common deficit is the lack of coordination and integration of the public, private and the voluntary sectors, resulting in unequal coverage and duplication of services (Bennett et al. 1995, Brugha/Zwi 1998, Bennett et al. 1994). Thus, "the miracle of the market" has not occurred (Leonard/Leonard 2000: 3) and, ultimately, the need for reforms is large (Mogedal et al. 1995, Cassels 1995).

Ideally, in a health system characterised by institutional pluralism<sup>7</sup>, the division of labour should be based on each organisation's relative strengths, but it is impossible to

---

<sup>5</sup> Such opportunities are the reappraisal of public policy and health policy in particular, and rapid inflows of international aid (Macrae et al. 1994: ix)

<sup>6</sup> For country studies, cf. for example Tibandebage/Mackintosh 1999 (Tanzania), Killingsworth et al. 1999 (Bangladesh), van der Geest et al. 2000 (Zambia), D. Leonard 2000 (Africa), Silva 1997 (Zimbabwe).

<sup>7</sup> When speaking of institutional pluralism, institutional-organisational pluralism is meant that refers to the existence of different provider types, namely public, private and voluntary sector organisations.

determine in the abstract what the relative strengths of each organisation are.<sup>8</sup> Secondly, this pluralism is accompanied by a multitude of different interorganisational relationships between these providers, ranging from conflicts, co-existence, dependency and interdependency to co-operation and competition, regulation and co-ordination (cf. Rogers/Whetten 1982, Brett 1998a, Robinson et al. 2000). A system based on institutional pluralism and interorganisational relations has significant implications for the quantity and quality of health care, efficiency and equity objectives. It also raises concerns about how it is "getting along", that is, how it manages itself so as not to end up in disorder. Thus, any reform discussion in relation to a government's endeavours to improve and extend services and to bring them closer to the people will centre around the following key question: Which sector or which provider type should be focused on and promoted and how, and how should the mix of interorganisational relationships be shaped?

A number of (District) studies have investigated specific aspects of health care provision in Uganda relating to these issues, including:

- The research on the informal survival strategies and private sector activities of government health workers (Asiimwe et al. 1997a, 1997b, McPake et al. 1998) and the quality of care and accessibility of the public sector (McPake et al. 1999);
- A study of the scope of urban private practitioners and the consumers' perception (Okello et al. 1997);
- A government health service review at the District level (Kipp et al. 1991);
- A comparison between government and non-governmental organisations (NGOs) as regards resource utilisation, costs and consumer satisfaction in 1992/93 (Okello et al. 1998);
- An efficiency comparison between government and NGO hospitals (Pearson 1997);
- A study of patient-drugshop transactions (Whyte 1991);
- A study of the role of NGOs in the delivery of health services touching upon interactions with the District administration (Kwagala 1997);
- A study of the public/private mix (Assimwe/Lule 1993, Bennett/Ngalande-Banda 1994);
- A qualitative District pilot study on access of the poor (Girard/Ridde 2000);

---

<sup>8</sup> For a conceptual elaboration of relative strengths, see Chapters 1.2 and 2.2.

- A survey on a variety of public sector health care provision aspects (Azfar et al. 2000); and
- A qualitative study on local government health care provision in two Districts (Golooba-Mutebi 1999).<sup>9</sup>

But there has been no *comprehensive* comparative performance analysis that simultaneously includes *all three* sectors (public, private and voluntary) and that is combined with an examination of the institutional-organisational factors and the impacts of interorganisational relationships to explain each sector's performance and the performance of the system as a whole. Likewise, there have been no comparisons between private and NGO clinics. The aim of this thesis is, therefore, to study institutional pluralism and interorganisational relations in health care provision by means of a case study of Kamuli District in Eastern Uganda to see how these affect service delivery. It will be demonstrated that, while institutional pluralism is superior, the present institutional-organisational arrangements and the prevailing interorganisational relationships make the system's health care provision fail, and what we find is a situation of institutionalised pathologies. Yet this institutionalisation is not irreversible, and there is potential to move to a situation of healing organisations.

The focus of this thesis is on the institutional factors of provider performance, and, as such, it recognises the utmost importance of having the appropriate institutions and organisations for service delivery and provision. The next section spells out the rationale behind institutional pluralism and provides the theoretical frameworks used in approaching this research problem (these will be further elaborated in Chapter 2).

## **1.2. The Case for Institutional and Organisational Pluralism and the Implications**

### **1.2.1. From "Either/Or" to "Both/And" Conceptualisations**

Institutions can be understood as "rules of the game", i.e., the complexes of formal and informal "rules, enforcement characteristics of rules, and norms of behaviour that

---

<sup>9</sup> The decentralisation of health services has equally constituted a research focus (e.g. Bagambisa 1995, Hutchinson 1999, Kisubi/Mugaju 1999, Kostansjek 1997). Medical-anthropological studies (for example Allen 1991, 1998, Whyte 1992, 1997) are not primarily concerned with the above research aspects.

structure repeated human interaction" through constraints, incentives and enhancement (North 1989: 1321). These human interactions occur between individuals and within and between organisations. Social order and (political) culture are the sum of specific patterns of informal institutions, in which organisations are embedded, whereby informal institutions may support or subvert formal institutions within a given context. Informal institutions have thus a major effect on how an organisation functions (cf. Atkinson et al. 2000: 619). Organisations, in turn, can be defined as social systems that have been actively established to pursue specific aims and objectives (cf. Hill et al. 1989: 24-25); hence, organisations are the manifestation of both formal and informal institutions.

The study of institutions (and hence of organisations) has been experiencing a renaissance throughout the social sciences, and despite the differences in assumptions and foci among the disciplines, the common conviction is that institutional arrangements and the rules of the game do matter (Israel 1987, Powell/DiMaggio 1991, Batley 1996, Grindle/Hildebrand 1995, Grindle 2000). In other words, it has been realised that institutional weaknesses and inappropriateness slow down development (Ostrom et al. 1993, Toye 1995). Translated to the micro-level, service delivery fails because of inadequate intra-organisational institutions and inappropriate interorganisational institutions combined with inappropriate incentives.<sup>10</sup>

Acknowledging the importance of institutions implies recognising the large spectrum of possible institutional arrangements. From this follows the existence of institutional choice, and specifically, the necessity to find the "right" institutions and to have the "right" type of organisation in place for service provision. This aspect is a crucial one and equally particularly relevant for health care provision in light of the inadequacies briefly described above but also in light of adjusting economies in which the state has to undergo changes (Batley 1994b).

The broader development debate is about the appropriate roles of the public, private and voluntary sector organisations.<sup>11</sup> It is clear now that the path to sustainable

---

<sup>10</sup> The intra-organisational set-up applies to those institutions operating within organisations, namely among organisational members and between them and the end-users. Interorganisational institutions refer to the relationships between organisations.

<sup>11</sup> The term "voluntary" is imprecise, since many organisations are not run on a voluntaristic basis. Other terms are "solidaristic" or "third sector", although, in the end, each term has its weaknesses. Instead of discussing endless attempts of definitions and terms, the term "NGO sector" and "voluntary sector" is used interchangeably.

(economic) development is not a choice between more or less government or more or less market – none of these extremes has proven to be of practical relevance (Bennett 1991, Nwankwo 1997). By overcoming the contextless "either/or" dichotomies – state versus markets, or state versus NGOs – in which orthodox public administration theorists and structuralists, neo-liberals, and proponents of a third way of "development from below" (Wegner 1993) have engaged, each provider type's strengths (and weaknesses) can be fully appreciated according to the circumstances.

This call for "getting the institutions right" demands a role-redefinition, intrasectoral reforms (mainly regarding the public sector), re-balancing of the sectors' role and reforms regarding the relations between the public, private and voluntary sector, but also a change of perception on the part of the different agents (de Janvry et al. 1993, Batley 1994b, Batley 1999a, Nwankwo 1997, Preker et al. 1999).<sup>12</sup> Moving away from a mere substitution strategy, the search for adequate institutional arrangements encompasses a "both/and" notion implying a new balance and a complementation of the sectors and provider types for the provision of goods and services. Given an intellectual trend and an even more pragmatic practice, broader institutional conceptualisations of development are now underway, which recognise context specificity, historical experience and cultural expectations (Evans 1997a: 1). Equally relevant is the ability to create an open system that allows for a wide range of institutional arrangements to provide services (World Bank 1993, Grindle 1997).

These developments are equally reflected in the discussions about health care provision:

Historically, the debate about the appropriate roles for public and private sector[s] [organisations] in health care has been polarised [...]. During recent years the tone of this debate has changed; it has been recognised that neither a purely private nor a purely public health care system may be appropriate (Bennett 1997b: 93).

Especially in the 1990s, a move has been underway to what can be called a "co-ordinative and contractual approach", as the pluralism and diversity of providers and their interactions require co-operation, co-ordination and contracts (Tizio 2000; Perrot 2000; Preker/Harding 2001, WHO 2000). Growing recognition and consensus that state reform should foster a reduced role for government in direct service delivery implies that the role

---

<sup>12</sup> The New Public Management practice in effect in rich countries has equally nurtured the discussion and rethinking of the roles of the sectors (Batley 1999a: 755), as has the donors' growing disillusion with the governments of developing countries (Green/Matthias 1995: 566).

of the state changes and increases as to *managing* other actors. In other words, the government's "behind-the-scenes" roles, such as policy analysis, co-ordination, regulation and enabling become more important (Batley 1999a: 756). It is important to note, however, that these roles must not necessarily be taken on by the state alone.

As noted above, a system based on institutional and organisational pluralism with its resulting interorganisational relationships needs some form of order through "governance", namely guided social, organisational or intentional action by government or other agents. The three main governance mechanisms are competition, regulation (including enabling) and network co-ordination (these are elaborated in Chapter 2.3). The difficult task lies in allowing for, fostering and promoting the most useful combination of service providers as well as the most appropriate mix of competition, regulation and network co-ordination in order to organise the ensemble of the providers and to optimise the system output – that is, to promote efficient and equitable provision in the health sector as a whole. The success of these approaches depends fundamentally on the government's capacity to undertake the new roles expected of it (Bennett et al. 1995: i) and to guarantee this openness.

The analysis and the search for the best institutional and (inter)organisational constellation take place at two levels: (1) improving the functioning of institutions operating intra-organisationally, and (2) identifying and implementing/realising the most appropriate interorganisational relationships and governance/co-ordination mechanism. In other words: What is the best mix of efforts in improving the efficiency of public providers and in developing government capacity to negotiate and monitor contracts and regulate the private sector?

### 1.2.2. Potentials and Pitfalls of Institutional Pluralism

Institutional and organisational pluralism refers to the existence of different provider types, namely, public, private and voluntary sector organisations, as well as institutional arrangements based on combinations thereof. Each of the three sectors, given its institutional set-up, has specific strengths and weaknesses (see Chapter 2 for a more detailed conceptualisation). From this, it follows that institutional pluralism fosters a diversity of solutions, structural redundancy and more competition, in order to allow for

the best use of resources (Leonard 1983: 289; cf. Preker et al. 1999).<sup>13</sup> Likewise, institutional pluralism, and thus institutional diversity, may allow for "valuing difference and working with diversity" thereby taking into account the varying needs and preferences of different social groups (Beall 1997, Mathauer/Ng 1997). The main advantage of institutional pluralism is that it enables a division of labour according to each organisation's relative strengths for optimal system performance, in that each organisation can concentrate on what it does best (Nugent 1993, Simon et al. 1993, Simon et al. 1997). Consequentially, competition and consumer choice would produce a division of labour based on relative strengths, at least in theory. However, this does not come about automatically, since competition is imperfect and since state agencies and voluntary sector organisations also operate on the basis of other principles.<sup>14</sup>

The search for relative strengths is also relevant for the provision of only one service or good. People differ in their ability to pay for health care, which results in market segmentation and product differentiation. The various types of organisations may thus play different and complementary roles. Alternatively, we may find that all three provider types offer the same good or service, while not each of them may actually be skilled enough to do so. Hence, reforms to improve service provision must be based on sound knowledge of the appropriateness and fit of each. The argument is that it makes a difference whether there are several provider types or just one, since they are run on different principles, implying different advantages and disadvantages. Bennett argues that institutional pluralism may increase both equity and efficiency, when governments maintain the provision of the whole range of health care services, instead of segmenting the market by type of service between the various providers (1997b: 109).

Institutional pluralism also opens opportunities for the creation of co-operative institutional arrangements and public-private partnerships to produce synergies by pooling resources and utilizing each organisation's relative strengths (cf. Ostrom 1996).<sup>15</sup> That said, institutional pluralism is accompanied by dependency and interdependency, which poses numerous challenges (not only) for the government. One example of these

---

<sup>13</sup> In theory, institutional pluralism also increases consumer choice, which is considered to be a welfare increase per se.

<sup>14</sup> In addition, the division of labour between the sectors is also the product of economic, institutional, and above all, political factors (Preker et al. 1999: 11).

<sup>15</sup> For the growing literature on partnerships, cf. Nwankwo 1997, Moyo 1997, Cornwall et al. 2000, Jalal 1999, Unom 2000, Bennett 1998.

challenges is personnel siphoning, i.e., the drain of health workers from the public to the private sector where more attractive salaries may be gained resulting in acute staff shortage in the public sector (Green 1992: 85, Bennett et al. 1994: 4). Interdependencies also result from the private practitioners' treatment of diseases of public health significance and the need for a comprehensive referral system in a context of unequal coverage. Other problems arising from institutional pluralism are goal conflicts between the different sectors – for example, the private sector is interested mainly in profit – and the overall fragmented nature of the health care system, particularly due to the atomisation amongst NGOs, as found in Uganda (see Chapter 3.3). This makes overall integration and a comprehensive approach difficult.

Clearly, institutional pluralism provides huge potentials by allowing for a division of labour that is based on relative strengths and for interorganisational relationships that produce synergies. But the challenges and implications of interorganisational relations and interdependency must be adequately considered. This indicates the importance of governance to ensure efficiency and adequate health services for everybody.

Anticipating the results of the empirical analysis in the following chapters, we will see, however, that there is a huge gap between the expected advantages of institutional pluralism as described above and what we find in reality. In such a case, Brett (2000c) notes, one may question the coherence of the theory itself, or else ask whether the preconditions and assumptions for this theory to be valid are (fully) met in the given instance. In fact, the case for institutional pluralism is based on a number of preconditions that may not necessarily prevail in LDCs, namely the existence of a *functioning* public, private and voluntary sector according to theory. Yet in an environment that is characterised by weak state institutions, weak civil society, low levels of trust and collective action, high rates illiteracy, and above all, extreme poverty, deprivation and insecurity, which is typical of LDCs, including Uganda, it is questionable whether the required assumptions can exist. Hence, apart from inherent, "natural" state and market failures as well as the acknowledged weaknesses of the voluntary sector, the failure of

public, private and voluntary sector organisations is even more severe due to underdevelopment that undermines the presence of these assumptions.<sup>16</sup>

Likewise, the second dimension and implication of institutional pluralism, namely the need for conducive interorganisational relationships to effectively manage the interplay and antiplay of the various agents, is based on specific assumptions, like managerial capacity and the agents' willingness to interact constructively as well as their mutual trust. They may not exist either given the prevailing conditions in LDCs. These gaps urge us to explain what we actually find on the ground and to reflect on the implications of the concept of institutional pluralism in LDCs.

This raises another question, namely, whether a system of institutional pluralism is still superior to a one-sectoral set-up, even if the related assumptions are not met, so that all providers perform inadequately. From a methodological point of view, the question is thus why operate with a model of institutional pluralism at all. There are various reasons. First, donor policies are based on the rationale of this model, as is the administration and health care system of LDCs (World Bank 1997b, WHO 2000) and that of Uganda (Fallers 1965). Second, the model's intellectual thrust is very powerful and constitutes a useful analytical approach to the research problems of "real" health care, even in a situation where the assumptions are not met. Thus, it should allow us to get insights on feasible institutional reforms. Likewise, the empirical analysis should indicate whether it will be worthwhile to attempt to fulfil these assumptions in the prevailing context or whether policy makers should search for a different approach.

While the focus is on incentives and principal-agent relationships, eclectic use of institutional analysis approaches and concepts of interorganisational relations will be made to examine and explain why organisations (providers) and the organisational system function the way they do. By making eclectic use of institutional analysis, it is possible to look at both actors (individuals) and organisations (see Chapters 2, 7 and 8 for further conceptual elaboration).

---

<sup>16</sup> The distinction into inherent sector failures and failures due to underdevelopment is an artificial one, since, empirically, the differences are fluent and barely distinguishable.

### **1.3. Aims and Rationale of the Thesis: Research Questions and Research Focus**

The aim of this research is to examine institutional pluralism and interorganisational relations in health care provision by means of a case study of Kamuli District in Eastern Uganda. It undertakes a comparative performance analysis of the public, private and voluntary sector as regards access, efficiency in staff resource utilisation and quality of care.<sup>17</sup> The thesis assesses and explains each provider type's relative strengths and relative performance by choosing an institutional analysis approach in order to study the effectiveness of the accountability and financial responsibility mechanisms as well as the staff's incentives. It then analyses the impacts of the prevailing interorganisational relationships upon organisational performance and the performance of the system as a whole. This includes looking at the effectiveness of regulation, enabling and coordination and the way in which organisations interact.

The case study provides a detailed micro-level analysis for Kamuli District. By comparing the findings with other District or national studies, it reveals that what is found in Kamuli is typical for Uganda.<sup>18</sup> Moreover, while the prevailing constellation, combination, extent and degree of problems described may be specific to Uganda (particularly to the more deprived Districts), the nature and complexity of the multi-dimensional problems of health care provision found in Uganda reflect the challenges LDCs with characteristics similar to Uganda are faced with. In other words, inasmuch as it is argued that relative strengths and weaknesses can only be determined empirically, and not a priori (see Chapter 2), and since they are contingent upon the intra- and interorganisational institutional set-up and the sum of informal institutions, the functioning of each country's health care system is, in principle, specific. This notwithstanding, many African countries suffer from similar institutional deficiencies, so that their problems in health care provision are equally similar, if not identical. This study will thus contribute to the understanding of the recurrent problems of health care

---

<sup>17</sup> See Chapter 2 for the selection of these performance criteria.

<sup>18</sup> There are, of course, inter-District differences, so that the findings of Kamuli are more representative of similarly deprived and less developed Districts and those in the third group of decentralisation, and less representative of the more advanced Districts in the central region (Buganda) and the south-west.

provision in LDCs and may hence provide more general lessons, and the broader policy implications derived from the Ugandan case will be relevant for similar countries.<sup>19</sup>

Focusing on an organisational system, the originality of this research lies in the simultaneous application of institutional and interorganisational analysis to the subject of relative strengths and provider performance. Further, how organisations interact, why they interact the way they do and what the impact of these interactions is has been heretofore little addressed. Thus, this research addresses the issues that are at the top of the current research agenda in health care (cf. Bennett et al. 1995, Mills et al. 1997, Batley 1994b, Batley 1999b, Preker/Harding 2001) and that reflect the problems and goals spelt out in Ugandan health care policies (see Chapter 3.3). The research also provides some methodological reflections on how to define and determine relative strengths (see Chapter 2.4).

Specifically, the following general research questions are addressed:

1. Comparative performance analysis

- What are the relative strengths of each curative health care provider type?

2. An intra-organisational institutional account

- What accounts for these strengths or weaknesses?
- How do intra-organisational institutional mechanisms affect performance?

3. Interorganisational relationships

- How are the relationships between the service providers governed and how does this affect performance?
- How do the various health care providers interact with each other and what is the impact of these interactions?
- Why do the providers interact the way they do?

---

<sup>19</sup> Moreover, while this study is concerned with health care provision and while the institutional and organisational aspects of health care systems seem to be more advanced in both practical and theoretical terms, the study also contributes to the general understanding of (social) service delivery in pluralistic systems and the institutional and inter-organisational factors explaining performance or malperformance.

Anticipating Chapter 3, which outlines the present situation of health care provision and local government in Uganda, the following hypotheses were derived and provided the starting point for the field research. As we will see, some of these hypotheses will be confirmed, while others must be rejected or qualified in a place like Kamuli District.

1. NGOs have relative strengths in curative health care over public and private sector organisations given their value-drivenness.<sup>20</sup>
2. The public sector performs worst in curative health care due to a lack of functional accountability and financial responsibility mechanisms.
3. State regulation is insufficient and ineffective and hence does not correct market failures and imperfections.
4. Provider co-ordination increases efficiency in resource use.
5. NGO – public sector partnerships create synergies.

In order to keep this research within a reasonable scope, the study of relative strengths focuses on curative health care without ignoring the utmost importance of preventive/promotive services.<sup>21</sup> Further, the focus is on biomedical health care providers, with an established facility and premises.<sup>22</sup> Hence, the research excludes home care, self-medication, and "traditional" healers (sorcerers, bone-setters, etc.), even though, admittedly, the differences between these categories are blurred.<sup>23</sup> The analysis of interorganisational relationships in Chapter 8 is based on both curative and preventive/promotive health care (PPHC) providers. An additional question is whether the poorest have equally access to quality services.<sup>24</sup>

---

<sup>20</sup> For the purposes of this research, an NGO is understood as a non-governmental, not-for profit organisation, formal-legally independent from the state and outside direct state control, delivering services and operating in more than one community.

<sup>21</sup> As curative health care services consume 70-80 percent of the public health sector budget and since they are vital to the sick in the short term, the study of curative services is a key issue for the analysis of government health systems (Leonard/Leonard 2000: 3).

<sup>22</sup> Biomedicine refers to the scientific, allopathic clinical-medical knowledge, often (misleadingly) termed Western medicine, in contrast to alternative techniques of therapy (Allen 1998, see Chapter 4.5).

<sup>23</sup> Given the importance of biomedicine in reducing the burden of disease (WHO 2000: 9) and since people increasingly accept and demand biomedical care (cf. Adome et al. 1996, Whyte 1992), the focus on biomedical health care providers is well justified.

<sup>24</sup> This concern follows from the growing consensus that inequalities in health outcomes between the poor and the rich are unjust, whether these occur between countries or within a country (Wagstaff 2000: 5).

#### 1.4. Research Methods and Data Collection

This research started with a pilot study and action research undertaken for the German Development Service (DED) on the promotion of devolution and intersectoral collaboration. Uganda was chosen, in discussion with the DED, because of its reform-orientation, policy commitments towards intersectoral collaboration and the ambitious and far reaching process of decentralising power to its 45 Districts. Fieldwork was carried out in Kamuli District in Eastern Uganda in three phases: from May to November 1997, January to May 1998 and April to September 1999.

Kamuli District is situated 160 kilometres northeast of Kampala, the capital, and off the Kampala-Kenya road. It is bordered by Lake Kyoga in the North and by the River Nile in the West. The tarmac road ends in Kamuli Town. About 561,000 people live in the District. Administratively, Kamuli District comprises 4 Counties (LC4, local councils), 23 Subcounties (LC3), 133 Parishes (LC2), and 1130 villages (LC1).<sup>25</sup> Kamuli Town (the administrative District headquarter) and three rural Subcounties were chosen as research sites (see Annex 1.1 and Chapter 4 for the choice for Kamuli District and the selection procedures for the Subcounties).

The methods used for data collection as well as the analysis were both quantitative and qualitative, thereby combining the strengths of both approaches as well as balancing out their weaknesses (Yach 1992, Hentschel 1999). Table 1.2 summarises the methods applied for the various topics and issues (see also Annex 1 for further elaboration).

This mix of methods, known as "methodological integration" (Warwick 1993) enabled extensive cross-checking of information and triangulation, thereby improving objectivity and validity. For example, the government health unit records, one of the most doubtful data sources, could thus be crosschecked with the observation data (see Annex 1.10 for further elaboration). Likewise, while health professionals may behave differently during the researcher's presence, the view of Health Unit Management Committee (HUMC) members, the consistent household respondents' answers and DED health professionals' observation provided a good understanding of what was actually going on.

---

<sup>25</sup> See Chapter 3.3 for a discussion of the administrative system.

Table 1.2: Research methods and research aspects

Methods	Research aspects
<p><b>Exit interviews (146)</b> with open and closed questions at 16 providers (see Annex 4 for the distribution of interviews)</p>	<ul style="list-style-type: none"> <li>• Patient-provider interaction, user's perception of providers, reasons for utilisation</li> <li>• Access</li> <li>• Experience with and perception of Subcounty councillor, HUMC, PPHC interventions</li> </ul>
<p><b>Household interviews (112)</b> with open and closed questions (see Annex 1.11 for the distribution of respondent characteristics)</p>	<ul style="list-style-type: none"> <li>• Same as above</li> </ul>
<p><b>Focus group discussions (52)</b> with the LC1 Executive Committee, a group of men, women and youth in <b>15 communities</b> (action research in 1997-98, in 2 rural Subcounties, anonymously referred to as Subcounties A and B<sup>26</sup>)</p>	<ul style="list-style-type: none"> <li>• Same as above</li> <li>• Perception of decentralisation, functioning of the LC system, elections, council representation, accountability, voice mechanisms</li> <li>• Satisfaction or dissatisfaction with state and non-state service provision</li> </ul>
<p><b>Focus group discussions (15) with the groups of 10 PPHC NGOs</b></p>	<ul style="list-style-type: none"> <li>• Member's/beneficiary's perception of PPHC NGO service provision</li> </ul>
<p><b>Focus group discussions with communities (12)</b> (in 1999).</p>	<ul style="list-style-type: none"> <li>• Follow-up of above LC issues</li> <li>• Patient-provider interaction, user's perception of providers, reasons for utilisation</li> <li>• Access</li> <li>• Experience with and perception of Subcounty councillors, HUMC, PPHC interventions</li> </ul>

<sup>26</sup> If not further specified, data collection took place in all 4 places (Kamuli Town and the three rural Subcounties).

cont. (Table 1.2)

Methods	Research aspects
<b>Facility survey: Semi-structured interviews (key questions) with</b> <ul style="list-style-type: none"> <li>• Health professionals at public, private and NGO providers</li> <li>• Drugshop attendants</li> </ul>	<ul style="list-style-type: none"> <li>• Resources and services available, revenues, problems of the facility</li> <li>• Staff satisfaction, referral behaviour, supervision</li> <li>• Exemption practice and deferral payment</li> </ul>
<b>Semi-structured interviews with</b> <ul style="list-style-type: none"> <li>• HUMC members</li> <li>• Secretaries for Health at Subcounty and District level</li> <li>• Chairpersons of Subcounty and District Health Committees</li> </ul>	<ul style="list-style-type: none"> <li>• Supervision</li> <li>• Health facility management, decision making, planning</li> <li>• Problems of facility, staff behaviour and incentives, drug supply and availability</li> </ul>
<b>Semi-structured interviews with</b> <ul style="list-style-type: none"> <li>• LC2, LC3, LC5 Executive Committee members →</li> <li>• Parish Chiefs, Subcounty Chiefs, Subcounty Accountants →</li> <li>• Chief Administrative Officer and Deputy →</li> <li>• Chief Financial Officer and Deputy →</li> <li>• DMO, Sectional Heads of DMO, Assistant Drug Inspector →</li> <li>• Women leaders →</li> <li>• Health Assistants, Community Based Service Officers, Agricultural Extension Officers</li> </ul>	<ul style="list-style-type: none"> <li>• Perception of decentralisation, administrative culture, operation of the LC system</li> <li>• Same as above, and donor funding</li> <li>• Same as above</li> <li>• Range of services, planning, supervision</li> <li>• Co-ordination, regulation of non-state providers</li> <li>• Gender aspects of decentralisation</li> <li>• Range of tasks, planning, supervision</li> <li>• Co-ordination and interaction with NGOs</li> </ul>

cont. (Table 1.2)

Methods	Research aspects
<b>Observation at health units and drugshops (32 providers)</b>	<ul style="list-style-type: none"> <li>• Staff behaviour, consultation time, waiting time, patient encounter, privacy, etc.</li> </ul>
<b>Drugshop observation study</b> in 6 drugshops by a local nurse	<ul style="list-style-type: none"> <li>• Sales, prescription patterns, credit provision, costs,</li> <li>• People's buying behaviour</li> </ul>
<b>Health units/patient records</b> <sup>27</sup>	<ul style="list-style-type: none"> <li>• Patient numbers, revenues, income, expenditure</li> <li>• Clinical-medical assessment of patient treatments by DED health professionals</li> </ul>
<b>"Healthy patient" test</b> (visit of a healthy person at all health facilities in Kamuli Town and simulation of being sick)	<ul style="list-style-type: none"> <li>• Examination procedures, staff behaviour, treatment quality, user charges, waiting time, consultation time</li> </ul>
<b>Semi-structured interviews</b> with <ul style="list-style-type: none"> <li>• Sectional Heads of District Departments of health, education, agriculture, community development, and water</li> <li>• Staff of 20 NGOs in Kamuli and regional headquarters</li> </ul>	Network analysis <sup>28</sup> <ul style="list-style-type: none"> <li>• Interaction and co-ordination among departments, between the administration and NGOs, and among NGOs</li> <li>• Planning, funding</li> </ul>
<b>Participant observation</b> during <ul style="list-style-type: none"> <li>• NGO-Local Administration networking workshops</li> <li>• NGO Forum and working group meetings</li> </ul>	Network analysis: <ul style="list-style-type: none"> <li>• Nature and form of interaction, interaction problems</li> <li>• Willingness and capacity to interact</li> </ul>

<sup>27</sup> Results are reported for one year (August 1998 – August 1999). If available, data was collected for the previous two years to crosscheck.

<sup>28</sup> This network analysis included all the health care providers.

cont. (Table 1.2)

<b>Methods</b>	<b>Research aspects</b>
<b>Interviews at the national level with</b> <ul style="list-style-type: none"> <li>• Ministries (MoH, MoLG, MFEP, MoA), donors</li> <li>• Umbrella NGOs, medical bureaux</li> <li>• Medical Council (UMDPC)</li> </ul>	Included a selection of these topics: <ul style="list-style-type: none"> <li>• Civil society, SWAP, policy making, health policy implementation, decentralisation problems, NGO co-ordination,</li> <li>• Regulation</li> <li>• Health expenditure, health policies</li> </ul>
<b>Analysis of District documents</b> <ul style="list-style-type: none"> <li>• Minutes of committee meetings, department and committee reports, district work plans, district budgets</li> </ul>	<ul style="list-style-type: none"> <li>• Triangulation of the issues above</li> </ul>
<b>Analysis of primary data of DED evaluation</b> <ul style="list-style-type: none"> <li>• 60 exit interviews at 3 providers</li> <li>• 60 household interviews in 3 areas</li> </ul>	<ul style="list-style-type: none"> <li>• User costs and access, user's choice of provider</li> </ul>
<b>Qualitative interviews and informal talks with DED health professionals</b>	<ul style="list-style-type: none"> <li>• Utilisation, problems of facilities, staff behaviour, incentives, resources and services available, medical practice, staff knowledge</li> </ul>
<b>DED annual reports</b>	Same as above
<b>Observation</b> <ul style="list-style-type: none"> <li>• Council meetings, electoral meetings,</li> <li>• at District Headquarters</li> </ul>	<ul style="list-style-type: none"> <li>• Administrative culture</li> <li>• Planning and budget allocation</li> <li>• Relationship between councillors and Executive Committee</li> </ul>
<b>Newspaper clips</b>	<ul style="list-style-type: none"> <li>• Health care issues</li> </ul>

See Annex 2 for the list of interviews and focus groups.

### Key questionnaires

Semi-structured interviews with the various types of respondents (providers, civil servants, councillors, and so forth) were based on key questionnaires. The advantage is that they allowed for flexible adaptation to explore more extensively emerging topics in order to understand meanings and contexts. At the same time, as a core set of issues were covered in all interviews, comparisons and quantitative analysis were still possible.

### Focus group discussions and action research

Both the focus group discussions in the 15 selected communities during 1997-98 and the individual discussions with staff of all 20 NGOs operating in Kamuli District and located in Kamuli Town followed an action research logic (for further elaboration on the selection procedures, see Annex 1).<sup>29</sup>

In addition to the respondent-interviewer relationship, group interviewing takes advantage of the group interaction and dynamic which is a stimulus to elaboration and expression and which thus produces new and additional data (Frey/Fontana 1993: 32). This is particularly the case for the rather abstract and complex nature of research topics that were investigated (such as local government service delivery problems, council representation, accountability, transparency, voice, reasons for choosing one provider rather than another, etc.). The disadvantage of group interviews is that the view of individuals cannot always be followed up during the session; likewise, weaker group members may keep silent. But at the same time, observing these group interactions also allows the researcher to get an idea of the power relations prevailing within a community and a group, which is important to get an idea of the social context.

Another interest of this research was how people's problems and the related causes can be dealt with, which is why an action research approach was used. Action research means that the people themselves are involved in the "research process", i.e. they reflect on and analyse their "research problem". This is followed by a solution-finding process in which the people concerned identify and discuss a possible course of actions in order to overcome or at least reduce the problems. Action research aims, thus, at promoting people's problem solving capacity in order to change and improve their social, economic

---

<sup>29</sup> Ten NGOs engage in curative and/or PPHC services, three NGOs are partly involved in PPHC activities. The other seven NGOs work in agriculture, women and community development (see Table 4.7).

and political living conditions (Fals-Borda 1987). Focus group discussions provide a good starting point for this to take place (for the strengths, weaknesses and the modalities of the action research, see Annex 1.5).

#### Facility survey

To study relative strengths of the various health care providers, a sample had to be selected (see Chapter 4.3 for the procedure). Based on purposive sampling, the core sample comprised 16 curative health care providers (see Table 4.3 for a list). Further information was collected on another 16 providers (however, no exit interviews and record analyses were conducted in these cases). DED reports and interviews with DED staff, as well as health unit visits and observation during 1997/98, provided further data on another 11 government health units. In all, information was collected on a total of 43 health care providers.

#### Exit interviews

Exit interviews have the advantage of allowing for direct triangulation and comparison of the patient's views and statements with the researcher's observation thereby enabling the researcher to correct respondent errors. The patient's recall period is minimal, allowing the researcher to get his/her immediate impression and/or facts that one could not find out easily in household interviews. On the other hand, exit interview responses may also be distorted by the patient's social desirability behaviour and their reluctance to make (negative) statements about the provider's services whilst in physical proximity. Therefore, the exit interviews took place out of hearing and out of sight of the provider (see below on considerations of reliability and validity and the means applied to increase them). The technicalities of how exit interviews were conducted and how respondents were selected and classified in poor and "better-off" groups are outlined in Annex 1.7.<sup>30</sup>

#### Household interviews

To extend the insights into the patients' views, household interviews were undertaken. 12 catchment areas (LC1 zones) were chosen, which were located about 4-6 km from the government or NGO clinics and in an area where alternative providers (drugshops and

---

<sup>30</sup> This is not to say that the relatively "better-off" people are not poor.

informal private practitioners) operated.<sup>31</sup> One of the objectives was to examine how and whether the very poor have access to health services. Therefore, a sample was selected in which at least half of the household respondents belonged to the presumably poorest.<sup>32</sup> Random and other selection procedures were attempted, but posed practical problems (see Annex 1.7). For that matter, the research team started a transect walk roughly 5 km from the health unit, following the footpaths clock-wise through the zone. Every fifth home was chosen for the interview, if there was an adult at home; otherwise, the next home was targeted. Making full use of the research assistant's experience and judgement, these households were classified as poorest or "better-off" (i.e. less poor) by means of asset, wealth and social indicators.<sup>33</sup>

These included the housing type and condition (roof and walls)<sup>34</sup>; sleeping facilities (where possible to observe without entering the property: bed, mattress, mat, or floor); the overall state of the compound; possession of assets (e.g., livestock, bicycle, radio, dryer, latrine); condition of the children (obvious malnutrition); the number of the children not going to school; and the educational level and main occupation of the respondent and of the spouse, where relevant. Self-evidently, wealth and asset indicators do not really capture the full extent of poverty, which ultimately means being "excluded from full part in the society in which they live" (de Hann 1999). Further, this poverty "measurement" does not grasp health status, which in turn may not correlate at all with these indicators chosen. Finally, people may have a very different understanding of what means poor or who is poor. But while the chosen approach of this study has its limitations, it produces a good approximation of what we are looking for.

This sample is not random and hence not representative. Also, since the household wealth of the sample households was not quantified, there is some uncertainty about

---

<sup>31</sup> The selection of these catchment areas was again purposive, in that zones with similar features were chosen (located to the north of and within similar distance to the health centre and to the next trading centre).

<sup>32</sup> 55 percent of Uganda's rural population are categorised as poor below the poverty line (World Bank 1993, in Oloka-Onyango 2000: 44). But even the highest expenditure in the seventy-fifth percentile is only 1.3 times that of the poverty line, so the characteristics of those above the poverty line are very similar to those just below it. For the Eastern District, to which Kamuli District belongs, the percentage is even higher. In a representative sample, in which wealth and assets are quantified, the poorest are usually referred to as the bottom quartile (cf. World Bank 1996: 80).

<sup>33</sup> For a statistical procedure of classifying household in quintiles by using wealth indicators on the basis of a representative sample, see Filmer/Pritchett 1998 and Gwatkin et al. 2000.

<sup>34</sup> The state of the roof (grass versus iron sheets) and walls (mud versus brick stone) are also indicators used in the Ugandan National Household Survey 1995/96 (MFEP 1996).

whether the poorest 10 or 30 percent in the rural areas were identified. Still, without denying that poverty differences exist among the poorest, this sample selection procedure provided valuable insights of how the very poor cope as regards health care seeking in comparison to the relatively better-off, who are nevertheless poor. The research team did come across and spoke with extremely poor people, some of them very sick, with the bare minimum to survive on and unable to pay for and seek health care.<sup>35</sup>

Household interviews are equally subject to respondent error, and in particular, recall bias (Kroeger 1983 in Pannarunothai/Mills 1997). While household responses are subject to verification, they can be confirmed by triangulation with other data. Exit and household interview results sometimes differ. But since bias in exit interview results is more likely, household interviews are usually given more credibility and hence validity when there are differences. Different sample rationales as regards drugshop utilisers explain the different results between the exit interviews, the household survey and the drugshop observation study. The drugshop observation provided an indication of all consumer transactions, whereas exit interviewees were patients or attendants that bought drugs for a patient. Household respondents usually only remembered the more severe disease incidents.

#### Data analysis

All interviews and focus group discussions were recorded by taking notes. Exit and household interviews were processed with SPSS. A great part of the data was of qualitative nature and therefore coded later during the data analysis process. Focus group discussions and all other interviews were coded and processed by means of a content analysis. The primary data material of the DED evaluation was equally processed with SPSS or by means of a content analysis.

#### Reach, reliability and validity

The research questions touch delicate and personal issues about people's health, their ability to seek treatment, and their ability to pay. The motives and rationales behind the exit and household interviewees' providing the researcher with their "truth" differ among

---

<sup>35</sup> All of the these people or a related household member were interested in the interview, and it was felt that this was extremely important in order not to exclude this central group of people, but to find out how they cope. After the interview, we left the sick respondents some money in order to go to a health facility.

the better-off and the poorer respondents.<sup>36</sup> Likewise, health professionals wanted to make me believe that they behave ethically and that the services they deliver do not give cause for complaint. Further, respondents may unknowingly provide a wrong answer (for example as regards the question whether they have obtained a full dose of drugs or not at a health care provider). In order to find out what can be considered to be "true", it is necessary to take into account what people are expected to say on the basis of their interests and motives. In case of two contradictory statements, triangulation with a third source often helped. But when triangulation was not possible, only one's instinct to judge the respondents' versions of "truth" remains. Formalised into an "interpretative framework",<sup>37</sup> most weight was given to the statements of those respondents who had the least incentive to hide or distort information, instead of weighing every statement equally. In other words, I believed some people more than I did others – i.e., credibility rather than internal validity was used as the criterion for evaluating "truth" (Yach 1992: 605).

The research assistants as well as some NGO staff whom I befriended constituted crucial and valuable key informants, providing important insights, but also helping reflect about the various versions of the "truth". Further, DED health professionals had been working in Kamuli's government health facilities for several years, and some of them had comparative country experience. Thus, they could obtain crucial insights into what was happening at the health units. One may argue, however, that Ugandan health workers behaved differently in the DED workers' presence. Yet, there appears to have been a process of habituation, otherwise the DED health professionals could not have witnessed the quite appalling incidents at the health units that they did. One may also argue that the DED health professionals' view was distorted by their own interests in seeing their own "truth". However, a recent evaluation in 1997, together with many internal discussions within the DED health team, focused on the structural problems in health care provision, which yielded a realistic judgement of the limited leverage the technical DED intervention had on the system's functioning. For these reasons, their statements were an overall valid means for triangulation. Nevertheless, what was "true" or not could not be fully clarified at some points, so the interpretation there remains speculative. In such cases, I have to spell out the problem in order to contextualise the possible "lie" or "truth" when

---

<sup>36</sup> Also, respondents hardly reported STDs and were also reluctant to admit bribes.

<sup>37</sup> Personal communication, Barbara McPake.

presenting and interpreting the empirical data in order to draw out the wider implications of such divergent statements<sup>38</sup> (for further elaboration on the reliability and validity see Annex 1.10).

The strength of this study lies in its exploratory and qualitative character. Therefore, given the non-random selection and the sample size of both the household respondents and the health units, quantitative statements are not claimed to be representative for the whole of the population of Kamuli District or beyond. However, the results are highly indicative, since the findings reflect what other studies on particular aspects have found as well (see the literature indicated in Chapters 1.1 and 3 to 8).

### Confidentiality

The institutional analysis of accountability issues and interorganisational relations was of a very delicate nature. In order to obtain information on these aspects, I promised confidentiality to the respondents. Therefore, to protect the respondent, his or her position is kept anonymous as much as possible, even though indicating the precise position may strengthen an argument.

### Limitations of the study

Obviously, the strength of the study could have been increased with a representative and larger sample, but time and funding constraints did not allow for this. DED colleagues on a voluntary basis carried out the analysis of quality of clinical care, so again a larger budget would have enabled a more comprehensive and detailed study.

Another weakness of the research was the prevailing language barrier. Although I undertook some language training in Lusoga (the local language) which allowed me to greet and ask basic things as well as to follow a conversation broadly, research assistants played a key role in translation and focus group facilitation. Translating questions into a different language increases the scope of error (Bulmer 1993: 207), but this was minimised by a "decentring translating process" for the key questionnaires, namely an iterative process of back and forth translation, until both language versions of the questionnaire were identical (cf. McKay et al. 1996, WCW 1997). On the other hand, there are also advantages of working with translators (see Annex 1.2).

---

<sup>38</sup> I owe this point to Barbara McPake.

It was particularly difficult to obtain detailed information from private practitioners, especially from the rural based ones, as well as from drugshops. Given the rural providers' illegal status, informality and inadequate service provision, they were possibly afraid of being pinpointed, and even the explicit explanation that the research interest in them was nurtured by the general motive of finding out how services could be improved and what kind of support providers would need did not help much. Here, long-term anthropological and ethnographic research would have been required, but this was not undertaken, since it would not have allowed for the analysis of other research questions.

Finally, a danger of qualitative research is the problem of observational bias, specifically the distortions of the researcher's judgement by the absorption of local views. Again, triangulation and continuous reflection on the information gathered and its "truth" are therefore necessary to minimise this effect.

## **1.5. Overview**

Chapter 2 begins with clarifying the nature of the good of health care (Section 2.1). It then specifies the analytical-conceptual frameworks used for the empirical analysis, namely the sector model (Section 2.2) and the governance mechanisms and interactions (Section 2.3). Section 2.4 provides methodological reflections on how to define and determine relative strengths.

Chapter 3 outlines the nature and structure of health care provision in Uganda and the historical legacies prevailing in today's health care system. The historical-institutional account of local government evolution up to 1986 reveals that accountability never became institutionalised (Section 3.1). Section 3.2 analyses the post-independence organisational/institutional changes in the health care system up to 1986. The discussion of the health policies since 1986, policy-making and the role of donors (Section 3.3) and the local government development since 1986 (Section 3.4) then reveals the constraints with which today's decentralised health care system is faced. The nature of Uganda's health care system in the 1990s and the key features of the three sectors are outlined in Section 3.5. Chapter 4 provides the necessary background of the empirical study in the

four chapters that follow and therefore focuses on health care provision (Sections 4.1-4) and utilisation (Section 4.5) in Kamuli District in more detail.

Chapters 5 and 6 are devoted to a comparative performance analysis of the public, private and voluntary sectors. Chapter 5 analyses the providers' accessibility by assessing and comparing each provider type's payment procedures, the total direct financial costs incurred by the patients to get treatment, the extent of informal charges, the exemption practice, the deferral payment options, physical accessibility, and the utilisation rates in relation to whether people are poor or "better-off" (Sections 5.1-8). An overall assessment is provided in Section 5.9.

Chapter 6 deals with the issues of efficiency in staff resource utilisation and quality of care. Section 1 focuses on the efficient use of staff resources. Quality of care is assessed by the following indicators: drug availability; staff behaviour; the provision of privacy; waiting time; the presence of and attendance by qualified staff; the quality of consultation and examination; clinical quality of care; and the patients' satisfaction with medical care (Sections 6.2.1-2.9). Section 6.3 concludes with a discussion of which provider type performs best or least worst over the three performance criteria of access, efficiency in staff resource utilisation and quality of care.

Chapter 7 aims at explaining the performance and malperformance noted in the previous two chapters. Institutions that produce accountability, financial responsibility and equity between the staff's obligations and rights are considered key for organisational performance (Section 7.1). For each provider type, the operation of such institutional mechanisms is analysed, providing further insights into why they are not functioning (Sections 7.2-4).

Chapter 8 focuses on interorganisational relationships in order to further explain organisational (mal)performance. After some methodological considerations (Section 8.1), the chapter examines how state regulation and supervision of private clinics and drugshops (Sections 8.2-3) as well as NGO clinics (Section 8.4) function. This is followed by an assessment of the effectiveness of network coordination (Section 8.5). Section 8.6 examines the potentials and pitfalls of partnerships. Section 8.7 analyses the actors' incentives and the prevailing "interaction culture" and interaction structure to explain why organisational actors interact the way they do. A study of the referral system shows the

gaps caused both by the providers' referral indiscipline and patients' self-referral (Section 8.8).

The final chapter, Chapter 9, provides an overall conclusion. It summarises the potentials and pitfalls of institutional pluralism found in Kamuli District (Section 9.1). From this, wider implications and reflections follow (Section 9.2). A guide to policy action is provided in Section 9.3. The final section, Section 9.4, addresses the question of institutionalised pathologies versus healing organisations.

## Chapter 2

### Health Care Provision, Institutional Pluralism and Interorganisational Relations

This chapter sets out the analytical-theoretical frameworks for studying institutional pluralism and interorganisational relations in health care provision. First, it is necessary to discuss the nature and the characteristics of health care and of health care markets (Section 2.1). Section 2.2 examines the institutional characteristics and attributed strengths and weaknesses and the assumptions related thereto of each sector *as a service deliverer/producer* – in contrast to *provision that ensures the availability of a service*<sup>39</sup>. The next section introduces the conceptual framework for studying interorganisational relationships and their impact upon organisational performance, namely governance mechanisms (2.3.1) and interactions (2.3.2). The final part of this chapter (Section 2.4) discusses the process of defining relative strengths (2.4.1), the criteria selection process (2.4.2) and the chosen performance criteria (2.4.3). It is crucial to note that these theoretical frameworks and models are mere tools to guide the analysis of institutional pluralism and interorganisational relations, in that they indicate how in theory and under what assumptions they are valid. But they equally assist in examining how these models may not function. In the latter case, there is need to further inquire and explain why they do not function.

#### 2.1. Goods Characteristics of Health Care

Health, as defined by the WHO, is "a state of physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 2000). This definition goes beyond the narrow notion of health as being related simply to the mechanics of bodily organs and includes social and economic relationships. Apart from direct health care activities

---

<sup>39</sup> Production refers to the act of physically generating and delivering a service ("rowing"), whereas provision and ensuring the availability of a service refers to shaping the arrangements of production ("steering", or, as it is termed here, "governance") (Batley 1994b: 8). Commonly the term "health care provider" is used for an organisation or individual that delivers a service, and this meaning is applied, unless specified otherwise.

(curative, preventive and promotive), a multitude of non-health care related factors affect health outcomes, such as income and employment opportunities, (female) education, and water and sanitation (Abel-Smith 1994, WHO 2000). Health and access to health care are considered a human right and of intrinsic value for expanding one's ability to choose the sort of life one wishes to lead (cf. World Bank 1993, Mills 1997b). What people really desire is improved health, so health care is a derived demand. Illuminating the characteristics of health care goods helps one understand the prevailing incentives related to its provision and consumption.

From a consumption perspective, some preventive and promotive health care (PPHC) services constitute pure public goods (e.g., vector control and health education), which are non-excludable and non-rival, so that people are not willing to pay for them and markets will not provide them. Certain PPHC activities, such as immunisation and family planning, which are excludable and rival goods, have very strong positive externalities and meritorial character (cf. Griffith 1988, World Bank 1993). However, PPHC with a future benefit is often little valued, so that people are again less willing to consume and pay for them (Bloomington 1994, Bennett 1997b, Colclough 1997).

Curative services constitute a private, i.e., an excludable and rival good, for which people are in principle willing to pay. Still, markets for curative health services are not in equilibrium in most developing countries (Leonard/Leonard 2000). This is because the production characteristics of health care goods cause market imperfections and failures. This happens for three reasons. First, while contestability in the production of ambulatory care at the primary level is in principle high<sup>40</sup>, supply in practice is low, that is, provider choice is still more limited than it is for many consumer goods. Second, health care goods are characterised by low measurability, in that health care outputs and outcomes are qualitative, intangible and therefore difficult to measure. Third, informational asymmetries between the provider and the patient make it difficult for the latter to assess the appropriateness and quality of the activities of the provider. Health care services are hence highly complex goods, which makes monitoring agent behaviour particularly difficult and costly (Preker/Harding 2001, Russell et al. 1999).

---

<sup>40</sup> Contestability refers to the possibility of entering or exiting the market as a provider.

In reality, the distinction between public and private goods is not that clear. Some goods show both private and public characteristics. For example, the treatment of communicable diseases is of individual and collective benefit. Also, externality, excludability and merit are not a matter of either/or but rather a matter of degree, as they constitute scalar concepts.<sup>41</sup> The categorisation into public and private is eventually a question of interpretation and judgement that requires a political decision to "determine" the degree of externality, merit and desirability of exclusion or rejectability (Batley 1994b, Bennett 1991). In other words, a service has to exhibit the characteristics of both market failure and be considered of fundamental importance to be designated "public" (Corry et al. 1997: 7). Hence, the distinction is relative and what is classified as a public service will vary with the circumstances (above all the epidemiological profile) and the economic wealth of a country (Fisher 1998: 5).

There are three rationales for state interventions in health care markets. First, public goods with large positive externalities require intervention, because the market does not provide them. Secondly, as health is considered to be a fundamental right and a "merit good", state intervention (public financing or other forms of provision) is necessary to provide access to health services for the poor who could otherwise not afford it. Thirdly, market failures and imperfections must be addressed to improve the market functioning and to raise welfare (World Bank 1993, cf. Bennett 1991, Mills 1997b).

While the consumption characteristics, specifically the public-private good distinction, provide guidance on whether the state should intervene or not, they do not help in specifying the form of intervention. At this point, the production characteristics (contestability, measurability, information asymmetry) are relevant for thinking about the how of state intervention, the degree and nature, and the level and form of intervention, whether as a producer (direct service delivery) or a provider (ensuring the availability of the service by regulatory and enabling activities) (McPake 1997). Based on the strengths and characteristics of each provider type and governance mechanism as assumed by theory, Preker et al. (1999) categorise the various health care goods by means of their production characteristics and outline whether provision should be based on market competition, "buy options", or left under hierarchical control. The actual functioning of

---

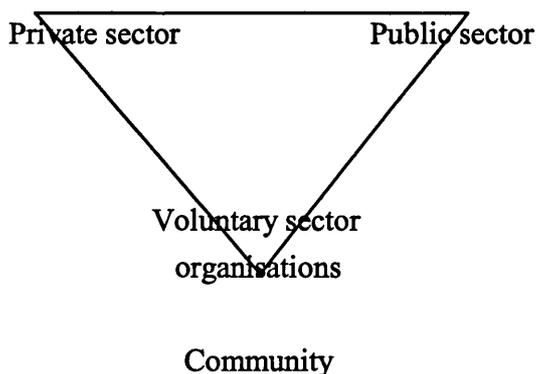
<sup>41</sup> Moreover, excludability is also related to the technical aspects of service provision.

the sectors and their strengths and weaknesses as regards the production of services are illuminated in more detail in Section 2.2. Section 2.3 then examines the governance mechanisms and their strengths and weaknesses, as theoretically presumed.

## 2.2. Private, Public and Voluntary Sector Organisations: Strengths and Weaknesses in Health Care Provision

For developing countries, the most common model is one with three sectors or three poles (cf. Figure 2.1) to capture organisational pluralism into organisational types and sectors (cf. Uphoff 1993). These are (1) private sector organisations, (2) public sector organisations, which consist of all kinds of state agencies, and (3) voluntary sector organisations, encompassing non-governmental organisations, community based groups, self-help groups and other forms of associations that do not fall under the previous two sectors. The sectors do not operate in isolation. For example, the functioning of the market is related to the effectiveness of state regulation (cf. Section 2.3).

Figure 2.1 (cf. Wegener 1995): The sector poles



In this conceptual framework, the sectors constitute ideal-types<sup>42</sup> and are analytically

---

<sup>42</sup> An abstract ideal-type is an "idealised description of the 'forms of action' involved in the functioning of particular institutions" by relating them to social facts. The thrust of an ideal-type model is to point to the difference between the actual and potential capacities within the operation of a given institution and organisation (Brett 1973: 6-7).

differentiated by their particular compliance mechanism that is manifested in the organisational and institutional set-up. Their compliance mechanisms imply specific incentives and disincentives for behaviour and thus predict specific strengths and weaknesses in relation to organisational performance. In reality, the sector attribution is not that straightforward and we must be aware of its limitations (see Section 2.2.4). The sector model serves analytical purposes, in that it provides an idea about the key features, the functioning of the compliance mechanisms, and in relation thereto, the assumed strengths and weaknesses of each sector, which will be outlined below. In the health care literature, a health system's and the providers' strengths and weaknesses are commonly assessed in terms of technical and allocative efficiency, quality of care, and access (World Bank 1993, Bennett et al. 1994, Colclough 1997, WHO 2000). The former aspect follows from a health care system's needs, whereas the latter aspect is based on the understanding that health is a human right, to which everybody should have access. The need for quality of care goes without saying (cf. WHO 2000) (see Section 2.4 and Chapters 5 and 6 for further elaboration on these performance criteria).

Kaufmann provides a useful conceptualisation for the study of the internal "technology" and the effectiveness of compliance mechanisms. He suggests three components to look at – guidance, control and feedback – and adds that an effective compliance mechanism requires a fit and link between the three: "[G]uidance is exercised by any process ... that indicates to single actors standards by which they can ascertain the value or the expected utility of their actions in a wider context". Control elements ensure that the expected value or expected actions are realised. Finally, feedback and evaluation maintain the chain of actions and "facilitate its adaptation to unexpected problems" (Kaufmann 1985: 219).

### 2.2.1. The Private Sector

When discussing the private sector, it is important to note that it is not a homogenous entity. The extent and type of activity is diverse ranging from informal to very formal health care providers (Kumaranayake 1998: 4), so that the strengths and weaknesses apply to different degrees. The fundamental assumption of the market is the "homo oeconomicus", whose prime interest is profit maximisation. The overall argument of neo-

liberals is that the private sector is superior in technical and allocative efficiency due to competition, the price signal and the client's exit options, which imposes hard budget constraints. The question of quality inextricably follows from this, as the provider will be sensitive to the preferences of the consumer, so that for-profit agencies will (should) maximise quality for a given level of input (World Bank 1987: 39, in Bennett 1997b: 95). Maximising efficiency derives from the congruence of the elements of guidance, control and feedback that are all expressed *within* the price (cf. Kaufmann 1985: 222). But because the guidance dimension of private sector organisations is based only on the logic of maximising efficiency, market failures are produced, namely externalities, exclusion and unequal access and distribution, which reduce allocative efficiency. Also, private sector organisations will usually not supply public goods, but this is not to say that they could not produce them.

Further, there are inherent market imperfections in health care, such as informational asymmetries due to low-measurability of health care services and a low number of suppliers. Information gaps are particularly critical, since most patients are unable to judge the value of a specific service or to compare prices among providers, particularly when they have fallen sick. As a result, supplier-induced inefficiencies and ethically unacceptable behaviour arise (World Bank 1993: 131, Bennett et al. 1994: 3). For example, providers may offer unnecessary services and deliver poor quality services at higher prices than would be charged in a perfectly competitive market.<sup>43</sup> Mills stresses that

Conclusive evidence is lacking, at least in the poorest countries, that non-public services necessarily perform any better in terms of efficiency (1997b: 249).

There is no such thing as a "perfect" market, since market imperfections are inherent and since market failure is a "natural" by-product of markets. Thus, most markets require some form of correction and regulation. However, in Uganda, as in other LDCs, markets are less developed, and market imperfections and failures are particularly severe, given

---

<sup>43</sup> Where information is particularly imperfect about skills, a "market for lemons" will exist, in which lower-price, low-quality practitioners will compete higher-cost higher-quality providers out of existence if the latter are unable to demonstrate their superior quality (Akerloff 1970 in Leonard/Leonard 1998: 35).

the conditions prevailing there, including an "economy of affection"<sup>44</sup>, and low levels of trusts in contractual agreements, in the laws governing market transactions, and in law and regulatory enforcement (Ruzindana 1995 in Nicholls 1998). Further shortcomings include low literacy rates, under-capitalisation and low saving rates (Kasekende/Atingi-Ego 1999), poor business ethics and high levels of opportunism in the general context of extreme poverty, deprivation, scarcity and uncertainty (Munene 1991, 1995; Munene et al. 1997, 2000; Nicholls 1998 for Uganda). As in many African countries, important institutions, such as professional associations, or health insurance markets are poorly developed or absent (Leonard/Leonard 2000).

### 2.2.2. The Public Sector

The compliance mechanism primarily used by the state is hierarchical control.<sup>45</sup> Hierarchy is characterised by the existence of stratified authority and the respective following rules whereby one "actor" directs and controls the activities of another one through rules within certain bounds (Miller 1992: 16, Mitchell 1991). This allows the state to perform functions that other sectors cannot. In day-to-day behaviour, hierarchy is thus manifested in "duty, authority and adherence to rules and procedures about how tasks shall be performed" (Moore 1996: 3). In its ideal-typical form, state service delivery is very efficient if it is based on hierarchical bureaucracy of the Weberian type and on democratic accountability.<sup>46</sup> Accountability is "a function of the leverage exerted" over agents by their principals (Brett 2000c: 41; see Chapter 7 for further elaboration). Democratic accountability mechanisms refer to the chain of civil servants being accountable to elected politicians who are again accountable and responsive to the citizens.

The Weberian model of hierarchical control and bureaucracy is efficient only if the conditions of standardisation, insulation of bureaucrats from society, and impartiality are

---

<sup>44</sup> This is a network of support, communication and interaction among structurally defined groups connected by blood, kin, community and other affinities, which aim to service the needs of dependants, thereby preventing the accumulation of savings (Hyden 1983: 8, in Munene et al. 2000: 342).

<sup>45</sup> Governments increasingly introduce other compliance mechanisms (see Section 2.2.4). Note that hierarchy is also exerted within non-state organisations as a principle of structure and compliance, which will be discussed where pertinent.

<sup>46</sup> Uganda's administration is based on the Weberian type (Fallers 1965, Brett 1993), as are those of other developing countries (cf. Simon 1993, Preker et al. 1999).

met (Moore 1996). It is therefore considered to be particularly appropriate for routine tasks (Batley 1994b: 10). The strengths are neutrality, fairness and clear responsibility chains. Further, professionalism and codes of conduct make civil servants adhere to standards (e.g., quality of care). Most importantly, state service provision allows for altering distribution, pursuing equity objectives and other collective goals of society (Brett 2000c). In theory, we would therefore expect the state to be better than the market in delivering low-measurability health care goods and in providing the poorest access to its services.

However, state hierarchy implies inherent weaknesses. Democratic accountability is deficient due to imperfect rules about the aggregation of individual values (Arrow 1963, Preker et al. 1999). "Perfect" hierarchical control fails, because laws and regulations require interpretation. Orders may be ambiguous and objectives may be multiple and conflicting (Hood 1976 in Larmour 1997). Ultimately, hierarchy suffers from principal-agent problems and information asymmetries, even more since there is no congruence in the devices for guidance, control and feedback. In particular, there is no *inherent* feedback mechanism within hierarchy (Kaufmann 1985: 222). These deficits cause state failure, or more specifically hierarchy failures, which result in lack of or weak incentives for performance. Another consequence is the rise of "internalities", i.e., goals that apply within non-market organisations to guide, regulate and evaluate agency performance and the performance of agency personnel deviate from the public interest (Wolf 1988: 66). These are palpable in the pursuit of private interests, opportunistic behaviour, corruption and rent-seeking (Mackintosh 1992). Another problem is cost expansion due to the separation of revenues and spending (Niskanen 1971).<sup>47</sup> The results of these deficits are allocative and technical inefficiency, inequity and poor quality.

Decentralisation theories claim that such state failures are less severe in devolved state agencies, which is why decentralisation has been suggested as a major structural reform to improve performance within the public sector. The key argument for decentralisation is that increased local autonomy over decision-making, based on local legitimisation by the population to be served, will make health care planners and

---

<sup>47</sup> For the problems of tax financed health care, cf. Joenson/Musgrove 1997.

providers more responsive to local needs. This will also increase their accountability in terms of both the quality of care offered and the use of resources, as well as of social development goals (Atkinson et al. 2000: 620).<sup>48</sup> Even though not an argument against devolution, this may pose new problems, not least for the health care system (Mills 1994, 1997b, Collins/Green 1994, cf. Brett 1998b for Uganda).

The existence and nature of state failures is independent of the type of regime. But as for markets, state failures are particularly severe in LDCs, in that the related assumptions for functioning state provision are not fully met in the context of weak state institutions, lack of collective action, low levels of social capital, a weak civil society and high rates of illiteracy, all of which weaken accountability. Moreover, informal institutions and rules, such as the "politics of the belly" (Bayart 1992)<sup>49</sup>, the "economy of affection" (Hyden 1992) and the tendency towards "personal rule" (Kjaer 1999) undermine the insulation of bureaucrats from society, their impartiality, and their neutrality. This leads to patronage and clientelisation and subverts the operation of formal institutions (often imported from the West) (Munene et al. 2000). Uganda is no exception to this, as we will see.

### 2.2.3. The Voluntary Sector

There is great diversity of organisations in the voluntary sector. For the purpose of this study, the focus is on non-government organisations and church-affiliated organisations that deliver health services.<sup>50</sup> The ideal-type voluntary sector organisation is structurally separate from government, self-governing, and enjoys a significant degree of autonomy. Its distinct compliance mechanism is based on value-drivenness and solidaristic concerns and motivations (Brett 1993, Streeck/Schmitter 1985). These are nurtured by norms prevailing within a community, religious belief or other humanitarian convictions, which limit the pursuit merely of self-interests. Compliance is driven by social responsibility

---

<sup>48</sup> For discussions on the benefits of decentralisation, cf. Biehl 1987, Maddick 1963, Rondinelli/Cheema 1983, Rothchild 1995, Samoff 1990, Simon 1993, 1994a, Smith 1985, Wunsch/Oluwu 1990, Bossert 1998.

<sup>49</sup> This refers to "eating" in a wide sense. It is more than corruption in that it ultimately denotes a power struggle and a struggle for social mobility and allocating scarce resources, whereby amassing and redistributing wealth (including state resources) turns a person of power into a person of honour (Kjaer 1999: 96).

<sup>50</sup> Cf. Green (1987: 38) for the range of types of voluntary sector organisations in health care provision.

and solidarity vis-à-vis others, whether within the immediate community context or on a wider level (cf. Wegener 1995). Solidarity can be distinguished into altruism, reciprocity, and loyalty (Neubert 1997: 70), each of which gains relevance under particular arrangements and circumstances. Religious belief may nurture all three aspects.

Altruism can be defined as an individual disposition which "guarantees the inclination of actors to contribute without expecting a benefit of the same kind" (Hegner 1985: 410), whereas loyalty is manifested in the belief that "keep[ing] faith with another person or group of persons without economically weighing the advantages and disadvantages of that behaviour step-by-step, at least in the long run, is more favourable than breaking faith with the collectivity" (ibid.: 411). Reciprocal behaviour is based on "do ut des" – there may be a temporary forgoing of advantages, but it is expected that "the other(s) will respond in some way in the future" (ibid.).

The guidance component of solidarity directs behaviour, but control and feedback components are rather elusive because they are not inherently defined within the compliance mechanism. A voluntaristic organisation must therefore set up specific accountability mechanisms, since altruism and loyalty by themselves provide no accountability basis, whereas the threat of withdrawal from a reciprocal relationship may exert some pressure on both sides. Further, donor dependency and hence accountability to donors constitute a surrogate or complement for the elusiveness of solidarity (Brett 1993). Despite the common attribution of solidaristic motivation, the NGO sector is best characterised in terms of its diversity in size, financing and services provided (Green/Matthias 1995: 569). Given this diversity and the elusiveness of the compliance mechanism, it is more difficult to make absolute, general statements about the advantages of voluntary sector organisations.

NGOs are said to deliver high quality services at lower cost to the poorest and most disadvantaged people, that is, they are considered to be more efficient than the state. This technical efficiency is thought to result partly from their ability to react quickly to changing needs, to make decisions at the health facility level without reference to a higher authority and to use funds and human resources flexibly, as they are not as constrained as government bureaucracies are (Gilson et al. 1994: 18). Given the voluntary sector's solidaristic motivations, we would expect it not to exploit the information

asymmetries that result from low-measurability goods, which explains its higher quality services. Likewise, solidarity guarantees better access for the poorest (Green/Matthias 1995). Because of their strong motivational basis and greater flexibility, NGOs are also believed to be more innovative than the state. Operating at the local level and therefore closer to the people, and allowing for a higher degree of participation makes them more responsive and more effective in mobilising resources than the state (Bebbington/Farrington 1993, Jessen 1992).<sup>51</sup> It is important to note that, apart from solidaristic motivations, NGO performance in service provision requires collective action, trust, effective accountability structures, and an ability and willingness to participate.

Following the concept of state and market failures, Salamon argues that the inherent features of voluntary sector organisations cause "voluntary sector failure" (1987: 111), such as lack of professionalism, lack of scale and lack of integration.<sup>52</sup> They are accused of wanting management systems, failing to meet national health needs and quality standards and being unplanned and technically and allocatively inefficient (WHO 1985 in Green 1987: 40, Robinson/White 1997). Overall, available evidence as to their efficiency is limited and variable (Gilson et al. 1994: 18). Further, accountability mechanisms are often less clear and participation is costly, which again questions their cost-effectiveness (cf. Brett 1993, 1996a). Finally, NGO staff may not be motivated by altruism, but by high salaries, such that they emerge as a privileged group on a second labour market. Self-interest may be equally strong and result in opportunistic behaviour and malfeasance (cf. Nabuguzi 1995, Neubert 1997, Klempp 1996 for East Africa).

So, while arguments on efficiency, service quality, equity and resource mobilisation can be made in favour of NGO health care provision, the same arguments can be used against NGOs (Green 1987: 50). It is therefore hard to see any theoretical justification for the premise that the NGO types we are talking about have an *overall* comparative advantage over state provision (Green/Matthias 1995: 570) or market provision in *all*

---

<sup>51</sup> Bennett argues that the fee collection performance of missions is probably better (Bennett 1991 in Mills 1997b: 253). Other parts of the NGO health sector have been little studied (ibid.).

<sup>52</sup> While these failures are empirically valid observations, the conceptualisation as "voluntary sector failure" is unjustified, because these failures do not follow from their compliance mechanism but from a lack of organisational capacities.

situations.<sup>53</sup> In sum, NGO performance is based on several assumptions. Whether these are all present in a context like Kamuli, is an empirical question.

#### 2.2.4. The Institutional and Context Contingencies of the Sectors' Appropriateness

The intellectual thrust of the sector model is about carving out the ideal-typical key characteristics of the three sectors, thus providing an idea of each sector's strengths and weaknesses. Yet, these general attributions of strengths and weaknesses do not provide universally applicable rules, as they only spell out the problems involved in the provision of health care, rather than giving us an *absolute* indication of which sector is appropriate *in a specific context*. For example, when one sector performs better in a given situation, it is unclear whether it derives from its inherent compliance mechanism or whether this is only due to the failures of the other two sectors. Strengths and weaknesses of the various agencies are relative and contingent upon each other within a given moment and location; they are situational.

Furthermore, the strengths of each sector cannot only be determined on the basis of the nature of the good and a sector's compliance mechanism. The functioning of health care markets also depends on the local epidemiological profile, socio-economic conditions, civil society, the nature of interorganisational relationships, and, in particular, the extent of regulation – all of which are often underdeveloped (Bennett et al. 1995: 4) (see below and Chapters 7 and 8). It is very difficult to make universally valid statements on the sectors' specific strengths and role without specifying the multiplicity of factors that affect performance (cf. Mathauer 2000). Hence, relative strengths can be determined only empirically. This latter point is even more valid once the sector assumptions are not (fully) met, as is the case for Kamuli District. It is then again an empirical question of which provider type operates best or least worst.

The ideal-type sector model stands against a continuum of organisations that do not fit clearly into one sector and that may comprise more than only one compliance mechanism (Kenis/Schneider 1991, Green 1987, 1995). Further, the conventional sector conceptualisation of the state is now moving towards a new ideal-type. Governments have increasingly come under reform pressures to move to the New Public Management

---

<sup>53</sup> The comparison between NGOs and markets is rarely found in the literature.

model as a new (ideal-)type of administration. There are also many other possible institutional arrangements for delivering services, such as co-production and collaboration between various organisations (Batley 1994b, Ostrom et al. 1993, Bennett 1991; see Section 2.3). Hence, in practice, the conventional sector boundaries are blurred, and we will see in Uganda that a process of hybridisation has taken place. What often remains is the sectors' formal-legal basis, whereas objectives and interests of public sector organisations or NGOs have become private (cf. Green/Matthias 1995).<sup>54</sup>

Despite its limitations, the sector model provides a useful initial conceptual framework needed for examining and understanding institutional pluralism and to guide the search for the best institutional arrangement in a specific situation. On the other hand, in the end, any role attribution must be context-specific (cf. Robinson/White 1997: 16, Green 1987: 51). In that sense, Preker et al.'s (1999) guidelines on which service provider is adequate to produce which health care goods are only indicative. Brett notes that

Optimal results are only achieved when the most appropriate type of agency is selected for the tasks in hand. This is a matter of relating agency to context on the basis of a rigorous understanding of the principles of each type, *and* sound empirical knowledge of the situation in which it will have to operate (1993: 301, my emphasis).

It is therefore most relevant to understand the functioning of the compliance mechanism and the institutional set-up of an organisation in a given context. This set-up is the array of institutions that constitute the chain of guidance, control and feedback, as well as other (informal) institutions. These must be critically examined further in order to explain organisational performance or malperformance (for further elaboration see Chapter 7).

### **2.3. Interorganisational Relations**

Interorganisational relations are an inherent part of institutional pluralism and create, but also meet the need for some order. They refer to interorganisational institutional

---

<sup>54</sup> The boundaries between the public and private sector are also blurred due to double-employment and the fluctuation of health workers between the sectors.

mechanisms – "governance mechanisms" – and interactions. Governance mechanisms denote those institutional mechanisms at the system level that "govern", "steer", "control" and "co-ordinate" organisations<sup>55</sup> (see Section 2.3.1). Here, interactions are defined as an event where "two or more organisations transact resources of any kind" (Van de Ven/Ferry 1980: 297) or where one organisation *directly* interferes in the affairs of another. Interactions represent a continuum from obstruction/restriction and conflict to co-operation and collaboration (see Section 2.3.2). Governance mechanisms are closely interwoven with interactions. However, not every interorganisational relationship is governed in one way or the other; organisations may also co-exist (cf. Brett 1998a).

### 2.3.1. Governance Mechanisms

The three ideal-type forms of governance are (1) competition (market co-ordination), (2) regulation (hierarchical co-ordination), and (3) network co-ordination (for this tripartite distinction, cf. Moore 1992, Francis et al. 1991, Powell 1991, Robinson et al. 2000). Governance mechanisms serve to increase organisational performance and, on an aggregated level, to increase system output, such as allocation, distribution, efficiency, equity and responsiveness (Kaufmann 1985: 210).

Analytically, the "technology" of the governance mechanism is identical with the compliance mechanism (of sectors), in that organisations are made to behave in a certain way. However, their entry points differ. The compliance mechanism refers to intra-organisational aspects of delivery, whereas the governance mechanism addresses interorganisational relations and the interorganisational aspects of provision. In the case of competition and the price mechanism, however, the compliance mechanisms and governance mechanisms are identical, since competition relies upon the existence of other organisations' behaviour and supply. As a compliance mechanism, market competition works on technical efficiency; as a governance mechanism, it affects allocative efficiency. It is useful to apply again Kaufmann's conceptualisation for the study of the "technology" of governance mechanisms by looking at the fit and the link between guidance, control and feedback (cf. Section 2.2). Each governance mechanism

---

<sup>55</sup> Other terms used are "steering" or "coordination" mechanisms (Bradach/Eccles 1991, Kaufmann et al. 1985, Kickert et al. 1997).

will be discussed in relation to these three elements to outline their strengths and weaknesses.

#### 2.3.1.1. Competition

The space associated with competition is the market, the co-ordinating instrument of which is the price, which motivates and regulates interactions and transactions (Marshall 1991, White 1993). The health care market does not necessarily consist only of private sector organisations; rather, any set of organisations or individuals can constitute a market if they compete. In Kamuli, for example, public, private and NGO health clinics compete against each other, and NGOs also compete among themselves for donors and target groups (cf. Fowler 1998). Provided that there are no market imperfections and failures, competition produces allocative efficiency. This strength derives again from the congruence of the elements of guidance, control and feedback. But because of the one-dimensional logic of the market, there are market failures that reduce allocative efficiency. This is more so the case if the functioning of the market is severely undermined by market imperfections and underdevelopment (cf. Section 2.2.1).

It is questionable whether allocative efficiency of the health care sector as a whole increases in a competitive setting when there is still undercoverage or duplication of efforts (Green 1987, 1992, Bennett 1997b). Likewise, competition is often incompatible with integration, which is why it may be difficult to bring private practices into referral systems (Bennett et al. 1994: 4, cf. WHO 1996: 4). Thus, competition fails to solve many concerns of an interorganisational system. Bennett (1994) concludes that the neoliberals' claims of greater efficiency benefits are likely to materialise only if the market is effectively regulated.

#### 2.3.1.2. Regulation

Regulation serves to address market imperfections or to reduce market failures. It can be broadly understood as the state's actions to manipulate prices, quantities, distribution and quality of services (Maynard 1982 and Roemer 1993 in Kumaranayake 1998: 8) in order to affect access, equal coverage and quality standards as well as to achieve integration of services. This includes such tasks as accrediting health facilities, licensing medical

schools and physicians, establishing a referral system, fixing price levels, regulating the sale of drugs, reviewing medical practices and guiding the location of clinics (ibid.). The rationale behind regulation is based on some form of public interest in order to overcome or reduce market failures (Bennett et al. 1995: 30).<sup>56</sup>

The traditional basis of regulation is hierarchy, involving a bureaucracy accountable through hierarchical chains to politicians (Batley 1994b: 13). By means of hierarchy and regulation, i.e., legislative power and power over resources, information and accountability, the state is able to alter the distribution of resources, to guarantee equal access and to provide incentives to influence private providers' behaviour. If services by specific private or NGO organisations are mutually exclusive or conflicting and express motives beyond mere altruism, the state is the only entity that can act as a "primus inter pares". Its regulatory capacity constitutes "a potential integrating framework to both reinforce, regularise and rationalise [non-state] provision, reflecting some broader notion of *public welfare* [...]" (Robinson/White 1997: 24, emphasis there).

However, regulatory approaches are costly and may fail to achieve planned objectives, as governments may misjudge the impacts of an intervention due to information deficits or because some of the stakeholders are too powerful and dominant. A distorted regulatory intervention may be the result. In that case, regulation may even worsen the problem (Bennett 1997b: 114). This is because hierarchy suffers from a lack of congruence between the devices for guidance, control and evaluation and because it has no *inherent* feedback mechanism (Kaufmann 1985: 222). As mentioned above, this makes state service delivery fail and, likewise, it explains the limits of regulation. Another problem is "regulatory capture", where the regulating body is sympathetic to or influenced by the regulatee, for example through bribes, or where it operates on the basis of perverse incentives, so that the purpose of the legislation is undermined (Kumaranayake 1998: 16).

The capacity and effectiveness of regulation also depend upon a number of factors, namely the availability and validity of information, funding and resources for implementation, effective monitoring and enforcement and the willingness of private

---

<sup>56</sup> The alternative to the "public interest theory of regulation" is "self-interest or capture theory of regulation" (Kumaranayake 1998) (see Chapter 8.2).

providers to collaborate in providing this information (Bennett et al. 1994: 9). States often feel that they do not have the capacity, even though they have the authority to supervise and monitor (WHO 1991 in Bennett et al. 1995: 37). In fact,

There is an irony 'that the need for regulation is greatest in economies which have the most limited capacity to manage it' (Adam et al. 1992: 77 in Batley 1994b: 13).

If these fundamental prerequisites for regulation are absent, it is even more difficult to say whether poor state regulation (or state service delivery) is still superior to competition in an imperfectly functioning market.

Because of the limits of hierarchic regulation, the government's role as enabler for non-state provision is increasingly propagated in both developed and developing countries.<sup>57</sup> Incentive-based instruments are oriented at promoting non-state health care providers and at fostering market conditions, particularly in cases where it is difficult to monitor their behaviour (Bennett 1997a). Although having a more positive connotation than regulation, enabling is directed at the same parameters, namely, influencing prices and the quality and quantity of health care. Enabling aims to increase the number of private providers, particularly in rural areas for a geographically more equitable provision, to improve their quality of care, or to encourage them to perform certain activities, such as PPHC or disease notification (Bennett et al. 1995: 33).

The respective instruments comprise tax breaks and exemptions, financial incentives for public health activities or other specific behaviour, as well as incentives such as training, technical support and provision of free supplies (Bennett et al. 1994: 7-8, Bennett/Ngalande-Banda 1994: 36). Enabling is closely related to and precipitates interaction and co-operation (see Section 2.3.2). It has been argued that non-state providers should be promoted when they have a long-term comparative advantage in provision and in financing, for example, by meeting a need which is otherwise not catered for, making a positive contribution to the health system or improving coverage (Gilson et al. 1994: 21).

That said, enabling may suffer from the same shortcomings as hierarchical

---

<sup>57</sup> Cf. for example Osborne/Plastrik 1997, World Bank 1997b, Robinson et al. 2000, Batley 1994b, 1999b; for the health sector, cf. Bennett et al. 1994, 1997b, World Bank 1993, Preker/Harding 2001.

regulation, since the logic of guidance, control and feedback is elusively structured. There may be the same informational asymmetry resulting in the provision of the "wrong" incentives. A fundamental precondition for the success of a regulatory and incentive-based approach is therefore an open and trusting relationship between the different parties (Bennett et al. 1994: 10, cf. Mackintosh 1997 in Kumaranayake 1998: 9), not only for implementation and monitoring, but also for the formulation of such incentives. Hence, enabling is less of a one-sided unilateral process and can be implemented on the basis of contractual obligations (Kumaranayake 1998: 33).

The interaction with non-state providers raises new questions of accountability and probity (Batley 1994b: 13). In order to effectively perform its new roles of regulation and enabling, a government needs the technical capacity of a bureaucracy, but transparency and other external factors are equally necessary, such as a critical civil society and media to control self-granting and corrupt practices (Bennett et al. 1995: 31, 37). The simultaneous practice of hierarchical control/regulation and enabling poses conflictive tensions within the public sector and are difficult to manage (cf. Batley 1994b). So far, such incentive instruments have a short history, and evidence is limited (Bennett 1997b). The ultimate question is whether LDCs fulfil these preconditions and requirements for regulation and enabling to be effective. Given these shortcomings, Mackintosh (1999) argues that in practice regulation is a mix of formal regulatory rules *and* informal patterns of behaviour and that effective formal regulation therefore needs to be grounded in the local culture and legitimate with those who have to conform.

#### 2.3.1.3. Network Co-ordination

In response to failures of competition and regulation, alternative institutional mechanisms such as co-ordination and mutual adjustment of two or more parties received increased attention in the 1990s, in both developed and developing countries (Kooiman 1993, Messner 1995, Kickert et al. 1997, Robinson et al. 2000, Hewitt 2000; for health care, Tizio 2000, Mackintosh 1999<sup>58</sup>). Like regulation, network co-ordination aims to achieve integration and to address efficiency (the use of resources is optimised through mutual adjustment as to space, time and content, as well as through resource pooling), prices

---

<sup>58</sup> Note however that the latter two scholars do not explicitly refer to the term "network co-ordination".

(access), quantities (and location) and quality.

Network co-ordination can be generally understood as a manifestation of "rules of the game negotiated and agreed by" interdependent actors within more or less stable patterns of social relations (Rhodes 1997: 7, cf. Klijn 1997: 14). Its instruments are mutual adjustment, interest mediation, negotiation, bargaining and persuasion to shape the arrangement of service delivery (Robinson et al. 2000, Hewitt 2000).<sup>59</sup> It can be viewed as an "interaction process in which actors exchange information about problems, preferences and means, and [then] trade off goals and resources" (Kickert et al. 1997: 9). The element of guidance within this governance mechanism is therefore much more open in nature. The elements of control and feedback are rather elusive if and when no clear a-priori agreements have been established within an arrangement of network co-ordination.

Network co-ordination seems to be more adequate in dealing with the growing diversity, dynamic and complexity of the problems with which a society must cope, which is for example clearly illustrated in Tandler's case study of Brazil (1997). This is because network co-ordination spreads accountability and responsibility around public and private actors (Kickert et al. 1997 Kooiman 1993, Evans 1997). Further, as development and poverty eradication are multi-dimensional problems with intertwined causes, one single organisation will not be able to deal with the complex challenges of poverty eradication and health improvement. Problem solving may be more effective through integrative approaches based on co-ordination and co-operation (cf. Zeitz 1980) in order to ultimately optimise the use of scarce resources and to respond effectively to people's needs. Finally, network co-ordination implies transaction costs (just like regulatory and enabling schemes), but these should be offset by the benefits gained through better services and optimised resource use.

The rationale for co-ordination is not necessarily based on solidarity; it may be induced by sheer necessity and recognition that other forms of governance are less adequate in a given situation. Yet effective network coordination relies upon a number of conditions. It depends on the capacity and willingness of organisations to coordinate and collaborate, as well as reciprocity to come to an agreement (cf. Benz 1994). Furthermore,

---

<sup>59</sup> Cf. Francis et al. 1991, Benz 1994, Scharpf 1993, Hanf/Scharpf 1978, Jansen/Schubert 1995, Majone 1985, Kaufmann et al. 1985.

it is contingent upon mutual trust to co-operate in the pursuit of national policies; in other words, it requires high levels of social capital, whereas strong power differences are a severe obstacle to network co-ordination. For network co-ordination to take place at the local level, some degree of decentralisation is necessary to provide the actors with room to manoeuvre. Whether these conditions are met in an LDC context is therefore a critical question.

#### 2.3.1.4. The Institutional and Context Contingencies of the Governance Mechanisms'

##### Appropriateness

The ideal-type governance mechanisms described above have various derivatives in reality. For example, within the New Public Management rationale, the state applies market derivatives, such as competitive tendering and contracting, which constitute a mixture of a regulatory approach and competition (Batley 1999a, Russell et al. 1999, Broomberg 1994, Mills 1997a for the health care sector; cf. Lingnau 1996 for the public sector in Uganda).<sup>60</sup> Further, regulation and network co-ordination can also be exercised by non-state actors; one of the possible forms is "state-sponsored self-regulation" (Kenis/Schneider 1991: 35; cf. Bennett et al. 1995).

The governance mechanisms complement each other; for example, regulation can only take place in relation to non-state providers.<sup>61</sup> Each governance mechanism is appropriate under particular circumstances, and each calls for a specific role of the public sector and specific responsibilities (Batley 1994b: 9).<sup>62</sup> Like the ideal-type sector model, the conceptualisation of governance mechanisms illuminates their operation, assumptions and their strengths and weaknesses. But even though it is obvious that market failures and imperfections call for regulation, this conceptualisation does not provide a-priori guidelines or prescriptions as to which mechanism is most suitable for a given situation. In the abstract, it is not known whether regulatory failure is the least bad option in

---

<sup>60</sup> Depending on the type of contract, contracting can be classified as competition, enabling, network coordination, or collaboration. For the different forms of contracts, cf. McPake/Ngalande-Banda 1994, Mills 1997a, Perrot/Adams 2000.

<sup>61</sup> In this study, state regulations of quality of care in public sector facilities is subsumed under the state's (internal) compliance mechanism of hierarchy.

<sup>62</sup> Cf. Robinson/White 1997, Batley 1994b and Kumaranayake 1998 for an overview of existing and potential arrangements.

comparison to market failure or whether network co-ordination is more adequate than hierarchical regulation.

More so, the transaction costs of the governance mechanisms are difficult to grasp. The actual functioning of governance mechanisms depends on institutional aspects relating to guidance, control and feedback, as well as to autonomy, accountability and transparency (cf. Bennett et al. 1995: 39). Which governance mechanism is most adequate is thus an empirical and context-specific question. Again, the question becomes even trickier if the assumptions of the functioning of these governance mechanisms are not fully present. It is therefore crucial to understand the contextual factors and informal institutions that affect these mechanisms. This point is also made by Mackintosh/Tibandebage who emphasise the enormous importance of a "contextual understanding of the informal regulatory relationships" that shape a pluralistic health care system in a given place and moment (2000: 3). Another major concern is the organisational capacity of governments to administer the new roles assigned to them, as well as the capacity of other organisations that participate in network co-ordination.

### 2.3.2. Interactions and Synergies

Interorganisational relationships involve different kinds of interactions, ranging from conflict and restriction, to (inter-) dependencies, co-operation and partnerships. Conflicts refer to disagreements and disputes over setting priorities, goals and interests (Rogers/Whetten 1982, Van de Ven/Ferry 1980). Co-operation can be understood as *constructively* working together in the pursuit of individual and collective benefit, and the term partnership is increasingly used for such arrangements. Co-operation can take on various forms, such as joint ventures, co-production, co-funding and joint decision-making. These arrangements are an adaptation for generating better performance by combining the sectors' strengths in order to overcome one sector's weaknesses of provision. The benefits of co-operation are synergies and efficiency gains, which derive from the exploitation of complementarities and relative strengths among organisations thereby saving resources, from mobilising and pooling of extra resources, from improved program design and from increased accountability by partners with mutual control (cf. Evans 1997a, Tandler 1997, Paul 1992, Salamon 1995, Esman/Uphoff 1984,

Robinson/White 1997). Ostrom (1996) concludes that co-production of public goods is a means to achieve higher levels of welfare. Yet, like network co-ordination, co-operative interaction requires the willingness and capacity of the actors.

Further, interactions are intertwined with (inter-)dependency and affected by power structures. Power is based on an organisation's possession of resources (Pfeffer/Salancik 1978), which translates into the ability to make another organisation do what it wants or to influence and determine collective decisions according to an organisation's own interests (Jansen/Schubert 1995: 13). Large inequalities in power distribution are problematic, in that they can cause open and latent conflict between organisations and hence fully undermine the potential synergies of co-operation.

Interorganisational interactions may also suffer from many other problems, such as the breaking of agreements, state instrumentalisation, corruption, cronyism, politicisation and clientelisation. Not only do they reduce efficiency gains through foregone successful co-operation, but they also distort accountability, ownership and participation. In many instances, NGOs prefer to avoid contact or co-operation with the state in order not lose control over their goals and approach, which may be quite different from that of the state (cf. Bratton 1989, Fowler 1991a, Sandberg 1994, Simon et al. 1993, Robinson/White 1997). Hence, the realisation of synergies and the use of complementarities cannot be taken for granted, and the interaction between public and voluntary sector organisations may not necessarily deliver a beneficial impact. Like governance mechanisms, this is contingent upon the context.

#### **2.4. Determining Relative Strengths and Performance Criteria**

The term "relative strengths" – or "comparative advantages" – is widely used in the literature<sup>63</sup>, but there is no clear or uniform definition or understanding of it. While it may

---

<sup>63</sup> Cf. Green 1987, Gilson et al. 1994, World Bank 1997b, Simon 1993, 1994b, Bebbington/Farrington 1993; Fowler 1990, 1991b; Carroll 1992; Heidjen 1986; Sandberg 1994; Steinich 1997, Paul 1988; Ridell 1994 (using the term "comparative advantage(s)"); Triche 1990 in Werna 1993 ("relative strengths"); Hirschman 1970 ("comparative efficiency"); Ostrom et al. 1993 ("comparative strengths"). Here, the term "relative strengths" is preferred in order not to confuse it with Ricardo's "comparative advantages" of two countries exchanging products.

be very straightforward to clearly state what relative strengths mean in relation to health care provision, that is efficiency, access and quality of care (see Section 2.2), it is important and insightful to illuminate this definition process from a methodological point of view.

#### 2.4.1. A Notion of Relative Strengths

Complex methodological problems make the evaluation of organisational performance very difficult (Brett 1993: 273; cf. Green 1987). So, the question of how to determine the "optimal" division of labour based on each organisation's relative strength is also a little answered one. The literature that explicitly deals with relative strengths, institutional/organisational choice and the search for the optimal division of labour on a theoretical basis are institutional analysis and institutional choice approaches, concepts of state modernisation and NGO sector discussions.<sup>64</sup> These diverse approaches are at least implicitly (if not explicitly) based on a notion of relative strengths in search for the "right" organisation to provide adequate services, but their methodology, depth and rationales for this search differ.

They also vary in the criteria chosen as well as in the respective operationalised indicators, in accordance with which the superiority of one organisation over another is to be assessed. The fact that they vary in the definition of what it is "better" means that no such "better" exists in general, and that there may be different interests involved in the definition of relative strengths. Trade-offs will have to be made between criteria, so the choice (and weighing) of criteria will determine the final attribution of relative strengths. Hence, there is a fundamental difficulty in comparing organisations, as Brett points out, because "performance criteria are not absolute but relative to social expectations, the

---

<sup>64</sup> The approaches under review are the work by Ostrom et al. 1993, Wunsch 1994, Schuppert 1994a, 1994b, Müller 1993 for institutional analysis/choice; Naschold 1998, Prittwitz 1998 for the concepts of state modernisation; Cernea 1988, Fowler 1990, Bebbington/Farrington 1993, Riddell 1990, Riddell/Robinson 1993, Salamon 1995 for the NGO sector discussion. The extensive literature on organisational theory is not included, as it is concerned with organisational-technical and management principles, but not with comparing different provider types per se.

availability of resources, the task at hand and the organisational alternatives available to achieve given ends" (1993: 281). Ultimately, a (normative) choice has to be taken to select the "relevant" criteria.

#### 2.4.2. Criteria Selection Process

It is crucial that performance criteria and indicators reflect the needs and preferences of the users and beneficiaries of services in order to come up with adequate policy recommendations. It is also the users and beneficiaries that must make the final decision regarding trade-offs between criteria (cf. Ostrom et al. 1993: 117). Equally insightful are the providers' perceptions and views that help understand the feasibility of achieving the performance indicators.

External actors can contribute to this definition process by drawing on a wider sphere of experience in order to suggest pathways (Farrington/Bebbington 1993: 89, 115; cf. Carroll 1992: 37). The advantage of an outsider's view lies in his or her ability to judge the potentials and limits, given the knowledge about what else has been attempted and achieved elsewhere. Such comparative knowledge will be particularly important where different local groups have contradictory objectives or when they do not know what might be possible. Also, unlike the people concerned, the (external) social scientist is not caught up in the social processes he or she studies, and thus he or she "should therefore be able to see their situation more objectively than they" (Brett 1973: 9). Furthermore, any analysis is based on normative assumptions, which determine the choice of unit of analysis, the selection of evidence and the criteria against which the object of analysis is assessed (ibid.: 6). What is hence important is to expound those assumptions and values openly. The observer's side is not an imposed view or theoretical extract but eventually the balanced and reconciled conclusion of empirical analysis that favours the poor and vulnerable.

Therefore, the selection of the criteria to be applied in the case study will be based, on the one hand, on people's views and needs. For that matter, people were directly asked about their views and preferences. The providers' perception on what they think constitute relative strengths were equally assessed. The view of NGOs in particular not only lessens the possible problems of people's short time-horizons, information deficits

and non-consideration of externalities but also help to represent the views of the marginalised and the poor given the voluntary sector's assumed advocacy for the poor. On the other hand, the criteria selection takes into account the observer's view, i.e., the researcher's perspective, which is informed by the health care literature and Uganda's health care policies as a reflection of the current systems needs (see Chapters 3.4 and 3.6).

### 2.4.3. Performance Criteria

There are a multitude of factors that influence a person's health, as mentioned in Section 2.1. Since it is not a single disease incident that determines health status, but many factors in conjunction, and since people use several providers even for one disease incident (see Chapter 4.5), the impact of a single health care provider cannot be measured.<sup>65</sup> Thus, given the focus on *service delivery* and *provision* and *health care providers*, the performance criteria must refer to intermediate measures of health, namely to the health care providers' *output*. It is thereby assumed that health care outputs have an impact and translate into improved health.<sup>66</sup> Asking people about their preferences as regards health care was therefore directed towards the level of health care outputs.<sup>67</sup>

People's views, their utilisation behaviour and the reasons behind it, as well as the private sector and NGOs' perceptions, will be discussed in Chapter 4. Anticipating these results, the following three performance criteria have constantly recurred in the observer's model and the actors' views; they shall therefore guide the comparative performance analysis of service providers.<sup>68</sup>

- Efficiency
- Access
- Quality of services

---

<sup>65</sup> Further, the curing of a disease is not only contingent upon the practitioner's, but also upon the patient's efforts and skills (Leonard/Leonard 1999: 6).

<sup>66</sup> There is a complicated chain that leads from health care services to health care outputs and to health outcomes.

<sup>67</sup> Cf. Haddad et al.'s study (1998) of community perceptions on primary health care quality, in which people chose criteria primarily at the output level.

<sup>68</sup> These are the internationally promoted health goals (Berman 1995 in Bossert 1998). It is not surprising that the criteria used in the literature are congruent and complementary with people's views, in that the former uses criteria from the real world (cf. Haddad et al. 1998: 391).

While the people's preferences put emphasis on quality and access concerns, it is equally necessary to apply a macro and long term view that includes efficiency (allocative, technical efficiency and cost-effectiveness) as well as sustainability.<sup>69</sup> An organisation has relative strengths if it performs better (than another organisation) in these criteria.

*Technical efficiency* relates to "the capacity of the individual, organisational unit, facility, operation or activity to produce measurable results in proportion to the resources extended" (Carley 1980: 64), whereby minimal input for maximal output is sought.<sup>70</sup> In this study, the efficiency analysis is confined to an efficiency analysis of staff resource utilisation. *Access* implies that everybody is able to receive a decent package of health care services independent of his or her income and ability to pay. *Quality of care* is understood as the health care production process that protects the patient's dignity and that comprises an appropriate consultation and examination, correct treatment (drugs) and friendly staff behaviour and commitment.

In practice, there are often trade-offs in the realisation of these criteria (Green 1990, Gilson et al. 1997, WHO 2000). This is because the aspects are interrelated by the financing mechanism, which affects access and equity, and quality of care (as well as sustainability). Access determines service utilisation, and hence cost-effectiveness and technical efficiency. The latter is again related to quality of care. On the other hand, *ceteris paribus* (low) quality of care equally determines service utilisation and again efficiency (see Chapter 6). The comparative performance analysis in Chapter 5 on access, 6.1 on the efficiency of staff resource utilisation, and 6.2 on quality of care will further elaborate on the understanding and operationalisation of these performance criteria.

---

<sup>69</sup> Given the huge donor support to the Ugandan government (see Chapter 3), full local self-reliance is still unrealistic, which is why sustainability is not included as a performance criterion. Sustainability can be defined as the ability of a system to function effectively without external support or with a minimum of external inputs and without endangering the future functioning of that system (cf. Flessa 1998: 3, Lafond 1995: 63).

<sup>70</sup> Having decided beforehand that the aim is to compare curative health care providers, the focus is not on allocative efficiency at this point. However, without technical efficiency, there is no allocative efficiency.

## **Chapter 3**

### **Historical Legacies and the Nature and Structure of Health Care Delivery in Uganda**

This chapter provides the background and context for the comparative performance analysis and the study of interorganisational relationships. Section 3.1 depicts a historical-institutional account of the local government development and its decline from colonial times up to 1986, which is followed by an analysis of post-independence organisational change in the health care sector up to 1986 (Section 3.2). This serves to illuminate the historical politico-administrative and structural legacies prevailing in today's decentralised framework and health care system. Section 3.3 discusses the health care policy developments from 1986 to the late 1990s and the role of donors in health care funding and agenda setting. After 1986, Uganda's administrative system was again decentralised, the formal-legal structure of which and the actual implementation will be outlined in Section 3.4. Sections 3.3 and 3.4 are crucial for understanding the current administrative context of health care provision as well as the enormous constraints impinging upon Uganda's health care system. It is against this background that the nature and structure of the current health care delivery in Uganda can be discussed in order to outline the research problem (Section 3.5).

#### **3.1. Local Government during Pre-Independence and Re-centralisation in the 1970s**

Colonial rule began in 1884. The colonial state established a centralised administrative system with standard bureaucratic practice for the central state apparatus. At the local level, the system of "indirect rule" was introduced, whereby traditional chiefs were used at lower levels, who – in a hierarchical stretch – were then responsible to the county chief, the district commissioner, and finally to the governor (Brett 1992, Mamdani 1996). The chiefs were in charge of collecting taxes, maintaining law and order and supervising the administration of services, such as primary schools, dispensaries, primary health care, local roads and water. There is no scope to outline in detail the incremental establishment of local

administration/government structures from 1919 up to independence and its later destruction during the 1960s and 1970s (cf. Richards 1982, Sathyamurthy 1986, Golooba-Mutebi 1999). The crucial points, however, will be noted:

There was rapid change, which meant that by the 1950s the administrative system was (formally) a copy of the Western orthodox bureaucratic model (Brett 1992: 13). The European-introduced conception of civil service bureaucracy along Weberian lines, though, was structurally incompatible with the traditional Ugandan institutions of state and lineage, creating tensions and an accountability dilemma between the universalistic norms of the former and the particularistic relationships of the latter (Fallers 1965: 238, Burke 1964: 36, 230).<sup>71</sup> This became manifest in interpersonal and inter-group conflicts, when a chief had to satisfy "traditional" loyalties, such as claims from kinsmen and clients, while this would be against the impartiality norm of the administration. The participation of a chief in both systems was thus ambivalent and the reaction was possibly agitation against the local government or withdrawal from it (Fallers 1965: 240). By the 1950s, civil servants had masters at the local and central level, which further complicated their position. Systemic problems included the omission of favoured people on the tax register, personal interests interfering with the administrative day-to-day routine and the misappropriation of funds by chiefs. Likewise, it was found that

The men in charge of the medical dispensaries have been known to demand [...] pocket money before they will treat the sick. If the chief is receiving his cut, it is extremely difficult to render anyone accountable (Fallers 1965: 116).

It was also reported that almost no council meeting went without the attempts on the part of the councillors to increase their allowances (ibid.).

Decentralisation proceeded, and with independence, Uganda inherited local governments in formal-legal terms. Local governments underwent serious capacity building between 1962 and 1966 to strengthen local ownership and accountability (Kaswarar 1989 in Kwagala 1997). However, significant distortions and problems prevailed and service provision was ineffective and inefficient. At the same time, further legislation reshaped again intergovernmental relationships in favour of central

---

<sup>71</sup> It is important to emphasise that both European and African "traditions" and customs were frequently themselves colonial inventions and in parts excessively conceptualised as dichotomisations in the process of establishing and legitimising colonial rule (Ranger 1983).

government. The 1967 Constitution then sharply reversed these achievements and precipitated a process of recentralisation. Simultaneously, President Obote began to erode democracy in the 1960s, which was then fully eliminated when Amin's military regime took over in 1971. During the 1970s in particular, service quality and efficiency severely degenerated, and accountability and popular participation in development activities rapidly decreased.<sup>72</sup> This re- and overcentralisation process in the late 1960s and particularly 1970s was aggravated by the politicisation of local governments, which allowed and legitimised the tyrannical behaviour of local chiefs towards the citizens. There was thus a continuation of the "decentralised despotism" that had emerged by the end of the colonial rule (Mamdani 1996). In sum, although Uganda had experienced a phase of local government in the pre-Independence times up to the late 1960s, accountability or an appreciation for accountability had never really been institutionalised. As we will see in Chapter 7, this is still one of today's crucial deficits.

### **3.2. Post-Independence Organisational Change up to 1986: Service Provision Breakdown and Rehabilitation**

Biomedical health care was brought to Uganda in 1878 by the Imperial British East Africa Company, which sent doctors to look after its staff. In 1894, the Colonial Office took over administration and set up a medical department in the Ugandan Protectorate to cater for the colonial staff's health care needs. Given numerous epidemics, it was soon realised that this "cordon sanitaire" could not be upheld and health care services were extended to Africans (Okuonzi/Macrae 1995: 125).<sup>73</sup> Local chiefs were put in charge of supervising the administration of social services like primary health care (Brett 1992: 12). At the same time, the missions offered health care services as part of their evangelisation strategy. Together with other non-governmental organisations, they made up a large share of health care facilities.

After independence in 1962, the state claimed responsibility for the provision of services, with health care (expansion) having high priority in order to strengthen the

---

<sup>72</sup> This was also due to unfavourable economic policies.

<sup>73</sup> For the introduction and social construction of biomedicine in Africa, cf. Vaughn (1991).

state's legitimacy as a newly emerging nation-state and as a democracy that takes care of its people. Donor funding was very low during those years. Health was not specifically supported, but assistance to multisectoral programmes, which included health care, accounted for about 75 percent of all aid agreements (Kasekende/Atingo-Ego 1999: 624, 628). The central government was in charge of hospital services, and local governments offered primary health care, all of which were offered free of charge and financed through the tax system. Almost 10 percent of all development expenditure was spent on health services, since the government aimed at increasing agricultural production through a better health status. After 1947, the district administrations' percentage of expenditures allocated to health rose from about 3.5 to almost 20 percent in 1970, while the central government "consistently allocated a minimum of 6.5 percent of the total recurrent and capital budget to health services" (Scheyer/Dunlop 1985: 27). The churches and other NGOs, which charged a small fee for their services, kept an important role in the health sector throughout (Nabuguzi 1995: 196). In addition, there were some 50 registered private practitioners operating in the larger cities and towns offering various curative services to those willing and able to pay (Scheyer/Dunlop 1985: 28, Iliffe 1998).<sup>74</sup>

Up to the early 1970s, Uganda had one of the best developed health services in Africa. In 1970, an estimated 60 percent of the population did not have to travel more than ten kilometres to their nearest health post (Wiebe/Dodge 1987). An increasing number of people used these facilities. People had gained a relatively high health status, which was reached through the "cumulative and synergistic interaction" with the national economic development strategy (Scheyer/Dunlop 1985: 25).<sup>75</sup> However, this health care system was characterised by a curative and urban bias, with insufficient attention to preventive and promotive aspects of health (Macrae et al. 1996: 1097, cf. King 1966). It was also based on the critical assumption of continuing and massive economic growth (Scheyer/Dunlop 1985).

The overthrow by Amin in 1971 was the starting point for a continuous decline, both economically and politically. The policies introduced in the 1970s led to

---

<sup>74</sup> Little information is available on informal private practice, but it must have been much lower in comparison to what was observed during the 1970s (Iliffe 1998).

<sup>75</sup> For health status data, cf. Scheyer/Dunlop (1985).

economic regression, fiscal crises and hyperinflation, consequently also causing disruptions in the health care sector. These included fiscal and logistical difficulties, staff shortages due to the expulsion of the Asians, a brain drain and attrition due to low or non-existent salaries (Dodge/Wiebe 1985, Wiebe/Dodge 1987). In 1973, about half of the some thousand physicians left the country, creating serious problems in the health care delivery system (Scheyer/Dunlop 1985: 32). Likewise, as Asians had overwhelmingly owned the pharmaceutical industry, only half a dozen registered pharmacists remained (Williams 1985: 61). Ministry of Health (MoH) plans could not be implemented, and government services deteriorated rapidly. By 1975, few drugs and other medical supplies could be imported, and thus the government health services were increasingly unable to deliver services and to respond to health problems. The decline of both the civil service in general and social services in particular led to an upsurge of informal private activities, known as *magendo*.<sup>76</sup> *Magendo* became a normal part of life and constituted an important source for income or indeed the most important one, once people were unable to make a living on regular wages (Scheyer/Dunlop 1985: 29). For the health sector this meant that it became increasingly difficult to get free access to treatment and drugs:

A sick person or his relative has to grease so many hands to get to the point of treatment, and pay even more bribes after diagnosis in order to get supposedly free drugs (Kironde 1985: 65).

Also, village health workers of primary health care have been reported to pick up their salaries and sell the issued drugs on a private basis, while otherwise not having been seen and known in the village as health workers (Stockely 1985: 221).

As real salaries declined and as government doctors did not receive the respective appreciation expected towards their profession, many opened private clinics to work in parallel (Iliffe 1998: 148). Using one's government position for additional income was very widespread, but, because of the patients' urgent needs, it became most obvious in the health sector. On the other hand, many health professionals continued to work with little or no pay, so that medical staff was no more corrupted than other government workers (ibid.: 156). Likewise, laboratories, pharmacies and drugshops

---

<sup>76</sup> *Magendo* denotes the parallel, informal economy and blackmarketeeing (Bergschlosser/Sieger 1990).

began to mushroom all over the country, selling and issuing certain drugs for which they had no licence. The administration was incapable of enforcing statutory controls and registration (RoU 1987, Adome et al. 1996), or, as Iliffe claims, the MoH seemed to have been completely ignorant of them (1998: 153). This "privatisation" was equally fostered by changes on the demand side. Because of the bribes in the government sector, most people in despair went to private practitioners or unlicensed pharmacies to save time and money (Kironde 1985: 65).

There was also a general expansion of biomedicines in the 1970s (Whyte 1991). This can be explained by people's strongly felt need for curative medicine, whether in the informal or formal sector, because of the high morbidity prevailing. As a result of ubiquitous drug availability, profitability and affordability from the 1970s onwards, the utilisation and acceptability of biomedical/pharmaco-chemical medicine for treatment increased. In these years, de-institutionalised and above all unregulated biomedicines became widely accessible through specialised laypersons. Awareness and expectations of biomedical means grew, but so did suspicion and mistrust (Whyte 1992, 1997).

Simultaneous with this "privatisation" trend, and because of the state's inability to provide essential services, the church health facilities gained even more relevance whilst being able to keep autonomy from the predatory state. In contrast, the Ugandan and international NGOs were exposed to strong state hostility, so that they disengaged. By 1978 – the beginning of the civil war – health services had totally broken down. The political situation had also affected mission hospitals and lower-level health units, many of which closed down. After liberation from Amin in 1979, the situation was, however, reported to have deteriorated even further given the political vacuum and the direct impacts of the war on the health status (Scheyer/Dunlop 1985). It seemed that

Uganda's health care system had been reduced to a state where care delivered may have been worse than no care at all (USAID 1980, in Birungi 1994b: 61).

Overall, people had lost trust into government services and had increasingly resorted again to traditional medicine (Kironde 1985: 67; Enns 1985: 53).

During the 1970s, there were no longer any clear health policies, nor was there a health debate or a discussion of primary health care (PHC) after the Alma Ata

conference in 1978 had taken place. Nor was there an integrated legal framework for government action. Rather, a confusing plurality of single declarations prevailed (Macrae et al. 1996: 1097). There were a small number of community-based health care organisations and activities dealing with health education and immunisation, which appeared to be loosely scattered around the country at the local level.<sup>77</sup> They were funded by international donors and the churches, some of them being successful, others not (Brett 1992: 70). But the medical-curative bias continued to prevail, more so since it was difficult to put PHC issues on the agenda (LaFond 1995: 65).

After the overthrow of Amin, the new government's immediate response was to seek donor relief assistance, and the aid agencies stood in the forefront of health care provision. A few years later, the government's efforts concentrated on rehabilitation and recovery to the pre-1970 levels of delivery.<sup>78</sup> On the basis of the existent local PHC organisations, vertical selective primary health care programmes were added, such as the Ugandan National Extended Programme on Immunisation (UNEPI) funded by UNICEF, and the Ugandan Essential Drug Management Programme (UEDMP). This strategy of rehabilitation was considered to be distinct from the long-term goals of health system development and should rather constitute an interim phase on the basis of which more comprehensive and integrated health care could follow (Macrae et al. 1996: 1098).<sup>79</sup> Policy choices reflected opportunistic motivation to attain political stability and support, and memories of the past were strong factors in shaping these policies. The intended return to previous expenditure levels for health care was not economically feasible given the population increase and the changed epidemiology (Scheyer/Dunlop 1985: 41), since Uganda was trying to run a health care system of the size of the one in the 1960/70s with only 10 percent of previous expenditure levels (LaFond 1995: 64). Despite or rather because of these government efforts, government employees in the mid 1980s still did not earn a living wage and

---

<sup>77</sup> An idea of the extent of this can be inferred from the number of 30 founding members of the Uganda Community Based Health Care Association (UCBHCA) in 1986 (interview, UCBHCA staff 1999).

<sup>78</sup> The aid agreement's share for health was 7.5 percent during 1979-85 (excluding the multisectoral assistance) (Kasekende/Atingi-Ego 1999: 629). For a detailed account of the capital expenditure, cf. Macrae et al. 1996.

<sup>79</sup> A first step in this direction was the establishment of the UCBHCA in 1986, which was mainly funded by UNICEF.

thus had to continue to have a second or third job. The result was a process of institutional collapse, in that the trend of rapid and uncontrolled "privatisation" and "informalisation" during the conflict period continued into the post-conflict period (Batley 1994a; Macrae et al. 1996). Home treatment, private practice by governmental health workers and the charging of informal fees in governmental health units became widespread. Whereas doctors generally practised in towns, the less qualified practitioners usually operated in the countryside (Iliffe 1998: 162). In fact, this waxing informal market was and is not a phenomenon unique to Uganda, but a general feature of health care services in Africa (Batley 1996, D. Leonard 2000).

These institutional-organisational adjustments went hand-in-hand with social adjustments, as the behaviour of government health workers and social relations at work had changed concurrently. Not only had the boundary between the public and the private sector become blurred, but also the distinction between moral and amoral categories (Whyte 1991, Munene 1995). Obbo (1991) notes that one of the most significant changes at the micro level was that professionals ignored standard ethics in order to survive. As a consequence, institutionalised biomedicine has been "indigenised", in that

The transaction of medicines has been adjusted to the more general pattern of social relations in the community. [...] People attempt to personalise the professional therapeutic relationship so that they are treated not just as patients, but as friends (Whyte 1992: 172).

Treated this way and preferably at the health worker's home, people hoped to be more likely to get good treatment.

A further structural change during those years grew out of the strong rise of voluntary sector organisations, which began to run their own health care services, especially from 1980 onwards, on a fee-for-service basis. By the mid-1980s, a large proportion of health services were provided by the voluntary sector, although their operations were still hindered by the state (Nabuguzi 1995). The expansion of the voluntary sector was also enhanced by the increasing trend of donors to fund and promote NGOs, as the government's legitimacy and capacity had become more and more questioned (Bennett 1994: 30). However, in the absence of clear government policies and given the strong dominance of donors, who were not co-ordinated by the

government, this meant further fragmentation of the institutionalised health care system, which had already been disintegrated by the processes of privatisation and informalisation.

In sum, these institutional-organisational changes – namely the informal privatisation and marketisation – are not at all captured by a neo-liberal approach. In the case of Uganda, privatisation meant increased participation of private, non-government actors, resulting in new roles and relationships between the state and non-state actors. It was not a deliberate policy choice of pursuing "a wholesale divestiture of public assets" (Kumaranayake 1998: 2) that considers market failure as the lesser evil in comparison to state failure. Instead, this move from state to non-state provision was largely supply-side driven by government health workers, who were frustrated by a state that did and could not look after them anymore. Thus, independent of the policy regime, it was a spontaneous and decentralised response and reaction to state failure, or rather state *absence* in service delivery, which was itself governed by market forces.<sup>80</sup> The institutional-organisational changes were also induced by the increase of NGO facilities, which can be explained by means of theories of voluntary sector evolution in a context of state failure (cf. Weisbrod 1977, Salamon 1995, Chazan 1992).

### **3.3. Health Policies, Policy Making and the Role of Donors after 1986**

#### **3.3.1. Reconstruction in the Late 1980s**

While the first half of the 1980s was still characterised by chaos and civil war, major political, economic and administrative changes were introduced with the take-over by the National Resistance Army in 1986 and in the years that followed. In a state of "normalisation", there was again more room for a national policy thinking process. A number of systemic cross-cutting reform projects were initiated in the late 1980s, such as decentralisation (see Section 3.4), democratisation, structural adjustment, liberalisation, privatisation and civil service reform (cf. Lingnau 1996, Brett 1996b).

---

<sup>80</sup> Batley (1996: 725) identifies other services that similarly underwent some form of informal or unintended privatisation, as the failure of public services often results in the private sector and communities stepping in to fill the gaps.

The last reform initiative has been rather ineffective, thus blocking further improvements in public sector provision (Langseth/Mugaju 1996).

The Health Policy Review Commission in 1987 and the resulting White Paper of 1989 confirmed the previous strategy of rehabilitation parallel to the development of further PHC (Okuonzi/Macrae 1995: 126). Macrae et al. (1996) argue that the health policies of that time still failed to realise the severity of the country's crisis. No changes in structure or funding were undertaken, so that investment still concentrated on physical construction and hardware for secondary and tertiary facilities. Without downplaying its positive outcomes, which also allowed for national reconciliation, this strategy led to many negative outcomes, such as deficits in programme implementation due to unaddressed institutional weaknesses in planning and management capacity, finance instruments and necessary reforms for adequate staff remuneration. Important health needs as well as nutrition, sanitation and water concerns were left out.

Another result of these policy choices was the division of labour between government and donors, in that the donors' vertical programmes were run parallel to the government health system (Okuonzi/Macrae 1995). Until the 1990s, donor support did not really focus on the development of a systemic policy or a unified national health strategy, but was rather concerned with the design and implementation of specific, single projects and programmes to pursue their own interests and agenda (Macrae et al. 1996: 1103). In light of the donors' dominance in agenda setting, this projectisation approach further reinforced the already existing fragmentation of the health system – given the lack of government co-ordination – and also led to duplication of effort and unfilled system gaps (MoH 1997, LaFond 1995).

### 3.3.2. Refinement in the 1990s and the Donors' Dominance

Another White Paper in 1993 attempted to mainstream the reform process into the national programmes to aim at the consolidation of existing services and reorientation of services towards comprehensive PHC. At that point, many more international advisers were involved in the process of macro health policy development, which was now also shaped by the increasing use of conditionalities for funds.<sup>81</sup> A very large

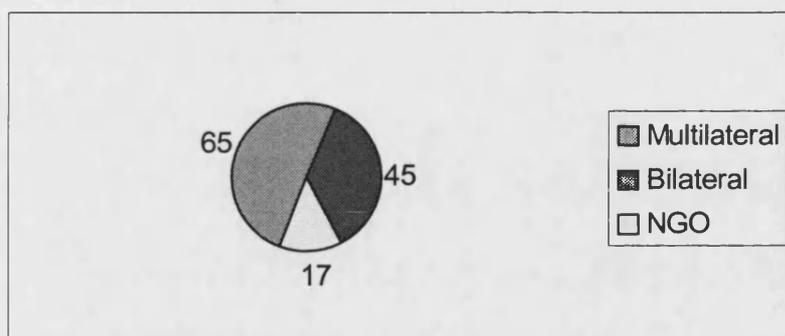
---

<sup>81</sup> For a detailed analysis of Uganda's aid flows, cf. Kasekende/Atingi-Ego (1999).

number of donors operate in Uganda, including the major international organisations (EC, UNDP, UNICEF, World Bank, WHO), bilateral agencies (CIDA, DANIDA, GTZ, KfW, DFID, USAID), and many non-governmental organisations as well as the churches with their national systems. In addition, there is a very exhaustive number of programmes and projects with smaller financial volumes concentrating in only one or but a few districts.

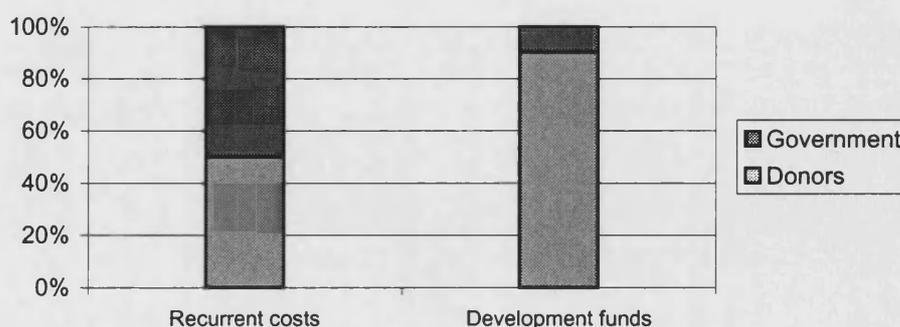
The donors' dominance is evident in the macro level health care portfolio. In 1995, 80 percent of the health care budget was donor funded (Iliffe 1998: 155), the amount and sources of which are shown in Figure 3.1. Apart from the strong dependence per se, the resulting division of labour between donors and government funding, as illustrated in Figure 3.2 and 3.3 below, is equally problematic.

Figure 3.1: Donor funds by source for 1991/92 (in US\$ million)



Source: World Bank (1994)

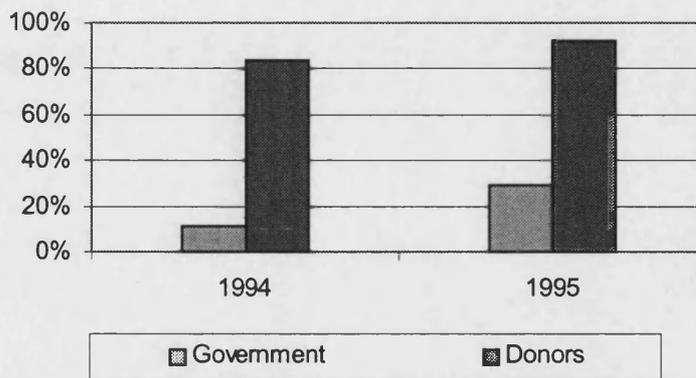
Figure 3.2: Government and donor contribution to recurrent and development funds



Source: Data for 1994/95, in MoH (1997: 12, own calculations)<sup>82</sup>

<sup>82</sup> Cf. Smithson (1993) for similar high figures for the previous years.

Figure 3.3: Health expenditure channelled to the Primary Health Care level<sup>83</sup>



Source: MoH 1997, cf. LaFond 1995, Hutchinson 1999

Further, 77 percent of the recurrent expenditure on PHC was donor-financed, whereas the government financed 80 percent of recurrent expenditure on hospitals in 1994. Despite policy commitments, government spending still concentrates on rehabilitating higher-level curative services, while donors implement their PHC programmes through health units, through their own project structures or through Ugandan NGOs. Smithson argues that government resources are spent on services that do not attract donor support, which on the one hand reflects conflicting priorities, but on the other hand some rational complementarity. This results in an extremely high recurrent cost overhang, in that donor funding amounted to 55 percent of total recurrent expenditure in the early 1990s (1993: 10).

The dilemma is that the operation of health care services, not to say the recurrent costs of future investment, cannot be maintained or absorbed by insufficient domestic resources (*ibid.*). At this point, the legacies of the mid 1980s policy choices for rehabilitation and capital investment without sufficiently taking into account the future maintenance costs became apparent. Hence, this investment pattern has severely impeded sustainability, as the enormous donor dependence at the moment will continue for some time to come. LaFond concludes that:

Uganda's health system recovery now rests on a fragile base, dependent on the interests of external funders (LaFond 1995: 69).

<sup>83</sup> This includes *all* curative services below the hospital level.

The donors' dominance is also evident in relation to the policy and planning process. As the external funding for health was much greater than the government's share (ibid.), health officials could not bargain with donors on an equal basis, so that donors were decisive in setting the agenda and in determining the framework and scope for interaction (LaFond 1995, Cannon 1996). The prevailing long-term collection of many diverse donor agendas and investment strategies further nurtures the fragmentation of the health system and distorts the planning processes. The fact that the donors compete among each other about the priority of approaches and determine the plurality or limitedness of approaches raises serious concerns of accountability, sovereignty and ownership as well as appropriateness (cf. Okuonzi/Macrae 1995, LaFond 1995). In particular, lack of ownership weakens the effectiveness of implementation. Even in 1997, the main problem of the planning unit within the MoH was its lack of information regarding where and with what budget donors operated, and what kind of programmes were being implemented (interview, MoH official, 1998).

The annual planning process for the District health care budget makes this dependency even more plain. The District draft workplan for health – listing possible District activities – is presented to the donors who then pick according to their agenda (interviews DMO officials, 1997, 1998; MoH official 1998; Weigt/DED District Health Planner, 1997). A resulting problem is that donor programmes are difficult to integrate with each other and with the district programmes due to the diverse donor particularities and conditions (interviews, DMO officials, 1997, 1998). That said, it is important not to forget the systemic constraints donors face within their internal bureaucracies and in relation to their funding channels.

### 3.3.3. Increased Stakeholder and Provider Co-ordination in the Late 1990s

As donors came to realise that there was little impact and sustainability with the project approach, there was a gradual shift towards policy formulation based on a consultation and consensus process. Both government and donors support the idea of a "Sector Wide Approach" (SWAP) to stop the fragmentation of the health care

system.<sup>84</sup> The SWAP is expected to lead to improved donor coordination and equitable financing of the health sector.<sup>85</sup> The latest co-ordination approach is the participatory development of poverty reduction strategy papers (PRSPs). SWAP and PRSPs finally mark an important turning point in attempting to streamline the health care system.

Further review and policy updates led to the 1997 Ten Year National Health Policy, again with strong donor input and guidance, which was translated into the National Health Strategic Plan 1997/98-2001/2. Its main concerns are, inter alia, the organisation and management of the health system, community empowerment, human resource development, health financing, legal aspects of health, and the role of the private sector (RoU/MoH 1998a, 1998b). Specifically, strategic focus is put on the following:

- According priority to major disease problems through (community) PHC;
- Ensuring a "Minimum Essential Health Care Package" to all, while the poor receive sufficient protection when institutional and financial reforms are considered;
- Establishing further institutional changes to promote efficiency, effectiveness and quality of care;
- Integrating non-governmental and for-profit service providers into the national health programme; and
- Strengthening partnership between government and private service providers.

As insufficient collaboration between the public, private, and voluntary sectors has contributed to a reduced health outcome than would be expected from available resources (MoH 1998b), more focus is being increasingly put on the issues of private and voluntary sector integration and partnership. The government's role is conceptualised as an enabler with the specific objective of "institut[ing] effective means of promoting private sector partnership with full understanding of the nature,

---

<sup>84</sup> The term SWAP refers to a framework within which all resources in the health sector are managed and co-ordinated in a coherent way in partnership between the donors and the recipients (Walt et al. 1999: 273).

<sup>85</sup> It is clear that this is a very difficult undertaking in itself given the large number of actors and competing goals as well as the high transaction costs and the power struggles involved in such a process.

scope and scale of its contribution to health care in the National Health Care System" (RoU/MoH 1998a: 16) and "seek[ing] to ensure that other providers [...] deliver services where they are best suited to do so." (MoH 1997: 4).<sup>86</sup> This growing consideration of the private and NGO health sector results from a general government policy in favour of privatisation but also from donor pressures to foster partnerships (Okello et al. 1997: 1).<sup>87</sup>

In order to catch up with the reality of the privatisation and informalisation trend, the government approved various legislation to allow for, regulate and formalise private clinics. Likewise, the legislation concerning pharmacies and drugshops was revised (see Chapter 8). However, the policy notion of partnerships is wide and elusive so far (cf. Birungi et al. 1999). The division of labour among the various sector is an open question, as it is not clear what areas of health should be financed by the state and what could be left to the private sector (PCGM 1998: 3).

### **3.4. Re-decentralisation after 1986 and Today's Local Government System**

#### **3.4.1. The Establishment of the Resistance Council System**

##### *The Distorted Structure...*

Continuing the analysis in Section 3.2 of the local government developments, the recentralisation process began with the countrywide establishment of the Resistance Council (RC) system in 1986. The RC system consisted of a five-tiered hierarchical structure, whereby the lowest level of representatives (councillors) was elected by the village adult population, while the higher levels, up to the National Resistance Council (the parliament), were set up by indirect elections. The system's rationale was based on the notion of participatory, grassroots and popular democracy.<sup>88</sup> Nonetheless, an indigenous movement for democracy and democratisation from below lacked. In practice, the RC system was a top-down creation and pushed by the government in the context of state-led democratisation (Nsibambi 1994, Burkey 1991).

---

<sup>86</sup> The policy does not make the explicit distinction between private and voluntary sector organisations.

<sup>87</sup> For an account on the emergence of the policy on private sector involvement and partnerships, cf. Birungi et al. (1999).

<sup>88</sup> Cf. Ddungu (1994) for the RC rationale and structure.

There was political decentralisation in the form of direct and indirect elections of councillors, but this was not accompanied by financial and administrative decentralisation. Civil servants and chiefs were employed by the central government and hence still accountable to them, while the RCs and their Executive Committees equally claimed accountability from them, challenging the chiefs' power, though they could not remove them from office. This double accountability structure was incompatible with and disruptive to the accountability chain between citizens, councillors and civil servants that is required in a devolved system for local democracy and bottom-up legitimisation. The central government kept substantial powers and the substance of local government was further watered down due to insufficient transfers of resources. Thus, the local level had hardly any influence over health care services, since salaries and funding as well as directives and decisions came from the central government level.

... and More Distortions in the Implementation

The key structural problem of this system was that devolution was only partial, if not marginal. The civil servants remained beyond the RCs' control, impeding bottom-up administrative accountability (cf. Tidemand 1994: 42). For that reason, there was a great deal of conflict and rivalry between state officials and RCs.<sup>89</sup> Moreover, RCs were overburdened with the tasks transferred to them. They lacked remuneration and control over state officials, and therefore they soon began to consider their efforts futile. As a result, they withdrew their participation and engagement (Burkey 1991: 33). Given the strong chiefly authority, which became institutionalised in the previous decades (Mamdani 1996), "liberation" and empowerment towards the chiefs via the structural reforms of the RC system was only limited. Although the chiefs had to give away certain powers, the complicated relationship between the two was not significantly smoothed. These legacies could not easily be ironed out in the years to come. Finally, due to distorted accountability structures and insufficient financial powers, service provision could hardly improve.

---

<sup>89</sup> While RCs had to struggle against chiefs, who often did not want to relinquish their powers (Nabuguzi 1994: 124), the civil servants complained about the RCs assuming powers beyond what the 1987 Resistance Council Statute had foreseen. Further, the political culture of the previous decades strongly prevailed (Mamdani 1996).

The RC system provided multiple opportunities for participation, but the over-representation of traditional elites and the better-off in higher councils impeded political renewal and reproduced the power relations at the local level (Tidemand 1994). In the earlier years of the RC system, people at the community level felt a strong "commitment to national reconstruction" (Brett 1992: 28). Yet, as people saw no benefits from their efforts, support and enthusiasm at the village level decreased over the years and people withdrew from village meetings (Burkey 1991). Participation could hence not gain a positive connotation, and neither was it practised.

This rather critical picture of the RC system should not hide the fact that the system did constitute an important element in increasing the democraticness of the polity and contributed to the democratisation process. Most importantly, it ended the tyranny and arbitrary rule of chiefs.

#### 3.4.2. Further Decentralisation after 1993: The Formal-Legal System

Recognising the flaws inherent in the RC-system, the NRM took a new initiative and passed the 1993 Local Governments (Resistance Councils) Statute, which further devolved financial and administrative powers. The local government system was then constitutionalised in the 1995 Constitution. The 1997 Local Government Act (LGA) precisised the role of the local government and introduced some few, but crucial changes, the most important being the introduction of direct elections.

#### *Transfer of Competencies and Tasks*

As corporate bodies, the Subcounty and District level enjoy the principle of general competencies, except for those tasks explicitly spelled out as being under the responsibility of the central government. Within this framework and the national priority areas, which includes PHC, local government has discretion in planning and providing health care as well as in allocating and spending resources. Table 3.1 illustrates this division of labour. The District Medical Office has the highest executive authority over all health care issues within the District and is in charge of planning, providing, guaranteeing, supervising and co-ordinating all health care services. It is led by the District Director of Health Services (DDHS) (for an organisational diagram, see Annex 3, Figure 1).

Table 3.1: Central and local government tasks

Central Government	Local Government
<ul style="list-style-type: none"> <li>▪ National standards</li> <li>▪ Health policy</li> <li>Control and management of epidemics</li> </ul>	<ul style="list-style-type: none"> <li>▪ Medical and health services (including hospitals)<sup>90</sup></li> <li>▪ Preventive and promotive health care</li> </ul>

### Financial Powers and Transfer of Resources

The local government has the power to levy and spend its own revenues along the national priority areas and to form its own budgets. Districts receive 35 percent of local tax revenues, while Subcounties get 42.25 percent of the revenues collected in their areas. The rest is shared between the LC1, LC2 and LC4 level (16.25, 3.25 and 3.25 percent respectively). Apart from local revenues, Districts receive conditional and unconditional grants from the central government as well as donor funds. The 1997 LGA also provides for equalisation grants, the implementation of which has been slowly taken up.

### District Personnel System

Decision-making power over personnel issues lies with the District and the District Service Commission is in charge of appointing, promoting, disciplining, etc. The staff that was previously employed by the central government now belongs to the District personnel system. The former central government staff's payroll is decentralised in the form of unconditional grants. Subcounties that employ additional staff have to pay them out of their available Subcounty budget. As regards the health sector, these are usually group employees (support staff) and nursing aids, but also some nurses and laboratory attendants.

### Local Legitimation

The main modification introduced by the 1997 LGA are the universal and direct elections of Subcounty and District councillors and the District and Subcounty Council chairpersons. The District and Subcounty Council are the representative organs of the people with the competencies of planning, decision-making and

<sup>90</sup> This excludes hospitals that provide referral and medical training.

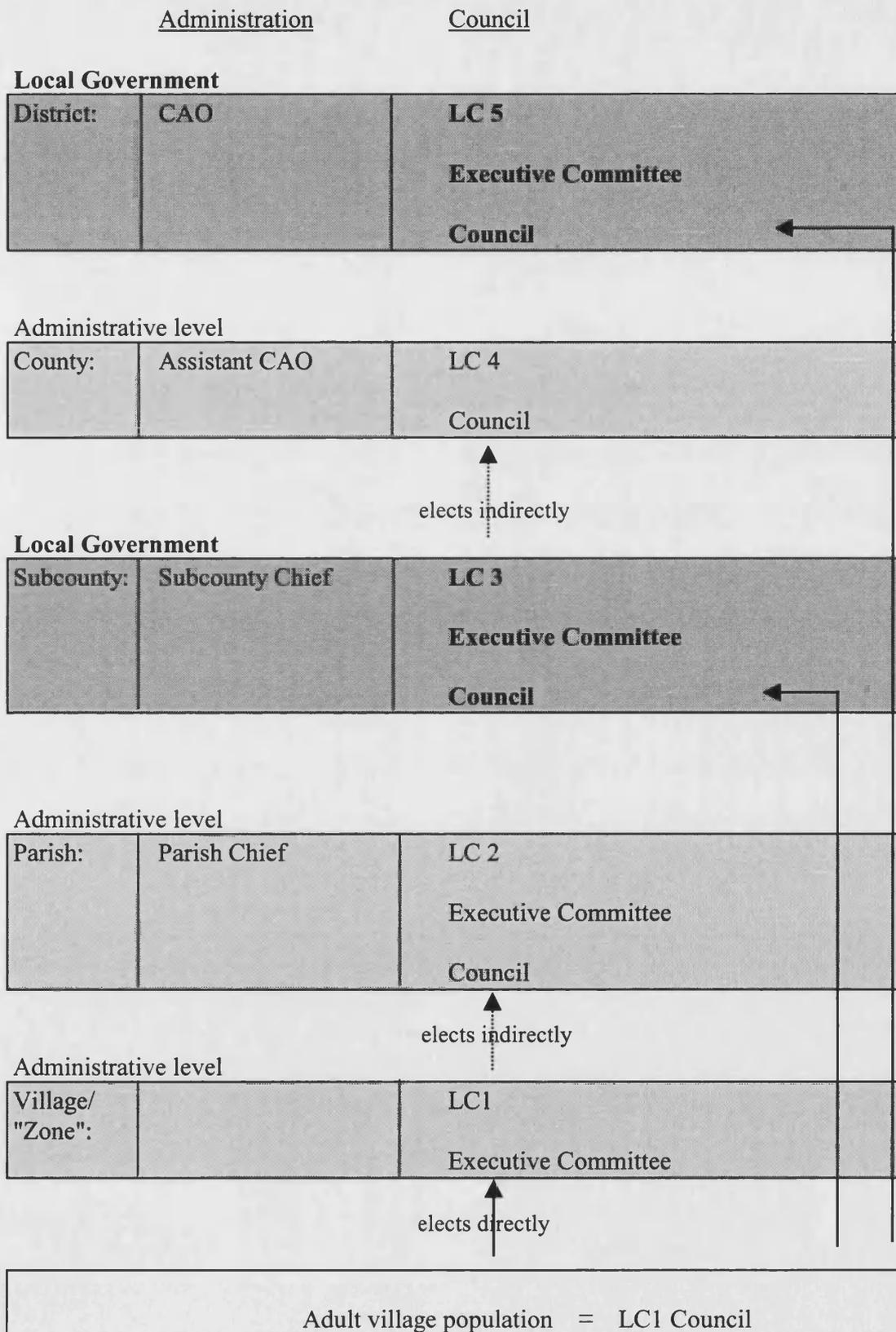
budgeting. The highest political head in the District is the chairperson of the District Council, to whom the administration answers. At the District and the Subcounty levels, there is an Executive Committee to perform the executive functions of the Council. It is headed by the Council chairperson and consists of five secretaries, one of whom is in charge of health and children's welfare. The councils can appoint a maximum of five committees to support the Council's tasks and functions, one of which is again concerned with health. In contrast to the LC3 and LC5 local governments, which enjoy body-corporate status, the 1997 LGA changed the role of the LC1, LC2 and LC4 into "administrative units"; they have no more political authority on their own, as compared with the 1993 Statute. Figure 3.4 illustrates the politico-administrative structure of the 1997 LGA.

#### *Intergovernmental Relations*

A significant degree of power is still retained by the central government (Brett 1998b), foremost by the Resident District Commissioner (RDC), who is the intergovernmental link representing the president and the government at the District level and who is in charge of monitoring local government activities. In addition, line ministries "shall monitor and co-ordinate Government initiatives and policies as they apply to Local Governments, ... [and] assist in the provision of technical assistance to Local Governments" (Section 98 (1), LGA 1997). The role of the MoH consists in ensuring implementation of national policies and adherence to performance standards on the part of local governments. It will inspect, monitor, co-ordinate government health initiatives, and where necessary offer technical advice, support supervision and training within their respective sectors (MoLG/PS 1997). Yet overall, the legislation on intergovernmental relations is not sufficiently specified.

In sum, apart from the intergovernmental relations, in formal-legal terms, the local government system has been substantially devolved, in that tasks and competencies, resources and legitimisation mechanisms have been transferred to the local level.

Figure 3.4: The LC-system in rural areas



### 3.4.3. The Implementation Status in Kamuli District

The following implementation analysis, with particular reference to Kamuli District, looks behind the formal-legal façade and reveals numerous shortcomings and gaps.<sup>91</sup> This section focuses on the macro-level, central government- and legislation-induced gaps and constraints, thereby setting out the politico-administrative context of service provision. District-made and Kamuli-specific problems will then be further discussed in the micro-analysis in Chapter 7.

#### *Insufficient Resource Supply Versus Assigned Functions*

The major problem of the local government consists in insufficient resources, so that assigned functions are not adequately matched financially. While the majority of services are provided through local government, this level got only about 30 percent of the national 1996/7 and 1997/98 budgets (ULAA 1996, 1997). Likewise, 80 percent of the total taxes are spent at the national level (Nsibambi 1997: 60).<sup>92</sup> The reason for this imbalance is twofold.

One is the small revenue base at the local level given the peasant economy, which generates only small incomes. This problem is aggravated by low, unreliable and hardly constant tax collection. For example, the total local tax collection rate came to 27 percent in 1996/97 (KDA budget, own calculations).<sup>93</sup> Secondly, this inadequate local revenue base is not compensated by a sufficient amount of conditional and unconditional grants transferred to the District level. Only 25 percent of the total central government funds are transferred as unconditional grant, and almost two thirds of this transferred amount is spent on salaries and wages.<sup>94</sup> Only 17.3 percent of the unconditional grants or 4.3 percent of the total budget for Districts is to be allocated to all other services such as PHC, agricultural extension, etc. (ULAA 1997). In the early 1990s, 90 percent of the non-wage recurrent budget at the District level was funded

---

<sup>91</sup> The starting point of this implementation analysis is 1995, when Kamuli District became financially decentralised. For studies on a variety of decentralisation aspects in other districts, and for Uganda in general, cf. DANIDA 1997, Makara 1997, MISR 1997, MoLG/DS 1995, 1996, Mukyala 1997, Villadsen 1995, Villadsen/Lubanga 1996, Nsibambi 1995, Nsibambi 1997a, 1997b, Tukahebwa 1997, Birungi 1996, Mugaju 1999, Azfar et al. 2000.

<sup>92</sup> This percentage refers to the recurrent budget only. For the total national budget, the figure only amounts to 14 percent (ULAA 1996, 1997).

<sup>93</sup> This percentage, however, varies tremendously over years and is particularly low during election years. For example, in 1995/96, it stood at 22 percent; in 1998/99, it was 53 percent (KDA budgets, own calculations). Other districts vary from 46 to 82 percent (Azfar et al. 2000).

<sup>94</sup> Equalisation grants are transferred as conditional grants.

externally, so that District budgets had the mere function of a pay-roll (LaFond 1995: 72, Smithson 1993: 11). This has considerably reduced, but the pay-roll still dominates the budget. As the central government runs a cash budget, it often cuts the monthly automatic release of grants, and this is the usual fate for health (interview, MoH official, 1998). Hence, from the District perspective, these grants are unreliable and hardly transparent (interviews, KDA officials, 1997, 1998; cf. ULAA 1997).

The problems of this funding portfolio are aggravated by the dominance of vertical central government/donor health care programmes that are to be implemented by the DMO.<sup>95</sup> Not only does this donor dependency make intradepartmental co-ordination and co-operation (and hence efficient resource use) very difficult; donor programmes themselves are not always appropriate as regards the specific District needs and often require adaptation (interviews, KDA officials, 1999). Donor disbursements are difficult to foresee and the flow of funds is not in accordance with District needs (interview, MoH official, 1998, Kamuli District officials and Kamuli NGO staff, 1999).<sup>96</sup> The development budget has been devolved to some pilot Districts (but not to Kamuli), but the centre still handles 70 percent of the development budget (Azfar et al. 2000: 60, 63).

In sum, these constraints hardly allow for an adaptation to local necessities and priorities or for pursuing locally adequate strategies of social mobilisation or closer collaboration with LCs (interview, DMO official, 1997). Resources are wanting for District priority programmes, so that "programmes from within the District tend to die", which leads to widespread frustration among department heads (interviews, department heads, 1997). The District level is thus still too much the implementing agency of central government programs and does not have the scope to design its own programs. This equally hinders local ownership of the investment and planning process.

---

<sup>95</sup> Hiscock et al. (1993) identified 16 separate PHC programmes in Uganda for the early 1990s.

<sup>96</sup> Uganda's bank crisis also interrupted the flow of funds in 1999. Further, Districts do not hand in their accountability reports for previous tranches in a timely manner, which equally interrupts the steady flow of resources.

### *Insufficient Personnel Sovereignty*

In practice, the Districts' discretion in personnel matters is limited. Important personnel decisions (e.g., over department heads) are still discussed and agreed upon with the "mother ministry" (interview, KDA official, 1998). As a consequence, it seems that the District Medical Officer (now the DDHS) is de facto accountable to the MoH rather than to the District, since it is the ministry that initiates promotion and career development. Further, the lack of resources does not allow the District administration to recruit and employ staff according to the District's needs. A newly employed civil servant will not be on the pay-roll for decentralised staff, which is currently covered by the unconditional grants, but get on the District pay-roll, thereby increasing the financial obligations of the District. In 1999, there was a recruitment freeze of health workers (The Monitor 5.12.1997), even though 18 midwives and a number of nurses were needed in Kamuli District according to the staffing plans, i.e., more than 25 percent of the staffing targets.<sup>97</sup> Likewise, 17 posts of extension officers for forestry, agriculture and community development were not filled in 1997/98 (interviews, department heads, 1997; KDA budget). However, apart from financial constraints, this gap also reflects the priorities at the District level (see Chapter 7).

### *Insufficient Local Legitimisation and Accountability*

The indirect election system, which was in place until the recent local government elections in April 1998, structurally impeded real representation of the local people at higher levels. This aspect and its implications are examined in greater detail in Chapter 7.

### *Unequal Intergovernmental Relationships*

There is a common understanding both at the District and the central government level, even among the pro-decentralisationists, that the decentralisation process has occurred too fast and has lacked the necessary preparation and capacity building (interviews, MoLG official, MoH official, KDA authorities, 1997, 1998). Guidelines are elusive, in that they do not prescribe specific quantitative and qualitative targets, and are often ignored. It is recognised that the centre has been weak in managing

---

<sup>97</sup> Whether this is a very serious issue is another question given that health units may be overstaffed in comparison with the low workload (see Chapter 6).

decentralisation. There is little enforcement and supervision, since there are only few guidelines. Also little capacity exists to follow them up or to enforce them. At the centre, there is a feeling that the Districts can now do anything they want (interviews, MoH officials, 1998), while the District authorities complain about interference from the centre, be it through the Resident District Commissioner, the Ministry of Local Government (MoLG), or the line Ministries. In practice, the relationship is characterised by both top-down dirigism and dominance as well as co-operation, discussion, and support.

It is in the light of these challenges and constraints outlined in the previous four sections, in which today's health care system must be contextualised and understood in order to carve out the research question.

### **3.5. The Nature and Structure of Uganda's Health Care System: Key Features of the Public, Private and Voluntary Sectors**

The Ugandan health care system comprises the MoH, District Medical Offices and government facilities, private and voluntary sector providers as well as "traditional medicine" practitioners. A continuing problem is that both government and non-state health services are mainly institution-based (as opposed to community-based) and biased towards curative care. For example, 63 percent of government recurrent expenditure goes to hospitals, where 54 percent of the qualified health personnel work.<sup>98</sup> Despite policy commitments, preventive and promotive services are seriously underfunded. Apart from interregional inequality, there is also an urban bias, as the majority of government clinics and hospitals, and particularly private clinics, are located in towns and the capital. For 1995, the national doctor-patient ratio was 1:20,228, again with an urban-rural difference (Hutchinson 1999: 8).

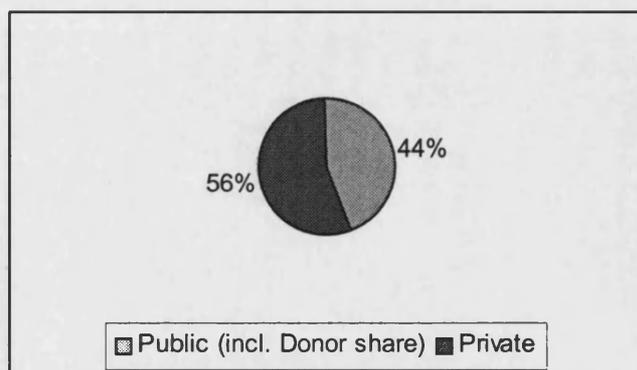
#### **3.5.1. Health Care Financing**

The total amount of health care expenditure in 1998/99 was US\$ 294.6 million. The sources of these funds and the per capita spending are illustrated in Figures 3.5 and 6.

---

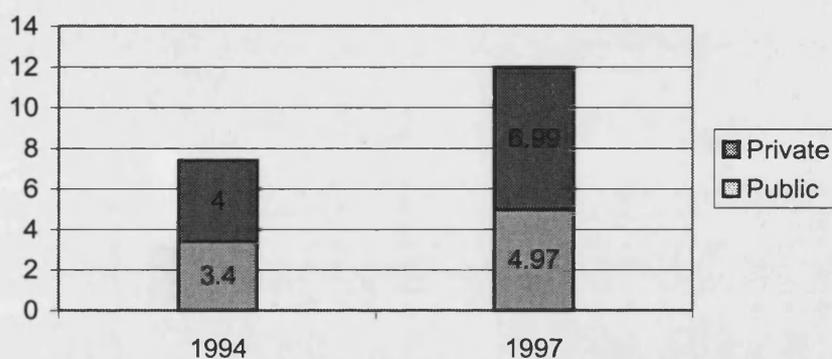
<sup>98</sup> For medical doctors, this number goes even up to 80 percent (RoU/MoH 1998a: 16).

Figure 3.5: Health care expenditure sources in 1997/98



Source: PCGM (1998b: 23)<sup>99</sup>

Figure 3.6: Per capita expenditure (in US\$)



Source: LaFond (1995), PCGM (1998b)

Private expenditure includes NGO donations and out-of-pocket payments in the NGO and private sector.<sup>100</sup> The per capita allocation for health is considerably below the SSA per capita average of US\$ 19 (MoH 1997: 2), and also one of the lowest on the African continent (World Bank 1994: 1). Furthermore, it is still below the minimum required to offer the minimum essential basic health care package, which stands at about US\$ 14-17 per capita (The Monitor 24.10.1997).<sup>101</sup> As of 1997/98, the public share constitutes 9.9 percent of total government expenditure, while the total national

<sup>99</sup> It is not clear whether the public figure includes user fee revenues of government clinics. Some health economists do so, e.g. Schreyer (1997: 27).

<sup>100</sup> However, the National Health Strategic Plan states that currently the total funding of the health sector is not yet fully established, particularly for private sources (RoU/MoH 1998a: 20).

<sup>101</sup> Estimated costs for the World Bank essential health care package amount to US\$ 10.08 per capita (MoH 1997: 47).

health expenditure stands at 4.0 percent of the gross domestic product (PCGM 1998b, Ojo et al. 1998).

The health sector in Uganda has indeed experienced growth in total funding since 1993 (RoU/MoH 1998a: 20), but there is still a need to find additional and alternative sources of funding for the health sector, whilst still guaranteeing access for all in order to provide a package that is mainly funded out of public sources.<sup>102</sup> The tax base, and more importantly, the state's tax collection capacity are still low in Uganda, as in other developing countries (cf. Livingstone/Charlton 1998). Alternatives to taxing include user fees at government clinics (see below) and the establishment of prepayment community schemes, attempts of which are under way in some Districts (World Bank 1994, 1998). It is also planned to establish pre-paid health care plans and insurance for the formal sector (Hutchinson 1999, MoH 1997).

### 3.5.2. The Public Sector

The state health delivery system consists of four levels of health care. Health centres and lower units, like dispensary-maternity units (DMUs) constitute the primary level, while the secondary level includes District and rural hospitals, and the tertiary level comprises general referral hospitals located in regional capitals. At the quaternary and highest level are the two national hospitals (Okello et al. 1998: 13).<sup>103</sup> The lowest level, on which this empirical analysis will focus (including the District hospital outpatient department), offers treatment and drugs for common diseases, inpatient facilities, maternity services and antenatal care. Larger units ("health centres") also provide simple surgery (suturing, dressing, draining) and laboratory services. Likewise, these units provide PPHC, which comprises immunisation, family planning (FP), nutritional education, and STD/HIV/AIDS counselling, advice and awareness-raising, on both a static and an outreach basis.<sup>104</sup>

Since the 1990s, most health units charge a user-fee with wide pricing structures, mainly for curative services. But no standardised practice exists as to the setting of the

---

<sup>102</sup> Government projections aim to keep the share of self-financing below 20 percent (MoH 1998a: 11, own calculations).

<sup>103</sup> The new National Health Policy aims to transform this system by extending the primary level to a four-tiered health facility structure.

<sup>104</sup> For a further elaboration on state PPHC services, see Chapter 4.1.

fees, their collection and their use. The underlying policy on cost-sharing has long been in an experimental stage, since there was no clear statement from the national level until recently (Iliffe 1998, McPake et al. 1999, DHSP 1998).<sup>105</sup> It was hence left to the Districts and Subcounties to decide about its implementation and the respective fee structures.<sup>106</sup> In practice, the objective of user fees is to supplement government funding, to improve drug availability, and to provide additional staff incentives through allowances. Ultimately, this is supposed to increase utilisation.<sup>107</sup> Even though user fees remain at the facility level, the amounts collected through user fees were very low in the initial years (1-7 percent of the total health unit budget), particularly in comparison to NGOs that collect 31-46 percent (data for 1991-1992, Okello et al. 1998: 18; cf. McPake et al. 1993: 1388). More recent figures cite 10 percent for government units (for Kamuli District, see Figure 4.2), but this is much less than their revenue potential (World Bank 1998). Reasons for low revenue collection include widespread exemption of non-eligible patients, poor management and embezzlement of user charges. Further, the introduction of user charges did not necessarily lead to improved quality of care and availability of drugs, so that utilisation rates remained low and perpetuated the problems. In fact, utilisation has dropped since the introduction of user-charges (Hutchinson 1999: 11).

The administrative culture and practice of civil servants in general and health workers in particular is still characterised by absenteeism, moonlighting, corruption, embezzlement and diversion of resources (Mugaju 1996, Munene 1995). One reason for this is that health workers' salaries are still paid irregularly – 37 percent of health workers report so in a study of ten Districts (Azfar et al. 2000: 41). Despite salary increases, salaries remain low for making a living.<sup>108</sup> The legacy of engaging in parallel income-generating activities continues as a practice, such as asking for informal charges, selling health unit drugs on a private basis and private practice

---

<sup>105</sup> Just one week before the presidential elections in March 2001, Museveni announced the abolition of user fees at government health centres. In practice, patients continue paying user charges (personal communication, Rebecca Hodgson, 2001).

<sup>106</sup> Only in 1996 did the MoH come up with tentative figures and ceilings for operations in government and NGO hospitals (interview, DMO official, 1999).

<sup>107</sup> The user fee rationale was derived from the Bamako Initiative, which aims at universal accessibility to PHC by user-financing under community control (cf. Wang'ombe 1997; Bennett et al. 1995).

<sup>108</sup> The staff is remunerated on a monthly salary basis and in addition receives a small top-up allowance from user charge revenues.

(Asiimwe et al. 1997). Doctors, medical assistants and nurses spend a large proportion of their time on duty in their private clinics or on other business. There is hence a great overlap between the public and the private sector, which affects the functioning of the former (McPake et al. 1998). The inefficient use of resource is also documented in very low bed occupancy rates at the primary level ranging from 0.2–42 percent (Okello et al. 1994).

The main source for drug supplies for health units is the DANIDA-funded Ugandan Essential Drug Management Programme (UEDMP), which was established countrywide in 1984. This drug supply system has been strongly susceptible to and has suffered from mismanagement and misappropriation both within the MoH – leading to unequal countrywide distribution of drugs – and within the health units – leading to acute drug shortage at the local level (UEDMP 1992 in Birungi 1994b).

Overall, given the widespread absence of qualified staff, the unavailability of drugs and informal charging, government services raise serious concerns in terms of both quality and access. This assessment, however, must be seen relative to the performance of the other two sectors.

### 3.5.3. The Private Sector

Private sector provision has gained considerably in size and scope in Uganda. 35 percent of those using formal health care facilities choose the private sector; this figure does not include the large utilisation rate of drugshops and informal private practitioners (MoH 1997: 20). As to the private sector's size, only estimations are available, not least because of the large number of non-registered clinics and drugshops.<sup>109</sup>

Private clinics provide mainly curative services and rather limited public health services, such as immunisation and FP (ibid.: 21). Okello et al.'s (1997) study of registered private clinics in Kampala, Jinja and Mbarara Districts found that less than 12 percent of them offer preventive services. On the other hand, health-related information and health education, which is more of a public good, is more willingly given to patients. Adome et al. observe that in the informal sector

---

<sup>109</sup> A survey in Kampala suggests that out of an estimated 400 clinics, 50 percent are not licensed (MoH 1997: 21). Further, it is estimated that about 63,000 "traditional medicine" practitioners operate nationwide (CIHI 1995: 20).

Trained para-medical personnel are more open in their explanations when interacting with customers, private patients and neighbours (1996: 17, cf. McPake et al. 1998).

For developing countries in general, there is little knowledge of the quality of care provided by the for-profit sector (Brugha/Zwi 1998: 107), and this is also the case for Uganda.<sup>110</sup> But quality is a critical issue particularly in an imperfect health care market. Because of the past, people have lost trust in government health units, and those who can afford private clinics prefer to pay a higher price to get better services with drugs being available (LaFond 1995, Okello et al. 1997). Yet lower income sections are less likely to use private clinics (Hutchinson 1999). Further, people appreciate that they are treated courteously and that waiting times are short (Okello et al. 1997: 23).

Section 3.2 illuminated the expansion and the privatisation and informalisation trend of the private sector. From 1989 onwards, official government policy has been that government doctors may practise in private clinics outside working hours, but not own private clinics. This has been widely ignored, however (Iliffe 1998: 161). In order to catch up with the reality of this privatisation and informalisation trend, the government approved various legislation to regulate and formalise private practice and the sale of drugs (see Chapter 8 for a detailed account). While the legislation requires private practitioners and drugshops to be licensed, it is estimated that the majority of clinics and drugshops are not (cf. Okello et al. 1997, MoH 1997). Moreover, most of the drugshops sell drug types that their licence does not cover and their prescription and dispensing patterns are dangerous (Adome et al. 1996, Whyte 1991).

In sum, accessibility of private clinics and quality of care raise concerns, but it is unclear whether the private sector performs better or worse than the other two sectors. Likewise, little is known about its cost-effectiveness.

---

<sup>110</sup> One study of two Districts found the private sector performing slightly worse in terms of the presence of basic equipment and also reveals some small differences between private clinics and health workers' home treatment (McPake et al. 1998: 34). For some qualitative evidence of drugshops' dispensing patterns, cf. McPake et al. (1998), Whyte (1991, 1997).

#### 3.5.4. The Voluntary Sector

For historical reasons, as outlined in Chapter 3.3, a large proportion of today's hospitals in Uganda are run by the churches (42 percent) (Nabuguzi 1995: 205), while the churches' and NGOs' share of lower facilities is about 25 percent (data from MoH 1997; interview, UCMB official, 1999; own calculations). The services offered in hospitals and lower levels correspond to those provided at the different levels in the public sector. Whereas government hospitals are run as if they are only supposed to offer curative services, most NGO hospitals have a stronger emphasis on preventive and promotive services (RoU 1998: 2).

All NGO and church units have to obtain a licence, unless they have been in place for more than 20 years. Yet in order to be recognised as a church-based or NGO clinic and to get support, the health unit must also be registered under the respective medical bureau (Catholic, Protestant, or Islamic). The medical bureaux serve as umbrella organisations and offer services to their member organisations such as training and education, subsidised drug supply, institutional support and advice on management and medical issues. Likewise, they supervise and coordinate and attempt to identify needs and problems at the local level.

NGO financing comes from several sources: 10 percent from the government, 10-20 percent by local or external sources, and 70-80 percent from user fees (Glotzback 1989 in Asiimwe/Lule 1993, also interview with UCMB official, 1999).<sup>111</sup> The fee-for-service scheme is usually run on a not-for-profit basis, which is a condition to be registered at the medical bureau. User fees are charged on complex pricing structures according to the type of illness and treatment. The revenues are mainly used to purchase drugs, so that the likelihood for a patient to receive drugs in NGO clinics is greater (Okello et al. 1998). Little is known about the effects of user charges on access. It is commonly assumed that NGO clinics are more successful in applying exemption practices and levy fees according to a patient's ability to pay (Robinson/White 1997: 20). Yet evidence from a health project in Uganda suggests that user fees can act as a disincentive for poor people in using NGO facilities (de Coninck 1992 in *ibid.*). The empirical analysis in Chapter 5 will examine these

---

<sup>111</sup> Another study of Okello et al. (1998: 18) reports that user fees contribute to 31–46 percent of recurrent costs, many times more than in government units.

assumptions to see whether NGOs are more successful in providing access to the poorest of the poor.

In a nationwide study, patients rated the NGO standard of care better than that of the government, although the difference is not statistically significant. Another study emphasises that NGO and church-based clinics generally have a better reputation (Adome et al. 1996: 11). Kafuko et al. (1993) find that there is not much difference between government and NGO clinics as regards the performance on national standard guidelines on rational use of drugs.

Pearson's study (1996) shows that NGO hospitals are more cost-effective than governmental ones (as regards expenditure per outpatient visits and inpatient stays). Patient throughput by physicians is about five times higher in mission hospitals than in governmental ones (World Bank 1993: 126). Little data on overall efficiency is available on lower units, however. Expenditure on drugs was found to be higher, as more drugs were used per patient (Kafuko et al. 1993). That said, poor record keeping and drug leakage at the government units distort the analysis, making a straight comparison difficult (Okello et al. 1998: 17). Overall, the evidence is mixed and it is not clear whether the NGOs' performance in providing curative health care is superior to the other two sectors.

Numerous Ugandan and foreign non-governmental organisations focus or specialise in specific areas of PPHC, including information/education/communication (IEC), sanitation, home improvement, FP, nutrition, STD, reproductive health, and HIV/AIDS awareness-raising and patient care. Their evolution must be seen in the context of the general growth of the NGO sector since 1986, when the political climate became more favourable for indigenous NGOs, leaving more room for collective action and self-help initiatives. Another reason for the rise is the donor trend and preference for increased financing of non-government organisations since the late 1980s in light of public mismanagement (Dicklitch 1998, Bennett 1994). Likewise, the rise of the NGO sector and self-help initiatives is a reflection of the apparent state failure and absence in providing PPHC services.<sup>112</sup> As such, their role is often one of "filling the gaps", supplementing, and complementing (MFEP 1993). By

---

<sup>112</sup> For the dynamics and role of the NGO sector, cf. MFEP (1993), Nabuguzi (1995) and Tripp (1994).

1997, there were about 1,800 registered NGOs engaged in development activities, of which 8 percent operate in health care. This figure does not include an estimated 750 community-based organisations, which do not have to be registered at national level (Riddell et al. 1998).

Given the sector's diversity, valid generalisations on the PPHC NGOs' performance are not possible. As regards institutional aspects, a very common drawback is that few NGOs are self-reliant – they need external support to run their services. In fact, from 1986 on, they became much more linked to the state in its financial role. Their frequently close connections with local elites and patronage relationships with the state and donors blur their mandate and representation of civil society (*ibid.*). Hence, similar sustainability and ownership concerns arise as was outlined in the discussion of the government (*cf.* Section 3.3). NGOs are also criticised for their lack of accountability and transparency in relation to government and donors (Becker 1998, Cannon 1996, Kwagala 1997; interviews, KDA officials, 1997, 1998). Another drawback to their operation is the structural difficulties of combining high professional skills with a bottom-up approach (Brett 1992: 70).

A health-specific networking and umbrella organisation is the Ugandan Community Based Health Care Association (UCBHCA), founded in 1986. In 1999, it had about 340 members (interview, UCBHCA official, 1999). Its main objective is to promote community capacity building, co-ordinate NGOs and contribute to PHC-policy formulation. Beneath the Executive Committee at the national level, members are grouped in District associations to co-ordinate and monitor PHC activities. However, many District organisations are very weak or not even existent as in Kamuli District. The main problem is the lack of funds intended to go down to the grassroots level and establish village health committees (interview, UCBHCA official, 1999). The UCBHCA is also the secretariat to the NGO panel that participates in implementing the DHSP/government programme of supporting NGO health activities, funded by the World Bank. For example, in 1997, about 100 CBOs and NGOs received support from the government to implement health services (Okullo 1998).

### **3.6. Conclusion**

This chapter examined the previous developments and the context of Uganda's health care system in order to illuminate the prevailing legacies with which it is faced today. As a result of the informalisation and privatisation trend in the 1970s, private and non-government actors got involved in the financing, provision and production of services, which also led to the fragmentation of the health care system. This changed and transformed roles, responsibilities, ownership as well as decision-making loci. The nature of the health policymaking process of the past decade explains why the inherited problems could not be quickly solved. Likewise, we have seen the shortcomings of decentralisation process and the way this affects health care provision.

The last section discussed the key features of the public, private and voluntary sectors. The government sector is still challenged with overcoming the problems that resulted from the turmoil of the previous years, that is low motivation, inadequate availability of qualified staff and drugs being some of the problems. While the private sector is highly utilised, little information regarding its performance is available. In an inherently imperfect health care market, it is doubtful whether the private sector provides superior services. Evidence of the voluntary sector's performance is equally elusive. Altogether, it remains unclear which sector performs relatively better. Moreover, very little information is available on the functioning and impacts of the prevailing governance mechanisms, that is the nature of the market, the effectiveness of regulation and the existence of network coordination, or the effects of interactions on organisational performance.

The task for the empirical analysis is therefore to compare comprehensively the three sectors along a set of performance criteria in order to provide a clear picture of each sector's strengths and weaknesses (Chapters 5 and 6). The context outlined in this chapter must be taken as the starting point for understanding and explaining each sector's performance by means of an institutional and interorganisational analysis (Chapters 7 and 8). Before doing so, the next chapter will outline the case study setting in more detail.

## Chapter 4

### **The Case Study: Health Care Provision and Utilisation in Kamuli District**

This chapter discusses health care provision and utilisation for Kamuli District in more detail. It provides the necessary background information for the comparative performance analysis (Chapters 5 and 6) and the institutional and interorganisational account (Chapters 7 and 8). Section 4.1 briefly outlines the health care expenditure situation and the role of donors in Kamuli District. This is followed by an organisational inventory of curative health care providers (Section 4.2). Section 4.3 describes the sample of curative health care providers under study and discusses their organisational structure and functioning. In Section 4.4, the promotive and preventive health care (PPHC) providers will be outlined. These are not subject of the comparative performance analysis, but are part of the study of interorganisational relationships in Chapter 8.

The final section shifts to the subject of utilisation, which is, however, very closely interrelated with provision, in that the two affect each other. The focus on biomedical care will be located in the context of medical pluralism (Section 4.5.1) in order to understand people's notion of biomedicine (4.5.2), health care seeking patterns in the biomedical sector (4.5.3), and people's preferences and utilisation factors (4.5.4). The latter does justice to the claim of basing the performance criteria selection and operationalisation both on the actors' view and the observer's perspective, as argued in Chapter 2.

Kamuli District belongs to the kingdom of Busoga, the ethnic group living there being the Basoga. However, Kamuli is not comparable with its neighbouring Districts. Jinja town, for example, is one of the most pulsing development centres in the country. In Kamuli, 95 percent of the population live in rural areas, and the main activity is agriculture. For 1995, the national HDI average is 0.328, but Kamuli's HDI (0.335) is second lowest in the Eastern region, and there are only nine other Districts in the country with lower HDIs out of 39 Districts at that time (UNDP 1997). A number of health and health related indicators are worse than the national average, e.g. child mortality and the percentage of the population living within a 5 km radius of a health unit, which is only 50%, whereas the AIDS infection rate is lower (KPU

1997). The doctor-patient ratio is 1:75,000, much lower than the national average. Kamuli's physical terrain is characterised by small hills, woodland and bush, which gets more flat and open towards Lake Kyoga in the North. During the rainy season, many roads near swamp areas are not passable. Nevertheless, for example in comparison to the mountain region in Eastern Uganda, physical access to social services is much easier. It is also important to note that homes are scattered in the bush, that is, a village is not an agglomerations of homes.

#### **4.1. Health Care Expenditure and the Role of Donors in Kamuli**

Public per capita spending from District resources (including donor funds and central government transfers) stood at US\$ 9,684 in 1997-98 and at US\$ 12,381 in 1998-99, and at US\$ 1,156 for health in 1998-99 (KDA budgets, own calculations).<sup>113</sup> The donor funds that were directly provided to the District for health care amount to US\$ 322 million for 1997-98 and 250 million for 1998-99. The main share (47.6 percent) of the total external funds received originated from the District Health Services Pilot and Demonstration Project (DHSP), followed by the Sexually Transmitted Infections Programme (STIP) (15.9 percent), both financed by World Bank funds, and the German Development Service (DED) (8.0 percent) (*ibid.*). Other donors include USAID, UNICEF and the Spanish government. There is no information available on the volume of NGO funds in Kamuli District.

With the exception of the DED, donor support is of financial and technical nature; in other words, there is no expatriate staff operating at the local level. Programmes are implemented through the DMO structure or local NGOs, which are hence subject to the same institutional patterns and rules of the game as for their own activities. The DED, on the other hand, has been sending personnel since 1991 and engages at the operational level of government health units. The impacts of this intervention are of technical nature, namely better organisation of health units and improved knowledge of some health workers. However, an evaluation study indicates that the overall performance of government clinics has not been affected by this

---

<sup>113</sup> 1 US\$ = 1,100 USH (Ugandan Shilling) (exchange rate for 1998/99)

external support (Koppenleitner/Mpabulungi 1997). Therefore, the DED activities do not pose a methodological difficulty for this study.

#### 4.2. Service Inventory of Curative Health Care Providers

Kamuli District has a total of 50 health care facilities of different affiliations with an average of two clinics per Subcounty (see Table 4.1). In Kamuli town, there are seven formal health care facilities and a huge number of drugshops within an area of 300 x 300 metres (see Table 4.2). The hospital is located two kilometres from the town centre. Kamuli town and Kamuli District do not have a pharmacy which is entitled to sell class A and B drugs.

Table 4.1: Inventory of formal health care facilities in Kamuli District<sup>114</sup>

Facility type	Number	Affiliation
<b>Government (health centres and dispensaries)</b>	27	MoH
<b>NGO/Church clinics (dispensaries)</b>	18 <sup>115</sup>	3 Jinja Diocese 11 Busoga Diocese 1 Fellowship 1 Seventh Day Adventist 2 NGO/community based <sup>116</sup>
<b>Private clinics</b>	4	-
<b>Referral hospital, Outpatient department (OPD)</b>	1	Jinja Diocese

Source: Own inventory<sup>117</sup>

<sup>114</sup> Note that this categorisation into provider types does not necessarily correspond with people's notions about different providers.

<sup>115</sup> This is the number of NGO clinics that were found on the ground.

<sup>116</sup> One of these is registered only as an NGO, but in practice is run on a private basis.

<sup>117</sup> The official DMO records are incomplete, in that they do not include the private clinics or all NGO clinics. This inventory does not include the many informal, unregistered private clinics (see below).

Table 4.2: Formal health care providers in Kamuli town

Affiliation	Number	Highest Qualification
Government	1	2 Medical Assistants (MAs) <sup>118</sup>
Referral (NGO) hospital	1	5 Doctors
NGO/church clinics	2	MAs
Private clinics	4	MAs, Doctors
Drugshops	+/- 16 <sup>119</sup>	

In rural areas, government clinics are staffed with a medical assistant, while rural NGO clinics are run by a midwife or a double-qualified nurse-midwife. The clinic coverage is unequal; in some Subcounties there is only a government or only a NGO clinic. Not only are the health units unequally spread between Subcounties, but also within Subcounties.

Many health workers (medical assistants, nurses or others with lower qualifications, retired or government-employed) operate unregistered clinics or provide services at home.<sup>120</sup> Many of these private clinics, and drugshops as well (see below), are owned by DMO staff or government health workers (McPake et al. 1998). All of these providers dispense drugs, most of them administer injections, and some offer over-night admission. The providers are unequally spread, between and within Subcounties, depending on the quantity, quality and performance of the alternative, formal health units. In addition, there are many (unregistered) maternity homes in rural areas, most of which also provide curative treatment.

The DMO's drugshop record of 1998 lists 43 registered drugshops. Inference from this study in three Subcounties suggests that the total number of drugshops amounts to at least 300 for the whole District.<sup>121</sup> In combination with the unregistered rural private practitioners, there is a dense coverage of places where people can

<sup>118</sup> Medical assistants are a specific category of health professionals whose training is shorter than that of doctors.

<sup>119</sup> These are located within an area of 300 x 300 metres; and 7 drugshops are situated on one street.

<sup>120</sup> It is more difficult to identify these informal, unregistered private practitioners, because they usually practice from their home. Given the time and cost constraints, it was not feasible to carry out an inventory for the whole of the District.

<sup>121</sup> That is, visible and established shops solely selling drugs, as opposed to hawkers, people selling drugs from home in a much more informal setting, or other shops that also sell some drugs.

obtain drugs. At drugshops, patients would describe their symptoms and ask the shop assistant to compile a couple of drugs for a specific amount of money or they would ask for a specific drug they wanted (cf. Whyte 1991, see Chapters 5 and 6). Most of the drugshops also administer injections. Drugshops at smaller trading centres or at road junctions usually have a smaller range of drug types for self-medication and first aid, whereas the drugshops of medium to large trading centres are well stocked with a large variety. Often, these are also run by better qualified staff that provides some medical advice.

Thus, while the actual organisational spectrum in the private sector is wide, the differentiating lines are blurred. The (urban registered) private clinics on one hand and (registered or unregistered) drugshops on the other only constitute poles, and the spectrum of quality is equally fluid. Drugshops have taken up a niche in the market, and drugshop utilisation must thus be differentiated. It cannot be merely equated with home treatment or self-medication, as is often done in the literature (Wallman 1996). Home treatment and self-medication do include buying drugs at drugshops. Yet, when people spell out their symptoms, get advice or receive an injection, drugshops constitute a health care provider *outside* of home treatment, just like clinics. But again, this distinction is not clear-cut.

#### **4.3. The Health Care Provider Sample for the Comparative Performance**

##### **Analysis**

This section outlines the selected sample of health care providers. The distance of the three rural Subcounties to Kamuli town is relatively equal, but not in terms of ease of access to Kamuli town by public transport. Most remarkable is Kamuli town with 8 facilitates (including the hospital) and one of the rural Subcounties with three clinics in close proximity.<sup>122</sup>

While the study covered all clinics in Kamuli town (public, private and NGO), a selection had to be made among the health care providers in the rural Subcounties in order to be able to focus this study within the given time and financial constraints.

---

<sup>122</sup> It is not exceptional to find two units closeby.

The same two Subcounties were selected where the action research had taken place during the first two research phases (one with a government clinic, one with NGO clinics) and a third one with the similar characteristics and the same distance to Kamuli town, which had both a government clinic and two NGO clinics. This Subcounty sample is representative of the distribution of formal, registered clinics. In a second step, a selection had to be made from among the drugshops and informal private providers, given their large number. By asking food or cloth shopkeepers, triangulated by observation, the most popular drugshops and informal private practitioners that were located near these formal, registered providers could be identified. This enabled a comparison between the providers that competed with each other. However, this selected sample is biased in that it does not include the more remote drugshops.

Table 4.3 highlights the core sample (dark shadowed), where the data collection methods included exit interviews, interviews with providers and an analysis of record books, where they were existent and made available. At the lightly shadowed providers, less detailed information could be gathered.<sup>123</sup> Likewise, Table 4.3 enumerates the alternative providers nearby to get a fuller picture of the organisational inventory within the chosen areas.

With the exception of one, all drugshops under study were run by unqualified staff. In total, 9 out of the 15 rural drugshops had a licence.<sup>124</sup> As for private clinics, drugshops are registered under a qualified person, while the clinic is often owned or run by unqualified staff. The drugshop observation study, which collected data on the drug sales and the prices, comprised six shops, all having been licensed at least once during the past two years.

---

<sup>123</sup> Given their illegal status, rural private providers were often reluctant to provide their records if actually existent, which is why they were not included in the core sample of health care providers.

<sup>124</sup> The sample rationale was to select the well utilised drugshops. It is hence not accidentally that they were licensed, but this was not the selection criterion. None of them belonged to DMO staff.

Table 4.3: Organisational inventory in selected areas

	Kamuli town	Subcounty A T.C.	Subcounty B T.C. B1 T.C. B2	Subcounty C T.C. C1 T.C. C2
Study units	1 gov't clinic 2 NGO clinics 4 private clinics 1 NGO hospital	1 gov't clinic 5 drugshops 1 rural priv. clinic	3 NGO clinics 7 drugshops	1 gov't clinic 2 NGO clinic 3 drugshops 1 rural priv. clinic
Government	uG-1 (HC)	rG-2	no government clinic	rG-3 <sup>125</sup>
NGO/church	uN-1 uN-2 Mission hospital	no NGO clinic	rN-1 rN-2 rN-4 <sup>126</sup> 1 NGO Project	rN-3 rN-5
<u>Private sector</u>				
Registered clinics	P-1 P-2 P-3 P-4	none found	none found	none found
Unregistered clinics (rural)		rP-1 (MA) 2 clinics outside T.C. (MA)		rP-2 (dispenser)
Drugshops	D-1 15 drugshops (+/- 2)	D-2 D-3 D-4 D-5 D-6 5 drugshops	<u>T.C. B1:</u> D-7 D-8 2 drugshops  <u>T.C. B2:</u> D-9 D-10 D-11 D-12 D-13  <u>in-between the T.C.s:</u> 1 rural practitioner 2 maternity homes	<u>T.C. C1:</u> D-14 D-15 1 drugshop  <u>T.C. C2:</u> D-16 3 drugshops 1 midwife

uG = urban government clinic

P = private clinics

uN = urban NGO clinic

rG = rural government

D = drugshop

rN = rural NGO clinic

T.C. = trading centre

priv. = private

govt' = government

All of the provider types offer curative treatment. This is the common ground that allowed for comparison. For the discussion of the results, these provider types are differentiated into lower-level providers (drugshops; rural private practitioners,

<sup>125</sup> By the DMO's as well as DED's judgement, the three chosen government facilities belong to the group of well working government facilities (interview, DMO official, 1999; DED reports 1997-99).

<sup>126</sup> rN-4 and rN-5 were hardly functional, since the midwife in one clinic had died, while that in the other was on training for several months.

usually unregistered; rural NGO clinics; government dispensaries) that are utilised first, and higher-level providers (government health centres; urban private and NGO clinics; hospital OPD). This meets with people's perceived distinctions of disease severity and the observed utilisation and referral behaviour (see Section 4), but this is obviously not a clear-cut division. The remainder of this section provides more detailed information on the providers' operations and management.

#### 4.3.1. Services

In rural areas, the service range is most comprehensive at government health centres, whereas NGO clinics offer curative and reproductive health (RH) services, but no laboratory (with some exceptions) and dental services or minor surgery.<sup>127</sup> Medical assistants running a private clinic provide curative and sometimes dental services as well as minor surgery. In town, the largest service spectrum is delivered by the Mission hospital (except that there are no FP services), followed by the urban government clinic. The private and NGO clinics are comparable in that all of them offer curative care including treatment for sexually transmitted diseases (STD), some offer maternity and RH and some offer dental services.

#### 4.3.2. Health Unit Management

Government clinics are affiliated to the Subcounty local government in which they are located, whereas church clinics are attached to the respective church Parish and the (regional) diocese. The government health units and the rural NGO clinics are managed in similar ways. They are led by an in-charge (I/C) and are guided and directed by the so-called health unit management committee (HUMC).<sup>128</sup> The HUMCs' tasks are to supervise the running of the clinic and to participate in decisions on its management, such as user fee rates. User fees are set with the approval of the LC3 Council in the case of government clinics, while the NGO clinics do so in agreement with the regional headquarters.<sup>129</sup> The HUMC composition of the various provider types is similar, but at the NGO clinics, their appointment or election takes

---

<sup>127</sup> Catholic units, however, do not offer FP services.

<sup>128</sup> The urban NGO clinics have no HUMC. Private clinics are managed by their owner(s).

<sup>129</sup> The Ministry of Health and the diocese headquarters provide guidelines on user charge rates, but considerations of cost recovery and the communities' ability to pay determine the final amount.

place at a lower level (see Table 4.4, cf. Hutchinson 1999: 104 for government clinics).

Table 4.4: HUMC composition

	HUMC composition	Selection Process
<b>Government clinics</b>	<u>10 members</u> Chairperson, Vice, Treasurer, 3 opinion leaders, 1 women representative, LC1 chairperson near the clinic, staff representative, I/C (as Secretary)	Members are nominated by the LC3 Executive Committee and seconded by the council. The LC1 chairperson of the health unit's location is an ex-officio member.
<b>NGO clinics</b>		
<b><u>Protestant</u></b>	<u>7 members</u> Chairperson, Treasurer, 4 representatives per zone, I/C (as Secretary)	Members are elected by the Parish Development Committee.
<b><u>Catholic</u></b>	<u>7 members</u> Chairperson, I/C (as Vice), Treasurer, Secretary, 3 community members	Members are elected by the Parish Executive Council. <sup>130</sup>
<b>NGO Hospital</b>	Board of Governors includes church community members, the Superintendent, the DMO, LC5 chairperson and the CAO	Members are appointed by the Bishop; District authorities are co-opted ex-officio.

Source: government guidelines for HUMCs, interviews.

#### 4.3.3. Financing and Funding

As Table 4.5 shows, the financing of the health care providers varies enormously. There are no insurance or pre-payment schemes in place in Kamuli District. In light of low user charge revenues, government services are primarily tax- and donor-financed. At some NGOs, salaries are donor-financed, whereas others, just like private providers, are fully reliant on user charge revenues. Given this varying degree of subsidisation, the providers' starting positions for their operation are unequal. This has different implications upon user costs and drug availability, which will be examined in the following chapters.

<sup>130</sup> Both for the Protestant and the Catholic clinics, these electing committees are elected by the Parish committee, which is again elected by the actively practising community (cf. Kassimir 1995).

Table 4.5: Funding and financing sources

	Staff salaries	Staff allowances	Drugs/medical supplies	STD kits	FP	Operating costs <sup>131</sup>	Buildings
<b>Government clinics</b>	<u>Decentralised and District staff:</u> Decentralised funds District revenues <u>Other staff:</u> Subcounty revenues User fee revenues	UCR  <u>Lunch allowances:</u> MoH	mainly UEDMP, District funds, UCR	DMO/MoH	DMO/MoH	UCR  Subcounty revenues	MoH/donors and community
<b>NGO clinics:</b> <b>uN-1, rN-1,2,4,5</b> <b>(Protestant)</b>	Donors	UCR	partly UEDMP, partly UCR	some receive through the DMO	DMO/MoH	UCR	urban: donors rural: donor and community
<b>uN-2</b>	UCR	-	UCR	-	-	UCR	Church
<b>rN-3 (Catholic)</b>	UCR	-	UEDMP bought with UCR	-	not offered	UCR	Church
<b>Mission hospital</b>	Delegated funds UCR	UCR	UEDMP bought with UCR and delegated funds	DMO	not offered	UCR	Church
<b>Private clinics</b>	UCR	UCR	some receive from DMO	UCR (where offered)	UCR	UCR	UCR
<b>Drugshops</b>	Sales	-	-	Sales	Sales	Sales	Sales

UCR = User charge revenues

<sup>131</sup> Operating and maintenance costs include expenditure for cash and receipt books, paraffin, bed linens, the construction of rubbish pits or latrines and electricity.

#### 4.3.4. Cost-Recovery through User Fee Revenues

Table 4.6 demonstrates the cost-recovery rates for the various providers. Government clinics have the lowest cost-recovery rate, followed by the rural Protestant clinics. Urban NGO facilities have a higher cost-recovery rate. One of them is in fact fully self-reliant, like the private clinics. Since July 1998, the hospital receives – at least officially – a monthly rate of about USh 11 million (= approx. US\$ 10,000) as delegated funds from the MoH. These are used to lower user charges, to increase staff salaries up to government levels as well as to purchase drugs. Yet the hospital has still to recover a major part from its own user charge revenues. Before the granting of the delegated fund, the hospital had to recover 90 percent.

Table 4.6: Cost recovery rates

<b>Provider type</b>	<b>Provider</b>	<b>Percentage of own revenues in relation to overall resource inputs<sup>a)</sup></b>
<b>Government</b>	rG-1	28
	rG-2	30
	rG-3	16
<b>Rural NGOs</b>	rN-1	46
	rN-2	43
	rN-3	90-100 <sup>b)</sup>
<b>Private clinics</b>	P-1, P-2, P-3, P-4	100
<b>Urban NGOs</b>	uN-1	100
	uN-2	58
<b>Mission hospital</b>	Mission Hospital	45

Source: records, interviews (own calculations)

- a) Resource inputs comprise staff salaries and drugs, but exclude supervision costs, funds for construction and rehabilitation of buildings, STD kits, and other medical supplies. Vaccination supplies are fully funded from external sources both at government and NGO facilities.
- b) The Catholic clinic used to receive regular donations, but these fell to an estimated 10 percent of the total income (data from interview, nurse rN-3, 1999, own calculation).

#### 4.3.5. Drug Supply

There are considerable differences in drug supply. Government health units obtain Essential Drug Kits (EDK) from the Ugandan Essential Drug Management

Programme (UEDMP) via the DMO. The kits are partly funded through the UEDMP, and partly purchased from the DMO's budget for those clinics that are not included in the UEDMP (interview, DMO official, 1999). Drugs are hence provided on a highly subsidised basis. The amount of EDKs per unit is controlled and set in the MoH once a year, on the basis of a health unit's patient load. This provides an incentive to government health workers to forge patients' numbers in order to receive more kits, a practice that is still common in health units (cf. McPake et al. 1998). Furthermore, the UEDMP supply is not fully reliable (cf. Birungi 1994b). In Kamuli District, three to four clinics usually do not obtain their kits. This is partly due to insufficient accountability records on the use of drugs. In mid 1999, however, 12 government clinics, that is, 54.5 percent of all government health units did not receive their EDKs, including the selected rural government units.<sup>132</sup>

An additional drug supply source is the Sexually Transmitted Infections (STI)-Program funded by the World Bank. Pre-packed STI kits are delivered to the DMO and then to the health units, provided there is staff trained in STI management. However, these STI kits do not come regularly, so that STI drugs are not available during many months of the year (interview, in-charge uG-1, 1999 and DED-professionals). Finally, health units are supposed to use user fee revenues to buy drugs on the local market in order to supplement the drug stock or to fill gaps when essential drugs ran out<sup>133</sup> (see Chapter 6.2.1 for the units' practice).

The NGO and church units' sources of drug supply vary depending on whether a clinic is registered or not. Whereas non-registered clinics usually buy drugs from the open market, registered clinics receive subsidised EDKs from the Joint Medical Store (JMS) if their patient load is above a pre-defined level. The JMS is assisted by the UEDMP and jointly run by the Catholic and Protestant medical bureaux. Church and NGO clinics can directly buy at the JMS, or, as in the case of the Catholic clinics, the EDKs are delivered to the DMO from where they are distributed to the clinics. The drugs that are not available through the EDKs are bought in Kampala or Kamuli town. The EDK supply through the DMO has also not always been reliable. One of the Catholic units did not get its kits three times in the past two years. Only when the

---

<sup>132</sup> While this is partly due to missed deadlines of handing in records, as one in-charge admitted, this group also included those clinics that in the past have been very correct in their accounts.

<sup>133</sup> Note, however, that there is no pharmacy in Kamuli District that could legally sell class A and B drugs.

in-charge threatened to go to police to report the "loss" of the kits, did the responsible DMO officers quickly replace the money (interview Bülow, DED health worker, 1999).

The rural Protestant clinics are not integrated into the UEDMP. Therefore, they buy the required drugs from the local drugshops about twice a month. The drugs stored are rather small in quantity and include few types, since the drug purchase is a function of the cash available from user charge revenues. Also, as the units buy small amounts, they cannot get them at lower wholesale prices. So far, the urban NGO clinics do not receive EDKs. One of them still buys its drugs at wholesale drugshops in Kamuli town, admitting that there is no drug management scheme as yet, so that it buys weekly or sometimes even daily if needed. This implies high administrative costs and the loss of wholesale cost reductions. The other one buys drugs on a wholesale basis and has a more efficient supply and management system. Yet drugs are not necessarily sold at lower prices at this clinic.

The private clinic practitioners usually buy drugs in Kampala or Jinja once a month from pharmacies on a wholesale price basis. 50 percent of the rural drugshops under study buy their drugs outside Kamuli District; the other 50 percent buy in Kamuli town at wholesale shops. The Mission hospital uses the delegated funds to finance its drug purchase (EDKs and additional drugs) from the JMS. Since the end of 1998, the expenditure of delegated funds was made particularly difficult by the District Administration, so that smooth and cost-effective drug supply was interrupted (see Chapter 8). An additional drug supply source is the STIP mentioned above, of which some few NGO clinics and the hospital are part.

In sum, reliable drug supply is best guaranteed in the private sector and in those NGO clinics that are not dependent upon the UEDMP. Likewise, health care providers have different starting positions as regards drug supplies and costs.

#### **4.4. Promotive and Preventive Health Care Services (PPHC)**

##### **4.4.1. Government Services**

Most governmental PPHC activities are institution-based, i.e., they are attached to the health units. They usually offer static and outreach immunisation, STD/HIV/AIDS counselling and awareness-raising, antenatal and postnatal care, and growth

monitoring. Basic FP services are available in all units, while more sophisticated methods are provided only in Kamuli town. In addition, there are four HIV testing centres linked to government centres across the District.<sup>134</sup>

An important link between the health unit and the community is the health assistant (HA) who mobilises the community and attends outreach activities of health units. Other tasks comprise basic health education, household and sanitation inspection and sensitisation (e.g., on latrine construction). A health assistant is in charge of a whole Subcounty, with an average population of 23,000 in 50 zones and an average area of 12 x 12 km. A crucial drawback to the HA's activities is inadequate facilitation in terms of transport and field allowances. Continuous and regular contact with each community is thus limited. Accordingly, 80 percent of the respondents in the household survey reported that they had never had contact with the health assistant.

In the 1990s, based on the rationale of community-based health care (CBHC), various donor programmes supported the training of community-based health care workers who should provide basic health and nutritional education to the communities. The CBHC workers are elected by the community as volunteers, but there is a limited structure, management or coordination at the local level. The programmes seem to function at various degrees of effectiveness, but again a general problem is the lack of voluntarism in the absence of remuneration (Almeda, DED-report 1997/98; interviews, health workers and chairperson SCHC Subcounty B, 1999). This prevailing "allowance culture" is problematic, in that it makes local institutions lose out.<sup>135</sup>

Following the same CBHC logic, the 1997 Local Government Act foresees the chairperson of the Women Councils at the village level as the Secretary for Women and the Public Health Co-ordinator (Section 48, 2-i). However, these office holders had hardly been made aware of their roles and no training was provided in the Subcounties studied. Likewise, none of the household respondents was aware of such a function. In practice, this position has never been taken up. The lower LCs who are

---

<sup>134</sup> These are run in collaboration with the non-governmental AIDS Information Centre Programme. Vector control is not decentralised and hence not under the responsibility of the DMO (interview, DMO official, 1999).

<sup>135</sup> Donors institutionalised the payment of allowances for field workers. This has created an allowance culture such that "voluntary" community activities are no longer carried out without payment.

also in charge of mobilising for immunisation and other promotive health care activities undertake some of the tasks. Their activity level varies again from person to person depending on their motivation and voluntarism.

Although the communities are well aware of the institution-based PPHC services, they are under-utilised. Further, the government field workers' presence on the ground is rather thin, and only 30 percent of household respondents had seen or had contact with any kind of village health workers (cf. Azfar et al. 2000 for a similarly low figure).

#### 4.4.2. NGO Services

The Mission hospital provides some PPHC services at the facility level (immunisation, antenatal care, nutritional education). The NGO clinics at the lower level offer immunisation and antenatal care, and the Protestant clinics also provide FP services. The latter have established a village health worker programme to carry out outreach activities, such as growth monitoring, FP advice, nutritional education, sanitation, AIDS awareness-raising and immunisation. The Protestant clinics' project and catchment area is one Parish (i.e. a Subparish of the church with about six to eight villages), which is usually covered by three to four village health workers. They work part-time and receive a small allowance. They are much more present than their government counterparts. Three quarters of the household respondents in the project areas had seen or had contact with the village health workers.

In addition, there are about 20 local NGOs in Kamuli District, more than half of which are engaged in PPHC field activities. Table 4.6 lists those NGOs under study. None of the NGOs in Kamuli has or is able to mobilise substantial local resources – they are all dependent upon external funding from both donors and government programs. There is no UCBHC District association and only three PPHC NGOs are registered with UCBHCA in Kampala.<sup>136</sup>

---

<sup>136</sup> One of the NGOs found on the membership list at the UCBHCA headquarter had never been heard of in Kamuli.

Table 4.7: PPHC activities of local NGOs in Kamuli

Organisation	Targeted beneficiaries	Main activity
<b>Health and AIDS</b>		
- AEGY - KAASFA - KAMASO - IMAU - NACWOLA - NASCRUD	Community, People Living with AIDS (PWAs)	AIDS prevention and related activities: condom distribution, counselling on medical care, treatment advice, guidance in advanced planning for economic survival; home care of the sick; food support to PWA; set-up of and advice to self-help groups
- Red Cross Kamuli Branch	Community, Red Cross members	Blood donor recruitment, health/drug education, first aid education, AIDS prevention
- Busoga Diocese	Community	FP sensitisation, distribution and sale; health education (sanitation, AIDS prevention, nutrition), growth mobilisation, immunisation
- UTHA	Traditional healers	Information exchange, improvement on traditional healing, drugs and herbs
- KAEA	Community, adult literacy groups	Adult literacy (integrates AIDS awareness raising in its activities)
- KADIWODA	Women groups, community	Economic empowerment of women Related activities: AIDS awareness-raising, health education
- CCF - FFWP	Community	Community development Related activities: health education
<b>Other fields:</b>		
- UNFA - KREDA - SAFA	Community, farmer groups	Improved food and crop production and nutritional diet
- USSIA - UWFCT - Kiribawa	Women, women groups, community	Economic empowerment of women
- Maria's Care	Youth, children	Vocational training; orphan's care

Field agents work on a voluntary basis or receive a very small allowance, which is often their sole income source, apart from their garden activities. All NGOs lack transport funds or means for their community activities. Nevertheless, most of them are very committed, and only a few NGO staff seemed to pursue a personal agenda. However, it is very striking that the household respondents knew virtually none of the

PPHC NGOs, other than the VHWs of the Protestant clinics.<sup>137</sup> This was equally revealed by the focus group discussions (1997-99), most of which only knew one or two NGOs. In sum, it appears that the NGO presence is equally thin given the large intervention area.

#### **4.5. Health Care Seeking Behaviour and Utilisation Factors for Curative Services**

##### **4.5.1. Medical Pluralism**

Popular understandings of ill-health are strongly influenced by biomedical concepts. Nonetheless, what constitute "normal" physiological activities, and hence health or the absence of disease, may not feel "normal" for somebody who feels unwell (Allen 1992: 219). In fact,

Clinical objectification of the human body is unlikely to be the only starting point for [people's] understanding [of] symptoms which might be ascribed by a biomedical professional to disease, and bodily malfunctions may be less readily separated from other forms of affliction (Allen 1998: 3).

Rather are there pluralistic conceptions of and linkages between health, affliction, causality and healing, whereby people question much more the why of suffering. Views and interpretation of illness (i.e., subjectively feeling unwell) vary enormously, as do the choices for seeking treatment.<sup>138</sup> Accordingly, people do not wholly accept professional knowledge as the only means of making decisions regarding treatment. A starting point for health care seeking is whether the illness is considered to have an impersonal or an interpersonal cause. In the former instance, the cause of the illness is of accidental nature or a predictable result from the sick person's behaviour. For example, it is recognised that certain, rather minor diseases just happen. The treatments chosen are home treatment, biomedicines ("Whites' medicine") for "White" illnesses or local herbalists for illnesses believed to be "African", but both types of treatments are pursued in practice (Allen 1992: 233, cf. Allen 1991). For illnesses with interpersonal causes, which make reference to personal and social

---

<sup>137</sup> Apart from the Protestant clinics' outreach activities, only two respondents mentioned two NGOs. It is possible that we did not sufficiently prompt people to remember some of the local groups they have heard about.

<sup>138</sup> Cf. Adome et al. (1996: 38) for a collection of examples of popular notions of aetiology.

relationships among dead or living people, one would have to find out why a person was afflicted and aim to solve the interpersonal problem. Alleviating the symptoms would only be a by-product of this process. The therapy choices consist of ancestor invocation, communication with wild spirits and accusations of sorcery (ibid.: 239). Yet it is important to note that people's perception of the disease can shift between the two spheres (Whyte 1997: 28).

Treating symptoms is most prevalent for the most common kind of affliction, i.e. sickness. As it is cheaper and simpler than treating causes, it is often the first strategy chosen for relief (ibid.: 25). But then, simultaneously or sequentially, in tandem as well as complementary, biomedical treatments are combined with other practices in order to eventually find a cure and increase the chances of recovery (Allen 1998, Janzen/Arkininstall 1978, Jitta 1996). Abundant drug consumption is often the result.

#### 4.5.2. People's Notion of Biomedicine

The medical-pluralist notion reveals the numerous paths of health care seeking and treatment. Hence, the focus of this research on biomedical services only touches upon one section within that spectrum. Yet, as mentioned in the previous chapter, biomedicines have become widely available and gained increasing popularity and acceptance. They have become a crucial component of self-treatment. A "commodification of health" took place, that is, "the tendency to treat health as a state which one can obtain through the consumption of commodities" (Nichter 1989 in Whyte 1997: 211). This has translated into a treatment-seeking pattern of "a pill for every ill" (Adome et al. 1996) and reflects the symptomatic approach of treatment. People desire health, yet they do not (necessarily) demand health care as it is delivered in the formal system (Whyte 1991: 141).

As in other countries, both providers and users have developed a strong preference for injections and antibiotics (Birungi 1994a and the literature indicated there). Pre-existing notions of treatment and medicines provide the basis for the "cognitive appropriation" of new drugs (van der Geest et al. 1990: 183). That is, in the process of cultural re-interpretation, people give meaning to drugs in relation to traditional therapy (Bledose/Goubaud 1988 in Adome et al. 1996, Le Grand et al.

1999: 90). For example, during an "African injection", a common therapy in rural settings,

The skin is cut with a razor or a small knife, and herbal medicine in powder form is applied. ... It is said to increase the effect of the medicine, because it is placed where the pain is, thereby avoiding the slow process of digestion (Adome et al. 1996: 52).

Accordingly, injections are believed to be the most powerful means of restoring and maintaining health (WHO 1991 in Birungi et al. 1994, cf. Le Grand et al. 1999). This is because the injected medicines are delivered directly into the blood stream, which is "best for diseases such as malaria and acute respiratory infections that 'move in the blood'" (Birungi et al. 1994: 4). Birungi (1998) also reasons that Uganda's high level of morbidity (with malaria as the top cause of illness, followed by acute respiratory infections) encourages the overuse of injections.

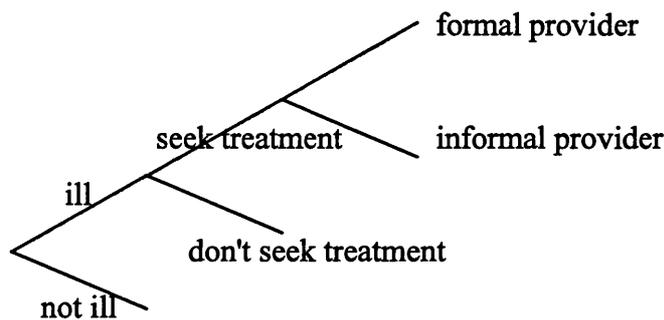
Antibiotic injections are associated with strong improvements in STDs, measles, or pneumonia, and because of their strength they are equally applied for less severe diseases. Since antibiotics are more expensive, there is also the belief that they are better, and the fact that oral antibiotics are 'wrapped' in a container (i.e., the capsule) indicates to people that they must be powerful (Adome et al. 1996: 52). The preferences for polypharmacy is accordingly nurtured by the attitude that a powerful treatment should be composed of many different kinds of tablets and capsules, often crushed together (van der Geest et al. 1990: 184). Asimwe/Lule (1993) argue that the many small private informal clinics and drugshops also pushed this culture in which patients associate good care with the provision of injections and other drugs regardless of medical appropriateness.

#### 4.5.3. Health Care Seeking Patterns in the Biomedical Sector

A number of decisions are taken in relation to seeking treatment, which are summarised in Figure 4.1. The first "decision" is whether to report an illness. The Uganda National Household Survey of 1995/96 revealed an illness-reporting rate of about 30 percent for the lower income quartiles, i.e., about 30 percent of the interviewees reported an illness 30 days prior to the survey (Hutchinson 1999: 20). However, this does not imply that a person will seek treatment in each case of illness self-reporting or at a biomedical provider. Usually, there is an initial period of observation and treatment at home. The second decision is hence whether to seek

treatment. Thirdly, as mentioned above, the patient and the family decide where to go. People would consult household members, near kinspeople and neighbours in order to decide which treatment to choose and in order to mobilise resources. They then shop around between different providers, also depending upon the financial implications of the treatment chosen (Birungi 1994b, Ogden/Bantebya-Kyomuhendo 1996).

Figure 4.1: Treatment seeking decisions



(from Chawla/Ellis 2000)

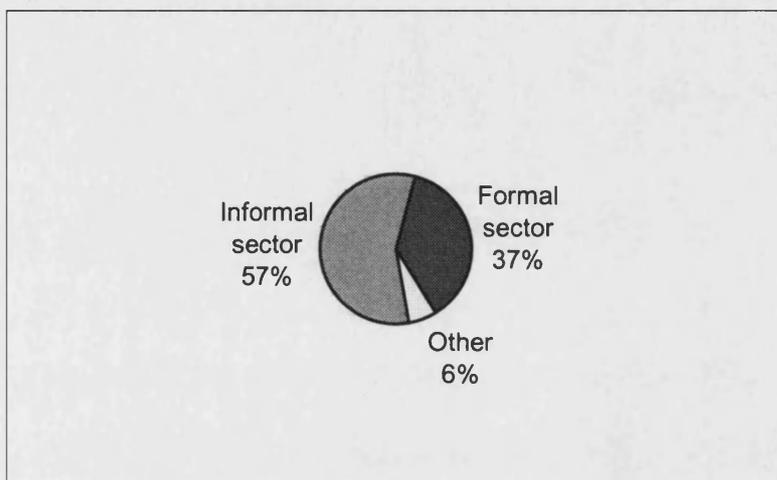
All of these decisions are a result of behaviour intention, which is again shaped by attitudes (expectations about the service as well as experiences of the past), social influences (social norms and support to go or to refrain going to a particular service)<sup>139</sup> and self-efficacy (a person's belief that he or she can use and get the desired service) (Vries/Backbier 1994 in Amooti-Kaguna/Nuwaha 2000). In other words, the factors influencing utilisation encompass qualitative, financial/economic, and cultural aspects, which make choice of treatment contingent upon availability, affordability and acceptability (Jitta 1996: 162). These are also strongly age and gender-specific (Aljunid 1995; cf. Neema 1999, Hutchinson 1999, Wallman 1996 for Uganda).

MoH sources suggest that only 50 percent of the population choose providers within the formal sector, and of those using formal providers, 40 percent use government, 35 percent use private, and 25 percent use NGO services (MoH 1997: 20). The numerical superiority of government facilities for overall Uganda is thus not reflected in utilisation rates of formal curative health care providers. In the Kamuli

<sup>139</sup> This includes intra-community factors, such as kinship or informal safety networks that offer their members support in case of need (Birungi 1994b, cf. Hentschel 1999).

District household sample, use of non-formal providers is even higher, as Figure 4.2 indicates. This seems to be due to the selection bias of this sample towards the poorer households.

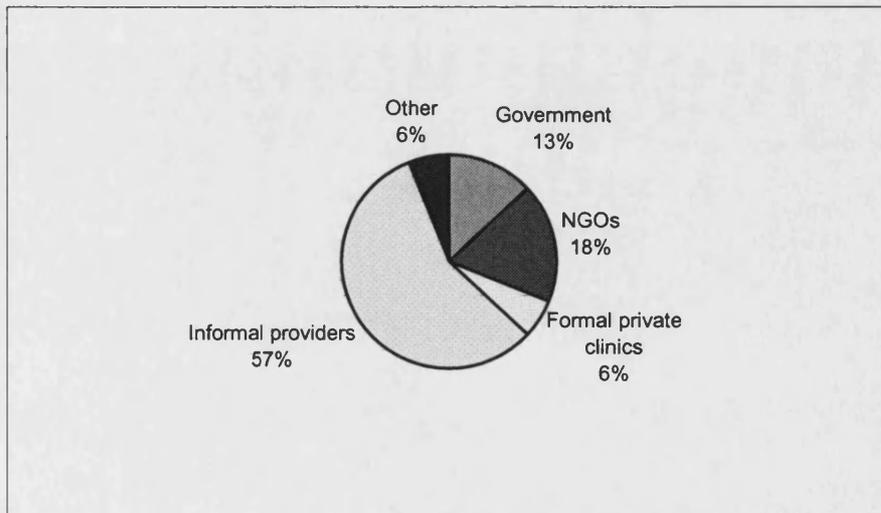
Figure 4.2: Utilisation rates



Source: Household survey

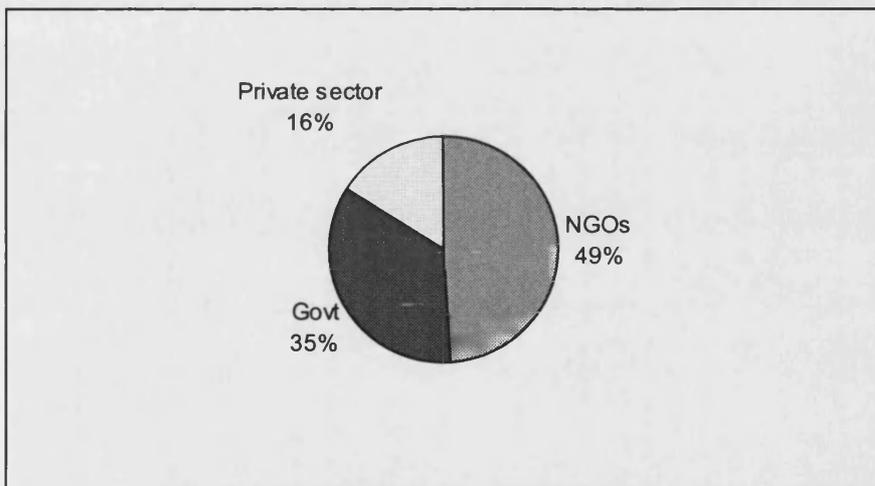
In Kamuli town and the peri-urban area around, people have a choice between various providers, which are all within more or less the same distance, so that the utilisation rates of the different providers can be compared (see Figure 4.3) and particular in the formal sector (see Figure 4.4). This indicates again the predominance of drugshops and informal rural private practitioners and the marginal relevance of the government and the formal private sector.

Figure 4.3: Utilisation of urban and peri-urban household respondents



Source: Household survey, (peri-)urban respondents<sup>140</sup>

Figure 4.4: Utilisation rates in the formal sector of (peri-)urban households



Source: Household interviews

This utilisation rate indicates the high relevance of drugshops in people's health care seeking choices. In order to understand this utilisation behaviour further, a closer look into people's disease perception is necessary. In addition to the differentiation between impersonal and interpersonal causes or African versus White diseases,

<sup>140</sup> DED evaluation data reveals an identical picture for Kamuli Town: in 57% of cases, drugshops and other informal providers were used, while in 43% of cases formal health care providers were chosen (DED data, own calculations).

people also make a distinction between minor and severe diseases.<sup>141</sup> As many studies report, the utilisation behaviour of patients depends upon the specific disease condition (Leonard/Leonard 2000 and the literature indicated there). On the other hand, this differentiation into minor and severe is not clear-cut and also influenced by health beliefs and health knowledge (Jitta 1996, Ndyomugenyi et al. 1998, Hentschel 1999, Adome et al. 1996, Allen 1992, 1998).

Problems that people perceive as rather minor (e.g., minor fever, cough) are treated at home or people would go to the nearby drugshop.<sup>142</sup> They would ask for specific drugs or leave the choice to the drugshop attendant. Too often, people assume and hope that the health problem is only minor. This optimistic pragmatism – hoping to get by without expenditure – appears to be necessary in light of the prevailing high illness rate and the higher costs of going to a clinic or to a higher-level provider in Kamuli town. In fact, 45 percent of the exit respondents interviewed at higher-level providers had first sought treatment at a drugshop or other informal private practitioner. However, people often first use drugshops to relieve the pain whilst trying to look for some money in order to go to a higher-level provider.

In case of a more serious problem where self-medication is assumed to fail or has actually failed, people would rather choose higher-level service providers (cf. Ogden/Bantebya-Kyomuhendo 1996). For example, one respondent said:

"The disease was very serious, so we knew we would waste our time and money in drugshops."

The following quote describes similar motivations:

We eventually go to the doctor should home treatment fail to bring relief 'soon enough'.... The expectation is that the cost of going to the doctor (in terms of time, if not money) will be offset by the satisfactory results: we will get well (Ogden/Bantebya-Kyomuhendo 1996: 142).

Within this rationale of seeking treatment, the urban clinics constitute some form of later or last resort for the rural population if the service provider options in the rural areas fail (cf. Girard/Ridde 2000: 3 for Northern Uganda). People will then spend more money and time on transport and user charges to use the alternatives in Kamuli

---

<sup>141</sup> Indicators for the severeness of the disease include the length of the time the illness takes to be cured, response to oral therapy, whether the sick can still work or not, body temperature and loss of appetite (Birungi 1994 et al.: 9, cf. Jitta 1996: 158).

<sup>142</sup> Cf. Ogden/Bantebya-Kyomuhendo (1996) for a discussion on the household as a locus of health care and the nature of the home treatment process.

town, where the range of services is larger and the staff is more qualified. This occurs largely on a self-referral basis, as many patients do not bother to go to the rural government clinic, but choose to go directly to an urban provider. This discrimination between different providers according to the patients' understanding of diseases has been observed all over the world (Hentschel 1999; cf. K. Leonard 2000 for Tanzania and Cameroon).

As a result of this disease discrimination, people "pingpong" and shop around. They use a number of different providers when seeking treatment, which could be noted among 40 percent of the household respondents, both the poorer and better-off ones. Likewise, only 60 percent of the exit respondents were familiar with the health care provider, whereas 40 percent of them were first-time users.<sup>143</sup> Because of the informality of service provision, the absence of an insurance system (which may link a patient to a provider) and the low technology health production, exit and transaction costs of shopping around are in fact low. Many people pingpong around to find a place that suits them better than the previous ones visited, in terms of both costs and successful curing. Shopping around is very essential, because the patient often does not get cured the first time. Hence shopping around recovers the trial-and-error practice of many providers (see Chapter 6) and influences the treatment seeking behaviour the next time the same disease occurs.

#### 4.5.4. Preferences and Utilisation Factors for Treatment Seeking

Having provided a general picture of people's health care seeking behaviour and their disease perception, we can now look more closely at the specific preferences and priorities that determine people's choices of one provider over another. In fact, patients know where and within what quality range they can get treatment in rural areas. Similarly, K. Leonard (2000) notes that the sick (or in fact husbands and mother-in-laws) make active choices between the options.

People's reasons and criteria for choosing one provider rather than another were identified by asking focus groups and household respondents about their preferences among health care providers.<sup>144</sup> More than three fourths of the exit respondents stated

---

<sup>143</sup> McPake et al. report an even higher rate (75 percent) of first time users (ibid. 1998: 18).

<sup>144</sup> For similar studies that analyse patients' provider choice, cf. Lavy/Germain 1994 and the literature listed in Leonard/Leonard (1998: 7).

an explicit and positive reason for having chosen the health care provider. The most frequent and important factors mentioned were quality, price, distance, and staff behaviour. Likewise, their understanding of quality services could be further understood. This includes:

- Successful and quick curing;
- Price, financial accessibility, cost security;
- Value for money;
- Provision of credit;
- Positive experience made in the past;
- Qualified staff;
- Drug availability and quantity (in types) of drugs;
- Physical access;
- Staff behaviour and commitment;
- Waiting time;
- Examination of the patient; and
- Trust and confidence in the service provider, friendship, and risk perceptions.<sup>145</sup>

NGO and private practitioners add privacy during examinations and confidentiality about diagnoses as another important aspect that affects people's choice.<sup>146</sup> People's derived preferences and criteria are clearly oriented towards observable outputs, which refers to getting adequate treatment and drugs in a comfortable environment, while the outcome effect of curing and recovery is implicitly expected. Obviously, each person weights and applies these factors differently, depending on previous experiences, ability to pay and future expectations. Overall, however, the household survey revealed that quality of services is valued most – and far above price – in deciding where to go<sup>147</sup>: 82 percent of respondents ranked quality first versus 14 percent for price.<sup>148</sup> Thus, quality is most decisive in

---

<sup>145</sup> For similar preference identification, cf. Haddad 1998; for Uganda, Ndyomugenyi et al. 1998 and Okello et al. 1997; for methodological reflections, cf. Hentschel 1999.

<sup>146</sup> Being a delicate aspect, particularly because of the high prevalence of STDs, privacy was not explicitly named by the communities. For the results of a discussion process on relative strengths among all NGOs in Kamuli District, cf. Mathauer (2000).

<sup>147</sup> Respondents were asked which factors were most influential in choosing one provider rather than another.

<sup>148</sup> This is similar to what K. Leonard (2000) for Tanzania and Chawla/Ellis (2000) for Niger find.

determining acceptability and utilisation. Distance, closely followed by staff behaviour, comes last. It is clear that these verbally articulated preferences (attitudes) of what respondents consider as most important might not necessarily be as clear-cut in people's actual behaviour and choice when seeking treatment in light of the interaction between attitude, social influences and other (situation-specific) factors. Further, this ranking process is affected *inter alia* by the present financial situation and the location of a household. For example, if people live nearby a health care provider, distance is not considered and valued consciously.<sup>149</sup> In contrast, long travelling times imply opportunity and travelling costs and increase the total costs for treatment. Likewise, not only are the absolute costs decisive, but also the income of the user as well as cross-price elasticity (cf. Griffin 1988, Aljunid 1995, Abel-Smith/Dua 1988). In many cases, people have to make trade-offs between these preferences, which will be further illuminated in the following two chapters.

The identification of people's preferences and factors for provider choice served to ensure that these are included in the relative strengths and performance criteria. In Chapter 2, these were anticipated as access, efficiency (of staff resource utilisation) and quality of care. In fact, these go hand-in-hand with people's views, but as expected, efficiency considerations are not mentioned, as they are not of concern to the consumers. Chapters 5 on accessibility, 6.1 on efficiency of staff resource utilisation and 6.2 on quality of care will further elaborate the understanding and operationalisation of these performance criteria by integrating people's indicators. The providers' performance will then be compared along each criterion and indicator.

---

<sup>149</sup> The sample selection could not control for absolutely equal distances and incomes.

## Chapter 5

### Unequal Accessibility to Health Care Providers

An organisation is superior in service provision if it performs best in the main performance criteria of efficiency (of staff resource utilisation), quality of care and accessibility, the choice of which has been explained in Chapter 2. Efficient and quality services are of no use if people, especially the poor, are unable to use them. This chapter compares the accessibility of the different provider types.

It is important to note that accessibility is only an intermediate indicator for a health care system's ultimate objective of fair financing of health care in order to avoid impoverishment through seeking health care (WHO 2000).<sup>150</sup> This also implies that the health care system provides access to a basic package of services to those unable to pay when in need, thus guaranteeing horizontal equity (equal access for equal needs).<sup>151</sup> While absolutely equal access is unrealistic, it is nevertheless a goal to strive for in a health care system. The other objective of fair financing is to achieve greater equity in health, which is one of the major concerns in developing countries. This is based largely on the notion that health is an intrinsic value and everybody should enjoy it (WHO 2000, World Bank 1997a, DFID 1999). Poverty and ill health are correlated, i.e., the poor are in greater need of health care. It is therefore even more important to address fair financing.

Since this analysis compares provider performance and their output and since health outcome is not determined by a single health provider intervention, access to providers is the appropriate indicator to examine this aspect. Access is in fact a widely used indicator for this subject.<sup>152</sup> Hence, the providers will be compared on the basis of whether people have access and whether the poorest of the poor are equally able to access adequate services. The assessment will also use qualitative

---

<sup>150</sup> Fair financing means that "the risks each household faces due to the costs of the health system are distributed according to the ability to pay rather than to the risk of illness" (WHO 2000: 35).

<sup>151</sup> Need can be understood as self-reported morbidity (Waters 2000: 600). While this approach is commonly used, it may not truly reflect inequalities, since the poorest may be less likely to acknowledge that they are sick, and when illness is reported, they may be less likely to decide to seek treatment (cf. Birdsall/Hecht 1997: 350).

<sup>152</sup> Cf. Green 1992, Mills 1997b, Birdsall/Hecht 1997, Baker/van der Gaag 1992, Coulibaly/Diallo 2000, Girard/Ridde 2000, Puentes-Markides 1992, Waters 2000 (and the literature indicated there). Note, however, that access to services in general registers less inequality than health status indicators (Birdsall/Hecht 1997).

evidence of people's ability to pay, although a systematic study of people's ability to pay was beyond the focus and scope of this analysis. Ability to pay is a complex concept, as it is not congruent with utilisation or demand but is also related to the opportunity costs of payment strategies. For example, people may utilise a service whilst foregoing other fundamental expenditure on food or education, sell assets or get into debt (McPake et al. 1993, Russell 1996).

The focus is on financial access, but this is not to ignore that access is also determined by cultural and institutional factors, such as disease notions and the providers' behaviour, which affect a patient's decision of whether and where to seek treatment, if at all (Puentes-Markides 1992). (Financial) access is also gendered and determined by age (Ojanuga/Gilbert 1992; for Uganda, cf. Hutchinson 1999, Wallman 1996, Obbo 1991, Neema 1999).<sup>153</sup> Further, MCPake et al. (1993: 856) note that it only makes sense to talk of access to services when these are at least of some minimal level of quality. Functional access, namely the existence of the required adequate services, will be dealt with in the next chapter on quality of care.

Before comparing financial accessibility to providers, it is important to provide an overall idea of people's total expenditure and medical expenditure (Section 5.1). To assess financial accessibility to providers, particularly for the poorest, the following aspects will be examined:

- Payment procedures (Section 5.2);
- Total direct costs incurred by the patient to get a consultation (where available) and treatment (Section 5.3);<sup>154</sup>
- The extent of informal charges (Section 5.4);
- Exemption practice (Section 5.5);
- Deferral payments (Section 5.6);
- Physical accessibility (transport means and costs) (Section 5.7); and

---

<sup>153</sup> Given the focus on comparing provider types, an intra-household differentiation between sexes was omitted.

<sup>154</sup> Due to time and resource constraints, it was impossible to carry out an opportunity cost study that would include, for example, the value of lost labour time, whilst seeking treatment or attending a patient. However, waiting times were compared, which also constitute opportunity costs for people and hence a crucial factor in people's perception of service quality (see Chapter 6.2.4).

- Utilisation rates and expenditure patterns at the various provider types compared between poorer and better-off people (Section 5.8).

Some of these aspects are also contingent upon the negotiation power of the patient, expectations of both the patients and the staff, and staff behaviour and incentives. Furthermore, there is also a relationship between various aspects of access and the received quality of care (Puentes-Markides 1992). This chapter will point to these connections and the possible trade-offs between accessibility and quality, which will be further elaborated in Chapter 6.2 on quality of care. The final section of Chapter 6 then concludes with the overall attribution of relative strengths. In discussing the results of the comparative performance analysis in this and the following chapter, the providers' incentives and disincentives will constantly emerge as a critical issue. How these incentives are shaped will then be examined more thoroughly in Chapters 7 and 8 by means of an institutional analysis to explain provider performance.

### **5.1. Household Expenditure on Health Care**

Private out-of-pocket household medical expenditure per month stands at US\$ 6,064 for the total population of Kamuli, at US\$ 9,528 for the richer part and at US\$ 3,675 for the poorer half of the population in Kamuli. In comparison, the national average amounts to US\$ 6,389 (1999 National Household Survey Data, in World Bank 2001b). This must be set against the total household consumption expenditure of US\$ 128,493 (total of Kamuli population), US\$ 77,238 (poorer half of the population in Kamuli), and US\$ 153,209 (national average). My household survey results from Kamuli indicate an average expenditure of US\$ 3,691 per household per month in 1999. The poorer group spent US\$ 3,357; the better-off group US\$ 4,129. Figure 5.1 shows where the household respondents spend their medical expenditure.<sup>155</sup>

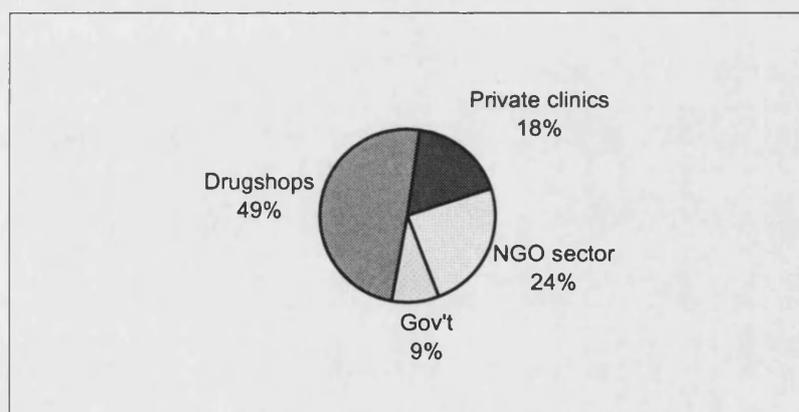
The problem with out-of-pocket expenditure is that it is usually regressive if no sliding scale is built in user charge rates and particularly if exemption is not

---

<sup>155</sup> Household expenditure is normally distributed.

adequately applied (cf. Fabricant et al. 1999: 179). This regressivity is also found in the 1999 National Household Survey data (4.2% of the poorer half versus 4.8% richer half in Kamuli), but in relation to actual household expenditure, the health care expenditure share is likely to be much higher and hence much more regressive. However, in comparison with 1995 household data, the gap between the two groups has reduced (MFEP1995, Table 11.02). Nevertheless, the question arises how people mobilise money to cover the costs for health care expenditure. One study in Uganda found that 49 percent of people make claims on kin or other households and borrow, whereas 15 percent use, sell, or pledge stores and assets; another 29 percent use a combination of these (McPake et al. 1992 in Russell 1996: 230). Girard/Ridde (2000) also report these strategies for Northern District, some of which cause impoverishment.

Figure 5.1: Household out-of-pocket expenditure at the health care providers



Source: Household survey

## 5.2. Payment Procedures

As said, there are no insurance or prepayment schemes in place in Kamuli District. All provider types charge a fee for service – either a flat user fee before attendance or user charges at the end of the delivery process (see Table 5.1). The Hospital OPD and one private clinic use a combination of the two. Laboratory charges are paid at the point of delivery at all places.

Table 5.1: Official payment procedures for outpatient curative care

	Government clinics	Private and NGO clinics	Hospital OPD
<b>Time of payment</b>	Before attendance: Registration fee (Drugs theoretically included in the fee)	After attendance: User charges  One urban private clinic: Before: Consultation fee	Before attendance: Registration fee  After attendance: Drug charges
<b>User fee/charge pricing structure</b>	Flat rate (varies across clinics)	- Drugs: based on the amount and types (consultation fee included) <sup>156</sup>	- Registration: flat rate - Drugs: based on the amount and types

The crucial difference at NGO and private clinics, mainly psychologically, is that people are examined before being asked for money. Payments are made in exchange for and upon receipt of treatment and drugs. On the other hand, this makes it difficult to pre-estimate the costs. Also, in contrast to government clinics where people pay informal charges at various points (see below), at the NGO clinics "you pay only once, there is no bribing" (FGD Subcounty B, 1999), i.e. once the provider announced the costs, it is a fixed payment. While there is more transparency in payment procedures, user charges themselves are less comprehensible and transparent to patients that use NGO and private clinics. But what really counts for people is that charges are set and fixed during the transaction.

User charges and payment procedures are not displayed at some government units, nor is this information or the drug prices displayed at the hospital OPD, the private clinics or at most of the NGO clinics.<sup>157</sup> Thus, none of the payment schemes offers real price transparency in practice, and it is difficult for patients to find out the correct charges. The payment procedure has a strong impact on the perception of access. The "consultation before payment" scheme creates trust, even though the patients know that they must bring money, whereas at government clinics, the patients always feel insecure, since they do not know whether they will get drugs or not.

<sup>156</sup> Private practitioners include a consultation fee, which is concealed by either adding a lump sum of about US\$ 1,000 on top of the drug costs or simply by having higher drug charges.

<sup>157</sup> Bennett et al. (1995) note that consistent policy implementation requires fee schedules to be displayed at facilities.

People resented the introduction of user fees at government clinics arguing that they do not get drugs and that they pay double, since they already have paid graduated taxes. Their demand on government provision is that it should be "free". Apart from dissatisfaction with services (see Chapter 6), the memories and standards of the earlier days of (officially) free government services still play a strong role in shaping today's perceptions, at least among the older generation, even though informal payments had already been charged before the 1970s (Fallers 1965). Yet there is reason to challenge people's notion. The introduction of user charges is also related to the fact that local and national taxes provide a very limited basis for funding social services, given the low local tax levels and very low collection rates in light of people's unwillingness to pay taxes.<sup>158</sup> Furthermore, it must be emphasised that there is nothing new about paying for health care. Church and NGO facilities have a long tradition of user charges, and neither do people usually mind paying at these places.

### 5.3. Financial Costs

This section compares and assesses the financial costs directly incurred by patients at the various provider types. Data was gathered through record book analysis, household and exit interviews, and focus group discussions.<sup>159</sup> Costs incurred at the different provider types are displayed in Figures 5.2 and 5.4. The relative cost differences are similarly reflected in the data on costs for one particular disease (adult malaria episode) (see Annex 5, Tables 1-2, Figure 1). While case mixes may not be fully identical, they seem to be comparable among providers, which thus allows for cost comparisons.

---

<sup>158</sup> Graduated tax rates are regressive, and collection methods are inconvenient in the context of local circumstances, and they are collected by force, which in sum increases their very negative image even further (Livingstone/Charlton 1998, Mathauer 1997, 1998). This lowers the willingness to pay directly for government services.

<sup>159</sup> Exit and household interview data are indicative and subject to verification and validity difficulties (cf. Annex 1.10).

## Rural clinics

Overall costs incurred at rural providers are presented in Figure 5.2, whereas Table 5.2 indicates the official user fees at government clinics.

Figure 5.2: Costs at rural health care providers (in US\$)

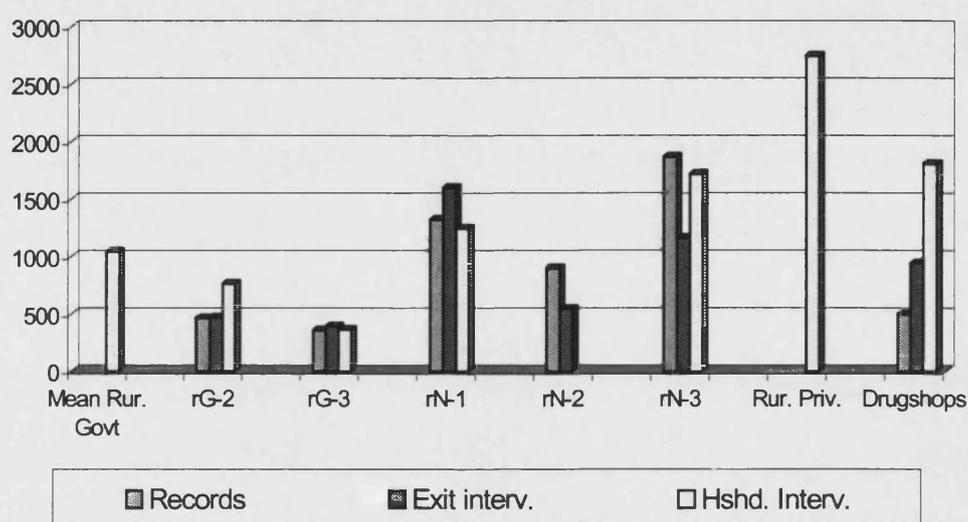


Table 5.2: User fee rates at rural government clinics (in US\$)

	rG-2	rG-3
<b>Adult: 1st visit</b>	500	500
<b>re-attendance</b>	500	250
<b>Child: 1st visit</b>	200	200
<b>re-attendance</b>	200	100
<b>Laboratory test</b>	300	no laboratory

The government clinics' official costs per se are low in comparison to the other clinics. Yet the considerable differences between the data sources (record book analysis, exit and household interviews) indicate that people also pay informal charges, particularly in light of the high number of child patients in the sample, whose official user fee rate is lower than that for adults.<sup>160</sup> These informal charges

<sup>160</sup> Cost statements of exit interview data for the most part do not include informal charges, possibly because people felt uncomfortable talking about it near the clinic. Also, health workers seem to have refrained from asking for informal charges during the researchers' presence.

serve to help the patient get attended to, get a lab test (fee-for-service payments) or to obtain (some) drugs (fee-for-commodity payments).<sup>161</sup> These informal charges often exceed the user fees threefold, as Table 5.3 indicates.

Alternatively, or even additionally, patients are often told to buy (some of) the prescribed drugs at the drugshop instead of receiving them at the clinic (for drug availability, see Chapter 6.2.1). Thus, most people either have to pay informal charges or else pay for drugs later in drugshops. Only a third of household respondents (16 out of 51) that used government clinics did not incur costs in addition to official user fees.

Based on the local average prices, a drug purchase at a drugshop costs a modestly estimated US\$ 300 for a simple malaria episode (Panadol and Chloroquine) and US\$ 1,300 for a treatment including antibiotics and Panadol. Given the widespread polypharmacy practice, costs for drugs are much higher in reality, as the household responses reveal, averaging US\$ 2,158 (see Table 5.3).<sup>162</sup> In sum, adding up user charges, informal payments, and/or costs for drugs may come to an approximate amount of US\$ 2,000 to 3,000 for rG-2 for example.

Table 5.3: Additional costs incurred at rural government clinics and respectively at drugshops due to non-availability of drugs at government clinics (in US\$)<sup>163</sup>

	rG-2	rG-3	Other rural gov't clinics
<b><u>Informal charges</u></b>			
Exit respondents	1,000–1,500	not reported	-
FGD	2,000, 5,000 <sup>164</sup>	not reported	1,000–2,000
Household respondents	1,000–1,500	500; 1,000	N/A
<b><u>Drug costs at drugshops</u></b>			
Estimation by price list	300–1,300	300–1,300	-
Household respondents	2,158 mean (n=19)	N/A	-

<sup>161</sup> Cf. Killingsworth et al. (1999) for these payment categories.

<sup>162</sup> Further research could analyse the average amount that people spend for the government clinics' prescriptions at drugshops.

<sup>163</sup> These are rather indicative, given the small number of cases in which the additional payments could be traced.

<sup>164</sup> This latter figure includes a bribe for inpatient services, which are higher than those for the OPD.

Based on the drugshop observation study, the average amount spent per visit is about US\$ 500, excluding those clients who just came to buy some aspirin for their stocks at home. The average amount paid per *visit* was US\$ 942 (exit interviews) and US\$ 1,835 for *illness episodes* (household interviews).<sup>165</sup> One special feature of drugshops is that a patient can buy any quantity of drugs, whether full dose or not, and decide upon the amount of money to be spent. In the exit interview sample, only 25 up to possibly 40 percent of clients decided upon the amount to be spent, while in 60 percent of the cases the drugshop attendant decided on the drug package and the amount.<sup>166</sup> Yet, in those cases where the patient left the decision on the amount to the owner, the average charges double, amounting to US\$ 1,030 (drugshop observation) and to US\$ 2,072 (exit interview sample), due to the incentive to the drugshop attendant to sell as many drugs as possible.<sup>167</sup>

Figure 5.2 does not indicate a clear price order along sectors. However, since provider choice does not exist across catchment areas, comparisons of the patients' costs are more meaningful within a Subcounty (see Figure 5.3). Combining this with the previous evidence of Figure 5.2, and Tables 5.2 and 5.3, in Subcounty A the government clinic *may* be the most inexpensive option if the patient does not have to pay informal payments and buy additional drugs. Otherwise, drugshops constitute the less costly alternative, particularly if the patient decides on the amount to spend. Rural private clinics are the most costly option. Yet the example of this government health centre shows that health workers demand informal payments almost up to the same level as private rural clinics, i.e., up to what the market will bear. In Subcounty C, the government clinic scores best, followed by drugshops. rN-3 is more costly than these two options, but still less expensive than private clinics.<sup>168</sup> In Subcounty B, the

---

<sup>165</sup> The differences are related to the different sample selection procedures of drugshop users. For the exit interviews, I was interested in *patients* and excluded customers who bought some aspirin or Panadol for their home storage. In contrast, household respondents presumably only remembered the severe incidents. In those instances, the treatment and related costs were presumably decided mostly by the owner or based on a government clinic prescription.

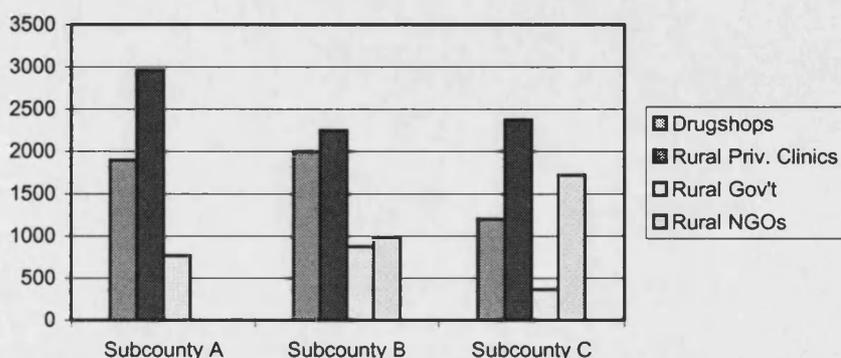
<sup>166</sup> In the drugshop observation study, almost two thirds of customers chose the types of drugs. Again, this large difference is due to the different sample selection procedures.

<sup>167</sup> Nonetheless, the owner would put together a drug package in accordance with his or her assessment of the customer's ability to pay (cf. Whyte 1991).

<sup>168</sup> Intra-Subcounty differentiation reveals enormous differences among drugshops: average charges at those near to the government clinic stand at US\$ 680, while those near rN-3 at US\$ 1,500. This shows again that alternative providers ask up to what the market will bear. It also qualifies the seemingly high prices at rN-3.

order is similar to that of Subcounty A. The Protestant clinics are on the lower end, followed by drugshops, with private clinics being most costly.

Figure 5.3: Cost comparison within Subcounties



Source: Household interviews<sup>169</sup>

(Costs at government clinics include informal payments, but not additional costs for drugs at drugshops.)

### Urban clinics

Figure 5.4 indicates that there are also considerable price differences among the urban providers.

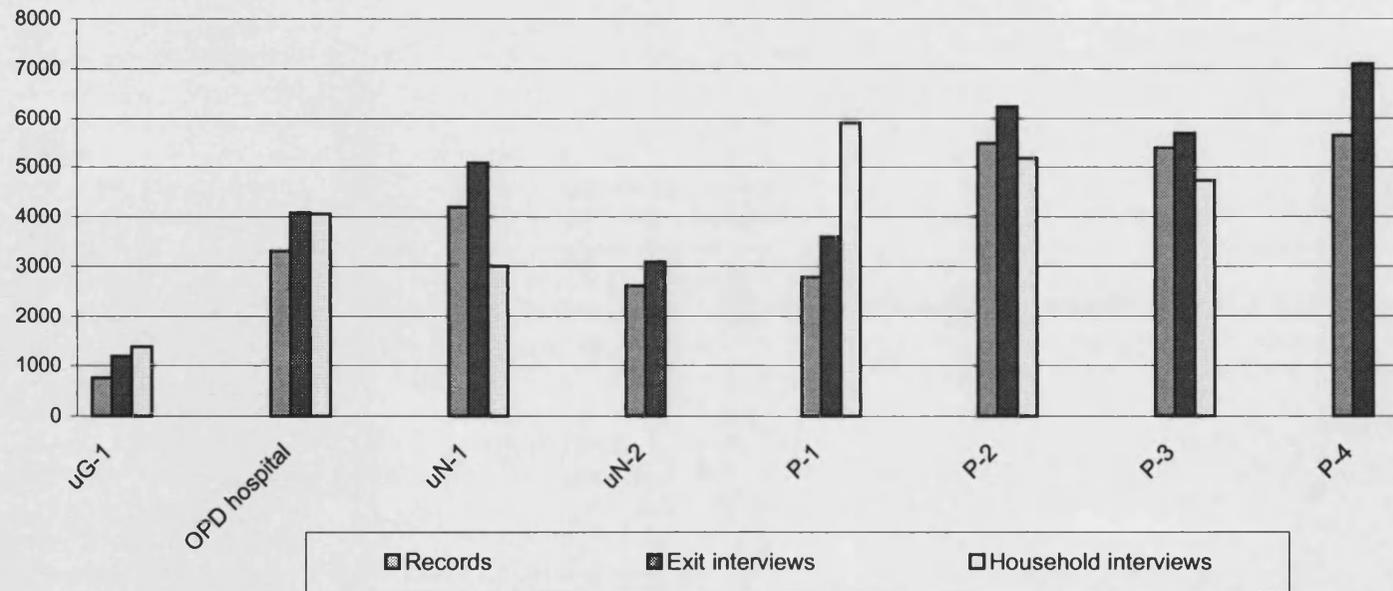
Overall, private clinics' user charges are clearly located at the higher end of the price spectrum, closely followed by those of the NGO clinics.<sup>170</sup> Controlling for the case mix, the hospital's charges are also low overall.<sup>171</sup> The urban government clinic is also at the lower end. However, as for rural government clinics, the clinic's official fees (see Table 5.4) stand in stark contrast to costs reported in the household interviews. Costs are hence only low if there are no informal payments or additional

<sup>169</sup> There is no government clinic in Subcounty B, but household respondents in Subcounty B had used rural government clinics of neighbouring Subcounties or the urban one in Kamuli town.

<sup>170</sup> The mean payments reported in Tibandebage/Mackintosh (1999) for Tanzania also reveal private clinics as being most expensive.

<sup>171</sup> Average patient costs are high, because the hospital OPD deals with more difficult and severe cases. These require more laboratory examinations and more expensive drugs, which increase the bill.

Figure 5.4: Costs at urban health care providers



drug costs at drugshops, but these may rise up to US\$ 2,500–3,500 (see Table 5.5). Again, costs are lowest at drugshops, where the patient usually decides upon how much to spend.

Table 5.4: User fees rates at urban providers (in US\$)

	uG-1	Hospital OPD	1 private clinic (exception)
Adult: 1st visit	500	500	2,000
re-attendance	-	-	(consultation fee)
Child: 1st visit	500	500	
re-attendance	-	-	
Laboratory test	1,000	1,000	
		(simple test)	

Source: User fee schedules

Table 5.5: Additional costs incurred at the urban government clinic and respectively at drugshops due to non-availability of drugs at government clinics(in US\$)<sup>172</sup>

	uG-1
<u>Informal charges</u>	
Exit respondents	1,000
FGD	1,500–5,000
Household respondents	500–2,000 (mean: 1,028; n=9)
<u>Drug costs at drugshops</u>	
Estimation by price list	300–1,300
Household respondents	400–6000 (mean: 2,300)

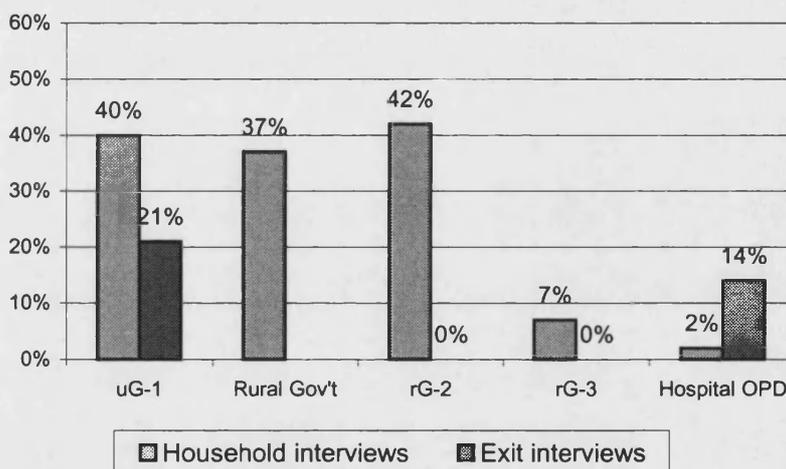
Overall, the price spectrum is wide, with the higher end of the spectrum being ten times lower in the case of malaria treatment, for example (see Annex 5, Figure 1). The different user charges reflect the different ways of financing and unequal subsidisation of clinics as well as the different profit margins of non-state clinics. The implications of these different user charges in terms of accessibility in relation to other access factors will be discussed in the last section of this chapter.

<sup>172</sup> As noted above, these must be taken as indications, given the small number of cases in which the additional payments could be traced.

#### 5.4. Informal Charging and Irregularities

Figure 5.5 provides some indication on the extent of informal payments at the hospital OPD and government clinics by counting the number of patients who had paid more than the official charges. In general, as the issue of informal payments was perceived as delicate, it was difficult to get information on the extent and amount of informal charges. Some respondents were reluctant to reveal their informal payments, whereas others did not know whether they had paid informal charges.<sup>173</sup> For example, one pregnant woman had been misled and was convinced that "those with pregnancies pay more money" (i.e., a higher user fee).

Figure 5.5: Extent of bribing



At rural government clinics, the differences between the percentage of exit and household interviewees shows that the former either did not want to tell us, or were not even aware that they had paid more than the official charge. Most probably, my and the research assistant's presence at rG-2 made the staff not ask for informal payments on those days. Yet the household interviews reveal that there is a high incidence of informal payments at government clinics, most often at the laboratory or the drug-dispensing window. Around 40 percent of patients paid informal charges at

<sup>173</sup> Killingsworth et al. (1999) note for Bangladesh that informal payments have naturally been integrated into the procedures. This is also the case in Uganda, and so the number of people who are not aware of paying informal charges is much higher.

government clinics, except rG-3.<sup>174</sup> All focus groups except those in Subcounty C complained, and the discussions confirm the very high prevalence and the amount of informal charges paid. The following quote from a female household respondent illustrates this point:

"If you have money, you get treatment, *depending* on the illness. They [health workers at government clinics] continue to ask for money, so it must be 'chai' [= 'tea' meaning bribe]. For immunisation [which is officially free], it is 500 Shillings, otherwise you don't get it" (my emphasis).

A common view of the focus group participants and the household respondents was that access to care (a consultation and drugs) depends upon the amount of money available at the time of illness. One focus group discussant stated that the amount of the bribe is negotiated. Health workers do not always necessarily explicitly ask for bribes,<sup>175</sup> but informal payments are also implicitly asked for and expected and enforced through rude behaviour (cf. Asiimwe et al. 1997b). Thus, people may prefer to avoid such negotiations, as these can be painful and abusive. The succeeding statements also suggest that health workers exploit emergency situations to increase the amount of informal payments:

"If the fever is high, it is 4,000. But we cannot refuse, because we get abused."

"The nurse touched the child and realised that it was very sick. She then rebuked me [for not having come earlier]. Then, a bit later, the child died in my hand, and they abused me. I really don't know why they were rebuking. They didn't examine the child, they wanted money."

As noted above, since user charges are often not displayed at government clinics, it may be difficult for patients to know the official costs and hence their bargaining position as regards the amount of the bribe. As we will see in Chapter 7, however, people refrain from arguing with the health workers due to fear for negative consequences. So, even if patients know the official user fee rate, they are unable to question the staff behaviour. Not only are informal charges problematic as regards financial access. The respondents' statements also revealed that the variance in

---

<sup>174</sup> In-patients make up the largest share of paying informal charges. These figures are similar to those found in the study of McPake et al. (1998, 1999) in two other Districts of Uganda. The Uganda National Integrity Survey of 1998 found that 28 percent of health care service users paid a bribe, but also mentions that because of underreporting, this figure may be actually higher. Health is thus the third most affected sector for corruption (CIETinternational 1998).

<sup>175</sup> The local expression for this is: "Have you brought your kin with you?"

payment increases insecurity and undermines trust and the perception of quality (cf. Hentschel 1999: 77 for other countries). In fact, many respondents did not choose government clinics because of the user charges *and* additional bribes that are unpredictable in the amount, while these payments still do not guarantee the provision of drugs. Although bribes are seen as illegitimate, people still consider them as a normal and inevitable part of the health care transaction, as in other transactions with the state, given the low salaries and unreliable salary payments (cf. CIETinternational 1998). Ultimately, however, in Uganda as in other African countries, informal charges and corruption are only a hurdle to access and do not lead to increased quality (ibid.; cf. Leonard/Leonard 1999: 10). A final point is worth noting. Given that informal charges are so widespread and normal and a "formal" part of the patient-provider transaction at government clinics, the question raises whether the term "informal" is still useful to grasp what is happening on the ground.

At the hospital OPD, none of the interviewees' responses indicated informal payments.<sup>176</sup> Yet there are some few irregularities at the drug-dispensing window. Even though patients had paid for their drugs, they did not get all types of drugs (for further elaboration, see Chapter 6.2.1). While these incidents are not informal payments in the strict sense (i.e., an additional payment to get a service), the result is the same, namely additional costs for the patient and additional income for the health worker.

It is much more difficult to identify irregularities at the other provider types. At those few private and NGO clinics, where patients do not get a receipt, it is very difficult to tell whether employed health workers inflate the bill to put the difference in their own pockets, as there is no fixed user charge. However, this is very unlikely, because employees would fear for their jobs. Although in no way comparable at all to the extent of the practice in government units, one nursing aid was found to engage in

---

<sup>176</sup> In-patients, however, pay "chai" in the wards to make the staff more willing to look after them. Likewise, supposedly free blood donations are sold (focus group discussions, 1999, personal communication with DED health workers). In the past, one of the dentists, who previously worked in a government clinic, used to charge informal payments, until this was discovered (interview, hospital staff, 1999). One key informant pointed out that OPD staff may work with two receipt books, opening up opportunities for additional charges. While this is possible, it could not be confirmed.

raising informal charges at a rural NGO clinic. According to her, she has not received any remuneration at all for her work for several months and therefore charged an additional USh 300 for antenatal care for her own pocket. Furthermore, during the "healthy person" test, where a healthy young adult visited all urban clinics and pretended the same combination of diffuse symptoms (cf. Chapter 1.4), it was found that one NGO and two private clinics had only pretended to have carried out a laboratory test for which the patient was charged, a common practice according to the DDHS (interview, 1999).<sup>177</sup> The result is an inflated patient bill without reciprocal service. All in all, NGO staff and private practitioners also attempt to increase their income through additional patient payments, even though to a much lesser extent than government health workers.

### **5.5. Exemption Practice**

Exemption is the cornerstone of any user fee policy. In light of the existence of (high) user charges, exemption mechanisms gain particular relevance for the poorest and the chronically sick who may find difficulties in paying the user charges and thus be excluded. Against this, it was found that only few clinics offer exemption for the poor, as Table 5.6 shows.

In the government clinics, there is a gap between policy and practice. Officially, government health units should exempt 25 percent of the patients (McPake et al. 1999: 853). This group should include AIDS and TB patients and the very poor, but what constitutes this latter group is not specified (cf. Girard/Ridde 2000: 4). Exemption is supposed to be granted either upon presentation of a certificate from the LC1 chairperson or at the discretion of the in-charge or other staff.

---

<sup>177</sup> The private practitioners were apparently certain in their diagnosis (clinical malaria). They took a blood sample, but did not deem it necessary to carry out a laboratory examination and just told the patient that the test was positive. The tests at the other providers on the same day (within two hours) had a negative result.

Table 5.6: Exemption policy and practice

	Policy		Practice
	Exemption provided	Who	Percent of total # of patients exempted
Government	Yes (to 25%)	Poorest, AIDS and TB patients	< 1% (poorest)
Rural Protestant clinics	No	-	-
Catholic clinic	Yes	Poorest, orphans, widows	6%
Rural private clinics	No	-	-
Urban NGO clinic 1	Yes	Poorest	2%
Urban NGO clinic 2	No	-	-
Private clinics	No 1 exception	Exception: chronic patients (pay consultation fee once)	N/A
Mission hospital OPD	Yes	Chronic patients (no registration fee) HIV patients (free drugs)	N/A
Drugshops	No	-	-

Source: Record books; interviews with health workers

"The patient tells you the story, then the staff exempts" (interview, nurse rG-3, 1999).

"The medical assistant looks at the patients, he knows the poor ones" (interview, HUMC chairperson rG-1, 1999).

The following observed incidents during the exit interviews illustrate that this discretion is not applied with generosity:

A poor looking, sick woman had walked for approximately three kilometres to the health unit, where she then waited for one and a half hours to register, only to be told that she lacked US\$ 100 to pay the full user fee amount. She was sent away and told to come back on the following day with all the money.

A terribly poor, very old man, with only two pieces of rags on his body and no shoes, had been beaten up by his neighbours. He was in pain and wanted to get a medical report to report the case to the police. Nonetheless, he had first felt to organise and borrow US\$ 500 from the LC1 Secretary for Defence in order to be attended in the health centre.

As exemption records are rarely available, it was difficult to get an exact indication of how many patients were exempted, but it is in any case very much

below the policy guideline. In the urban government clinic, a nurse and a nursing aid estimated 3-5 exemptions within three months, out of 800 patients per month.<sup>178</sup> Likewise, despite the intentional bias within the household interview sample towards the poor, exemption either upon presentation of a certificate or at the in-charge's discretion was rarely found (cf. Girard/Ridde 2000: 4 for a Northern District).<sup>179</sup> Only in Subcounty C, one household respondents had an exemption certificate; one other patient was exempted, because he was related to the staff.<sup>180</sup> Equally, AIDS patients report that they do not get free services at the urban government clinic contrary to the official exemption policy. In violation to the official exemption regulations, it was found that government health workers' relatives beyond the nuclear family, councillors and other office holders get free services. Also, HUMC members often request free services (FGDs 1999; interviews, HUMC member rG-3, 1999).<sup>181</sup>

There are several reasons for the gap between the exemption policy and practice. First, the policy itself is not clear enough to the staff. Second, as user fees and additional informal charging constitute important income sources, the staff is not interested in exempting patients.<sup>182</sup> Since it is difficult to get services without the payment of informal charges, which are enforced by rude and abusive staff behaviour, patients dare even less to come to the clinic with no money in hopes of getting free services. As a result, few patients ask for exemptions, leading to self-exclusion. The same phenomenon is found in Tanzania (Tibandebage/Mackintosh 1999). Furthermore, if a person presents a certificate to claim exemption, it is assumed that he or she may be treated in such an unfriendly manner as to deter him or her from coming back again. During the household interviews, some very poor households with sick members were found who did not seek treatment at all. Possibly, these

---

<sup>178</sup> While this figure cannot be fully taken as face value, it indicates in any case that exemption is very rare.

<sup>179</sup> This is consistent with other studies in Africa, for example Mackintosh/Tibandebage (2000), Fabricant et al. (1999).

<sup>180</sup> The extremely low exemption rate is confirmed by exit and household interview data collected in 1997 (DED evaluation data, own calculation). There is, however, one government health unit with widespread exemption, where people claim their inability to pay (interview, Bülow, DED health worker, 1999). A 50 percent exemption rate was found in another District (Koppenleitner/Mpabulungi 1997: 31).

<sup>181</sup> Cf. McPake et al. (1998), who mention the importance of authority in gaining access.

<sup>182</sup> Fabricant et al. similarly point out that if health facilities are allowed to retain user fee revenues, health workers tend to maximise revenue by granting very few exemptions (1999: 192, cf. Russell 1996).

people were not even aware of the exemption possibilities, which Girard/Ridde also conclude from their study in Northern District of Uganda (2000: 4). Likewise, Bennett et al. observe in LDCs that people's ignorance of eligibility for exemption is a frequent reason for not utilising services or for not claiming exemptions (1995: 25).

Finally, it may be difficult to receive an exemption ticket from the LC1 chairperson. On the one hand, poorer people are more reluctant to access the LC1 chairperson. On the other, LC1 services are usually not free of charge (Mathauer 1997). It is possible that people have to pay for an exemption ticket, but the study of this aspect was not further pursued.

Exemption practice in the rural NGO clinics varied. In the Protestant units, it is not official, but it is expected that everybody pays at least something and then pays the rest later on. However, the records reveal 4-5 exemptions per month in two units (i.e., 7 percent and 12 percent, respectively, of the total patient number), which were mainly granted to staff relatives, but also former staff relatives, the reverend and the supervisor's relatives, in spite of the staff's disagreement. In contrast, at the Catholic rN-4 clinic, exemption is official and institutionalised for the needy, and 5-6 percent of the patients get exempted. Either the patient asks the Father who is stationed at the Mission for an exemption certificate, or the staff requests the Father for exemption permission. During the household survey, I came across one of the exempted families. The female household head reports that it was not easy to approach the Father to ask for assistance, and the respondent needed the aid of one of the Sisters there to get introduced to him. This suggests that access to even ask for exemption is difficult in itself, as with the LC1s.

At urban clinics, exemption practice is little clear-cut across the sectors. The ultimate problem is self-exclusion, since most people without money would not utilise these clinics. At uN-1, where about 2 percent (based on the record books) of the patients are exempted, the nurse explained that

"We have no specified groups for exemption, we decide on the spot. If somebody comes on foot and looks bad and cannot pay, we exempt. Some AIDS patients are therefore exempted."

At uN-2, it was found that only staff family and friends were exempted, about 4 percent of all patients. Nor do the private clinics exempt vulnerable groups (yet they

do grant concessions; see Section 5.6). Only P-4 exempts the chronically ill patients from the consultation fee after the first visit. At the hospital OPD, chronic patients are partly exempted by not paying for registration, whereas AIDS patients pay the registration fee, but then get free drugs. That said, the latter reported that they are not always granted free treatment.

In sum, the exemption practice is inadequate in all three sectors. Even at the two NGO clinics that exempt the percentage is very low, so there is very little assistance in facilitating access of the poorest when they encounter financial shortages. Thus, NGO providers do not fulfil the expectations of the voluntary sector.<sup>183</sup> These very low exemption rates in government clinics are not unknown in Sub-Saharan Africa (Russell 1996). Evidence indicates that the implementation of effective and efficient systems of exemption proved to be difficult, whether this is based on means testing of income or on other forms of community involvement (Fabricant et al. 1999: 192). A general problem is to define "inability to pay" and in practice, it is difficult for health staff to assess a patient's financial situation (ibid., Russell 1996). For example, a man, that is poor, dresses poor, and has a poor health status, but who is a heavy drinker and has the money to go drinking, may not be perceived as poor by health workers and therefore not "deserve" exemption.<sup>184</sup> Given this complex notion of who is poor, it is difficult to find clear-cut definition of patients eligible for exemption. Gilson et al. (1995) note that there is no documentation of an exemption policy in a developing country that succeeds in distinguishing consistently and cost-effectively between those able and those unable to pay (in Bennett et al. 1995: 24).

## **5.6. Deferment: Credit Provision and Partial Payment for Partial Treatment**

In rural settings, income flows are seasonal and can be very irregular. In assessing the extent to which people have access, it is therefore equally necessary to look at the options of deferred payments. In fact, credit provision and partial payment for partial

---

<sup>183</sup> Another important research question is whether those exempted obtain the same quality of (clinical) care or whether they are treated worse.

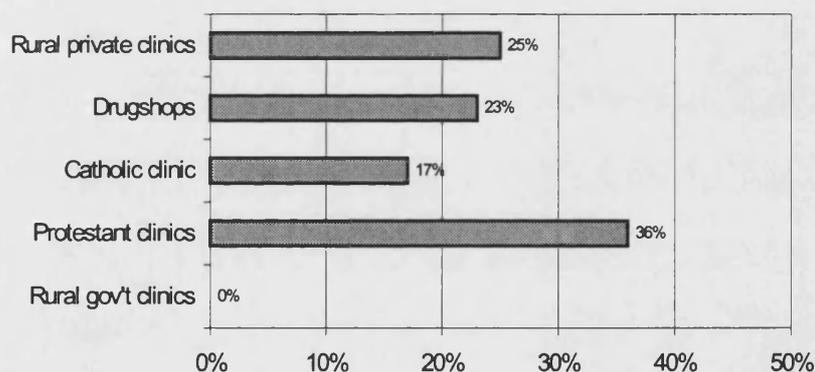
<sup>184</sup> I owe this point to Rebecca Hodgson.

treatment, i.e., partial payment of the full amount results in the proportionate provision of the drugs prescribed, play a very crucial role.

### Rural clinics

As Figure 5.6 shows, all providers in rural areas except government clinics offer credit.<sup>185</sup> At the rural Protestant NGO clinics, about a third of the patients are provided credit, but the rule requirement and understanding is that the patient pays at least something. More detailed data is available for one unit, where it was found that 36 percent of patients obtain credit of US\$ 450 on average, equalling more than 50 percent of the full amount. It is estimated to be equally high for the other units, whereas the Catholic rN-3 clinic provided credit to only a sixth of patients.

Figure 5.6: Percentage of patients with credit provision at rural health care providers



Source: Record books

The rural Protestant NGO clinics provide a full dose on credit, even if the patient does not pay the full amount. In contrast, at the Catholic clinic, if a patient who is unknown to the staff is unable to pay the full amount, he or she will be given only a proportion of the drugs and told to come back within a day or two and bring the rest of the money in order to get the remaining quantity.<sup>186</sup> This procedure is highly questionable, given people's symptomatic understanding of biomedical treatment and

<sup>185</sup> Another study found that some government health units in a District of Eastern Uganda offer credit (Koppenleitner/Mpabulungi 1997: 31).

<sup>186</sup> The reason for less frequent credit provision could be that this clinic has to recover all costs (including salaries) from its user charges, therefore being less willing to provide credit.

low treatment discipline, the latter of which is explicitly mentioned by the in-charge and focus group discussants.

Large shares of credit provided to the patients also result in large outstanding amounts of debts (about 11–25 percent of the theoretical income at Protestant clinics), which have serious sustainability implications. As patients succeed in mobilising about half of the user charge amount for their first visit, it is unlikely that they are unable to pay off the remaining sum. This indicates inadequate mechanisms to ensure debt repayments. The Protestant clinics are infrequently used, so that there is little interaction to enforce repayment. In contrast, debt repayment at the Catholic clinic is enforced via the parish community.

Credit provision is equally widespread at drugshops, where nearly a fourth of exit interview respondents got treatment on credit.<sup>187</sup> A large proportion of respondents named credit as one of the main reasons to use drugshops. Yet given the lack of mechanisms to enforce repayment, credit provision is dependent upon being a "daily customer", that is, the drugshop staff wants to be familiar with the clients who request credit (as regards their residence and reliability to pay off debts). Other factors for consideration include the seriousness of the sickness. Because of the physical and social closeness of the drugshops to the community, the provision of credit is both a moral and economic obligation, in that both sides benefit. Moreover, credit provision has a strong effect on trust-building. It makes the client feel cared for and hence ties him or her to a specific shop. This may be reinforced by the increasing loss of trust in government services due to informal payments, lack of drugs and rude behaviour. But since the same government health workers often operate their own drugshops, and even though they behave better in private practice, the explicit option for credit is a push factor in itself for the high utilisation of drugshops.

Many drugshops report large amount of outstanding credits and bad debts. Drugshops therefore prefer to provide the customer with the amount of drugs according to the money paid and tell him or her to come back to get more drugs for a full dose. One drugshop attendant describes the dilemma thus:

---

<sup>187</sup> That is, 5 out of 22 cases.

"The major problem with the village drugshop is that people are really poor, they do not know that this is business. They come and cry, so you treat, they get cured, and then they do not pay. That is why people get treatment according to the money they have which is not a full dose, so they do not get cured. Afterwards, they blame me that I don't treat. Nonetheless, I give tabs according to the money, otherwise the business gets lost" (interview, Subcounty C, 1999).<sup>188</sup>

Another strategy is to prescribe less expensive drugs or an inferior treatment if the patient does not have sufficient money. In sum, by allowing people to buy drugs of any amount, drugshops offer the most flexible deferral payment options, but this clearly goes on the expenses of appropriate treatment patterns.

The number of utilisation cases of rural private clinics is small in the household sample, but it appears that credit provision and deferred payment are equally important at rural private clinics: a reason for people to choose them.

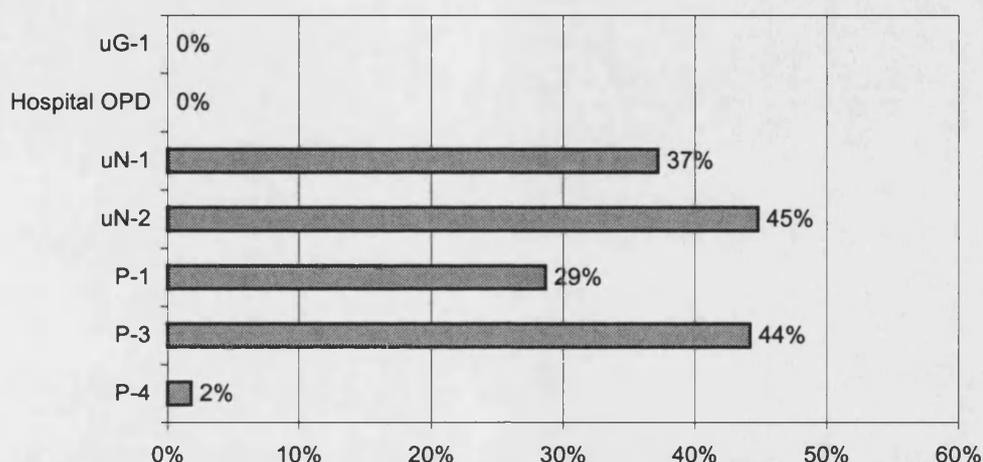
#### Urban clinics

In urban clinics, deferred payment practice varies much between and within sectors with different implications with regards to access (see Figure 5.7). The hospital OPD does not provide credit, so if patients are unable to pay fully for all prescribed drugs, they will obtain fewer types of drugs (usually the less expensive ones) in accordance with the money they have. They are then advised to buy in the drugshops in town. It must be emphasised, however, that no underdoses are given out.

---

<sup>188</sup> Cf. Whyte 1991 for similar quotes.

Figure 5.7: Percentage of patients with deferred payment at urban health care providers



Source: Record books<sup>189</sup>

At the private and urban NGO clinics, credit provision and partial payment plays an important role, as about 30–40 percent of all patients do not pay the full amount. Based on the record books, it was not possible to differentiate these two practices from each other.<sup>190</sup> On the basis of the exit interviews sample, inference suggests that only a fourth of these patients (7–10 percent in total) received treatment on credit, so they would pay at least half the amount required and receive treatment on credit for the rest. Thus, the majority made a partial payment for a partial treatment.<sup>191</sup> Again, as in rural areas, these clinics provide credit in order to offer an advantage over government clinics. One of the private practitioners was particularly inclined to give credit, whereby medical ethics seemed to play an important role:

"Sometimes people fail to bring money. So you have to give concession to the poor. For example, this morning there were two who could not bring all the money. The bill was 4,500, but he only brought 2,000. Yet, it is useless to give an underdose" (interview, P-2, 1999).

<sup>189</sup> The record books of P-2 did not allow for an analysis of this aspect. The estimated figure amounts to 30–40 percent.

<sup>190</sup> Some clinics have a book for creditors, but the private practitioners were very unwilling to hand them over. They wanted me to believe that all the partial payers had received treatment on credit.

<sup>191</sup> This latter category also includes patients who received a series of injections over a couple of days, so that they had to come back to the clinic several times. In these cases, (partial) payment occurs in relation to each injection.

P-4 is again exceptional in that he rarely provides credit. Presumably, he can afford to do so given the high demand for his specialist services.

Due to the lack of formal enforcement mechanisms, urban clinics have large outstanding bad debts. For example, at the two urban NGO clinics this constitutes about a tenth and a fourth respectively of the total amount of credit provided.<sup>192</sup> The problem is that

"Some pay it back, others not. Some women continue coming and say that the husband is not around. But we do not have the machinery to enforce and collect the outstanding credit, so most of them do not bring the money. So that is the problem: you treat the child, while other charges are not paid. I have stopped to calculate the outstanding amount of credit, because this is too frustrating" (interview, P-2, 1999).

Repayment is thus contingent upon social relations and enforced by threatening exclusion or a loss of reputation within town in case of non-clearance of debts.

Because of the problem of recovering debts, the NGO and private clinics prefer partial treatment for partial payment. This is the option for people who are not known to the staff at the urban private and NGO clinics. Furthermore, one of the private practitioners does not give out the prescription form, until the patient has paid the full amount. This serves to stop patients from simply going to the drugshops, where they can obtain the drugs for less money. Another practice is to provide symptomatic treatment with aspirin and Panadol until the patient comes with more money to get "real" treatment. Likewise, one practitioner explains:

"Poor persons don't get every treatment. We change to a treatment that the patient can afford. Sometimes, we accept to lose, but those cases are few" (interview, 1999).

Okello et al. (1997: 22) make the same observation in their private sector study in three major Ugandan cities. Again, one problem with the partial payment–partial treatment practice is that people may not return to get the rest of the drug dose, which may undermine curing and lead to drug resistance. This pattern is also gendered, in

---

<sup>192</sup> For large credit amounts (mainly inpatient services and operations), one practitioner asks for some deposit, for example a *gomez* (a woman's dress), until the patient has paid the full amount.

that men are more likely to return while women might not succeed in finding enough money to come back (interview, P-1, 1999).

There is a slight correlation between poorer people and those that receive credit or make a partial payment, yet it is just below the significance level.<sup>193</sup> It seems that poorer people are more in need and make use of credit and partial payment options. In contrast, the better-off people are much more in a position to come with sufficient money for full treatment. According to the practitioners, it is mainly the poor who have outstanding debts. There is thus some degree of cross-subsidisation among patients from the better-off to the less better-off. Cross-subsidisation in the private sector is also found in other countries (Gilson et al. 1994: 17). Moreover, "concessions", that is, reduced consultation prices or reduced profit margins on drugs, are more likely to be provided to the poorer clients. As prices at the non-state practitioners are inflated by high profits from dispensing drugs, they can then be "generously" lowered for concessions.<sup>194</sup> This has an important signalling effect to ensure that the poorer continue to perceive the clinics as accessible.

In conclusion, flexible deferral payment options are an important element in facilitating access, particularly in rural areas, where people do not have the constant incomes required in order to be forearmed against unexpected health care expenditure. Yet this raises the question why overall few poorer people utilise these higher-level clinics given the existing option of partial payment. Presumably, the overall amount to be paid during the first visit and the follow-up is still considerably high. Poorer people are unable to mobilise this amount of money within a short time. It appears that kinship and other group support mechanisms do not offset this dilemma. The large outstanding amounts of credits at the various providers may also be one explanation of people's pingponging (cf. Chapter 4.5.3).

---

<sup>193</sup> Chi Square p-value = 0.11

<sup>194</sup> Tibandebage/Mackintosh (1999) find the same in Tanzania.

## 5.7. Physical Access

Physical accessibility is of great importance, since travelling and other inconveniences increase opportunity costs and the total costs for treatment. Physical accessibility is strongly gendered, as males usually travel further than females to get treatment and they are more likely to have the travel means and money (Aljunid 1995: 338).

In Kamuli, the main modes of transport are by foot or by bicycle. Given the long distances and rough roads, it is often impossible for a sick person to cycle. It is also very difficult to transport a very sick adult patient who hardly can sit or hold him- or herself on the bicycle carrier. Table 5.7 shows the transport means chosen by people and the transport costs incurred to go to the health care provider. This provides an indication of physical accessibility.

All rural health care providers were reached by people's own means of transport, and no transport costs were incurred. Nevertheless, the problem of distance often impedes the caretakers in taking an adult patient to the government clinic. The record books showed that more than half of the patients (for both rG-2 and rG-3) reside within few kilometres of the health unit. Likewise, all rural church clinics are predominantly used by people who live nearby. Given the dense spatial coverage of drugshops, it is obviously much more convenient to go to nearby drugshops. Drugshops also offer "remote diagnosis", i.e., a customer explains the symptoms of the patient that stayed at home.

The urban private and NGO clinics are predominantly used by people living within the (peri-) urban area town, but the others had high transport costs. In contrast to the other urban clinics, only about 3 out of 10 patients at the hospital OPD came from Kamuli town or nearby, whereas the others were more serious cases from rural areas, who had come to use the hospital as a last resort. The average transport costs were US\$ 2,200 for those who purchased transport. The pattern for uG-1 is very similar to this.

In sum, physical accessibility of urban clinics is a problem, as the high transport expenditure may increase the costs for the treatment by 50 percent. The arduous transport of a sick patient makes people even more reluctant to go to town.

Table 5.7: Transport costs

	Rural govt clinics	Rural NGO clinics	Rural drugshops	Urban govt clinic	Urban NGO clinics	Urban private clinics	Hospital OPD
<b>% of exit respondents that incurred costs</b>	0%	0%	0%	29%	33%	28%	33%
<b>Average costs (in USh)*</b>	0	0	0	2,500	3,500 <sup>195</sup>	2,864	2,200
<b>N</b>	20	14	21	14	18	39	15

\* of those who incurred costs

<sup>195</sup> There were two people who had come from very far and had much higher transport costs than the average, thereby increasing the mean.

## 5.8. Utilisation Rates and Expenditure Patterns in Relation to Socio-economic Status

The remainder of this section analyses people's utilisation of and expenditure at the various provider types in relation to their wealth status (poorest versus better-off) to judge the providers' accessibility. Given the small number of cases for some providers in a two-layered comparison, this can only be indicative.<sup>196</sup> Differences in expenditure between the two groups will be reported only when these are statistically significant. The quantitative data of utilisation rates by itself is limited because utilisation rates are not a one-dimensional reflection of the ability to pay or of financial access. The "patients' experience of access to health care facilities is shaped both by the level of payment demanded in relation to their ability to pay, and by the relationships that frame the transaction...", such as exemption, deferred payment, and the perceived quality of the service, including staff behaviour (Tibandebage/Mackintosh 1999: 5). Moreover, utilisation rates are contingent upon the alternative health care providers (McPake et al. 1993: 1385) and the respective distance to these. However, combining the quantitative evidence with the assessment of the previous sections and contextualising it with people's stated reasons for (non-) utilisation, one can get an idea of the providers' (financial) accessibility in relation to socio-economic status, without ignoring the fact that there are other determining factors (see Chapter 6.2).

### Home treatment

Overall, there is a correlation between poorer people and incidents of home treatment.<sup>197</sup> This is in line with Hutchinson (1999: 21), who derives from 1995 national survey data that poorer people are more likely to self-treat. The reasons provided both explicitly and implicitly point at the lack of money for getting treatment and at the non-expectation of credit or exemption.<sup>198</sup>

---

<sup>196</sup> This is also why household data is not further broken down into gender and age groups, but it is hypothesised that this would show even much stronger differences between the poorest (including women and girl children) and the better-off.

<sup>197</sup> Chi Square p-value = .073; Gamma = -.593, Gamma p-value = .062.

<sup>198</sup> Ten out of 28 respondents stated that they had no money (including three people suffering from a hernia), ten used local herbs, while four assumed the problem not to be too serious and hoped that the pain would stop without treatment.

### Rural clinics

Whereas 70 percent of the exit interviewees belonged to the poorer group, there is no discriminatory correlation between wealth group and utilisation of rural government clinics or in average expenditure in the household sample, which is considered to be more representative, given the larger case number. This non-correlation may be due to two effects. Better-off people may be more inclined to use private clinics (see below). On the other hand, it may be easier for them to get access to the government clinic, as they are more likely to be friends with somebody (or be a friend of a friend) at the clinic, and therefore experience better treatment, thus enhancing their utilisation.

For the poorer patients, mobilising the amount of money for user charges (and for informal payments) needed to get access can constitute a problem in itself, to say nothing of the need for money to buy drugs at drugshops. Adding up user charges, informal payments and costs for drugs can amount to approximately US\$ 3,000 for rG-2. These costs come close to those in rural private clinics and urban clinics. Given the high illness-reporting rate, it is obvious that these costs are unaffordable to treat every ("minor") disease within a family, given the monthly household medical expenditure (cf. Section 5.1).

After the introduction of user fees at government clinics, utilisation rates dropped (cf. RoU 1993, in Nabuguzi 1995: 204, Hutchinson, 1999: 11; interviews, in-charges, HUMC members, 1999). While moral hazard may have been reduced, this is also because poorer people are financially deterred, i.e., the impact on utilisation by lower income groups is higher (cf. McPake 1993 in Aljunid 1995: 341). Likewise, Girard/Ridde (2000: 5) note for a Northern District that the percentage of non-utilisers increased. People then choose alternative providers, where they expect better quality for the money they pay and where they are offered credit.

One suggestion of a focus group participant sounds like a persiflage if it were not the real circumstances that people are facing. He argued that since people cannot afford to pay both the bribe and the cost-sharing at once, they should be offered credit. That way, they could first pay the bribe (to get attended) with their available money and then later pay the cost-sharing, once they have mobilised more resources (FGD, Subcounty A, 1998). Thus, in the absence of credit provision or insurance schemes, one reason for restricted access to government clinics on the part of poorer

people is their inability to quickly mobilise a large amount of money. The result is exclusion and self-exclusion by those who do not ask for the exemptions to which they are entitled.<sup>199</sup>

I also came across people who had to sell a goat or even land in order to cover their health care expenses at higher level providers. In other words, they lost major assets whilst seeking treatment. Similar examples are given by Fabricant et al. (1999) for Sierra Leone, Mackintosh/Tibandebage (2000) for Tanzania, and McPake et al. (1998) for two other Ugandan Districts.<sup>200</sup> During the household interviews, a couple of cases of very ill people were found who were stuck in their home and who did not go to a government clinic or a drugshop because of lack of money. The focus groups similarly expressed their resignation:

"If you have no money, you stay at home and just wait to die" (Subcounty A, 1999).

"People don't have the money to go to expensive clinics, quite often, they are sick, it continues like that until that person passes away" (Subcounty B, 1999).<sup>201</sup>

In sum, the evidence suggests that the public health system excludes the very poor who may not always be able to pay even lower user charges (cf. Nabuguzi 1995: 204).

For rural NGO providers, the overall assessment on access has to be differentiated among the various clinics. At rN-3, more than two thirds of exit respondents belonged to the poorer category, but there is seems to be no correlation within the household sample (the case number is very low). Yet, the interviews and the FGDs also revealed that one of the main reasons for avoiding this clinic are the high charges, which explains the overall low utilisation rates. Likewise, utilisation rates dropped sharply once user charges were introduced in 1998 (interviews, headquarter official, in-charge, HUMC member rN-3, 1999). Accordingly, household respondents and focus groups commented very negatively on the user charges, for example:

---

<sup>199</sup> People with no money are reluctant to go to a health unit, also because they do not want to be abused by health staff (cf. McPake et al. 1998: 30; see Chapter 6.2.4).

<sup>200</sup> A Ugandan health worker may argue, however, that if this person has a goat to sell, he or she is not actually poor (personal communication, Rebecca Hodgson, 2001).

<sup>201</sup> Similar views are mentioned in Russell (1996) and Fabricant et al. (1999) for other countries.

"When they treat somebody to your satisfaction, the amount is really high. You are scared to take another patient."

These comments must also be seen in light of the previously free services and people's misperception that "everything is given free from the UK" (interview, in-charge rN-3, 1999).

There is no correlation between wealth group and utilisation for the rural Protestant NGO clinics in the household sample.<sup>202</sup> Yet the poorer seem to pay less, as none of them paid more than US\$ 500 in the exit interview sample and US\$ 670 in the household survey, respectively. In general, utilisation is low, because people feel they get the same services at drugshops. This is because the midwives are occasionally absent (see Chapter 6.2.3), so that the units are run by a nursing aid. In this case, drugshop staff is not less qualified, and people get the services for even less money if they decide upon themselves how much to spend at the drugshop.

Rural drugshops are highly utilised by all groups, whereas there is a fairly negative correlation between the urban better-off and utilisation of drugshops, but it is not statistically significant. In the exit interview sample, only 7 out of 20 respondents, however, came from the poorer group. Also, on average, better-off people in rural areas spend US\$ 639 more than the poorer ones in the household sample, the difference being significant.<sup>203</sup> Similarly, poorer respondents in the exit interview sample had not spent more than US\$ 1,000.

Apart from other non-financial related factors, one of the major reasons for utilising drugshops is the uncomplicated financial access and credit provision, which is highly appreciated:

"At [D16], treatment and drugs are not expensive. But what is most important is that he gives credit. We don't see it as a place which gives best treatment, but he understands us best, because he gives credit" (FGD, Subcounty C, 1999).

"[D7] is faithful and trustworthy, he really cares for the life. Even if you do not have money" (FGD, Subcounty B, 1999).

---

<sup>202</sup> Likewise, 3 out of 6 exit respondents belonged to the group of the poorest.

<sup>203</sup> ANOVA p-value = .004; N [number of drugshop visits] = 161.

Without differentiating between urban and rural areas, the better-off spend US\$ 411 more (ANOVA p-value: 0.012; N = 277).

In contrast to government clinics, people get what they paid for. The decision on expenditure remains with the customer who can buy any minimal amount of drugs. Buying an underdose is one of people's responses which cope with money shortages and the inability to pay (see also Chapter 6.2.8 for the extent of underdosing). As drugshops are also more accessible in physical terms, people usually do not have to make trade-offs between price and distance. On the other hand, once the customer leaves the decision on the drug package and the costs to the drugshop attendant, average charges are very high, but they can be paid in instalments. In the household interview sample, more than a third of the sickness episodes cost more than US\$ 2,000 and a sixth more than 3,000, going up to 10,000, which is three times the monthly household medical expenditure. These sums come close to those at higher-level providers.

That said, there are clear trade-offs as regards quality (see also Chapter 6.2). In many cases the "drug package" prescribed at the drugshop does not cure the patient. In the exit interview sample, 45 percent of the patients had first visited a drugshop before utilising a higher-level provider. Having spent a lot of money at the drugshop level reduces people's access to utilise higher-level providers, as one NGO health worker explained:

"People take pain killers, which just relieve the pain, but do not cure. They keep going to the drugshops for two weeks and end up paying up to 5,000, until they come to the health unit without money" (interview, in-charge rN-3, 1999).

Yet one must strongly bear in mind the various reasons for going to drugshops in the short-term, namely the perceived (un)severity of the disease and the adequacy of drugshops in this case, but also the inability to mobilise enough money for treatment at and transport to a higher-level provider. This obstructs a long-term view in which people would realise that they lose out both financially and in terms of their health. By contrast, better-off people go more often or change sooner to higher-level providers, even for "minor" diseases, instead of wasting time and money at drugshops. In the exit interview sample, the ratio among the poor who first went to a drugshop against those going straight to a higher-level provider was 3:1, whereas it was 1:1 for the better-off people.

Likewise, better-off people seem to use rural private clinics more often, although there is no correlation in the few cases of the household sample.<sup>204</sup> As they all live very near the private clinics, distance may have been the major reason for utilisation. Yet better-off people pay on average US\$ 1,000 more.

### Urban clinics

Utilisation differences between the poorer and better-off are particularly remarkable at the urban clinics.

At uG-1, the utilisation rate and expenditure pattern do not correlate with the wealth variable in the household sample, but in fact, none of the rural poor had utilised this clinic, and only 11% of the rural better-off.<sup>205</sup> However, the qualitative evidence suggests that utilisation depends upon the on-the-spot cash availability. 75 percent of the urban and semi-urban and two thirds of all household interview respondents, as well as 63 percent of urban exit interviewees, named lower user charges and current lack of money as the main reasons for utilisation of the urban government clinic. Thus, the poorer urban and semi-urban population uses this clinic only if they do not have more cash on hand for going to other more preferred, but more expensive and better places, such as private and NGO clinics.<sup>206</sup>

In contrast, poorer people are less likely to use private clinics. In fact, in the household sample, almost two thirds of the variability between the two groups is explained by the wealth variable.<sup>207</sup> Likewise, three quarters of the exit interviewees at private clinics were better-off people. This correlation of the better-off being more likely to utilise private clinics is also confirmed by the national household survey of 1995 (Hutchinson 1999: 21). It was also found that poorer exit interviewees spent considerably less on private clinics per illness episode; they usually did not spend more than US\$ 5,000 per visit.<sup>208</sup> The exit interview sample also indicates that urban

---

<sup>204</sup> Seven households of the poorer category (13%) made nine visits, whereas eight households of the better-off group (17%) made 19 visits.

<sup>205</sup> Likewise, 4 out of 14 exit patients belonged to the poorest group.

<sup>206</sup> A similar argument is made by McPake et al. (1998).

<sup>207</sup> Chi-Square p-value = .019; Gamma = 0.643; sig-p-value = .02

<sup>208</sup> There was one case of a poor respondent; the injured woman paid US\$ 10,000 for several daily dressings.

NGO clinics serve a rather better-off clientele, as none of the respondents belonged to the poorer group.<sup>209</sup>

Since utilisation of these urban clinics requires considerable financial means, it is clear that lower income sections from rural areas are put off by the charges, even if credit is provided. Adding the average transport costs and the average user charges amounts to US\$ 7,500 for the NGO clinics and to US\$ 8,360 for the private clinics (exit interview data). The latter costs for one illness are more than ten times the average monthly medical expenditure per capita of US\$ 623 in the poorer half of the population.<sup>210</sup> Even though the NGO clinics are slightly less expensive on average, the price difference between for-profit and not-for-profit clinics is blurred. In light of the high illness reporting rate, access is restricted and constitutes a financial challenge, which is also expressed in the focus group discussions:

"One goes to these clinics if one has money (FGD, Kamuli town, 1999).

Access to the hospital OPD requires considerable financial means, and accordingly the rural clientele judges the costs as expensive. Among the household sample, there is no difference between the poorer and the better-off in terms of utilisation, but among the exit interviewees, about a fourth only belonged to the poorer group.

Also, the poorer people (in the household sample) have much higher expenditures, but the difference is not statistically significant. This is possibly due to the different case mix between poorer and better-off people and because poorer people postpone a hospital visit until a disease has become very serious. People are very reluctant to go to the hospital and shy away from the costs, once they are referred by lower-level providers (interviews, health workers, 1999 and observation). In sum, fear of high costs is one of the main reasons why people avoid going to the hospital. It also explains why people too often arrive too late at the hospital when the disease has become an emergency.

---

<sup>209</sup> In the household sample, there were very few using these clinics. Three households belonged to the poorer group, while another two belonged to the better-off; all of them lived in the urban or peri-urban area.

<sup>210</sup> Average household size: 5.9 people (National Household Survey Data, in World Bank 2001b).

In sum, this section reveals that there are considerable differences in utilisation and expenditure between the two groups, suggesting that poorer people are more restricted in their choice between providers. However, the implication of the finding that poorer people spend less on average at some of the providers (rural Protestant NGOs, drugshops, and private clinics) needs further detailed study. The question is whether lower expenditure results in underdosing or in a less severe degree of polypharmacy. At drugshops, it was found that there are a large percentage of treatments characterised by both (see Chapter 6.2.8).

### **5.9. Conclusion: Restricted Access for the Poorest and Ways Forward**

This chapter showed that drugshops are most flexible and best as regards financial access for the poorest, since the decision on expenditure remains on the customer's side. However, this flexible financial accessibility suffers from quality trade-offs (see Chapter 6.2). It was also found that, since NGO clinics are increasingly under financial pressure to recover their costs just as private clinics are, user charges of urban NGO clinics have converged with those of private clinics. This fact was clearly expressed in the focus groups' statements, one saying:

"NGOs are like private clinics, so long as you have your kin [= your relatives with money]" (FGD, Subcounty B, 1999).

Likewise, the government health workers have "privatised" government services by their informal charging strategies. In terms of the service transaction and payment procedure, the line between for-profit, not-for-profit and government clinics is hence blurred, and what we find is a process of hybridisation with private sector features dominating. This has negative impacts in terms of equity and access. So, as a result of this marketisation, access and the receipt of drugs are contingent upon payment and not based on people's ability to pay.<sup>211</sup> This is the case for all provider types, though on a more moderate degree for rural NGO units. As said, I came across people who had to sell a goat or even land in order to cover for their health care expenses at higher level providers, i.e., they lost major assets whilst seeking treatment. One

---

<sup>211</sup> This is also what Tibandebage/Mackintosh (1999) conclude in their study of Tanzania.

household was found that had not attended any provider during the recalling period, and another 20 households had only used drugshops but no other facility type. Thus, the key question is not actually about equal access in proportion to one's income and ability to pay. It is more fundamentally about access *at all*, given the rare practice of exemption.

This chapter also indicated the possible quality of care trade-offs in the case of insufficient availability of financial resources, since people resort to partial treatment and non-completion of drug dose. Another problem of financing services through user charges is the perverse incentive of providers to over-prescribe. This has negative implications on access and quality of care. The next chapter will therefore close the circle by comparing the efficiency of staff resource utilisation and quality of care between the health care providers.

The remainder of this section will consider some ways forward. The crucial point is to ensure that finances are available for health services for the most vulnerable (Bennett 1991). First, it is necessary to improve the state's capacity to increase tax collection to generate some degree of redistribution. Second, "redistributive health care" must be considered as a "normal and legitimate" norm within the health care system (Mackintosh/Tibandebage 2000: 4).

Since over half of the rural population in Uganda lives below the poverty line, one challenge lies in defining the ability to pay (cf. Russell 1996). It is very difficult for the staff to assess a patient's financial situation, but as nobody should be denied treatment because of lack of money, a first step to improve access is to provide credit. Parish chiefs or the LC1 Public Health Co-ordinator (a position that was currently not found to be in existence) could carry out the debt enforcement and could be granted a specific proportion of the debt recovery (e.g., 10 percent). (Horizontal) equity may also be increased by means of price discrimination by location of residence (cf. Fabricant et al. 1999: 195). Another very crucially required change is to move from "registration" fees to (sliding) user charges for the provision of drugs and treatment. At best, the setting of such charges is based on local consultation processes (Mackintosh/Tibandebage 2000). While charging user fees for drugs reinforces the curative bias and people's preoccupation with drugs, it does take people's perspective seriously, since they are willing to pay for drugs (van der Geest 2000: 64; McPake et

al. 1993: 1383). Above all it will promote again the use of government facilities and keep people away from drugshops, where the staff is usually unqualified. User charges could be increased on the basis of an open discussion of how to convert unofficial fees into official revenue. This contributes to reducing informal charging, which puts the patient in a very insecure position and hence deters his or her utilisation. Killingsworth et al. (1999) recommend for Bangladesh that such changes should be accompanied by a political consensus of intolerance for the most serious forms of rent seeking, which is also absolutely fundamental for Uganda.

The suggestion of raising user fees and increasing the rate of exemption must be carefully examined for Uganda. It may be promising to introduce incentives to the health workers to provide exemptions; for example, by a top-up allowance that is granted once the health unit exempts a specific percentage of patients. Patient (and household) eligibility must be clearly defined and established by means testing. Eligible patients should obtain vouchers or an exemption ticket from the local council, which entitles them to health care for a certain number of visits per year. The DMO's supervision should then check whether only eligible persons have been exempted by comparing the health unit's exemption records with the respective list of eligible persons. Ultimately, however, it is crucial to move towards redistributive prepayment schemes that should be combined with some co-payments in order to avoid moral hazard.<sup>212</sup> More knowledge is required on how the poor cope in order to find the best strategy (cf. Russell 1996). All of these measures must be seen in combination with other structural-systemic reforms in order to be effective (see Chapters 7-8).

---

<sup>212</sup> The principles of "monumokabi" groups (burial groups), which cover burial expenses by monthly payments of all households, could serve as a starting point for emergency insurance systems. For further elaboration on community-financing schemes, cf. Jakab/Krishnan (2001) and Preker et al. (2001).

## Chapter 6

### Relative Efficiency of Staff Resource Utilisation and Quality of Care

This chapter compares the different provider types along relative efficiency of staff resource utilisation and quality of care. The relevance of quality of care goes without saying, but is of particular concern given the informalised and privatised pluralistic health care provision. Likewise, efficiency is crucial in light of the tight financial situation the Ugandan health care system is faced with. Cost-benefit analyses and cost-utility analyses should be the preferred type of health economic evaluation, where both costs and benefits are measured in monetary units in the former procedure and benefits in QALYs in the latter, thereby allowing for wider comparisons (Anell/Norinder 2000). Due to practical and methodological problems, however, a technical efficiency analysis and cost-effectiveness analysis (CEA) are widely favoured by using *intermediary* outcome or output measures. Particularly for a comparative study of provider types, the analysis of technical efficiency and CEA are the conventional and most suitable approaches (cf. Drummond 1987, Pearson 1997, Sinanovic et al. 2000, Bitrán 1995), since it is not possible to assess the cost-benefit ratio of each intervention at each provider type given the multiple factors influencing health. For our purposes and for reasons explained below, the efficiency analysis is confined to the utilisation of one input factor, that of staff resources.

Cost-effectiveness refers to minimum costs for a given output, whereas technical efficiency denotes maximum output for given costs (cf. Mills 1997b: 245, Green 1990: 275). Thus, cost-effectiveness and technical efficiency – or derivatives of efficiency analyses as in this chapter – are about the "capacity of the individual, organisational unit, facility, operation or activity to produce measurable results in proportion to the resources extended" (Carley 1980: 64). Measuring inputs and costs of inputs is usually not that difficult<sup>213</sup>, whereas it is much more complicated for output, not least to define it. Moreover, measuring efficiency is challenging, because a number of factors (quality of care, case mix, input price, scale of operation) vary among the different providers and thereby affect the relation between inputs and health outputs (cf. Bitrán 1995). A technical efficiency or cost-effectiveness analysis

---

<sup>213</sup> Measuring opportunity costs is more complex, however.

or a specific efficiency analysis, as it is chosen here, therefore require one common output indicator that measures efficiency for a given level of quality of care. That said, there is no single quality index from indicators of many different aspects of quality of care that would provide such a comparable output indicator.

Given this methodological problem, the relative efficiency of staff resource utilisation is separately analysed (Section 6.1) from quality of care (Section 6.2) as do other studies (cf. Bitrán 1995, Sinanovic et al. 2000). But this is not to ignore their interrelation. For example, good scores on cost-effectiveness, technical efficiency and efficiency of staff resource utilisation do not necessarily say anything about quality. In order to increase quality, it may be necessary to increase costs, thereby possibly lowering the efficiency ratio. Only an overall discussion of the two aspects will then allow for making valid statements. Section 6.3 provides a summary and conclusion as to the overall attribution of relative strengths among the various provider types by taking into account the discussion on access in the previous chapter. Having a more comprehensive view of each sector's relative strengths, Chapters 7 and 8 can then attempt to explain performance and malperformance by means of an institutional analysis and a study of interorganisational relationships.

### **6.1. Efficiency of Staff Resource Utilisation**

Technical efficiency, or the efficiency of staff resource utilisation, refers to the relationship of inputs (here staff resources) to direct outputs. Output is operationalised by means of the utilisation rate as the number of outpatients per month (cf. Pearson 1997, Flessa 1998, Sinanovic et al. 2000, Bitrán 1995 for similar approaches). While this indicator is problematic in that, as McPake et al. (1999) point out, it suggests that patients can best judge the trade-off between costs and quality, one must equally consider that

If a service judged to be of higher quality from a professional perspective is not used, the cost-perceived quality position of that service is insufficient for effective health services to be delivered (1999: 862-3).

That is, the utilisation rate, which is a reflection of people's perception of quality and hence their choice, translated into health care seeking, is an important determinant of

cost-effectiveness and technical efficiency, as well as of efficiency of staff resource utilisation (cf. Chapter 4.5 for people's utilisation factors).

The input side is operationalised as staff numbers and salary costs. Salary costs constitute the main input factors, amounting to about three quarters. Other inputs are not considered, for the reasons stated below, thus not allowing for a comprehensive cost-effectiveness or technical efficiency analysis, but only for an analysis of the efficiency of staff resource utilisation. Other input factors include drugs and medical supplies, as well as running and maintenance costs. Given the huge problems that surround drug supply and provision and the different degrees of subsidisation (see Chapter 4), input costs of drugs are difficult to quantify, and instead drug availability will be discussed in Section 6.2 on quality of care. There is usually a shortage of operational and maintenance items, and clinics work with the absolute minimum. Mainly being a function of patient numbers, these inputs into the health production function are (proportionally) equal among the health care providers. Further economising (i.e., arithmetically improving technical efficiency and cost-effectiveness) would severely affect the quality of services. Because of practical difficulties in determining these costs and because they are comparatively low, they can be neglected. Likewise, external monitoring and supervision costs appear to be marginal in comparison with the overall costs of salaries (and drugs). Similarly, a study of South Africa showed that these were around 1.5 percent of recurrent costs (Sinanovic et al. 2000: 3). Finally, for similar reasons, costs for electricity and furniture can be neglected.<sup>214</sup>

The efficiency analysis of staff resource utilisation is based on the following indicators:

- Patient throughput per staff:

[Number of outpatients per month] / [number of staff]

- Patient throughput per qualified staff:

[Number of outpatients per month] / [number of qualified staff]

---

<sup>214</sup> Sinanovic et al. (2000) undertake a comprehensive cost-analysis including all furniture and equipment to compare different providers. However, while an additional closet, for example, increases the cost-side, and hence lowers cost-effectiveness, this seems to be of little meaning as regards cost-effectiveness.

- Staff salary costs per patient:

[Number of outpatients per month] / [Official staff costs per month]

The last indicator does not say so much about staff "cost-effectiveness" in its true sense given the varying input prices, and so rather reflects staff equity aspects, but it is still indicative.<sup>215</sup> The data presented below refers to the period of September 1998 to August 1999, and a longer time series where available helped to verify its representativeness.

Data on staff inputs was gathered by means of interviews with health professionals, HUMC members, NGO headquarter staff, DED health professionals, as well as DED reports, KDA budgets and other District documents, which allowed for triangulation. Staff costs only include salaries and lunch allowances, but exclude top-up allowances and costs for training. At private and NGO clinics, utilisation rates were calculated on the basis of record books, the data of which were confirmed by observation. Government clinics are known to record inflated patient numbers; however, the three government clinics in the core sample are well managed. My and the DED staff's observations showed that recorded patient numbers corresponded broadly with actual numbers (cf. Annex 1.10).

### Rural clinics

Outpatient and case throughputs per (qualified) staff in rural clinics are presented in Figures 6.1 and 6.2, respectively. Staff salary costs per patient are illustrated in Figures 6.3. Further evidence of another 11 government clinics is provided in Figure 6.4.<sup>216</sup>

Overall, NGO clinics perform much better than rural government clinics in terms of (official) costs per patient. As regards patient throughput per staff and per qualified staff, performance cuts across the sectors. One of the NGO clinics scores moderately, whereas rG-3 performs relatively well. Figure 6.3 indicates that the government clinics' patient throughput varies a lot. In fact, the two selected rural clinics are located in the lower half. Despite variance in government utilisation rates, the major

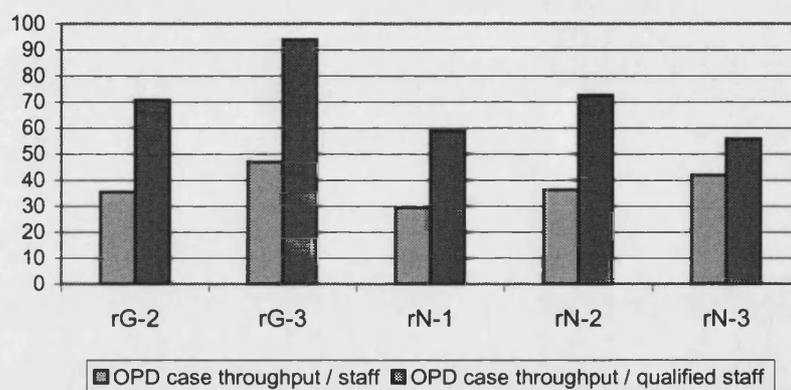
---

<sup>215</sup> I owe this point to Barbara McPake.

<sup>216</sup> Figure 6.4 is based on DED records of utilisation rates at rural government clinics.

factor and explanation seems to be variation on the input side. Some of the clinics are well staffed, and in fact they have too many nursing aids. This is also the case for rG-2. Likewise, NGO clinics operate with few staff, but utilisation rates are equally moderate. The Protestant clinics suffered from the widespread view within the community that their services are restricted to Christians. These rumours were actively spread by drugshop owners and possibly contributed to the low utilisation rates. In sum, there are larger variations within sectors, but no clear distinctions between sectors.<sup>217</sup>

Figure 6.1: Average monthly outpatient throughput per (qualified) staff at rural providers<sup>218</sup>



<sup>217</sup> During their study of 1992/93, Okello et al. found that outpatient throughput per skilled staff was larger in government dispensaries (smaller health facilities) than in NGO clinics (1998: 16).

<sup>218</sup> Inpatients were weighted with the factor six (cf. Pearson 1997).

Figure 6.2: Average monthly case throughput per (qualified) staff at rural providers<sup>219</sup>

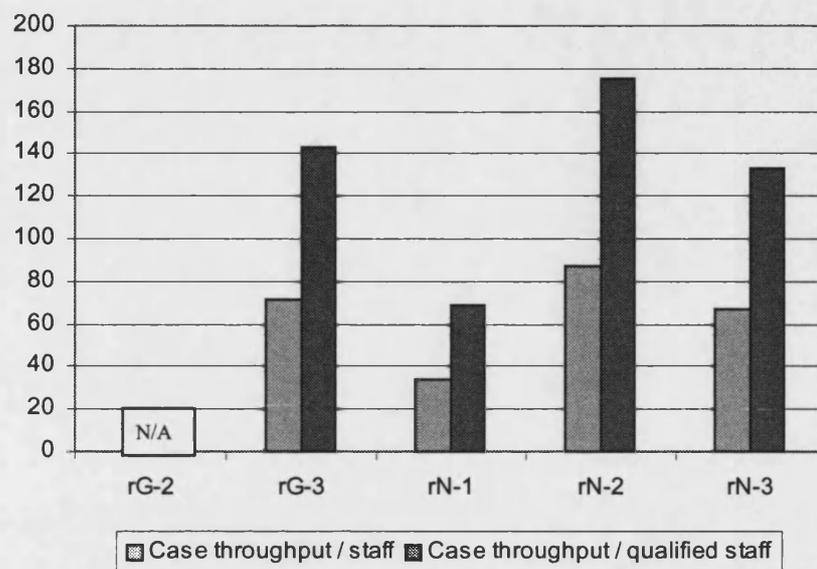
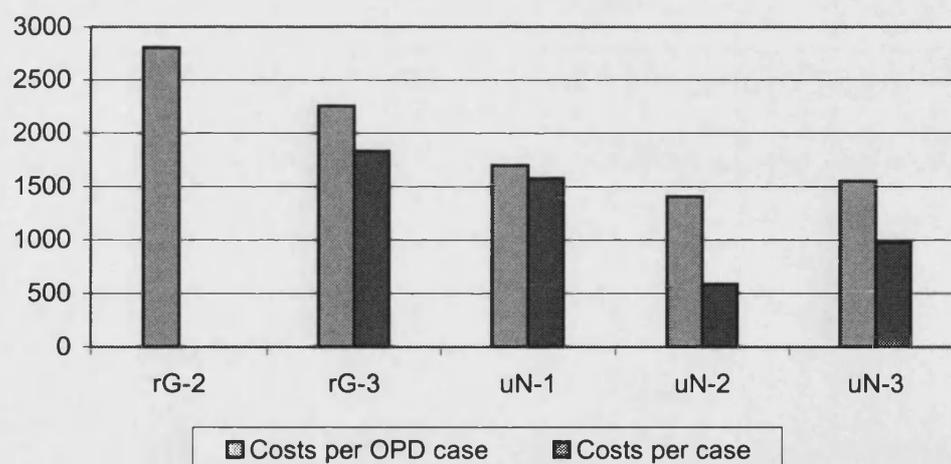


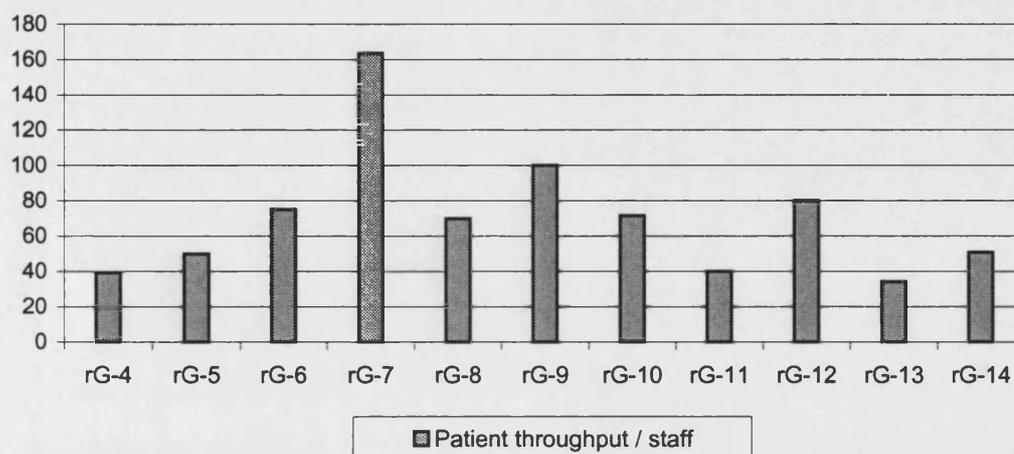
Figure 6.3: Average staff salary costs per patient at rural providers (in US\$)



Source: record books/observation (OPD number), District budgets (staff salaries), interviews with Headquarters and health workers (salary costs)

<sup>219</sup> Here, the cases include the maternity patients (deliveries, antenatal, postnatal and FP). Except of uG-2, the health workers are in charge of both curative health care and maternity patients, so that it is difficult to separate their OPD workload from that of the maternity. In calculating the number of total number of patients, deliveries were weighted with the factor six (cf. Pearson 1997).

Figure 6.4: Average monthly patient throughput at rural government health units



Source: DED reports, 1998-99

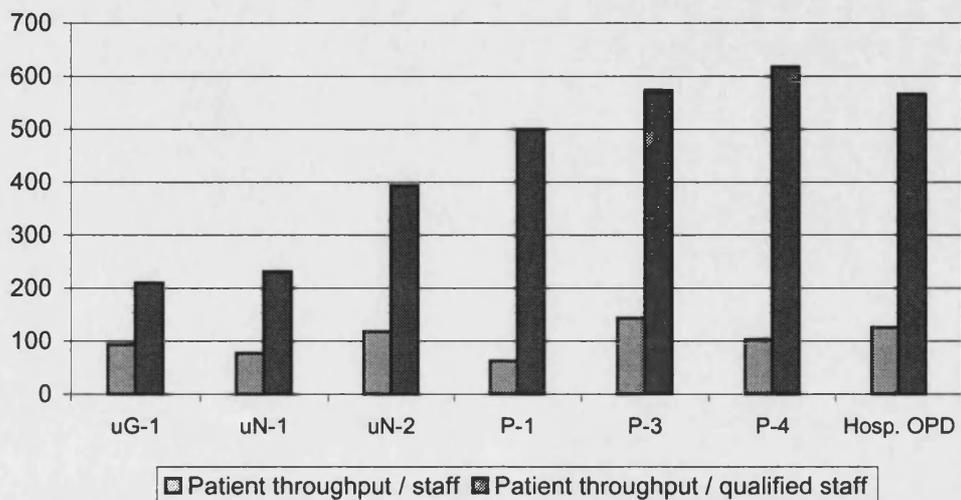
#### Urban clinics:

Figure 6.5 presents the scores of patient throughput per (qualified) staff for urban clinics. Staff salary costs per patient are illustrated in Figure 6.6.

With the exception of one NGO clinic, the non-state clinics including the hospital OPD have a considerably higher patient throughput, both in terms of the total number of staff and in terms of (highest) qualified staff. The score is best for private clinics run by a doctor. As regards costs per patient, the NGO facilities (uN-1 and the hospital OPD) and one of the private clinics, which is operated by an employed medical assistant, score much better than do the government health centre.<sup>220</sup> By contrast, the other NGO clinic is very cost-ineffective in comparison. This clinic has only opened recently, so that it may be less known to rural people as yet, thus explaining the low utilisation rates.

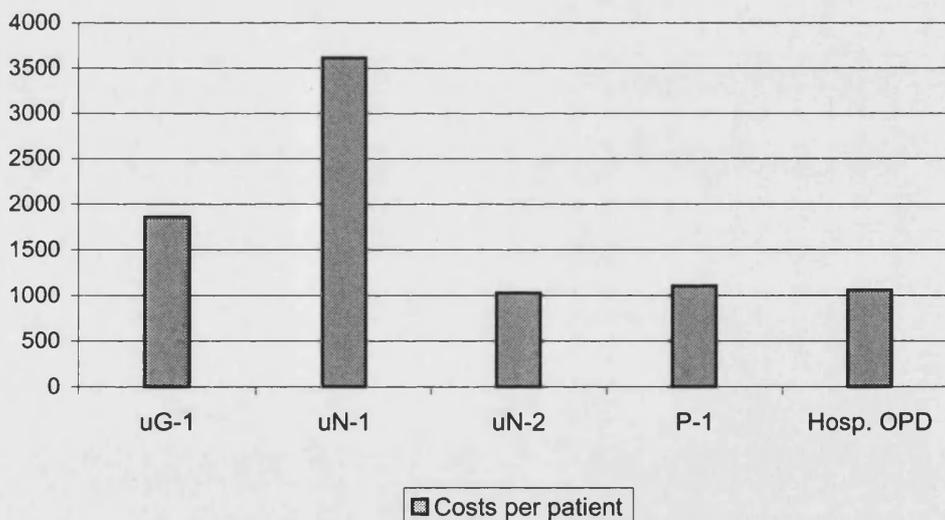
<sup>220</sup> The other private clinics are run by the owners, so that it is difficult to ascribe an explicit salary in light of the very different incentive structures operating in private clinics.

Figure 6.5: Average monthly outpatient throughput per (qualified) staff at urban providers



Source: Record books, facility survey<sup>221</sup>

Figure 6.6: Average staff salary costs per patient at urban providers (in US\$)



Source: record books (OPD number), District budget analysis, interviews with headquarters and health workers (salary costs)

Some further qualifications for both rural and urban areas are necessary. First, salaries and allowances of NGO staff are lower than those of government employees, so that NGO clinics are not simply more cost-effective as regards staff salaries. Nor

<sup>221</sup> Patient record books at P-2 did not allow for a precise analysis. The outpatient throughput is about 400-500 per month.

are employees' salaries at private clinics above government levels (see Table 7.1). Chapter 7 will further look into the staffing processes and thus provide explanations for the different levels of efficiency as regards staff resource utilisation.

Second, the occasional staff absences at rural NGO clinics and the very frequent staff absences at government clinics are not reflected in the above input side. In reality, staff input for these two provider types is much lower in reality. Since government clinics usually open for only three to four hours, i.e. half of the official time, and operate with a skeleton staff (see Section 6.2.5), total staff input at government clinics is much less than half the official one, (arithmetically) increasing the efficiency ratio. It equally indicates, however, that government clinics are often overstaffed in relation to the current utilisation rates. In other words, the patient load could be managed with much fewer staff than currently employed. In light of these qualifications on the input side, the above efficiency scores of staff resource utilisation must be seen rather as an estimation and approximate indication.

The time-use aspect raises two further points. First, people are aware of the fact that government clinics are only open during the morning and adjust their health care seeking accordingly. If the clinics were open all day, they could possibly attract more patients. This would also lower waiting times and improve service quality (see Section 6.2.4). While the inputs would go up, so would the output side, which may not necessarily change the efficiency score for staff resource utilisation. Secondly, dealing with many patients in a short time leads to quick examination at government clinics, translating into very "efficient", but possibly not effective time use. In contrast, more careful consultations would improve quality, but also increase inputs and costs. In sum, it is difficult to judge the efficiency of staff resource utilisation without further examining quality.

## **6.2. Quality of Care**

The attempt to specify quality of care comprises all methodological difficulties in defining relative strengths, as outlined in Chapter 2.4. Quality perceptions are specific to the context and contingent upon people's preferences, expectations and experiences. Hence, quality is very relative. The way quality is perceived affects

utilisation, and this is why it is very important to be aware of and take into account people's notions in a quality comparison on the one hand. On the other, there is a biomedical, professional approach to defining quality of care. However, the setting of biomedical quality standards is equally influenced by feasibility and resource availability. In a context of scarcity as in Uganda, standards should target a certain minimum, but simultaneously not be too demanding and hence unrealistic. The Ugandan National Treatment Guidelines provide a useful orientation, which will be used for the analysis of biomedical quality of care.

Combining people's views and expectations (cf. Chapter 4.5.3) and biomedical requirements, quality of care will be conceptualised as the service delivery process comprising a (biomedically) adequate consultation and examination by appropriate staff who provides correct treatment (drugs) and who treats patients with dignity by behaving in a decent way. Accordingly, the following indicators of process and clinical quality of care are applied:<sup>222</sup>

#### Process quality

- Drug availability (Section 6.2.1);
- Staff behaviour and commitment (Section 6.2.2);
- Adequate provision of privacy (Section 6.2.3);
- Waiting time (Section 6.2.4);
- Opening hours and presence of qualified staff (Section 6.2.5);
- Attendance of patients by qualified staff (Section 6.2.6);

#### Clinical quality of care

- Quality of consultation (Section 6.2.7);
  - *The provision of a clinical examination (6.2.7.1);*
  - *Quality of diagnoses (6.2.7.2);*
- Quality of treatment and prescription patterns (Section 6.2.8);
  - *Fit between diagnosis and treatment (6.2.8.1);*
  - *Rational use of drugs (6.2.8.2);*
  - *Use of clinically sterilised syringes (6.2.8.3);* and

---

<sup>222</sup> For similar approaches in quality assessments, cf. McPake et al. 1998, Koppenleitner/Mpabulungi 1997, Kipp et al. 1994 for Uganda, Sinanovic et al. 2000 for South Africa, Mliga 2000 for Tanzania, Aljunid/Zwi 1997 for Malaysia, and Bitrán 1995 for Senegal.

## Patients' view

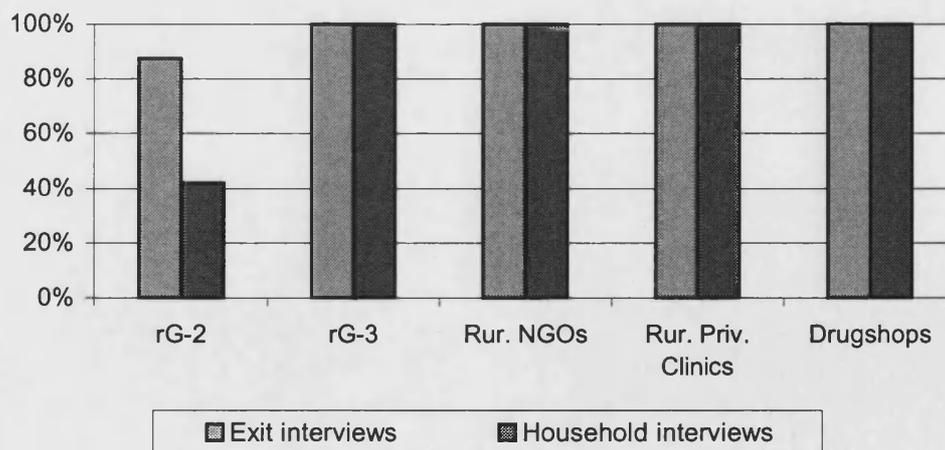
- Patient's satisfaction with service quality (Section 6.2.9)<sup>223</sup>

This subchapter will show that the quality of services differs significantly in many of the above aspects. The relationship with and the implications upon efficiency will be taken up in the concluding section.

### 6.2.1. Drug Availability

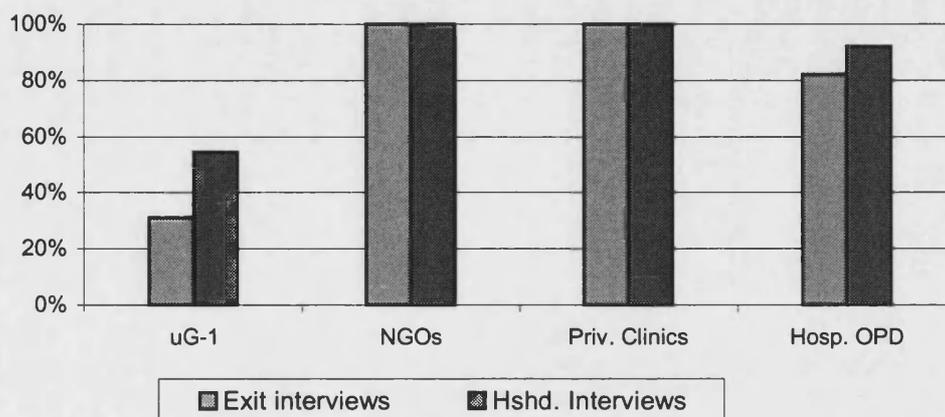
Chapter 4.3 showed that drug supply and costs/subsidisation differ tremendously among the various health care providers. This has implications for user costs, utilisation and drug availability. Drug availability, namely the provision of drugs to the patient at a health care provider, is one of the key elements of the health service delivery process, and in people's view, it is one of the most important features (cf. Whyte 1988, 1992, van der Geest et al. 2000). The previous chapter addressed the relation between the patient's ability to pay and the receipt of drugs. This section will examine the degree to which people have received (all) drugs at the various providers. As Figures 6.7 and 6.8 indicate, non-availability of drugs is only a problem at government clinics and the hospital OPD.

Figure 6.7: Percentage of patients that received (all) drugs at rural providers



<sup>223</sup> The above indicators are not exhaustive, but they allow for a balanced assessment of quality of care.

Figure 6.8: Percentage of patients that received (all) drugs at urban providers



At government clinics, drugs are in principle paid for with the user fees. Yet uG-1 and rG-2 are indeed typical cases for government clinics with limited drug availability in comparison to the other providers (cf. McPake et al. 1999, Okello et al. 1998).<sup>224</sup> Likewise, during all FGDs (except in Subcounty C), discussants emphasised that drugs are not available in the health units, unless one pays additionally and bribes health workers, or unless one has a relative or a friend that works at the government unit, which increases the likeliness of getting drugs. Focus group discussants complained that

"If you don't have money, they only give drugs to a specific class of people, i.e. the leaders and the rich, or those close to them."

"I was examined and diagnosed, but I have not got treatment, because I had no money, even though I am in pain, but ... I have no money."

"Someone died in [rG-2], because they had no drugs (FGDs, 1999).

Many patients received some drugs at the government clinics; however, during the exit interviews, I observed that underdoses are given out at these two clinics as

<sup>224</sup> My or the research assistants' mere presence probably had an effect on the staff's drug dispensing patterns on that data collection day and explains the large difference between exit and household interview responses.

Moreover, the exit interview score for rG-2 is most likely lower, because the first half of the respondents were merely asked whether they had received all prescribed drugs. We then realised the necessity of actually checking their drugs, since some people did not know or simply told us because of fear or maybe shame that they had got all types of drugs, while they had not.

well as at other health units (interview, Bülow, DED health worker, 1999; FGD, Subcounty B, 1999). At uG-1 and rG-2, patients were usually given some 5-10 aspirin or a few Chloroquine tablets, whereas the more expensive drugs had to be bought in drugshops. In rural health centres, at least 40 percent of the patients went to buy drugs at drugshops and spent US\$ 2,158 on average per illness. In the urban government clinic, this percentage is even higher, with 9 out of 20 people going to drugshops and paying from US\$ 400 to 6,000 (mean: US\$ 2,300) on average. McPake et al. (1999: 885) found that patients had to buy a mean of 31.6 percent of the prescribed drugs. rG-3 is somewhat exceptional among the government clinics. There, patients usually receive the prescribed drugs if the in-charge, who strictly controls the drugstore for fear of drug leakage by the other staff, has made them available to the OPD staff when he is not around.

The negotiations of informal payments and the receipt of drugs are very abusive in tone, and government health workers exploit the patients' imperfect information. This is exemplified in the following dialogue, which was witnessed by the research assistant, when a father went to the dispensing window in order to pick up the prescribed drugs for his sick daughter:

Nursing aid: "You think you can get all the drugs from here! You can go and buy from the shop".

Father: "Okay, if you tell me what to buy, I can go and buy, because I want my child to get better, other than giving me half dose."

Nursing aid: "If you think you must buy, you can go and buy."

This answer did obviously not help him and the father gave up.

This "referral" to drugshops presupposes people's knowledge and compliance in buying the missing items in accordance with their prescriptions, lack of which however negatively affects treatment correctness.<sup>225</sup> Being well aware of the lack of qualified staff at drugshops and their malpractice, the health workers' behaviour is very irresponsible. Accordingly, government health units are perceived only as a place to get a prescription. The dissatisfaction with user fees at government clinics is thus not so much due to the amount itself, but to the lack of an equivalent service for

---

<sup>225</sup> Since people are not usually told what to buy exactly, it is assumed that people buy the remaining drugs required by comparing the number of obtained drugs with the required number according to the prescription.

the money (cf. Golooba-Mutebi 1999). So, besides other reasons, poor drug availability explains low utilisation of government clinics. The following statement was heard from many respondents: "Why not go directly to a drugshop [instead of first wasting money at the health centre]?" At drugshops, drugs are available based on the ability to pay, and so drugshops play the critical role in the health care system by making drugs (again) available.

There are several reasons for the limited drug availability at government clinics. On the one hand, the UEDMP supply is not fully reliable (cf. Chapter 4.3). So, when clinics did not receive their kits, they have the option of giving out underdoses or no medication at all. The other major reason for inadequate drug availability is "drug leakage" at the health centre level, that is, the personal appropriation by health workers who then sell these drugs on a private basis.<sup>226</sup> The remaining drugs are not sufficient in relation to the patient load. McPake et al.'s study estimates that 76 percent (median) of drugs disappear into private channels (1999: 854). An informal monthly drug store check over a one-year period revealed that in half the clinics, the most essential drugs were existent in the store, including uG-1, rG-2, and rG-3. In the other half, even the most essential drugs were not available any longer only one month after the supply of kits (supervision reports, Müller-Stöver, DED doctor, 1999). Thus, the stores were practically empty, which also indicates that these units do not buy them on the local market.<sup>227</sup> The problem, however, with such a static indicator is that it does not measure drug flow and does not say anything about availability over time or about actual availability to people. Instead, it indicates different patterns and flows of leakage.

In order to supplement the EDKs and improve drug availability at the health centre level, government clinics are directed to spend 20 percent of their monthly user

---

<sup>226</sup> There are various strategies for making drugs leak from the store without creating a gap in the drug store records. One easy way is to give out underdoses or no drugs at all, but record a full dose in the record books. Another option is to report ghost patients.

<sup>227</sup> Another report studying drug availability in three government health clinics in Kamuli (including uG-1 and rG-2) found that two thirds of 19 selected essential drugs were available (Koppenleitner/Mpabulungi 1997: 40, own calculations). Similarly, Kafuko et al.'s (1993) analysis on rational drug use in six Districts within all regions reveals that for five conditions, 92 percent of the drugs are in place.

fee revenues on local drug purchases to buy the most essential missing drugs.<sup>228</sup> Some of the clinics do buy additional drugs, but in the three selected units, it is below the supposed level, namely 14 percent (uG-1), 5 percent (rG-2) and 8 percent (rG-3). The purchase volume is thus minimal, considering the local drug prices, and cannot fulfil the objectives of the user fee policy, namely quality improvement through increased drug availability. Overall, clinics act strategically and store some drugs for unforeseen supervisory visits by the DMO (or when visitors, including researchers, are around) and for those patients willing and able to pay additional charges. Hence, the resulting crucial question is whether the policy of using user fee revenues for drugs makes sense in the context of this high extent of leakage (McPake et al. 1999). In any case, it makes a cost-effectiveness analysis (including drug costs) useless.

At the Mission hospital OPD, there are also incidents where people do not receive all drugs, although at a much lower degree than at government facilities.<sup>229</sup> The problem of non-availability of drugs that are out of stock must also be seen in the context of the supply difficulties caused by the District authorities (see Chapters 4.4 and 8). However, following up the case of one exit interviewee revealed some irregularities. The respondent had paid the required amount at the drug-dispensing window, but was then told that the two drugs needed were out of stock. He was sent to the hospital's pharmacy (the drug store located at the other end of the hospital compound). There, he was given only one type of drug and again informed that the other type prescribed was out of stock and that he should go to the drugshops in town. He did not receive a refund (but he also did not ask for it). The attendant of the respondent (an active NGO volunteer), whom I knew and to whom I give much credibility, suspects that the drugs ended up in private pockets:

"Maybe the OPD nurses work together with the pharmacy. They cannot ask people for money and then not give them the drugs, because then people would question the payment. So, they send them to the pharmacy, where they then do not give out the drugs. You do not expect people going back to the window and

---

<sup>228</sup> The paradox is that there is no pharmacy in Kamuli District that is licensed to sell class A and B drugs.

<sup>229</sup> This must be differentiated from the cases in which patients are unable to pay the required amount (see Chapter 5.6).

ask for a refund afterwards. The poor people from the village would not dare. They do not know about the procedures."

In fact, a couple of outpatients were seen going to the pharmacy, obviously because they were told that drugs were not available at the OPD. On the other hand, one staff of the hospital management pointed out that

"Drugs are often stolen by the staff at the dispensing window, though they are not even government nurses. That is why for example antibiotics are given out at the pharmacy" (interview, 1999).

It was not possible to find out what really happened. Whether drugs are taken away or out of stock, the problem is that people are not given the drugs or a refund when they are sent to the pharmacy. Furthermore, there was one exit respondent who was told to buy some of the drugs at the drugshop. Comparing the amount of money he had paid with the drugs received and the hospital's drug prices, it seems that he had paid more than the drugs were worth. This patient was a poor peasant, came from far away, attended the hospital for the first time and was probably not familiar with the procedures. He did not receive the usual receipt and was hence not aware of being cheated. Altogether, drug availability can fall victim to the staff's informal income generation strategies, which are copied from government practice. NGOs do not exist in a vacuum or in a different sphere; rather the general environment of embezzlement, the allowance culture, and corruption influences their operations. Yet, these occur at a much lower extent than at government clinics and are more difficult to keep in secret (see Chapter 7 for further elaboration).

At the rural NGO clinics, there was no patient in the sample that did not receive drugs, and focus group discussions confirmed that drugs are available (cf. Okello et al. 1998: 19). Drug provision and availability to the patient is a function of drug supply and direct payment, that is, the patient's ability to pay. Therefore, only people who have money will actually attend those clinics. It is also one of explicated patients' rights at the Protestant clinics to receive drugs and proper treatment. At the urban NGO and private clinics, all respondents obtained drugs, except for three patients at the more expensive clinic P-4, who did not have enough money. At these clinics, drug availability is equally contingent upon the payment, with the negative implications upon access and quality of treatment.

In sum, at all provider types, complete drug availability is ultimately a function of the patient's ability to pay. The consequences are underdosing and/or weakened treatment discipline if a patient is unwilling to follow the prescription and to purchase what it says.

### 6.2.2. Staff Behaviour and Commitment

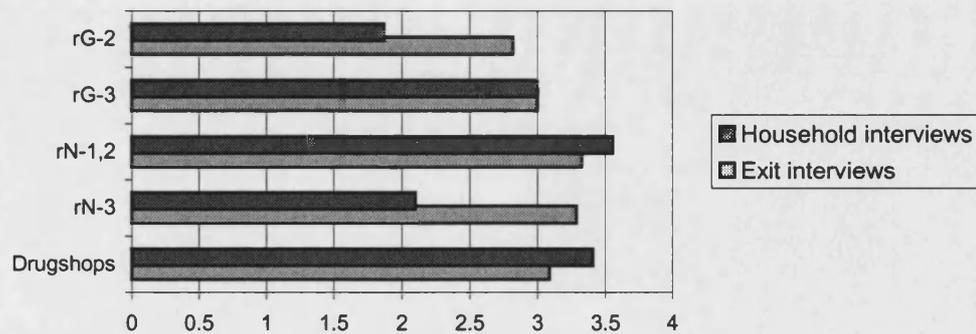
The attitude of health staff towards patients is a crucial element in health care provision. First, illness and medical care can threaten a person's dignity and his or her ability to exercise control over him- or herself; adequate staff behaviour is hence a fundamental part of easing people's anxieties (WHO 2000: 14). Secondly, staff behaviour will have an impact on the patient's contribution to recovery. For example the patient must know afterwards how to take the drugs prescribed (cf. Hentschel 1999: 77). Thirdly, an effective health consultation and examination requires interactive communication, in which the patient feels comfortable.<sup>230</sup> Moreover, friendly staff behaviour is very important for people, because it shapes the (access to the) service transaction.

To assess staff behaviour, people were asked what they thought about the staff behaviour. These statements could be triangulated by my own observation and that of DED health professionals. People's socio-economic background and their different expectations and experiences affect their assessment of staff behaviour. Whether and how the staff asked for informal payments and whether drugs were obtained will therefore also be part of their assessment. Figures 6.9 (for rural providers) and 6.10 (for urban providers) present people's assessment. These figures demonstrate considerable differences among and between provider types, with drugshops and the Protestant clinics scoring best in rural areas and private clinics scoring best in town.

---

<sup>230</sup> Hentschel emphasises the importance of a balance of control between the staff and the patient (1999: 77).

Figure 6.9: Satisfaction with staff behaviour at rural providers (means)

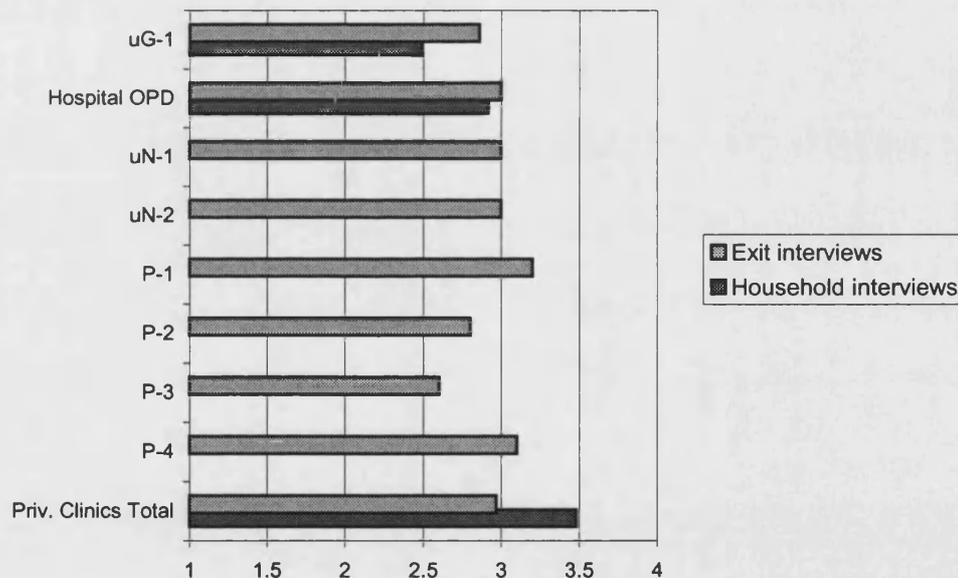


Answers were prompted: bad (=1), fair (=2), good (=3), very good (=4).

(Means were tested for homogeneity, but were not found to be significantly different.

This is also the case for Figure 6.10.)

Figure 6.10: Satisfaction with staff behaviour at urban providers (means)



Answers were prompted: bad (=1), fair (=2), good (=3), very good (=4).

(In the household interviews, case numbers for urban NGO and private clinics were very low, if not zero, which is why no score is reported.)

### Government clinics

Figure 6.9 and 6.10 reveals considerable differences between uG-1, rG-2 and rG-3, and these differences are confirmed by the available data of another 11 government

clinics.<sup>231</sup> This variability suggests a more differentiated view than the general bad reputation. In seven of these, the staff is unfriendly and rather rude. At the other seven units, staff behaviour is friendly.

With a score of 3.00<sup>232</sup>, rG-3 presents one of the positive examples, which is confirmed by my observation and focus group discussions. Patients are greeted and addressed in a friendly manner, the atmosphere is relaxed, and staff and patients chat together. People also mention that the staff is committed. At uG-1 and rG-2, in contrast, the average score is lower. People are dissatisfied with the lack of commitment, unfriendliness, abusing and rebuking, lack of drugs and long waiting times. The patient-staff relationship is cold and patients are not greeted or even looked at when entering the consultation room. Their body language shows discomfort if not fear.

It is particularly the poorer rural people who are confronted with abusive behaviour, which the following examples that a key informant witnessed at uG-1 illustrate:

Rural women who come for ANC often receive the insult:  
"You don't come dirty to the clinic, you just go out".

A patient was sent to the laboratory, but did not know where to go and therefore asked the nursing aid again, who answered: "Don't think that I am stupid. I told you where to go" (interview, key informant, 1999).

Rude staff behaviour lowers service quality, and at the same time, it serves as an enforcement mechanism for informal payments (cf. McPake et al. 1999).<sup>233</sup> Given the existing consumer surplus, it is difficult to resist pursuing this rent-seeking strategy (see Chapter 7 for further elaboration). Poorer people fear the health workers and suffer most from their rude and insulting behaviour, since they are least in the position to pay the additional high charges to "buy" better behaviour. This practice also seriously undermines trust, and in combination with lack of money, rudeness and abuse lowers utilisation. However, if people want higher level services but are unable to pay the charges in private and NGO clinics, they are forced to go to the urban

---

<sup>231</sup> This assessment is based on the DED health professionals' impressions collected through several years' observation of staff behaviour and patients' predisposition when coming to the clinic.

<sup>232</sup> This and the following figures are based on the household survey, given the higher validity of the responses there (cf. Chapter 1.4).

<sup>233</sup> Killingsworth et al. (1999) note the same for Bangladesh.

government clinic and make trade-offs between staff behaviour and trust on the one hand and financial considerations on the other. Having a friend or a relative working at a government unit was mentioned as an explicit reason to go there, as it guarantees friendly treatment.

Bad staff behaviour goes hand-in-hand with low motivation, low commitment and lack of responsibility. Again, the poorest suffer most. The following experiences that very poor looking patients made at various government clinics attest this point:

Waiting in a crowd of other patients for re-consultation, a baby died soundlessly in his mother's arms. As it turned out, the child had been examined at the laboratory and had very bad blood pressure. The mother was then sent back to the line, without anybody taking care of the direness of the situation. None of the health workers comforted the mother when she started crying and mourning her child (witnessed by an expatriate visitor).

Just shortly after the closure of the OPD, at about 2 o'clock, a young father arrived on his bike transporting a small boy, who was unconscious from malaria convulsions. Nobody looked after the two; the father was sent around several times between the OPD and inpatient wards. A nurse finally attended to him in the IP ward, presumably because she saw us observing the incident.

A very old and very sick man from the village came with a younger male attendant. He could hardly walk and sit or get down on the bench. He was breathing so badly that he fell from the bench and started groaning heavily. The medical assistant was not yet on duty by then, but this is not a reason for the nursing aid not to look after the patient. In fact, only when the witnessing research assistant looked after the two, did the nursing aid take notice and send the patient to the laboratory.

In another clinic, it is known that the medical assistant comes to work drunk, and probably due to his restricted clinical assessment, children were known to have died who otherwise could have been saved with the correct treatment. Patients are left on the wards without treatment for days and there is not even a note with the diagnosis (personal communication, DED doctor, Müller-Stöver, 1999). The list of such examples is lengthy. They illuminate that ethics and responsibility are not present. In contrast, at rG-3, respondents described the staff as motivated, committed and caring for the patients.<sup>234</sup> Thus, the variance among the health units suggests that bad staff behaviour is not inevitable. Good leadership and the in-charge's exemplary behaviour

---

<sup>234</sup> This positive assessment is also associated with the more adequate level of drug availability and the absence of informal payments.

can set the rules for interpreting and implementing institutions and thus create an atmosphere in which friendly behaviour and commitment is standard.

### Rural NGO clinics

At the Protestant rN-1 and rN-2 clinics, both the exit and the household interview sample produce a high score on staff behaviour satisfaction (3.56). Patients are treated in a very friendly manner. The staff chats with patients, the atmosphere is relaxed and patients feel relatively comfortable. People appreciate prompt attention and the staff's committed and caring attitude. Satisfaction with staff behaviour is strongly interrelated with payment issues, as one household respondent emphasised:

"They ask you in a friendly way how much [money] you have".

However, HUMC members mentioned that there had been two health workers in the past whose behaviour was not satisfactory, causing a fall in the number of patients. Personality factors and training in a government institution (versus a Mission training institution) were seen as the main reasons for their bad behaviour.

In contrast, rN-3 is rated rather low (2.10). People's negative assessment of staff behaviour is influenced by their dissatisfaction with user charges, particularly due to previously free services. Except for the Sister in-charge, the nurses were described as being rude, unfriendly and not committed and only talking politely to those who were well dressed. One female focus group discussant regretted:

"The behaviour of these people is as if they were trained to behave badly. ... They are quarrelsome. ... When you are pregnant and you go there, you are abused, they rebuke you before being examined. You can be walking towards her and the nurse says: 'Hurry up to come. Don't you know that time is passing!'"

The in-charge herself admits:

"We have the tendency to abuse patients and ask them: 'Why didn't you come to a health unit earlier?'" (interview, 1999).

Another reason for dissatisfaction is that nurses do not attend immediately when they are called at their home, which is right next to the clinic. One respondent complained that they once did not wake up at night: "You just stay at home or you die there". Overall, apart from the Sister in-charge, motivation and commitment among the other nurses appear to be rather low.

### Drugshops

Most of the drugshop staff are very friendly and caring. In fact, people's assessment is highest for drugshops (3.41). People appreciate the staff's good language, their greeting, commitment, immediate service and attendance, as well as the absence of rebukes and abuse. Another reason for people's satisfaction is the provision of credit. These are all aspects that people feel do not exist at government clinics. However, a third of the respondents relate the good behaviour explicitly to their business and money-mindedness, and almost a tenth (8 out of 86) of the respondents that made statements on drugshops did not consider the behaviour to be good. The reasons given were, for example, money-mindedness, denial of access at night because of a patient's lack of money, or being put on hold in favour of those customers with larger purchases.

### Rural private clinics

Overall, the rural private clinics are rated well, given their observed commitment and kind behaviour. But there are exceptions. For example, one expensive private practitioner, a senior medical assistant who is also employed in government, was reported to be committed only to the well paying patients and to put off clients who had little money. He could afford to do so in light of his other income sources – apart from his government job and his garden activities, he is a councillor (as is his wife), and another family member is an MP.

### Urban non-state facilities

NGO and private clinic users are generally satisfied with staff behaviour, resulting in a very high household score (3.5).<sup>235</sup> Everything that people miss at the government health units is mentioned positively at these clinics, specifically kind behaviour, immediate attendance, drug availability and absence of abuse and rebukes. NGO and private clinics depend upon a high patient load. Thus, friendliness and kindness are obvious elements of their services: "It is business, for which we pay", many respondents said.

---

<sup>235</sup> 3.53 for uN-1; there were no cases for uN-2 in the household sample.

Staff behaviour is also well assessed (2.92) at the hospital OPD. However, there is a difference in staff behaviour at the OPD and the wards, as inpatients are often only cared for, when they give bribes. The ethic of various doctors must also be questioned in light of the following incidents that were witnessed by DED health professionals:

A nursing aid reported the aggravation of a patient's state at the home of the doctor on duty (on the hospital compound). He told her, "I'm having my lunch. You come later. Don't bother me." When a present medical assistant and another DED staff reassured the nurse that her immediate call was correct, he said, "You really think that my lunch is not more important....!?"

A woman was having difficult labour. The doctor on duty was called from his home (on the compound) to look after her. He had to be asked twice and it took him two hours to come.

Further, in the past, doctors on duty in the inpatient wards have been absent (usually going to their private clinics), one was often drunk in the evening and therefore postponed emergency operations until the following day. Irresponsibility is also found among the nurses and midwives. Staff on duty was sometimes found to be asleep, to have gone for a walk, or to simply have been careless (interview, hospital staff, 1999). It is difficult to prove that the death of a patient was due to irresponsibility; nonetheless, it is known that post-operative patients or mothers in labour are not sufficiently supervised at night (personal communication, Krötz, DED-surgeon, 1999). Nevertheless, as expatriates note, who work in both the hospital and government clinics, the hospital staff has in general a better work morale and is more committed and motivated than their counterparts at government units. Furthermore, these happenings sharply declined when the hospital administration was fully taken over by Sisters; for example, the drunken doctor has been dismissed right away.

In sum, NGO and private clinics, as well as the hospital OPD, perform much better as regards staff behaviour, commitment and reliability, apart from some incidents at the hospital. Finally, it is also clear that many people choose a provider because a friend, neighbour or relative had recommended them. Consequently, social relations and trust become increasingly important factors for the functioning of health care and for people's choice of provider in that they lower the risk-perception and the

fear that surrounds the process of seeking health care. Birungi (1998), in her study on injection practice in Busoga, makes a similar point.

### 6.2.3. Adequate Provision of Privacy

Just as friendly staff behaviour of staff is key, so is the provision of privacy to respect the patients' personal sphere and to treat them with dignity. Granting privacy to the patients is part of the national standard rational drug use indicators (Kafuko et al. 1993).

Government clinics are the only provider type that does not offer privacy, and this is also a reason for insufficient clinical examinations taking place (see below). Usually, the windows and doors of the examination rooms are left open, while the other patients waiting in the queue sit on a bench in front of the windows, if not on the windowsill itself. In rG-3, patients are consulted in the open space on the veranda. Rarely does a health worker examine a patient in the examination room. There is usually neither visual nor auditory privacy, so that people do not like to undress or talk about "embarrassing" problems. The lack of privacy is not related to the conditions of the premises; instead, it appears that health workers aim again at aggravating services in order to force people with serious illnesses and greater need for privacy to go to their private clinics and homes.

In contrast, at the Protestant clinics, privacy and confidentiality are central components of their explicit "patients' rights". Likewise, the other NGO and private clinics and the hospital OPD examine in privacy. Clearly, the non-state clinics have recognised their relative strength in providing privacy:

"Why are we surviving? People need privacy and dignity, which is not provided in government clinics. People have nowhere to go, they want privacy, as some conditions cannot be attended to in the hospital, venereal diseases for example. So they come to the private clinics to be examined" (interview, P-2 practitioner, 1999).<sup>236</sup>

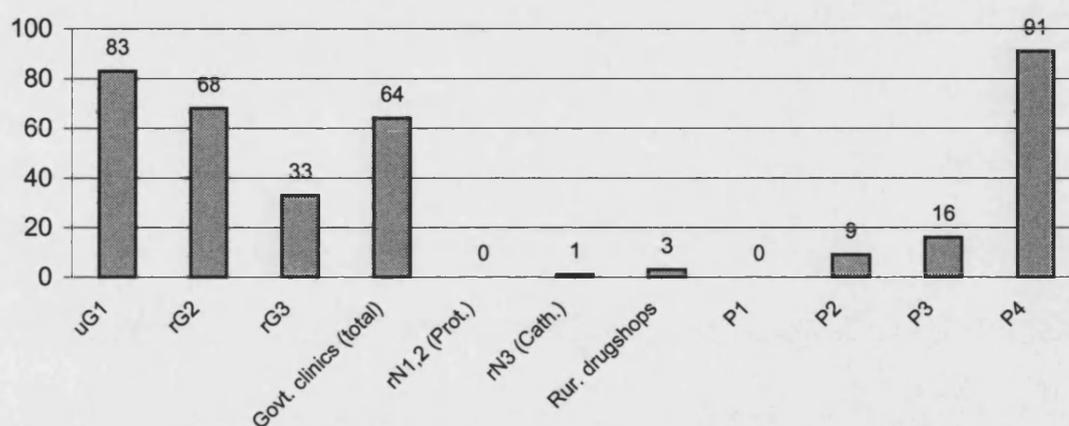
---

<sup>236</sup> For people's notions of "private diseases" (STDs), cf. Kaharuza et al. (1996).

#### 6.2.4. Waiting Time

Waiting times constitute important opportunity costs and a critical factor for people in deciding where to go and in judging quality of care. Figure 6.11 presents the different means of waiting time.

Figure 6.11: Average waiting time until registration/attendance (in minutes)



Source: Exit interviews

Apart from one private clinic, waiting times are longest in government clinics, especially in those with a higher patient load. This is because of the health workers' habit of waiting for an "adequate" number of patients to assemble before starting to attend. People would arrive early in the morning, also because they fear that they may not be attended to if they come late in the morning. For example, the dentist at uG-1 only works up to a certain time. Everybody thereafter is asked to come on the following day. Similar practices may prevail at other units as well. Intentionally making people wait, while the staff is around, is strongly resented by people. Moreover, the total waiting time is much longer, because the service delivery process itself is very time-consuming and resembles an assembly line. After registration and consultation, the patient has to queue for the laboratory examination, wait for the results, a second consultation, and possibly an injection or drug dispensing. Hence, a patient can spend the whole morning at the clinic, while the actual time spent with one health worker is very short. Making people wait serves to reduce quality and opens up rent-seeking opportunities for people who are willing to pay in order to

jump the queue. However, the waiting time must not necessarily always be considered negative. In rG-3, patients sit and wait for about half an hour on the veranda, where consultations take place (the majority are mothers with children), while the MA gives health education talks.

The waiting time is not problematic in those government and NGO health units with a low patient load where patients just drop in. Okello et al. (1998: 19) also report statistically significant shorter waiting times in NGO clinics.<sup>237</sup> Yet at the Catholic clinic, people complain that if the staff is not in the clinic but at their residences (on the compound, though), patients have to wait a long time for them to come over. By contrast, at the urban private and NGO clinics, waiting time is a function of the patient load and the time spent per patient, particularly at P-4. People also have to wait quite a long time at the hospital OPD (on average 39 minutes), and again, as at government units, patients have to queue at the various stations. This is one reason why many avoid the hospital OPD.

In sum, the argument that quick attendance (resulting in low opportunity costs) made in favour of non-state clinics does not fully hold true. However, for patients, the difference between government and other clinics is that patients are not intentionally made to wait at the latter.

#### 6.2.5. Opening Hours and Presence of Qualified Staff

The availability of qualified staff to attend to patient is self-evidently one of the most important elements in providing adequate health care. This section compares the opening hours and the average presence of qualified staff in the selected units (Tables 6.1 and 6.2), based on observation and key informant interviews.

---

<sup>237</sup> Azfar et al. (2000) found the average waiting time in government clinics to be 71 min. and 18 min. in non-governmental organisations.

**Table 6.1: Staff presence at rural providers**

	<b>rG-2</b>	<b>rG-3</b>	<b>rN-1</b>	<b>rN-2</b>	<b>rN-3</b>	<b>rN-4</b>
Highest qualified staff	MA	MA	Midwife	Midwife	Midwife-nurse 1 Nurse 1 Midwife	Midwife
Opening hours	9:30–13.30	10:00–15:30	7:00–18.00	7:00–19:00	8:00–13:00	7:00–20:00
Presence of qualified staff	seldom	seldom	not always; not on weekends	usually; not on weekends	not always	not always

**Table 6.2: Staff presence at urban providers**

	<b>uG-1</b>	<b>uN-1</b>	<b>uN-2</b>	<b>Hospital OPD</b>	<b>P-1</b>	<b>P-2</b>	<b>P-3</b>	<b>P-4</b>
Highest qualified staff	MA	MA	MA	Doctor			MA Doctor	
Opening hours	Officially: 24 hours In practice: 10:00–14:00	8:00 until evening	8:00–19:00	8:00–17:00	9:00 until evening 24 h presence of a nurse	8:00 until evening	9:00–18:00	9:00–18.00
Presence of qualified staff	10:30–14:00	9:30 until afternoon	9:00–18:00	8:00–17:00	9:00 until evening	9:00 until evening	9:00–18:00	10:00 until evening

Source: Observation and interviews

### Government clinics

Opening hours of rural government health units are the most restricted, and the hours are not compatible with people's farming activities. The presence of qualified staff is even worse. In 5 out of the 13 rural government health units, on which information could be gathered, the MA is usually present and works in the OPD only one day (i.e., about three hours) per week at maximum. In six units, the MAs come two to three times a week, while only in two cases is the MA said to be usually on duty. This means that at most times, lower staff – nurses and nursing aids – runs the OPD. Nurses, who are actually not qualified to examine and treat patients on their own either, are equally often absent, and some government facilities lack entirely a nurse, so that ultimately nursing assistants with no qualifications take over. A quantitative study in two other Districts revealed that unqualified staff contributed 71 percent of working hours (McPake et al. 1998: 858).<sup>238</sup>

### Rural NGO clinics

The Protestant clinics (rN-1, 2, 4) are usually open for the whole day (10 hours) as well as on weekends. The midwives' presence on duty varies, one of them usually being present, whereas the other two are more often absent. In their absence, especially on weekends, nursing aids attend the patients, although they have received only little training on the job. rN-3 is open during the morning, and patients have to call the staff at their residence (on the compound) in the afternoon. Respondents indicate that it is very difficult to be attended by then. This clinic must at least be granted some credit for the fact that patients are not treated by nursing aids, but this also implies that a patient may have to wait very long.

### Drugshops

According to business opportunities, most of the drugshops open early in the morning (8:00/9:00) until the late evening (21:00). Drugshops at the owner's or the attendant's residence are much preferred, since patients can even come very early in the morning or at night. However, some respondents reported that night services are not available

---

<sup>238</sup> McPake et al. (1999) report that staff rotate to guarantee daily staff presence whilst simultaneously allowing for the health workers' private activities, yet this rotation scheme presumably includes unqualified staff.

for people who are known to have little or no money. As said already, most drugshop attendants are insufficiently qualified, and nurses are only rarely found there.

### Urban clinics

At urban NGO and private clinics, opening hours are more convenient and longer from around 8:00/9:00 until the late afternoon or evening, so long as there are patients.<sup>239</sup> In all non-state clinics, qualified staff is usually present during the day, since they try to foster a reputation of always being present.

In sum, government clinics come off worst both in terms of opening hours and presence of qualified staff, whereas urban NGO and private clinics, as well as the hospital OPD, perform adequately.

### 6.2.6. Attendance by Qualified Staff

The presence of qualified staff does not imply that they attend to patients. For example, in a couple of government health centres, the MAs are present, but they do not work in the OPD.

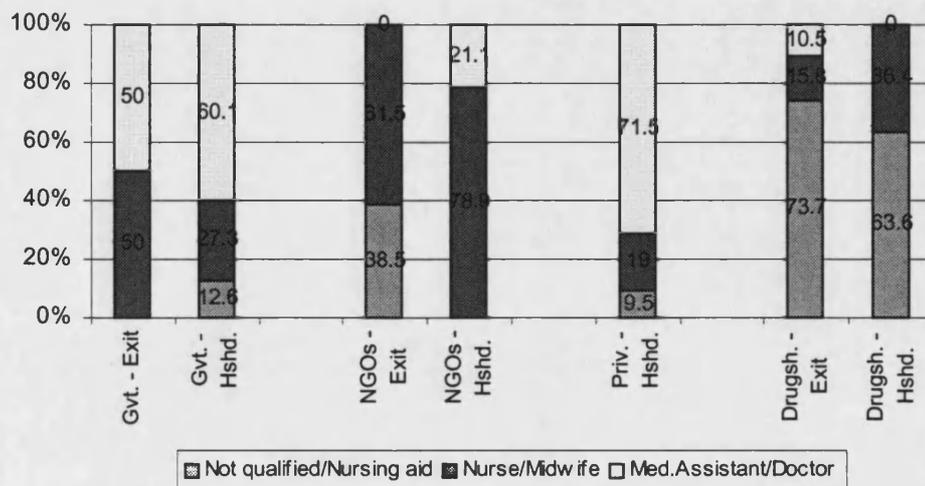
As Figures 6.12 and 6.13 show, a large proportion of the respondents were not attended by the clinic's highest qualified staff, but were looked after by unqualified staff. Not surprisingly, the percentage is alarmingly low at drugshops. At rural government clinics, only half of the patients were attended to by the medical assistant.<sup>240</sup> Adequate clinical quality of care is therefore doubtful. By contrast, patients at urban clinics are more likely to be attended by qualified staff, but again uG-1 scores worse than the others.

---

<sup>239</sup> Longer operating hours and more flexible clinic schedules were also advantages found in Malaysian private clinics (Aljunid/Zwi 1997: 92).

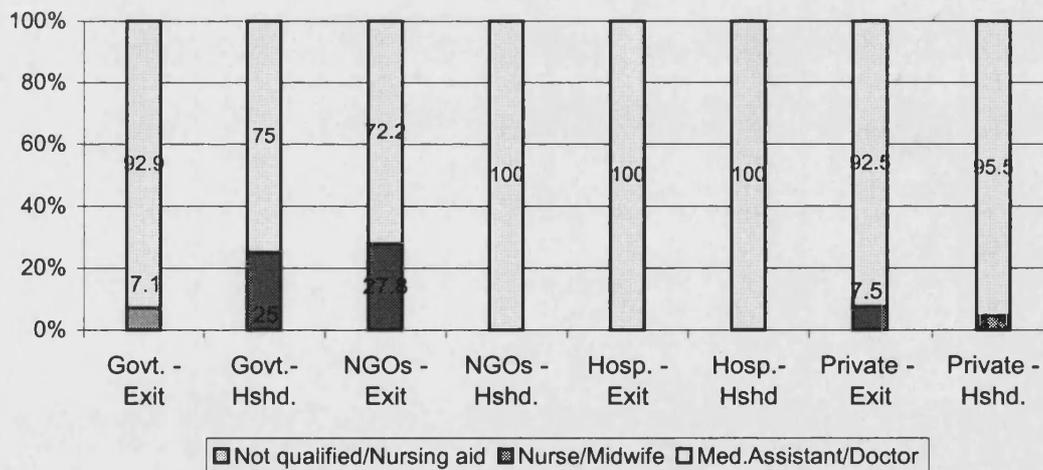
<sup>240</sup> The percentage from the household interview sample is higher. This is because people often take a male nurse for a medical assistant, whereas the respondents' answers during exit interviews could be verified through direct observation.

Figure 6.12: Qualification of attending staff at rural health care providers



Source: Exit and household interviews  
(Hshd. = Household respondents; Exit = Exit respondents)

Figure 6.13: Qualification of attending staff at urban health care providers



Source: Exit and household interviews

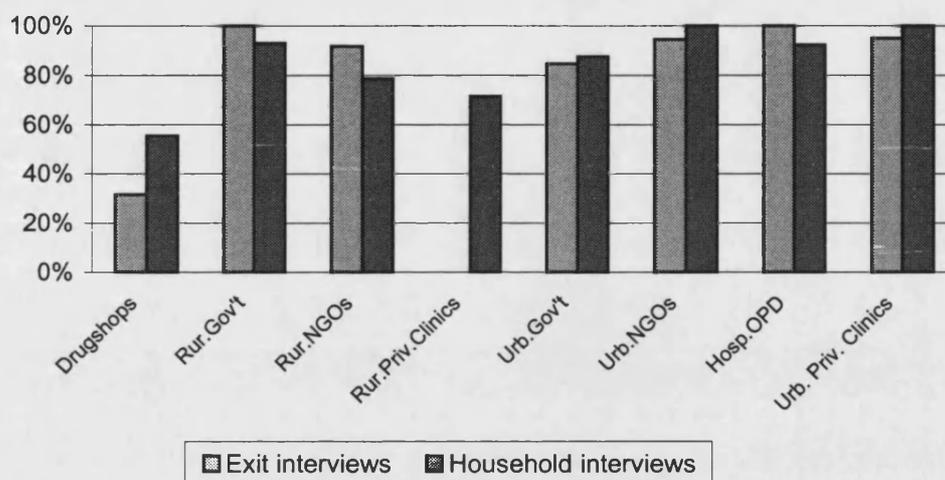
### 6.2.7. Quality of Consultation

#### 6.2.7.1. The Provision of a Clinical Examination

It goes without saying that a correct clinical examination is a central component of the health care production function. For an approximation, people were asked whether they had been physically examined (see Figure 6.14). With the exception of

those attending drugshops and rural private clinics, the majority of respondents affirmed the question. uG-1 is remarkable, because about 15 percent of the exit interviewees reported that they had not been physically examined at all.<sup>241</sup> This is about twice as much as the percentage of other urban providers. Whether or how people were really examined is unknown, so these answers cannot be taken at face value. However, drugshops and uG-1 stand out, which indicates that there are some differences in the actual examination.

Figure 6.14: Percentage of patients being examined, patient's perception



At government clinics, it is known that patients are seldom fully clinically examined (interviews, DED health workers, 1999). Examination instruments such as the blood pressure monitor, the stethoscope or a thermometer are usually locked away. Instead of receiving a careful clinical examination, people describe their history, symptoms and their view of the disease. This, together with the laboratory results, if a laboratory examination is deemed necessary (and where a laboratory is available), constitute the basis for the diagnosis and the treatment prescription. It also appears that health workers avoid body contact with and do not like touching a patient. A professional's medical analysis of the adequacy of the examination at government clinics revealed that three quarters of the examinations were incomplete

<sup>241</sup> Exit interview responses are considered to be more valid because of the shorter recalling period.

(Koppenleitner/Mpabulungi 1997: 35).<sup>242</sup> There is no corresponding data available for the private and NGO sector.

As a substitute, respondents were specifically prompted about a number of standard examination procedures and elements. This list was informed by health professionals and included lying on the bed, (partial) undressing, use of stethoscope, blood pressure check, laboratory examination, temperature check, touching, and examining eyes, throat, and ears. The results are presented in Figure 6.15.<sup>243</sup> Even though clinical examinations at the NGO and urban private clinics are likely to be equally incomplete or inadequate, this indirect analysis found that they still made more effort to examine patients than government workers did. Given the higher extent of qualified staff in town, examination in the private and NGO clinics and in the hospital OPD is in general more thorough. The level of examination at drugshops is lowest, but it is surprisingly high in relative terms, which indicates that drugshops actively seek to take their niche among the health care providers. Some drugshop staff carries out some superficial examining (e.g. touching, use of stethoscope) from my lay assessment. It seems that this kind of examination is often only of symbolic rather than of clinical value and serves to give the patient the impression of receiving an examination rather than contributing to ascertaining the diagnosis.<sup>244</sup>

It is difficult to explain the absence of physical examinations. Possibly, the prevailing professional culture is that the patient's mere description of symptoms suffices for the diagnosis and the treatment decision and that using an examination instrument is a sign of professional weakness and insecurity (personal communication, DED health professional, Kristen, 1999). In addition, a less careful and thorough examination saves time. It is again a manifestation of the prevailing low commitment and motivation and serves to lower the workload and the quality of

---

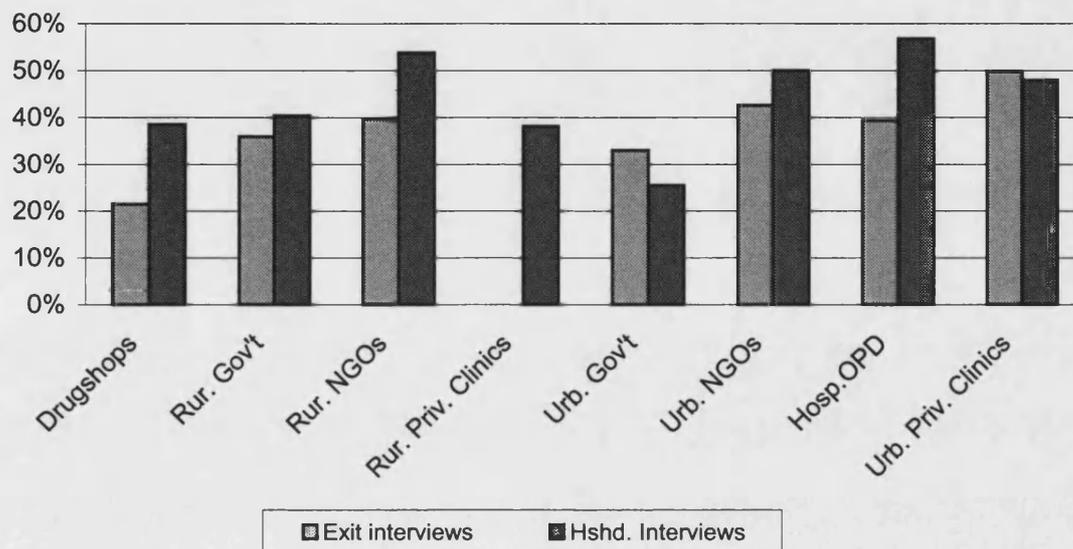
<sup>242</sup> This figure includes the results from Tororo and Jinja District, but Kamuli was found to be at the lower end.

<sup>243</sup> It is important to point out that this quantitative account of examination procedures is only a rough approximation and does not say anything about the correctness of an examination. Hence, the figures must be assessed in relation to each other. For disease incidents that did not require each examination element the maximum score of 100 percent was readjusted.

<sup>244</sup> This is similar to what Barbara McPake observed in nursing aids during ANC examinations at government clinics (personal communication, 2000).

care.<sup>245</sup> Clearly, the non-state sectors' efforts are a reaction to people's preference for being examined.

Figure 6.15: Relative examination quality (in %)



(100% = maximum quality level)

#### 6.2.7.2. Quality of Diagnoses

Short and incomplete examinations often result in wrong diagnoses and hence wrong treatment. Supervisory visits at government units revealed a high proportion of wrong diagnoses. On one day, the majority of diagnoses at one health centre were wrong, basically due to the failure to clinically examine the patient (personal communication, DED-health professional, Müller-Stöver, 1998). A systematic clinical analysis found that only a third of diagnoses were complete and correct (Koppenleitner/Mpabulungi 1997: 35). At the extreme are the following observations at various government health centres. These incidents cannot be excused by lack of knowledge, but only be explained by mere lack of commitment and carelessness on the part of health workers:

<sup>245</sup> However, I have nowhere witnessed informal payments specifically given to acquire a clinical examination (cf. K. Leonard 2000).

A boy reported tooth ache and was sent to the queue at the dentist's room, whereas he actually suffered from an abscess in the cheek, as was discovered later.

During an immunisation session, it was found that about half of the children were ill. The staff did not notice this, so that there were no consequences on the immunisations and neither were the children treated (personal communication, Müller-Stöver, DED doctor, 1999).

Very little information is available for the other providers. One government medical assistant strongly complained about the poor knowledge of the NGO health worker in the nearby NGO unit, as she had asked very basic questions about diagnosing that she was supposed to know. However, the referral rate of rural NGO clinics is very high, which reduces the opportunities for wrong diagnoses. At urban NGO and private clinics, conclusions about the correctness of the diagnosis itself can be drawn from a comparison between the diagnosis and the prescribed treatment.<sup>246</sup> These appeared questionable in at least 10 percent of the cases and revealed serious mistakes. The actual figure is probably much higher. There were also cases in which patients at private clinics had become severe hospital cases due to incorrect diagnoses and treatment. For example, a patient was treated for abdominal pain at a private clinic until he had to be admitted at the hospital where the diagnosis was changed to appendicitis. In contrast, the hospital OPD is most of the time run by a doctor, with the result that diagnosing is very good (interviews, DED health professionals, Kristen, Krötz, Müller-Stöver, 1999).

In sum, the data set does not allow for a clear judgement, but it seems that all provider types except the hospital OPD perform inadequately as regards diagnosing.

## 6.2.8. Quality of Treatment and Prescription Patterns

### 6.2.8.1. Fit between Diagnosis and Treatment

In addition to inadequate diagnosing (leading to inadequate treatment), another problem is the misfit between a supposedly correct diagnosis and therapy. Table 6.3 shows both the percentage of treatments that corresponded to the diagnosis and the

---

<sup>246</sup> This was carried out by DED health professionals.

percentage of adequate treatments. The sample is too small to draw firm conclusions, but it appears that there are no significant differences between the higher-level providers as to the fit between the diagnosis and therapy or the appropriateness of the treatment. At both government clinics and urban NGO and private clinics, treatments are flawed due to inadequate doses, overdoses and incorrect medications. One health worker at an urban NGO clinic admitted that because they lack inpatient facilities, they are unable to follow the correct six-hourly injection schedules, which is why they switch to suboptimal treatment (interview, nurse, 1999). Some private practitioners admit that they do not always fully follow the standard treatment guidelines for STDs, since this would be unaffordable for some patients.<sup>247</sup>

Given the low staff qualifications and the fact that drugshops prescribe and dispense drugs according to their stocks, the relatively high score of drugshops – not very much below that of the other providers – is surprising. Yet, as a large proportion of customers come with minor diseases and ask for one specific drug, there are relatively fewer opportunities to make severe mistakes.

Table 6.3: Treatment quality

	Government (N=50)	Drugshops (N=63)	Urban NGOs (N=63)	Private clinics (N=46)	Hospital OPD
<b>Appropriate treatments<sup>248</sup></b>	44% <sup>a)</sup>	36%	47.5%	44%	N/A
<b>Fit between diagnosis and treatment</b>	medium <sup>b)</sup>	45%	64%	73.3% (clinics run by MAs: 60%)	very good <sup>b)</sup>

Source: Patient books analysis<sup>249</sup>, observation at drugshops

<sup>a)</sup> Data was gathered during a clinical assessment by observing the consultation process (Koppenleitner/Mpabulungi 1997: 35).

<sup>b)</sup> Assessment by supervisory doctor: "very good" meaning that performance is better than at the other providers; and "medium" meaning not worse or better)

No comparable data is available for the rural NGO clinics and the hospital.

<sup>247</sup> This is also found at South African private practitioners (Sinanovic et al. 2000: 5).

<sup>248</sup> This category denotes a completely correct treatment in terms of dosis, length and adequacy of drugs.

<sup>249</sup> Patient cases were taken from the months of June and July 1999. Starting from the 1st of the month, every 10th case was analysed.

### 6.2.8.2. Rational Use of Drugs

The quality of treatments is furthermore flawed by irrational drug use, which includes polypharmacy as well as misuse, especially of antibiotics and injections. These and the use of unnecessary, expensive drugs are the most frequent problems induced by both providers and consumers in developing countries (Le Grand et al. 1999).<sup>250</sup> In other words, these are practices for which people have a particular preference (cf. Chapter 4.5.2). It is also the result of the practitioners' focus on the sale of pharmaceuticals (cf. Leonard/Leonard 1998: 1). Polypharmacy and irrational drug use are problematic due to resulting drug resistance and increased side- and counter-effects. Underdosing is another problem and a result of deferral payment patterns, as it was demonstrated in Chapter 5. National standard guidelines foresee the use of antibiotics in less than 20 percent of the patients and suggest the average number of drugs prescribed per patient to be less than 1.6 (Kafuko et al. 1993). For this study, a treatment was defined as "polypharmacy" if unnecessary drugs in relation to the diagnosis were provided. Table 6.4 and Figure 6.16 show how the different provider types perform.

Table 6.4: Rational use of drugs

	Government	Drugshops (N=63)	Urban NGOs (N=63)	Priv. clinics (N=46)	Hospital OPD
% of treatments characterised by polypharmacy	medium <sup>a)</sup>	36.7%	33.4%	33.2%	lowest in District <sup>a)</sup>
% of treatments that involved antibiotics	62% <sup>b)</sup>	57.1%	at least 50% <sup>251</sup>	at least 50% <sup>251</sup>	lowest <sup>a)</sup>

Source: Same as for Table 6.3.

<sup>a)</sup> Assessment by supervisory DED doctor

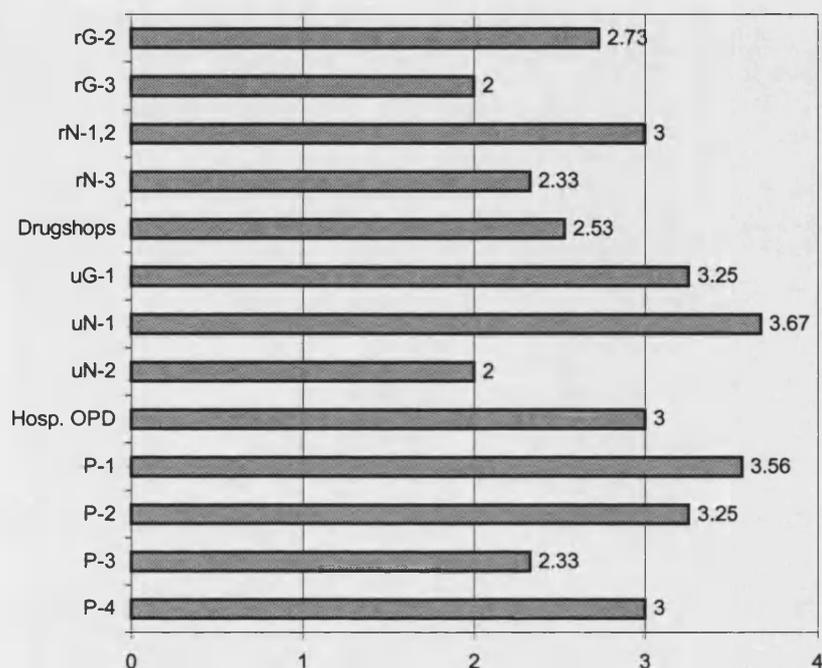
<sup>b)</sup> Data is based on direct assessment by observing the consultation process (Koppenleitner/Mpabulungi 1997: 37).

No comparable data is available for the rural NGO clinics and the hospital.

<sup>250</sup> For a detailed analysis of drug and antibiotics use and injection practices in government and NGO clinics, cf. Kafuko et al. (1993). Birungi et al. (1994) provide detailed insights into the injection practice in Busoga, but this is not differentiated along the provider types.

<sup>251</sup> Because of data gaps, the exact score cannot be calculated and thus constitutes an estimation based on the records.

Figure 6.16: Average number of drugs prescribed<sup>252</sup>



Source: Exit interviews

Again, there seem to be no differences between the providers in terms of the extent of polypharmacy or the use of antibiotics, except the hospital. Also, none of the providers came close to the national standard of 1.6 or less drugs prescribed per patient on average. These findings are also fully in line with the results of Kafuko et al.'s (1993) study. However, the extent and intensity of polypharmacy varies within and across sectors. There are some government medical assistants with a parsimonious approach, such as uG-1 and rG-3. Other clinics are characterised by an extreme degree of polypharmacy.<sup>253</sup> This is even more problematic, since many of the prescribed drugs are not in stock at the health centre or not made available to the patients. So, people are told to buy unnecessary drugs. The same variance can be found in the private and NGO sector.

<sup>252</sup> This data is rather indicative, also because of the small case numbers.

<sup>253</sup> For example, in one government clinic, a "normal" gastro-enteritis was treated with six drugs (personal communication, Schmeidl, DED doctor, 1997), which is unnecessary.

There are many reasons for this pattern of (over- and mis-) prescription. The practice in government clinics of listing symptoms and treating them separately is due to insecure diagnosing and lack of knowledge.<sup>254</sup> The staff attempts to be on the safe side by treating a number of possible diseases and symptoms with several drugs. There is obviously little knowledge about side-effects and the interaction of drugs. Apart from the medical problems, it is also a waste of drugs and makes the patient's purchase at the drugshop more expensive, which again has severe implications on financial accessibility. On the other hand, polypharmacy and overprescription is caused by the economic behaviour of government health workers, in that it allows them to easily take away even more drugs from the store and to forward them into private channels. In those few health units where patients are given all prescribed drugs, polypharmacy quickly results in drugs running short.

A spot check into the patient book at two rural NGO units similarly revealed polypharmacy, but it is considerably lower than at the urban none-state clinics. The lower extent of polypharmacy may be explained by the fact that Protestant clinics seek to be perceived as accessible in financial terms, but also by higher ethical norms (see Chapter 7.4).

While there are marked differences as regards the degree of irrational drug use among drugshops, their practice is overall dangerous for people's health. Clearly, the providers' treatment choice is not related to medical necessity, but based on financial consideration. Drugshops are not allowed to sell antibiotics, but the drugshop observation study showed that 57 percent of treatments comprised antibiotics. This is due to the fact that in many cases people decide on the types of drugs and demand explicitly "strong" drugs, and specifically antibiotics.<sup>255</sup> As said, many customers come and ask for one specific drug, which explains why the percentage of treatments characterised by polypharmacy (37 percent) and the average number of drugs is not higher than at other clinics. Yet, once the patient leaves the decision to the owner, a large number of drugs are preferred. More so, there is an incentive for the drugshop to

---

<sup>254</sup> This practice is common all over, not only in developing countries (Krause et al. 1999: 295). That said, it was shown in Tanzania that health workers have a fairly good theoretical knowledge, as a test showed, whereas they did not apply their knowledge in practice (K. Leonard 2001). This indicates that other factors are more decisive than knowledge.

<sup>255</sup> Cf. Adome et al. (1996), who also find high percentages of antibiotics use, which is fully indefensible from a medical point of view.

sell as many drugs as possible. In this case, polypharmacy is much more intense. For example, I came across an old woman suffering from backache, who was given seven different drugs and had to pay US\$ 5,700. Treatment characterised by polypharmacy can thus become very expensive. In almost a fourth of the cases, the drugshop workers ended up compensating a large number of different drugs with underdoses to give way to people's preferences for many different types of drugs while simultaneously coming to an end with people's set amount, unless customers explicitly demand a full dose. However, the following focus group statement reflects the general practice:

"We are not educated, we do not know whether it is full [dose] or not. They just write '3x1'. So, you are given some drugs, but not the right full dose. They break it in half and tell you: 'Take in the evening and morning'" (FGD, Subcounty C, 1999).

Another general problem is that drugshop workers would simply sell another similar drug if the one required and prescribed by the health centre were currently not available. Accordingly, focus group discussants complained:

"Since you do not know, you cannot argue with them."

"When you go sick, they prescribe according to their stock."

The trial-and-error practice of drugshop attendants is also apparent from their requests to clients to come back to report about how the drugs worked.

At urban NGO and private clinics, polypharmacy is equally widespread and the average number of drugs prescribed is highest. Further, as regards malaria treatment, practitioners very often start at a too high an intervention point with too heavy drugs in contradiction to the national treatment guidelines, which suggest beginning with Chloroquine. One practitioner almost consistently started with a Quinine injection for malaria treatment, which serves to satisfy patients' preferences for injections; two others begin straight away with Fansidar.<sup>256</sup> While this results in high client satisfaction, it is against the long-term medical interest of the patients.

---

<sup>256</sup> It is questionable whether this is always necessary. In any case, it is in strong contrast with the practice in the hospital and the government clinics.

As at government clinics, non-state providers practice polypharmacy to be on the safe side, due to insecure diagnosing. At the same time, it fulfils the demands of clients. But above all, since selling and dispensing drugs is an important part of the urban clinics' cost-recovery strategy, there is a strong incentive for polypharmacy. For example, one practitioner unnecessarily gave the sedative Phenagan to almost all his patients, which mainly serves to increase his bill. Partly, respondents are aware of this practice; for example, one focus group explicitly stated:

"Private clinics are very expensive. They seduce clients to buy drugs that may not be necessary" (FGD Subcounty B, 1999).

Exploiting the information asymmetry between the medical professional and the patient is a general feature of private clinics. But the deferral payment options (credit provision and partial payments for partial treatment) serve to cushion the high costs that result from polypharmacy. It must be noted, however, that there are differences among the providers, which are possibly due to differences in knowledge of side-effects, but also in professional ethics. In fact, the therapy of one private provider is characterised by a very low extent of polypharmacy (7 percent). Especially when the patient does not have much money, he explains that

"You give only very few drugs to the patient, and you have to convince the patient that your management is good" (interview, P-2, 1999).

Due to resource and time constraints, no detailed medical-professional analysis could be carried out for the hospital OPD. The qualitative assessment by DED professionals suggests that treatment is usually parsimonious with a much lower degree of polypharmacy, but it also depends upon the attending staff. The average number of drugs prescribed, however, was found to be relatively high.

In sum, the quality of treatment and prescription patterns do not differ strongly among government, private and NGO clinics, nor do the reasons and incentives for these practices vary tremendously. Due to poorly developed medical ethics and the lack of qualification, drugshops score at the lower end of the spectrum, whereas the Mission hospital OPD obviously stands at the higher end. Also, it became evident that in addition to medical implications of irrational use of drugs, there are equally financial ones. Irrational use of drugs does not only waste drugs, thereby impinging

upon treatment cost-effectiveness and drug availability, it also increases the patient's health care out-of-pocket expenditure and hence affects financial accessibility depending upon the providers' drug prices.

### 6.2.8.3. Use of Clinically Sterilised Syringes

Another concern of quality of care is the prevailing injection and sterilisation practice in Uganda. 43 percent of injections are accompanied by complications, caused by bad injection administration (Birungi 1994 et al.: 28). In this section, the providers' practice is examined as regards (un)sterilised (reusable) syringes. Table 6.5 shows that – cutting across provider types – the majority of providers allow their patients to bring their own home-sterilised injection equipment. While the sterilisation standards at health units may not be satisfactory either, there is no doubt that home sterilisation (boiling the syringe in a saucepan) is equally problematic from a biomedical perspective.

Table 6.5: Use of home-sterilised syringes

<b>Provider type</b>	<b>Patient allowed to bring own syringe</b>
Government clinics	Yes
Rural NGO clinics	Yes
uN-1	Yes
uN-2	No
Hospital OPD	No (use of single-use syringes)
P-1	Yes
P-2	N/A
P-3	N/A
P-4	No
Drugshops	Yes

There are two reasons for this practice. First, in the last two decades, people have consistently lost trust in the government health units, which was furthermore accelerated by the AIDS pandemic (Birungi 1998). People do not like to get injected

with a syringe that was sterilised at the clinic, but rather prefer to get a new syringe or to bring their own sterilised injection equipment to keep control over the sterilisation process. Birungi (1994b) conceptualises this as the "domestication" of injecting and sterilisation. Second, whether the shortage of syringes is real or artificially created by leakage, health workers cannot give out new (reusable) syringes for consecutive injections within a treatment schedule, unless the patient pays for it. Yet this would overtax the patient's ability to pay. Subsequently, it became common practice to give (or sell the patient) a new syringe for the first injection and then allow the patient to bring back the home-sterilised syringe for the remaining injections. The practice at rural NGO units is the same. As they have to pursue a cost-recovery strategy for their medical supplies, the main reason for this practice is to adapt to people's ability to pay. Drugshops also do not bother about home-sterilised equipment.

The "domestication" of (injecting and) sterilisation is strongly embedded, and no provider is able to ignore it. In fact, even among urban clinics, the use of home-sterilised syringes cuts across all sectors, which indicates that neither the private nor NGO clinics possibly enjoy full trust in light of the AIDS pandemic. The hospital OPD and uN-2 have formal guidelines for patient care and do not inject with home-sterilised syringes. One of the private clinics does not accept home sterilised equipment either and maintains professional standards, but this implies high user charges. Overall, incentives are contradictory in the private and NGO sectors. On the one hand, medical ethics would dictate professional sterilisation (or single use syringes), but on the other hand, the use of home-sterilised syringes makes these clinics more accessible. In addition, as home sterilisation is a widespread and accepted practice, rigidity could put off patients.

#### 6.2.9. People's Satisfaction with Service Quality

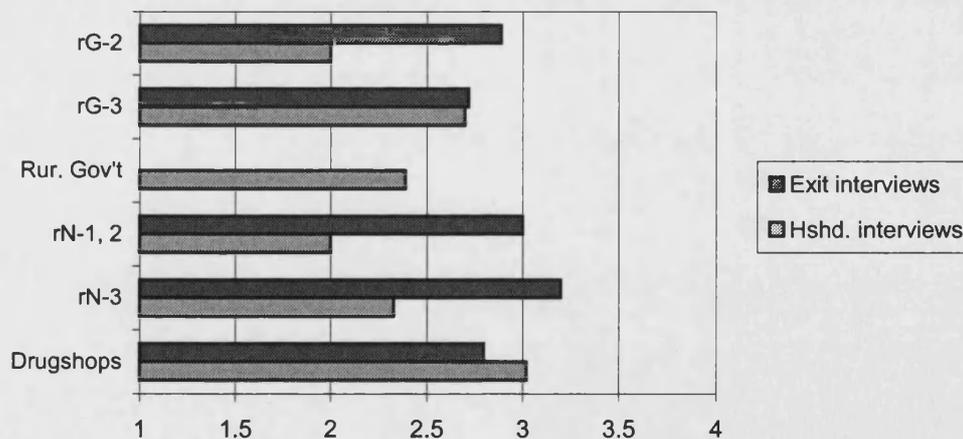
While the previous two sections were informed by a biomedical view on quality of care, this subsection looks into people's attitude and satisfaction with medical treatment. It is important to note that

Quality (and qualifications) of staff as perceived by users can be quite at odds with an objective assessment of their medical knowledge, accuracy of consultation and efficient dispensation of drugs (Hentschel 1999: 76).

People's assessment on the treatment is associated with cure and examination, but it is also mixed with perceptions of and feelings about staff behaviour, drug availability, costs and hence accessibility, which were examined in the previous sections and which illuminated already a great deal about people's perceptions. People's responses on how much they were satisfied with the medical treatment they obtained thus reflect a more general view on service delivery.

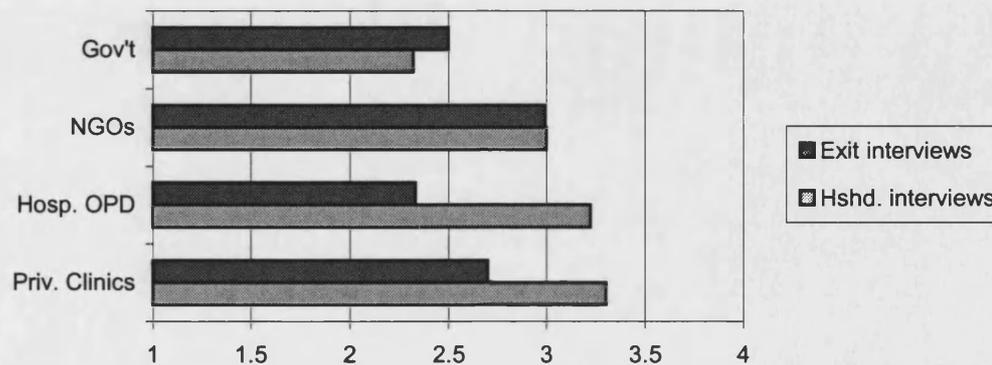
In interpreting the data, the crucial point is to take into account that people consciously chose a specific provider in the majority of cases, i.e., their choice is provider-specific and not sector-specific. Furthermore, socio-economic and educational levels, expectations and experiences, gender, age, etc., shape people's individual bundle of criteria that they apply to assess the medical treatment obtained. Obviously, these also vary from respondent to respondent (cf. Haddad et al. 1998, Ogden/Bantebya-Kyomuhendo 1996). Figures 6.17 and 6.18 illustrate the people's views and reveal considerable differences, whereby household scores are considered to be more valid given that people may feel less comfortable to make negative statements nearby a provider.

Figure 6.17: Patient satisfaction with the service quality at rural providers



Answers were prompted: bad (= 1), fair (= 2), good (= 3), very good (= 4).

Figure 6.18: Patient satisfaction with the service quality at urban providers



Despite these considerations, the following general remarks can be made. The lower (household) scores of uG-1 and rG-2, as compared to those of the NGO clinics, are in line with the previous assessment of quality of care.<sup>257</sup> In contrast, people appreciate the performance of rG-3, which, as a matter of fact, has a higher score than the drugshops in the same catchment area. This also shows that the satisfaction with medical treatment of one provider is relative to the existing alternatives (NGO clinics, drugshops) nearby. Yet in general, drugshops score very high, and one of the reasons for satisfaction mentioned is that they lead to a cure in many cases. Not surprisingly, in town, the hospital and the private and NGO clinics are assessed best. Overall, these results correspond to the assessment of clinical quality of care aspects.

### 6.3. Conclusion

This final section summarises this and the previous chapter to assess the providers' overall performance as to access, efficient staff resource utilisation and quality of care. The following points are the most salient:

- Chapter 5 revealed the differences in financial access, with drugshops being most accessible and private clinics the least accessible for the poorest. However, it was also shown that at all provider types, access is contingent upon people's capacity to pay, as is the provision of drugs.

<sup>257</sup> Okello et al.'s study in 1992 equally reports better scores for NGO clinics, but the difference is not statistically significant (1998: 16).

- In rural areas, there is no provider type that stands out as to efficient staff resource utilisation (patient throughput per staff). In urban areas, in contrast, the private clinics, one NGO clinic and the hospital OPD clearly perform much better as regards the efficient use of staff resources than government units do. This must be put in relation to quality of care, since a lower efficiency ratio may be related to higher quality of care. Yet, as we have seen in the previous section, government clinics do not perform better in terms of quality of care.
- Process quality (staff behaviour and commitment, privacy, efforts in examination, attendance by the highest qualified staff, drug availability) at non-state providers is much better than at government units, though there are some exceptions (rG-3 performing relatively well). This seems to be a typical finding. Bennett et al. (1999: 12) note that long waiting times, poor staff attitudes, availability of drugs and equipment at government facilities are problems in many sub-Saharan African countries, and D. Leonard (2000) equally concludes that NGO and church providers perform superior.
- However, in terms of clinical quality of care (quality of diagnosis and treatment as well as rational use of drugs), all providers, with the exception of the hospital OPD, scored unsatisfactorily. The differences are rather small, with the drugshops at the lower end. Here, the question becomes one of which provider is the least bad.<sup>258</sup>

In sum, since NGO and private providers overall deliver better quality, their efficiency score (of staff resource utilisation and assumingly in relation to other inputs) is even more favourable.

From this, it follows that it is vital to address clinical quality of care by supervising health units more closely and by educating both health workers, drugshop attendants and communities on the rational use of drugs. This can considerably improve the rational use of drugs, as both Kafuko et al.'s (1993) and Adome et al.'s (1996) studies have shown for Uganda. In addition, improving drug prescribing

---

<sup>258</sup> For similar findings, cf. Sinanovic et al. (2000) for South Africa, whereas Mliga (2000) found that government facilities scored better in treatment appropriateness.

practice could save enormous amounts of national expenditure for drugs; Le Grand et al. mention estimated savings of 50-70 percent of programme expenditure for Africa (1999: 91; cf. the literature indicated there).

The search for relative strengths has not produced a clear answer on which sector or provider type has *overall* relative strengths as regards *all* criteria. Instead, the providers perform better on some criteria and indicators, but worse on others. This is also partly due to the trade-offs among criteria. While urban non-state clinics scored well on drug availability and process quality, their disadvantage lies in their limited access for poorer income sections. Furthermore, the distinctions between the provider types are much smaller than expected. This is because the funding and financing mechanisms are very similar and partly identical among the various provider types. For all the NGO clinics, whether fully cost-recovering or not, the current funding and financing pressures led to a convergence toward the private sector. A similar marketisation has taken place in the government clinics, though for different reasons. Thus, in terms of the service transaction and payment procedure, the distinction between for-profit, not-for-profit and state clinics is blurred.

In rural areas, people can choose between government clinics and/or rural NGO clinics, drugshops and private practitioners. Clear-cut divisive features are the costs, drug availability and staff behaviour, whereas differences in medical quality of care are less obvious. Given the low commitment and hence resulting low quality of care in government clinics, drugshops are not much worse than government clinics. Since they are also more accessible, and given that people can decide on the amount to spend, they are the least worst option for poorer people, even though people are not enthusiastic about them:

"We don't trust the drugshops, they don't have qualified staff, and they refer to the clinics. [...] [However], you don't ask about their qualification. If you get better and cured, you continue to go, so you don't ask" (FGD, Subcounty A, 1999).

Neither do people see much difference between rural NGO clinics and drugshops, as one focus group spells out:

"In the drugshops we get the same drugs as from NGOs, so why should we go to NGOs?"

Moreover, if the NGO clinic is run by a nursing aid, because the qualified staff is absent, there is indeed not much of a difference. Hence, from a patient's point of view, a clinic's relative strengths are related to the patient's present financial situation and the perceived severity of the disease. For a poor patient, drugshops have relative strengths for minor diseases and constitute a form of first aid post. Given the low coverage of higher-level providers in rural areas, drugshops have come to fill out this large niche. In case of a more serious disease, poorer people may or may not have the choice between unsatisfactory, less expensive government clinics and better, but more expensive services at urban NGO or private clinics. In other words, poor people have to make clear trade-offs between price and quality.

The two chapters have also revealed that performance is only relative, as the term relative strengths suggests, depending upon the alternatives and the pressures put on the clinics to deliver. For example, since government rural clinics perform very poorly on drug availability, staff behaviour and informal payments, there is not much effort required on the side of non-state clinics to provide better services. The low standard at government clinics and drugshops weakens competition and the incentives to provide high quality services at other providers. Thus, the attribution of relative strengths is situational and temporary.

As said, the differences found are smaller than expected. Notwithstanding this, the evidence suggests that the institutional and organisational differences between the provider types account for these performance differences (with the exception of the institutions relating to access, where we have noted the convergence of the funding and financing mechanisms). The next task is therefore to analyse the intra-organisational institutional mechanisms and the incentive environment (Chapter 7) and the interorganisational relations, namely governance mechanisms and interactions (Chapter 8), that shape each organisation's performance. This will also illuminate the entry points for institutional redesign and reform and the ways forward to improve performance.

## Chapter 7

### **Explaining (Mal-)Performance: Institutional Deficits in Accountability, Financial Responsibility and Staff Equity**

The previous two chapters revealed that there are significant performance differences between the three sectors and also that none of them performs satisfactorily over all criteria. This chapter aims to explain the differences in performance and relative strengths of each provider type and to understand the high level of malperformance, since this is the crucial step to identifying strategies to improve health care services. Chapter 2.2 indicated that compliance mechanisms are decisive for organisational performance, but the fundamental question is how they function in reality in each specific context. So the functioning and operation of compliance mechanisms and other intra- and interorganisational institutional mechanisms need to be examined more closely. Institutions set up norms and rules (both formal and informal), and compliance with these is ensured through incentives and sanctions. These, in turn, shape and influence the behaviour of individual organisational actors and hence the functioning of organisations, determining performance or malperformance (Brett 2000c: 18; cf. Batley 1996).<sup>259</sup>

This chapter analyses the intra-organisational institutional mechanisms of accountability, financial responsibility and staff equity for the public sector (Section 7.2), the private sector (Section 7.3), and the voluntary sector (Section 7.4). The focus is on the empirical shaping of these institutions and on their actual functioning within the local context, or in other words, the relationship between the formal and the real. The public sector analysis – implicitly including the study of District-made local government problems – is the most comprehensive of the three sections, since it will also provide the basis to understand the functioning of state regulation and co-ordination to be examined in Chapter 8. Before going into this institutional comparison, the theoretical framework behind this analysis will be further outlined (Section 7.1).

---

<sup>259</sup> Cf. Ostrom et al. 1993, Preker et al. 1999, D. Leonard 2000, Bennett et al. 1994, Mills 1997b.

## 7.1. The Theoretical Framework

Institutional mechanisms can be understood as a set of institutions with a specific function. Specifically, intra-organisational institutional mechanisms refer to the rules that govern the relationships among organisational actors within an organisation as well as between the end-users and the organisational actor. These mechanisms are the focus of this chapter. Extra-organisational, or rather interorganisational institutional mechanisms, namely governance mechanisms, will be analysed in the next chapter. The intra- and interorganisational mechanisms are closely interrelated, but for analytical purposes, they are separately discussed. Competition constitutes both an intra- and interorganisational mechanism and will be addressed in this chapter.

While technical-organisational aspects – including the production function, knowledge and management – are not irrelevant, they are of much lower importance for performance and they are usually independent from the type of provider.<sup>260</sup> This chapter therefore aims to explain the outcomes identified in the last two chapters by examining the institutional mechanisms that shape the incentives of individuals working in an organisation, and how institutions influence their behaviour and affect organisational performance (cf. Esman/Uphoff 1984, Israel 1987, Powell/DiMaggio 1991, D. Leonard 2000, Brett 2000c).

One of the key institutional problems in health care is the principal-agent relationship, in which

The principal needs the efforts and expertise of the agent, but has only limited ability to monitor the agent's actions or evaluate whether the final outcome was satisfactory (Preker et al. 1999: 7).

The interests of the two differ, because agents will be tempted to increase costs or reduce efforts, whereas the principal will want good services for the lowest costs possible (cf. Brett 2000a: 16). The principal-agent problem is particularly severe in relation to the patient-provider interaction, given the information asymmetry within

---

<sup>260</sup> For example, although NGO personnel and government staff obtain their training from the same medical schools, government workers still perform worse (Leonard/Leonard 1999: 1). The organisational-technical aspect – medical knowledge or other factors – therefore do not constitute the decisive factor for (mal-)performance.

the delivery of health services.<sup>261</sup> To reduce principal-agent problems and to make providers perform effectively, there must be mechanisms whose function is to establish accountability, financial responsibility and staff equity. The following brief account of each will also explain why these aspects are crucial for performance.

The accountability mechanism ideally allows the principals (users and funders, who may be identical) to oblige the agent (the service provider) to be responsive to their concerns. First of all, this requires a shared understanding by principals and agents of what constitutes an acceptable level of performance (Brett 1993: 278). Second, it needs the existence of appropriate incentives for the agent and institutional arrangements that allow for monitoring and sanction of his or her behaviour; in other words, principals must have leverage over agents (cf. Brett 1993). It is important to note that participation, on its own, is insufficient to ensure accountability. As we shall see, different accountability mechanisms operate for each sector. The central question then becomes how these mechanisms function, what impacts they generate and in which way they are subverted by other informal institutions.

While service providers want to maximise their income, users want good services for lowest costs. A specific component of accountability is financial responsibility, which should ensure the most favourable balance between costs and outputs, namely efficiency and cost-effectiveness. Financial responsibility is strongest in a perfect market, where a "hard budget constraint" is imposed upon private providers, "who are only paid for what they can sell" (Brett 2000b: 24). Usually, in the public and NGO sector, the mechanism for financial responsibility is less strong. Although both sectors are confronted with a budget constraint, the search for the best output–lowest cost solution requires strong control by stakeholders and users. In their actual institutional shape, the mechanisms that establish financial responsibility and accountability are often identical, for example "patient exit" fosters both accountability and financial responsibility.

In order to ensure that providers apply their expertise and efforts to the benefit of the patient, appropriate incentives, specifically personnel equity, are required. This refers to the relationship between staff remuneration and obligations. Ideally, this is

---

<sup>261</sup> Other principal-agent relationships exist between the District Medical Office and government health units, between citizens and politicians, and between politicians and civil servants (see Section 7.2.2).

balanced in order to constitute what Munene calls "supply side accountability" as a reciprocal process between the employer and the employee, where the former fulfils his or her obligations towards the latter and vice versa (1993: 2). Incentives and disincentives, rewards and sanctions affect staff behaviour and hence organisational performance. Yet there can be a severe tension between achieving financial responsibility and meeting staff interests if the personnel incentive structure does not balance the rights and rewards against obligations and efforts (Munene 1995: 134). In the case of an imbalance, the staff may reduce efforts or withdraw from the organisation, with hierarchical controls and sanctions being unable to stop this. Remuneration and incentives do not only have to be financial and material; complements or supplements include professionalism and professional satisfaction or satisfaction by fulfilling other norms, such as altruism and/or religious beliefs. The principle of professionalism is that "individuals will perform well, since they have been both trained and socialised into a profession with a distinct ethos and set of professional standards", so that they do not abuse their discretion (Leonard 1993 in Moore 1996: 3, cf. Paul 1994).

An issue we will return to repeatedly in this chapter is that of perverse incentives. This is a situation where the set of incentives is such that the provider benefits most by performing badly. Perverse incentives are a by-product of health care markets. Yet, as Mackintosh/Tibandebage (2000: 8) point out, the health workers' response to these incentives is not given, but depends on the prevailing local culture and other institutions. Action upon perverse incentives comes into being when the agent is in a position to disregard control and accountability mechanisms and/or when the formal incentives offered to the provider do not take account of his or her needs and motivations, so that the provider exploits the prevailing opportunities to increase personal benefit. When ethical and professional norms have broken down, health workers may be particularly predisposed to respond to perverse incentives.

As already mentioned, it is important to study informal institutions if we are to understand and contextualise health care services. Social networks, social norms and values, and the nature of leadership set up the context of organisational and administrative culture, or what Tibandebage/Mackintosh (1999) call "institutional culture". It constitutes an established set of accepted institutions and norms that

ultimately influence service delivery (cf. Atkinson et al. 2000). In fact, informal institutions may be able to subvert formal ones, weaken prevailing incentives or moderate institutional mechanisms that are assumed to transform into greater responsiveness and quality of care (ibid.: 631). This may also account for a situation where the assumptions behind the sector conceptualisations are not met (cf. Chapter 2).

Finally, a crucial methodological question is how to prove the effectiveness and impact of institutional mechanisms upon organisational (mal-)performance. In other words, are the performance differences found in the previous two chapters due to different institutional set-ups and the prevailing (proper and perverse) incentives, as the theoretical framework suggests? The underlying logic applied is to examine whether and how the institutional mechanism of accountability, financial responsibility and staff equity function and how the operation of informal institutions may divert the formal mechanism. This should then permit to explore how the providers' incentives and behaviour are shaped by institutional mechanisms and how this accounts for perverse incentives, and hence provider (mal)performance.

## **7.2. The Public Sector: Severe Institutional Deficits**

Chapter 2 has outlined the strengths of the state, above all its power to alter distribution and to ensure equity through state provision. However, state failure, which is particularly severe in a developing country context like Uganda, since the public sector assumptions are not fully met, results in deviations from the public interest and affect service provision. Based on a detailed illumination of the deficits in the daily functioning of local government, the gaps in the institutional mechanisms of accountability, financial responsibility and personnel equity are to be revealed.<sup>262</sup> Chapter 3 analysed the formal-legal structure of local government and identified the implementation deficits due to factors that were beyond the control of the local level. This chapter looks at how the local government substance is affected by problems

---

<sup>262</sup> The statements on civil servants, especially in relation to the administrative culture, are general and not valid for every individual government worker. Some civil servants are very dedicated.

formed at the District level and below. While these micro-level gaps are the major factors for (mal-)performance, the wider national context must also be kept in mind, such as the financial constraints (cf. Chapter 3), lack of good governance and the high level of corruption (Watt et al. 1999), which equally impinge upon the health care system.

### 7.2.1. Financial Responsibility

Financial responsibility is best achieved under market competition. However, government clinics and health workers are not exposed to competition and health units are not forced to recover costs, so there is little impact when patients exit to use other providers. The DMO perceives the other non-state providers as competitors, but there are no incentives or other (quasi-market) elements within the public sector that make health workers compete. Thus, the problem of financial responsibility calls for an analysis of the way intra-administrative processes affect resource inputs decisions and the actual resource use at the level of the health unit.

#### 7.2.1.1. Salaries

The main share of salaries for DMO and health unit staff (i.e., formerly central government staff) is financed by the central government through unconditional grants based on historical budgeting. The District's payroll covers the salaries of all other staff and of additionally recruited staff. As a result of this division of financing, the District is reluctant to employ new staff given its precarious financial situation (though it should be noted that this reluctance is also an expression of its spending priorities, see below). Since the Subcounties' financial situation is even tighter, they often have to recruit low-qualified staff at lower salaries to compensate for staffing gaps at health units. Likewise, the health units are unable to employ (more expensive) qualified staff because of their small user fee revenues. Consequently, staff input decisions cannot be made flexibly in accordance with local needs, whereas staff dismissals are restricted by civil service regulations. Moreover, the use of staff resources is inefficient given the failure of staff to turn up to work (cf. Chapters 6.1 and 6.2.5). In sum, there is no mechanism that ensures financial responsibility as regards salary inputs.

### 7.2.1.2. Drugs

The main share of drugs, the Essential Drug Kits, is not funded by the District, but externally (central government and DANIDA). In theory, drug quantities are adequate, but supply is unreliable. Whether UEDMP drugs are embezzled at higher DMO levels or whether they leak from the unit (cf. Chapter 6.2.1)<sup>263</sup>, the health units often falsify records to account for the drugs (cf. McPake et al. 1999). The DMO purchases additional drugs, but the experiences of DED health professionals was that the DMO storekeeper was sometimes found to deny the full package of drugs to the health units giving the excuse that the health workers will only steal them. In-charges suspect that the storekeeper prefers to keep these drugs for his own private drugshop. Furthermore, written request forms are also easily "lost" by the storekeeper (observation by DED health workers, 1998). Management of drug inputs is hence inefficient, as is their use, so again, there is no mechanism at the local level that ensures financial responsibility. This is allowed to happen in the absence of a functional accountability mechanism and disciplinary action (see below).

### 7.2.1.3. User Fees

User fees rates are set at the Subcounty level and retained by the health units, which have spending autonomy over the revenues within the MoH guidelines. This provides more incentives for the generation of revenues in contrast to a system in which health units have to remit them to higher levels. This notwithstanding, revenues are very low, so spending on drugs, recurrent operational items and maintenance always falls short. Moreover, in-charges sometimes take out money for personal purposes, undermining the opportunities for efficient resource use. In other Districts, the user fee management was equally found to be under the discretion of the in-charges (Golooba-Mutebi 1999: 167). Furthermore, even though the District health budget allocates funds to the DMO to distribute the kits, the health clinics themselves often have to fetch the kits, and they rely on their user fee revenues to pay for transport to and from the DMO.<sup>264</sup> For the more distant health units, some of which have extremely low user fee revenues, these transport costs quickly amount to a week's

---

<sup>263</sup> The District Secretary for Health admits that usually half of the missing kits "get lost on the way" (interview, 1999).

<sup>264</sup> This has already been the case during the early 1990s (Munene 1993).

revenues (interview, Bülow, DED health professional, 1999). It is speculation to say what happens to the funds that the DMO does not spend as budgeted. But in any case, effective and efficient spending of user revenues is undermined this way.

In sum, the current funding mechanisms do not allow for autonomous resource input management, fully guided by local needs. Likewise, resource use is inefficient given the high degree of mismanagement. Hence, financial responsibility at the District or Subcounty local government level is poor and contributes to low technical efficiency.

#### 7.2.1.4. Budgeting Versus Actual Expenditure Patterns

In addition to the main inputs (salaries and drugs), the government health units are supposed to obtain further funding from the District and the Subcounty budget. However, the District authorities' budgeting and spending patterns reveal a number of irregularities and are not service-oriented.

For example, members of the District Executive Committee were paid allowances during the months of its non-existence before the 1998 local government elections. In the 1999/00 budget, a huge amount (US\$ 0.355 million = US\$ 300,000), including an enormous amount of allowances for electricity, housing, fuel and house servants for the LC5 Chairperson, has been allocated to the LC5 vote. The vote amounts to 14 percent of the funds under local discretion and 40 percent of the local revenues, even though the 1997 Local Government Act (LGA) only allows for 15 percent of local revenues. In comparison, the amount budgeted for health funded from the local revenues is only half of that.<sup>265</sup> The situation is further compounded by the fact that more than half of the discretionary resources (local revenues plus unconditional grants after pay-roll subtraction) are spent on the Administrative Headquarters and the Finance Department (KDA, Financial Committee Minutes 1998/99 own calculations). These practices leave little money to spend on development activities such as agriculture, health care, education or community development.

The District councillors' attempts to scrutinise and revise downwards the inflated votes for the LC5 office or the administration headquarter were blocked by the

---

<sup>265</sup> Because of central government grants ear-marked for health, the total share of the District budget spent on health is much higher, of course.

Speaker of the District council through a combination of poor information flow and suppressed debate during the Council meetings<sup>266</sup> (see the next section). As there are no representatives of the service departments on the Finance Committee and as the Committee is dominated by the Chief Financial Officer (CFO) and the Chief Administrative Officer (CAO), "the needs for health care get easily overridden by the interest of this Committee" (interview, member of the Executive Committee, 1999). District authorities usually utilise private clinics or go to Jinja and Kampala to seek health care, which may explain why they show little concern with the low quality of care in government clinics. This qualitative evidence is in line with Azfar et al.'s (2000) study of 10 Districts across all regions in Uganda where no correlation was found between household preferences and public official's knowledge of these preferences or resource allocations decisions.

Not only is there limited money budgeted to the social service departments, but the approved money, little as it is, does not fully reach the departments due to embezzlement within the District administrative headquarter (interviews, civil servants; cf. Munene 1993 for the education sector):

"So far we only got 7–8 millions [out of 12], there was connivance. The District authorities [the CAO and CFO] realised that by now they are overdoing it. Also the former CAO was chewing the money, but the new one is not better" (interview, DMO official, 1999).

The proper running of activities is hence made difficult for the social service departments. Likewise, District councillors do not receive their constituency allowances. With embezzlement being so obvious at the highest District level, it becomes institutionalised at the department level. For example, field extension workers complained that they are denied their allowances from the District department and the Subcounty level. Corruption and embezzlement is systemic and endemic to the public services (Watt et al. 1999: 46). It is institutionalised to an extent that it is openly acknowledged; for example, the following request was found in the District Council minutes:

"The chairperson appealed to the DMO to stop lending [money to DMO staff], because of the reimbursement delays for the accountability to be made. When somebody borrows, let the Committee know" (October 1998).

---

<sup>266</sup> For example, budget proposals are given out at most one day before or even on the same day of the Council meeting, which undermines the capacity of the councillors to examine the proposed spending.

At the Subcounty level, the financial situation and the spending priorities are similarly problematic. The Subcounties' actual revenues amount to US\$ 30,000,000–40,000,000 for the financial year 1997/98 (Subcounty budgets, own calculations). After subtracting 57.75 percent for the LC1, 2, 4 and 5 shares, the payroll, capital investment, the inflated LC3 chairperson vote and other payment obligations, about a tenth of the Subcounty budget is left for the allocation to the Subcounty's prioritised development activities. As at the District level, the Subcounty Council is given a fully worked out budget proposal, while the Executive Committee and the Subcounty chief attempt to impede amendments by councillors. This budget allocation results in US\$ 200,000 bids (about US\$ 180) per year for agricultural extension, sanitation mobilisation, and community development respectively. Likewise, financial support to the Subcounty's health unit(s) is minimal and amounts to an average of US\$ 500,000 (i.e., 1-2 percent of the budget total), but actual spending on health care is often 0 percent.<sup>267</sup> In the Subcounties under study, the approved budget for health was not spent, but misappropriated by the Subcounty authorities (interviews, Secretary for Health, Subcounty A and Chairperson Health Committee, Subcounty B and C, 1999). Again, as at the District level, health does not constitute a focus for councillors.

Subcounty chiefs lamented how difficult it is for them to stop the Executive committee members "eating money" (that is, the use of public funds for personal reasons). If they did so, one Subcounty chief argued, they would create enemies and may face accusations of "wanting to eat all by himself". He would therefore also serve himself in periods of scarce cash (interview, Subcounty Chief A and B, Secretary for Women LC3 Subcounty A, 1997).<sup>268</sup> This is confirmed by a ten District study, which reports that over 60 percent of Subcounty officials admitted the presence of corruption in the Subcounty (Azfar et al. 2000: 37). The Subcounty Council and the Health Subcommittee put little pressure on the Subcounty chief to make him accountable, and as a result, the actual allocation of the Subcounty funds is barely transparent. Often, it is only at the end of the financial year, if at all, that the Subcounty Health Subcommittees find out whether any money and how much has

---

<sup>267</sup> Data from seventeen 1997/98 Subcounty budgets and seven 1998/99 budgets, own calculations. In nearby Tororo District, Subcounty spending on health has also been low, amounting to up to 4% (Kostansjek 1997).

<sup>268</sup> In Subcounty A, out of the Subcounty's budget of US\$ 35,000,000, an estimated US\$ 1,500,000 – 2,000,000 per year are misused for private purposes. This does not include "legal" misappropriations in form of additionally granted allowances (cf. Golooba-Mutebi 1999: 225-7 for similar examples).

been spent on health care. These problems must be set in the context of Subcounties not yet being able to take up their responsibilities as autonomous corporate bodies in planning and acting for their citizens' needs. Districts are centralised from within, and hence, other than implementing the District's and central government's programmes, Subcounties currently constitute an agent of law and order and little more.<sup>269</sup>

In sum, there is no effective mechanism of financial responsibility, since decisions over resource inputs are taken too far from the operational level, and are thus unrelated to local needs, and in addition, they are captured by private interests. For both the Subcounty and District level, Brett's (1993) point about how the predatory Ugandan state denies itself the income required to provide essential services is clearly demonstrated in the case of Kamuli. Further, the absence of a financial responsibility mechanism explains the low level of technical efficiency and inefficient utilisation of staff resources at government clinics in particular and the low performance in general. Why this is allowed to happen and why misuse of resources at the health centre is not stopped will be discussed in the next section.

### 7.2.2. Accountability

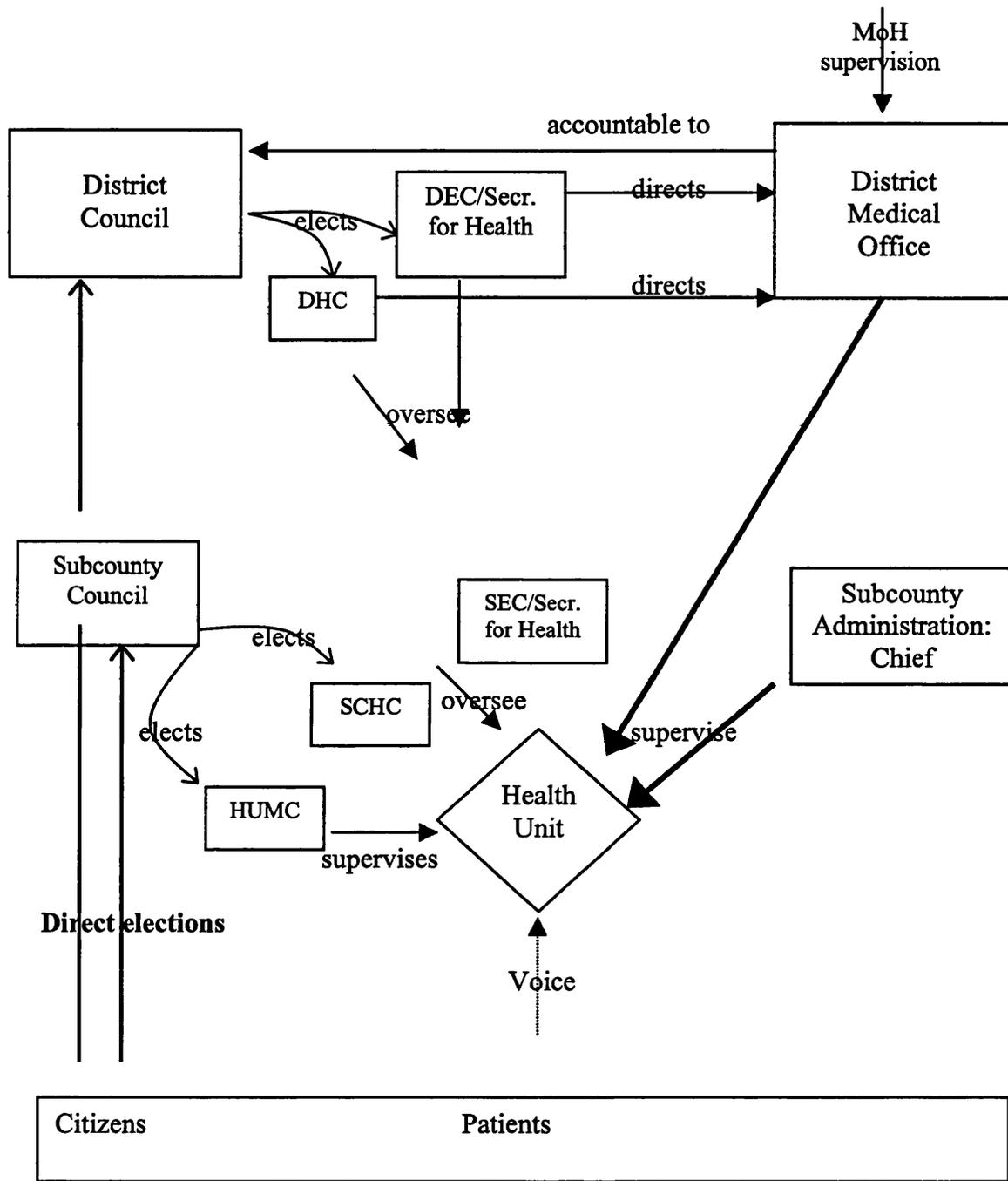
In order to secure adequate outputs in relation to inputs, a functional accountability mechanism is required. The 1997 LGA and MoH guidelines have established a number of nested formal relationships and institutions, which are depicted in Figure 7.1. Their objective is to make civil servants and health workers accountable to politicians and politicians accountable to citizens. Furthermore, providers are supposed to be accountable to users.<sup>270</sup>

---

<sup>269</sup> This is often the case in other countries as well (for example for India, cf. Mahal et al. 2000).

<sup>270</sup> Audit control systems may equally play an important role as a disciplining device external to the local government, but these aspects were not further examined (cf. Azfar et al. 2000: 70).

**Figure 7.1: Formal accountability chains in the public sector**



DHC = District Health Committee  
 DEC = District Executive Committee  
 SEC = Subcounty Executive Committee

SCHC = Subcounty Health Committee  
 Secr. for Health = Secretary for Health  
 HUMC = Health Unit Management Committee

Health unit monitoring and supervision is supposed to be carried out by the Health Unit Management Committee (HUMC), the Subcounty Health Committee (SCHC), the Subcounty Administration, and the DMO. All of these bodies should be accountable to the directly elected councils at the Subcounty and District level, which in turn should be accountable to their constituents. Exit and voice are additional means to increase accountability, but only if their signals are linked to intra-organisational institutions that translate into the right incentives for organisational actors to perform (Paul 1992: 1054). In this context, exit means that patients stop using a provider or that employees leave an organisation. Voice means that patients express their dissatisfaction directly to the provider, or to some other authority to which the provider is subordinate or through other types of actions and protests in order to bring about change to an objectionable state of affairs (Hirschman 1970: 4, 30). Looking into the functioning of these supervisory and bottom-up relationships and mechanisms reveals numerous deficits.

#### 7.2.2.1. The Health Unit Management Committee and the Subcounty Health

##### Committee: Lack of Community Involvement and Community Leverage<sup>271</sup>

Community involvement is understood to mean the participation of community members in decision-making and management of health units in order to create local ownership and foster transparency, thus contributing to overall better performance (cf. Bennett et al. 1995: 24). Participation is also a mechanism to allow the provider to find out the needs of the beneficiaries.<sup>272</sup> Brett (2000c) emphasises that participation only makes sense when partnered with accountability, that is, when people have some leverage over the provider. The HUMC and the SCHC constitute two mechanisms for community involvement in decision-making and management of health unit issues but, as we will see, they have no leverage and control over the health units.

HUMC members are appointed by the Subcounty Executive Committee and seconded by the Council. The HUMC monitors the health unit operation, and its tasks

---

<sup>271</sup> The District Health Committee is too far away from the community level to constitute a participatory mechanism, which is why it is not discussed in this subsection.

<sup>272</sup> An empirical evaluation of the impacts of beneficiary participation in a variety of countries is provided in Finsterbusch/van Wicklin (1987). For the problems and limits of participation, cf. Brett (1996a, 2000c).

include financial management, drug management and pursuing community complaints. Yet the HUMC's main problem is their operational and organisational weakness. None of the HUMCs of the studied government clinics met on a regular basis or were properly functioning. For example, the previous HUMC of rG-3 has not sat for the last two years. Meetings fail, because the HUMC members are not satisfied with their remuneration (cf. Golooba-Mutebi 1999: 158). Neither are members willing to do any additional work, such as consulting communities or occasionally visiting the health unit. As most members are not health professionals, they lack the knowledge needed for effective health unit management and hence are hardly acknowledged by the in-charge. They are not involved in decisions on user fee expenditure, which are usually taken solely by the in-charge. Often being unaware of their actual roles and responsibilities, they are in a weak position in relation to the in-charge and have a pro-forma existence, which leaves the latter unsupervised.

The flawed HUMC composition process contributes to its distorting their role as a supervisor. For example, according to the chairperson of the Health Committee in Subcounty A, the LC3 chairperson and Executive Committee members appointed those people who had supported them during election campaigns, without involving the Council or the Subcounty Health Committee in the seconding of the HUMC. HUMC members, as local councillors (see below), belong to the better-off socio-economic group, which confirms that formal structures for community participation do not provide for processes of liberation and empowerment. Instead, the HUMC has reproduced existing power relations. This pattern of elite capture is also found by Azfar et al. (2000), who note that access to committee memberships depend on income and education.<sup>273</sup> Also, many HUMC members are friends with the in-charge and given this "supervisory capture", control and supervision duties are not exercised. Another dilemma is that most people are reluctant to tackle problems of misbehaviour that would endanger somebody's position by criticising them due to fear of revenge. Hence, the HUMCs fail to investigate and publish failure of health centres. One Secretary for Health explains that

---

<sup>273</sup> My institutional analysis of a World Bank nutrition programme in Senegal in 2001 also revealed that the better-off and higher educated capture these committees.

"If you look at the problem and try to solve it, they accuse you of witchcraft. We do not feel comfortable [when addressing the management problems in the health unit], so we rather leave it."<sup>274</sup>

Finally, HUMC members virtually do not establish links with the community and thus do not contribute to identifying local health (care) needs and demands. They are often uninterested in consulting local people and do not consider this to be their task; rather they see themselves as mobilisers for health education (cf. Olsen 1997 in Hutchinson 1999: 104). Asked about the community's involvement in planning or decision processes of health care provision, none of the 37 focus groups, held in 1997, mentioned the HUMC or the Subcounty Health Committee, so it appears that people do not perceive them as a means for participation and consultation. This is very similar to what is found in Zambia (van der Geest et al. 2000) and Brazil (Atkinson et al. 2000) and is due to the fact that HUMCs are appointed at too high a level and thus too far away from the community. As a result, people receive little information about them.

Table 7.1 shows that exit and household respondents are hardly aware of the existence of HUMCs and that there are virtually no consultations by the HUMCs, which was confirmed by focus group discussions. Asimwe et al. (1997a) also mention the community's low awareness of the HUMCs in their study of two Districts. As HUMC members hardly ever visit the community, they do not provide a platform for community concerns. Further, they lack contact and interaction as well as support from the SCHC, the DMO and the Secretary for Health. In sum, the HUMCs do not have the power, leverage and knowledge necessary to effectively supervise and enforce health care performance.

---

<sup>274</sup> Golooba-Mutebi also reports an event in a neighbouring District where a health worker threatened a HUMC member with assault, if she did not stop interfering in the management of the health unit (1999: 161).

Table 7.1: Respondents' knowledge of and contact with government HUMCs<sup>275</sup>

	Exit Respondents	Household respondents
Aware of the existence of HUMC	54%	44%
Knows somebody on the committee	10%	11%
Knows of a HUMC member visit or a community consultation	6% <sup>276</sup>	0%

The Subcounty Health Subcommittees consist of four to five councillors that are elected by the Subcounty council. They are in charge of health care issues, particularly planning, within the Subcounty. However, it was found that they play hardly any role in supervising and controlling the health units. In many cases, they lack the skills and competencies for assessing and planning, and in Kamuli, they lack both operational and political strength, so that they have little leverage over health workers and no say in budget matters.<sup>277</sup> Thus, health care planning at the Subcounty level is in its infancy. Again, the committee members primarily perceive themselves to be mobilisers for health education messages (cf. Kostansjek 1997 for Tororo District), even though they rarely visit the communities.

Altogether, the provisions made for community involvement (through community representation and consultation) in the management of health units are not utilised due to the weaknesses of the committees. The communities have no leverage over these committees. As a result, these structures do not contribute to improving the accountability of health workers towards their patients. The next section inquires whether intra-administrative control constitutes a more effective accountability mechanism.

<sup>275</sup> These figures are gendered, in that women are much less aware of the existence of HUMCs and are more unlikely to know anybody on the committee. The differences between the exit and household survey results are related to the more urban population in the exit interview sample.

<sup>276</sup> These were two urban respondents, out of the total of 33 respondents.

<sup>277</sup> This may also be a question of Kamuli belonging to the last group of Districts having undergone decentralisation. For example, in Tororo District, which was decentralised two years before Kamuli, the SCHCs were found to be better functioning (Kostansjek 1997).

#### 7.2.2.2. Inadequate Administrative Control by Subcounty Authorities

The Subcounty Secretary for Health could, in principle, play a key role in supervising government health workers. In practice, this hardly takes place. Like the HUMCs, these officials often have no health background and are not respected by the in-charges. Alternatively, supervision chains are often interrupted due to personal relationships with health workers, undermining the threat of disciplinary action by the officials.

The following constellation in one of the Subcounties may be an extreme example, but it is not untypical. The Secretary for Health is a junior medical assistant who is in charge of a very badly run neighbouring health unit. He is hardly ever present on duty there, since he operates his own unlicensed private clinic and another drugshop. Likewise, little time remains for him to perform his tasks as the Secretary for Health. Given his own absence from duty, he has little moral authority in supervising the staff presence at other clinics. Furthermore, he lacks the professional authority, since the in-charge he is supposed to oversee is a senior medical assistant.

For Subcounty authorities likewise, it is difficult to exert control upon health units, because the main share of salaries and other resources is financed by or channelled through the DMO. Accordingly, health workers are accountable to the District administration and the DMO as the (potential) locus of supervision and disciplinary power. As a result, the Subcounties have no leverage over the District employed health workers. The Subcounties' irregular salary payments to their employees also weaken the accountability link and are very demoralising. Neither do higher-level political bodies support the Subcounties' concerns. For example, a member of the Town Council Health Committee lamented:

"The in-charge has more loyalty to the LC5. The LC5 says: "It is done that way", so then there is nothing to bother about" (interview, 1999).

#### 7.2.2.3. The Role of the DMO: Supervision Gaps

The first gap within the chain of support supervision of health workers results from the frequent absence of the in-charges. This gap is being aggravated by the DMO's inadequate supervisory practice. DMO staff visits the health units on a regular basis – the rural clinics under study were visited monthly in 1998. Yet the frequency of supervisory visits says nothing on their actual impact. First, these supervisory visits

focus on hygiene, sanitation and other infrastructure aspects, but much less on issues of health unit management, the collection and spending of user fees, drug leakage, quality of care (such as polypharmacy and irrational use of drugs) or the behaviour and attendance of staff.<sup>278</sup> Second, it appears that there is little concern and effort to improve the performance of health clinics. Supervisors have few incentives and little motivation to carry out these tasks, especially if there are no field allowances available. Local people seem to have little confidence with those in charge of supervision, or in any case do not count on them; for example, one FGD said:

"... the health centre receives drugs regularly, but the drugs end up in the private clinics. And since the drugs look the same, it is difficult *for us* to prove it"  
(Subcounty A, 1999, my emphasis).

The problems of drug leakage and staff absence are well known to the District authorities. Likewise, irresponsible behaviour and misbehaviour have been reported to the DMO, but no action was taken. As neither the DMO nor the respective in-charges query staff absences (with few exceptions), it is mainly up to the individual decision of the health worker whether and when he or she is on duty. In sum, intra-administrative control and monitoring are weak and do not contribute to improving accountability, and while the DMO is limited in the resources available, this is not a sufficient explanation for the poor quality of supervision.

#### 7.2.2.4. Lack of Political Accountability and Insufficient Local Legitimation

##### *Dominant Executive Committees and Weak District and Subcounty Councils*

The DMO's poor performance is also the result of weak intra-administrative accountability between civil servants and politicians. Although the District Health Subcommittee is much more informed and concerned about the problems of health units when compared with their counterparts at the Subcounty level, its influence upon the DMO is limited and its monitoring role ineffectual. This is because civil servants are still not used to holding themselves accountable to politicians and have

---

<sup>278</sup> However, an intervention study in Uganda showed that reinforced supervision of health workers' prescription patterns may improve rational use of drugs and the quality of prescribing (Kafuko et al. 1993).

difficulties in subordinating themselves to the political leadership (interviews, various department heads, 1997-99, cf. Hutchinson 1999: 120 for other Districts).

This goes together with the weak position of the LC5 and LC3 Councils. At both the District and Subcounty level, it was observed that the chairperson and the Executive Committee are very dominant, being rather detached from the Council and allied to the administrative authorities. The administration and the Executive Committee have taken over the Council's role in the allocation of resources. As mentioned already, budget decisions are taken by the chairperson and the Executive Committee in a top-down manner; concomitantly the Council's role has been downgraded to mere seconding. Further, the District and Subcounty Councils are helpless vis-à-vis the self-granting practices of the administrative leadership. Council meetings are run in a way that provides few opportunities for councillors to put across their views.<sup>279</sup> As a result, there is little accountability and responsiveness to the Council, and the relationships between the Council and the Executive Committee are the reverse of what they are supposed to be, distorting another element within the accountability chain.

The weakness of the Councils is also in part the result of the present non-party system in Uganda. While it is beyond the scope of this study to focus on this point in great detail, it is worth noting that the non-party system makes it very difficult and costly for councillors to build alliances and to aggregate local preferences in council decisions and actions. Similarly, the non-party system allows councillors to escape judgement on their performance, since they may always claim that they alone are powerless to bring about change in a personalised political system. Instead, the (election) system fosters individualised, localised patronage patterns, and as we shall see in Chapter 8, this is not counteracted by the involvement of NGOs.

### *Representation and Consultation Deficits*

Councillors and in particular Executive Committee members are characterised by a higher socio-economic and education status (cf. Tidemand 1994, Azfar et al. 2000, Tripp 2000). While this observation is true for many countries, it is problematic in a situation where these elites are not forced to perform because of the lack of

---

<sup>279</sup> This concurs with Golooba-Mutebi's observation that councillors are mainly addressed by being blamed, warned, reminded and ridiculed and that they do not dare ask questions (1999: 123, 251).

functioning accountability mechanisms. In Kamuli District, the socio-economic status of the elite was increased through holding public office, according to people's view. Given the self-granting practices and the increase in assets of those who "eat", this is probably true. However, the election of better-off people is not only the result of their greater ability to make themselves heard or to buy votes, it is also a reflection of a strong acceptance of hierarchy, patronage, authority and leadership, i.e. culturally induced subordination (Mathauer 1997: 30).<sup>280</sup> This is reinforced by the parochial open queuing system in electing the lower two LC levels (and before 1997 at all five Council levels). The lack of secrecy influences people's voting behaviour, and during an open election, I observed people running back and forth between candidates, assumingly in line with the "big men's" voting behaviour.

People's expectation of local councillors is not that they should simply represent the community, but also that they should be "bringing us something back", and "bringing something back" is more likely to be guaranteed by the better-off people. Rather than having a political agenda, Subcounty (and District) councillors win elections by spending large sums of money for sugar, soap and other gifts during the campaigning, thereby reinforcing patron-client relationships (cf. Golooba-Mutebi 1999: 244). As in other African countries, devolution is thus impeded by the prevailing patterns of patronage (Leonard/Leonard 2000). Since political power is linked with economic power, poorer people have limited access to council positions, which is highly problematic, as their concerns are not represented. For example, the better-off use private clinics, or else enjoy courteous treatment at government units, so they are unaware of what poorer people have to cope with when seeking treatment at government clinics. The capture by the better-off of the political system also explains why spending priorities are not poverty-oriented and why health receives so little attention. In fact, as Abraham/Platteau (2000) note, this elite capture is common to much of rural Africa.

One of the main roles of councillors is to consult with their constituents regularly (LGA 1997, Third Schedule, Section 8). However, none of the 15 communities to whom we talked to in focus group discussions during 1997 (before the direct Subcounty and District council elections took place in 1998) felt

---

<sup>280</sup> The quotes provided by Golooba-Mutebi (1999: 132, 235) on people's understanding of their leaders also illuminate this point.

represented and neither did anyone report having been consulted on any matter. Only four village councils (LC1s) out of the 15 communities had put forward an issue to the LC2, and in two cases, the community received feedback and their issue was settled. It seems that people do not bother to forward their concerns, since their case usually goes no further than the LC2 level. By contrast, many respondents mentioned that they address LC1 and 2 Executive Committee members on an individual basis for an individual issue. Furthermore, the feeling of not being represented was reinforced by the fact that most villagers do not know who their "representatives" are at higher council levels. As a result the communities perceived the higher Executive Committees as a part of the administration and not as their representatives.

After the direct elections at Subcounty and District level had taken place in 1998, the relationships have changed somewhat. The majority of male (94 percent) and seven out of ten female household respondents knew their Subcounty councillor. But only a seventh of the household respondents and 2 out of 12 focus groups reported that they have ever been consulted by them since the 1998 elections.<sup>281</sup> Accordingly, people are quite disappointed and frustrated with their Subcounty councillor:

"That man after having moved around for votes never came again. We have never approached him, because he never came back. Ever since he was elected, he does not give information back" (FGD, Kamuli Town, 1999).

"These people are just enjoying themselves, they just eat the money in their chairs. They told us they will do a, b, c, for the widows and the orphans etc., but since then, they have never come" (FGD, Subcounty C, 1999).

Likewise, 88 percent of household respondents had never forwarded a community concern to their Subcounty councillor, whereas a third of the communities, with which we had a focus group discussion in 1999 have done so.<sup>282</sup> In the few cases where they did, only half of the cases received feedback. A common strategy of councillors was to put them off, more so since LCs prefer to concentrate on activities for which they can charge a fee, such as settling disputes. It was also found that

---

<sup>281</sup> Without having carried out a systematic analysis, it appears that the contact between District councillors and their constituents is even less frequent.

<sup>282</sup> The difference between the two figures can be explained by the lack of information flow to the individual community members. Nevertheless, the score is low overall, and this is also related to the low degree of collective action and the individualised community life, which communities themselves complained about.

almost a seventh of the household respondents had contacted a councillor for an individual problem.

### *Distortions at the Lower LC Levels*

Local participation and legitimisation is distorted by two contradictory logics within the LC system. The 1997 LGA introduced direct elections of Subcounty councillors for direct representation of the communities. Yet, the prevailing practice is that people still have to forward their issues through the LC1 and LC2 level before an issue will be dealt with at the LC3 level. This constitutes a dead-end in some communities, where there is no functioning LC2 Executive Committee anymore or where the LC2 councillors are not interested in calling a meeting.

LC1 and LC2 meetings have lost their relevance, and none of the studied communities had regular general meetings anymore (cf. Golooba-Mutebi 1999: 118), which runs contrary to the 1993 Local Governments (RC) Statute and 1997 LGA. Local people blamed their councillors for not calling meetings anymore, but another reason was the lack of interest of community members. A general demoralisation and demotivation on both sides has taken place, and as a result meetings are only called for special issues (such as security and external projects). Golooba-Mutebi (1999) also mentions the lack of remuneration of lower LCs as a central reason for the absence of council meetings. This demoralisation must be seen in light of the creeping erosion of what the LCs were intended to be in the RC system, which was to be the people's representatives and the initiators of local community projects. The introduction of direct elections has not triggered a new dynamic for local participation, since the same organisational culture prevails.

Moreover, the 1997 LGA has downgraded the LC1 and LC2 levels to mere administrative units that serve (and often are instrumentalised) only as mobilisers for administrative tasks and for programmes and projects initiated from above. The mixture of LC roles, being both part of "political society", and mobilisers around government goals, along with their duties as assistants in tax collection (in theory at least), administrators and arbitrators<sup>283</sup> leads to a role conflict, since LC1 councillors

---

<sup>283</sup> Another main component of their work is to mediate and arbitrate local disputes in Resistance Council courts (cf. Resistance Council Committees' Judicial Power Statute 1988, Burkie 1993, Tidemand 1995).

have to serve and answer to both the state and the community. There is hence no separation between the executive and the judicative. In contrast to the rhetoric about and the original rationale behind the Resistance Councils system as a popular and participatory bottom-up system, a top-down mobilisation system had emerged, weakening the representational dimension. Further, in Kamuli as in other Districts, LCs shy away from taking on administrative responsibilities for fear of becoming unpopular within the community. Lacking the support of LCs, Parish chiefs have even more difficulties in performing their administrative tasks of tax collection.<sup>284</sup> Thus, the LC1 is no longer perceived as a level of relevance or with leverage (Mathauer 1997: 26).

Accordingly, none of the focus group respondents of 1997-99 (before and after local elections) felt that they have a platform to express their concerns about health or other services. For example, one group said that they have no voice option because they cannot go to the LC1s, whom they do not trust. Since the HUMC also fails to establish a link to the community, there is no functional mechanism at the local level through which people can exert leverage. Finally, the "recall mechanism" – the vote of no confidence – is rarely practised, even at the lower levels, and does no longer constitute a tangible accountability mechanism as a potential threat to councillors.<sup>285</sup> Things become more difficult still when it comes to recalling a councillor above the LC1 level, as this requires co-operation across Parishes and Subcounties. Finally, there is always the fear that taking a stand will prove harmful in the long run (see the next subsection):

"It is not easy for us to recall leaders because we fear to be singled out" (FGD, Subcounty B, 1999).

#### 7.2.2.5. Hierarchical Administrative Culture and Suppression of Voice

Deficits in local participation, legitimisation and accountability are also caused and reinforced by the prevailing "administrative culture". This refers to the sum of cognitive, evaluative and affective attitudes *within* the administration, manifested in the organisational culture, and along the citizens' attitudes *towards* the administration

---

<sup>284</sup> Likewise, Golooba-Mutebi (1999: 132) states that LCs do not have authority, or do not use their authority.

<sup>285</sup> This was already the case in the early 1990s (cf. Burkey 1991).

(cf. Jann 1983 for this categorisation). Both aspects shape the nature of interactions between civil servants and citizens, and the administrative culture is consequently a decisive factor for policy and service outputs. It is argued that for service provision to be effective, a responsive, co-operative, transparent and flexible style of administration is required (Simon 1993, Simon et al. 1997). The following account of the administrative culture at the local government level shows that the reality in Kamuli is far from being conducive to and supportive of the formally existent accountability mechanisms.<sup>286</sup>

### *Administrative Culture of Civil Servants*

The previous sections demonstrated the non-functioning of intra-administrative accountability mechanisms due to particularism and insufficient public interest, resulting in institutionalised embezzlement. Further, another characteristics of the prevailing administrative culture is a form of personalised hierarchy that is based on top-down command and use of threat to enforce compliance with the actions of higher authorities, even when those actions are not legal. A high power index and insecurity index prevails.<sup>287</sup> Lower cadres often fear questioning and objecting to the higher authorities, and as the administration goes unchallenged, lower cadres are often denied their salaries or allowances. Likewise, given the "long-standing hierarchical traditions and habitual deference to persons of higher social status" in much of Uganda (Golooba-Mutebi 1999: 236), lower LCs cannot imagine to dare recall their higher counterparts. The existing conflict avoidance strategy also explains why decision-making is captured by a few people, namely the Executive Committee or the Financial Committee. Due to fear for negative consequences, lower civil servants keep quiet. For example, a DMO official reported that they received less than two thirds of their supposed vote due to connivance among the District authorities and explained:

"We could only quietly make noise, and there was a private contact with newspapers.... Decentralisation is really the problem: If you make noise, they look at you privately [resulting in dismissal]" (interview, 1999).

---

<sup>286</sup> Jann's (1983) and Hofstede's (1987) conceptualisation and operationalisation of administrative and organisational culture informed this analysis.

<sup>287</sup> The power-distance index is composed of the indicators of many hierarchical levels and unequal relationships, and the insecurity index means avoidance of conflicts and uncertain situations (Hofstede 1987).

Similarly, a SCHC chairperson lamented the fact that the Secretary for Health never attends SCHC meetings and does not look after the health units. He then elucidates why they do not express their dissatisfaction:

"We have not raised this issue with the LC3, because it would be too delicate" (interview 1999).

This fear foils monitoring activities, intra-administrative accountability and transparency. Accordingly, NGO staff describes civil servants of both higher and lower cadres as driven by self-interest, who show little concern, commitment and engagement for the community. As a result, bribery, embezzlement and "eating" development funds have become a normal part of office life.

### Citizens' Administrative Culture

The administrative culture of local people is characterised by fear of the public administration, especially in regard to the agencies of law and order. This goes hand-in-hand with feelings of insecurity and resignation due to lack of knowledge about administrative procedures. People are well aware that money is "eaten", but do not see a way of opposing it. A common rhetorical statement was: "How can you make your boss accountable?" It was found that people's demands go unspoken, largely due to the persistent fear and mistrust that "the administration police might take us". The insecurity and fear for what will happen if one takes a negative stand is exemplified in the following quote:

"Some people fear that complaining will create grudges and hatred. The administrators call you wise. ...Maybe those people will not help you once you are in a problem" (FGD, Subcounty B, 1999).

As access to health care can be a matter of life and death, these experiences or perceptions have made people particularly wary about expressing their dissatisfaction to government health workers. Their anxiety of complaining is about getting an empty injection, wrong or no treatment, not being served the next time, being even more abused, or, as one group said, "having one's life terminated when being sick". Asking this group what they meant, they said:

"We really cannot say, but we just think that the staff can do anything bad to you" (Kamuli Town, 1999).

Likewise, another group thought:

"It would be easy to say something, but we fear to complain, as we don't know what could happen" (Subcounty A, 1999).

Whyte makes a similar point:

An open accusation might mean that you or your relatives will not receive help when you need it (1997: 207).

As a consequence, people often remain passive, withdraw and wait for what there is to come. Two percent of respondents mentioned that they would complain and use voice in case of being dissatisfied, but the consensus is that it is useless to express one's concerns.<sup>288</sup> Most often, people keep quiet and exit by using another place. This pattern is in line with Hirschman's note that the availability of exit often drives out the use of voice (1970: 76). Moreover, the ability to use voice is related to income, education and other attributes; so for the very poor, the use and the cost of voice can be too burdensome (Paul 1992: 1051).

In sum, the prevailing administrative culture contributes to the formal institutional mechanisms being distorted by individual interests. It also shows again that decentralisation has only resulted in a process of power reproduction of local elites.<sup>289</sup>

Overall, the various institutional mechanisms discussed in the previous subsections, which are supposed to ensure accountability, are deficient, resulting in the severe performance gaps of government health care provision as described in Chapters 5 and 6. People's (in)ability to pay and their need for privacy are not taken into account. Likewise, drug leakage, rude staff behaviour, absence when on duty and irrational use of drugs have become the norm. This is the result of the prevailing institutionalised pathologies within the local government system. Loewenson's (2000) account for Zimbabwe similarly points to the dysfunctional participation and accountability mechanisms that explain malperformance in the public sector (cf. Mills 1997b, Bennett et al. 1999).

---

<sup>288</sup> Mackintosh/Tibandebage (2000) also note for Tanzania that people are afraid to make complaints.

<sup>289</sup> We will see in Chapter 8 that the administrative culture also accounts for the struggle of civil society to operate as such.

### 7.2.3. Incentives and Staff Equity

This subsection will study in more detail the prevailing incentives – the rewards and sanctions – that government health workers encounter, and how these shape their behaviour and performance in a system where nobody expects consistency with the formal institutions.

Health workers have long suffered from salary irregularities, as payments could take months or even years, if they came at all. That said, as the staff payroll became a top priority within the allocation of resources at the local government level in the second half of the 1990s, the situation has improved at least for the District staff, though there are still cases where health workers do not receive their salary. For those health workers based in distant health units, it is very hard to take action regarding absent or irregular salary payments, both in terms of getting to the District headquarter by public transport and being heard by the District authorities when presenting the complaint. As a result, health workers would rather resign instead of forwarding their complaints.

Salaries of decentralised and District staff are slightly higher than those of employed staff in the NGO and private sector, as Table 7.2 indicates.<sup>290</sup> But despite considerable pay increases, salaries remain still low, especially in comparison to the earnings of self-employment in the private sector. In contrast to the District staff, Subcounty staff (nurses, laboratory assistants and mainly nursing aids) is more likely to be paid irregularly or not at all and not always provided with a work contract. Health workers who are employed by a health unit or by a Subcounty have to put up with even lower salaries and irregular payments. When these health workers have finally required experience and on-the-job training, they have often given up the hope of being paid and leave, after which the Subcounty recruits new staff along the same pattern (interview, Bülow, DED-health worker, 1999).

---

<sup>290</sup> This corresponds to the findings of a recent World Bank study of health care provision in Uganda (personal communication, Ritva Reinikka, 2001).

Table 7.2: Monthly staff salaries/incomes earned in the public, private and NGO sectors (in USh)<sup>291</sup>

	Government	Private clinics	NGO clinics
<b>Rural</b>			
<b>Medical assistant</b>	220,000 + 66,000 lunch allw.	450,000 (estimated) <sup>292</sup>	-
<b>Nurse</b>	90,000–120,000* + 66,000 lunch allw.	N/A	80,000–100,000
<b>Nursing aid</b>	40,000–60,000, D, SC 20,000 H/U	N/A	15,000–20,000 rN-1, 2 40,000–60,000 rN-3
<b>Urban</b>			
<b>Medical assistant</b>	220,000 + 66,000 lunch allow.	<u>Total income:</u> 1–3,000.000 <u>Net income:</u> > 700,000 (MA) ca. 1–2,000.000 (Dr)	227,450 hosp. 155,000 uN-1 200,000 uN-2 + 55,000–60,000 allw.
<b>Nurse</b>	90,000–120,000* + 66,000 lunch allw.	<u>Employed:</u> 100,000–110,000 70,000	90,000–120,000 hosp. no data for uN-1 160,000 uN-2 + allw.
<b>Nursing aid</b>	40,000–60,000	<u>Employed:</u> 30,000–60,000	70,000 hospital no data for uN-2

Source: DMO 1998, Interviews, estimation based on record books (1999)

D = paid by the District  
allw. = allowance

H/U = paid by the health unit

SC = paid by the Subcounty

\* Nurses who belong to the decentralised staff category receive a lunch allowance of USh 66,000.

This situation not only creates frustration and demotivation, but also forces health workers to find alternative income sources and enhances them to give leeway to perverse incentives, resulting in informal charging, the illicit selling of drugs, or being absent from duty to pursue other income-generating activities. Based on very modest estimations, a medical assistant can earn a weekly government salary with only 2.5 days private practice. As salary increases for doctors and medical assistants could never come close to the incomes earned in the private sector, the incentive for rent capture and drug leakage for private sale remains, as one focus group put it:

<sup>291</sup> Different salaries within one staff group are due to different staff qualifications (registered versus enrolled nurse) or different sources of funding (District, Subcounty or health unit).

<sup>292</sup> McPake et al's estimation amounts to USh 1,000,000 gross income. Given the price structure in the rural areas of Kamuli District, this would seem to be lower amounting to USh 600,000 for medical assistants with an estimated net income of USh 450,000. No data is available for the drugshops' income in Kamuli. McPake et al. found that (rural) private clinics are 2.6 times more profitable than drugshops (1998: 18).

"Since the law allows medical workers to run private clinics, it becomes difficult for them to concentrate at their government work and not take away drugs" (Subcounty B, 1999).

Despite the low salaries, public sector employment is still attractive, as it brings with it other benefits – free health care for the family, job security, retirement schemes, access to further training, prestige, an institutional base and often housing – which increase the overall value of the benefit package (cf. Martineau 2000, Bennett et al. 1994: 8), not to mention the fact that employment in the public sector offers opportunities for informal charging and resale of drugs.<sup>293</sup>

As in many other Sub-Saharan countries, the personnel system in Uganda's health care system fails, because pay and promotion are not linked to performance (cf. Asiimwe et al. 1997b). Health workers are paid a flat salary, and this creates the perverse incentive to reduce their workload as much as possible in order to have more time for other income-generating activities. Moreover, there are no clear promotional schemes (interviews, civil servants, 1997-99; cf. Kwagala 1997: 28), which affects staff motivation, and so another performance incentive is lost.<sup>294</sup> User fee revenues are supposed to constitute a financial incentive for good performance by being partly spent as staff top-up allowances. In reality income increases from user fee revenues are minimal (see Table 7.3) and are easily overtaken by informally charging half a dozen patients.<sup>295</sup> Opposite to the user fee rationale, the logic of informal charging is based on the delivery of *bad* services, which can then be improved by under-the-table payments to the health worker. As informal charging generates more income, the perverse incentive for bad performance or selling drugs dominates.

---

<sup>293</sup> Cf. Asiimwe et al. (1997b), who provide estimations for the income of these activities in a District in Western Uganda.

<sup>294</sup> In other Ugandan Districts, promotion was also found to be based on nepotistic considerations, gifts and payments (Azfar et al. 2000).

<sup>295</sup> Another problem is the unequal distribution of user fee revenues by not taking into account the staff's attendance, which causes conflict among staff.

Table 7.3: Allowances paid in government clinics (in USh)

	uG-1	rG-2 <sup>296</sup>	rG-3
<b>Medical assistant</b>	32,000 (IC); 22,000	19,000	14,000 (IC); 12,000
<b>Nurse</b>	19,000	19,000	10,000
<b>Nursing aid</b>	15,000	15,000	6,000-8,000

Source: Interviews with health workers and record books (1999)

Overall, the rates of official remuneration are not satisfactory, since – in the view of health workers – their obligations are not adequately balanced by the employers' efforts to cater for their needs. This explains malperformance, like staff absence, drug leakage for personal sale and informal charging. These strategies are a means to restore the contract between the employer and employee and hence seek to re-establish equity (cf. Munene 1993: 23).<sup>297</sup> In rural areas, staff absence and late showing is also related to the lack of accommodation on the compound of the health unit. At one extreme, we found a nurse who cycled about 20 kilometres each way from his home, about three days a week. In this way, health workers do not only feel neglected in material terms. Mackintosh/Tibandebage (2000) make the crucial point that nurses and nursing aids may also feel abandoned by doctors or medical assistants who are supposed to be responsible for patient care. Being left on their own, nurses may resort to ignoring patient needs or abusing patients (as the examples in Chapter 6.2.2 illustrated) as a way of dealing with their own helplessness and frustrations.

The various strategies of health workers – nurtured by the prevailing perverse incentives – must also be seen in the context of inadequate supervision and control. The DMO very rarely imposes sanctions on misbehaving health workers, and there is no real threat of being sacked (cf. Asiimwe et al. 1997b). DMO officials may also sympathise with the unsatisfactory remuneration of health workers and possibly feel that this current incentive situation does not justify sanctions for inefficiency. Further, Martineau points out that warning systems and disciplinary measures take a long time to be activated in many health care systems, so when they get activated they get

<sup>296</sup> Total monthly average allowances amount to USh 300,000, figures are estimated on the basis of the staff formula.

<sup>297</sup> This contract is particularly strained when health workers have to use their own money for transport in order to pick up drugs from the DMO (cf. Munene 1993: 11).

disassociated from the event (2000: 3). While this issue was not followed up systematically, this also appears to be the case in Kamuli. Another problem of rural health care provision in developing countries is the difficulty of replacing qualified health workers in remote areas, which may make them immune to disciplinary action (Cornwall et al. 2000: 2). In addition, the personnel system is politicised and nepotistic, and possibly, this even increased with decentralisation. The District Service Commission is often overridden by the Subcounty, in that the latter dismisses or keeps staff against the DSC decisions. The decentralised personnel system has hence not contributed to strengthening performance.

As mentioned earlier, professionalism may contribute to upholding standards, in that professional standards and professional values nurture motivation and guide performance (Moore 1996). However, the many examples of misconduct (cf. Chapter 6.2) indicate that commitment and professional values are low. This is because the situation of health workers has not been adequately resolved. When the civil service pay scales were restructured, medical workers received low priority.<sup>298</sup> In a status-conscious society, such as Uganda, the loss of income as well as status over the past years has been extreme. There was an enormous gap between the prevailing ideal of professionalism among doctors and health workers and what their actual situation afforded. Neither did the state fully support the doctors' professional aspirations any longer, and as a result, Iliffe notes, they have lost much self-respect (1998: 165). These less tangible changes need to be borne in mind, when judging the health professionals' behaviour and their giving way to perverse incentives.

The question then arises as to what can be realistically expected under these circumstances. Actions are predominantly shaped by perverse incentives and by the interests of health workers, namely the maximisation of their income and personal benefits, which results in the failure of government health care delivery. Health workers directly and intentionally contribute to lowering state performance in order to create opportunities for rent-capture and work actively to divert patients to the private sector. Financial responsibility mechanisms fall victim to the staff's strategies of reinstalling personnel equity, as they perceive it. In so doing, they can be certain that

---

<sup>298</sup> For example, a lay magistrate's salary rose to about US\$ 450,000 in 1994/95, three times more than that of a medical officer (Iliffe 1998: 167).

government officials turn a blind eye. In sum, this account of the public sector in Kamuli goes also closely together with Mills' analysis for developing countries:

In terms of low technical and operating efficiency, many of the explanations lie in the nature of the public bureaucracies and the lack of incentives they provide for efficient resource use. Decision-making is highly centralised, and planning and management structures are often weak (1997b: 250).

### **7.3. The Private Sector: Weakened Exit and Lack of Voice**

This section will analyse the degree and nature of competition, and related to this will be a discussion of the sorts of prevailing market imperfections and failures, and how this impinges upon financial responsibility, accountability and the health providers' incentives. As outlined in Chapter 2, the functioning of markets also depends upon the presence of certain institutions that often lack in a developing country context, the most important ones being state regulation, professional associations and insurance markets. The role of state regulation and professional associations will be examined in the following chapter, while there are no insurance schemes in Kamuli.

#### 7.3.1. Financial Responsibility

The degree of competition and the nature of the market vary according to the location of the providers in the different Subcounties. In general, however, contestability is high, since it is easy for any new provider to enter the market (cf. Chapter 8). Given the large number of drugshops and their closeness to each other, competition among drugshops is fierce, which keeps prices low and strengthens financial responsibility.<sup>299</sup> As the providers compete with each other, price levels *and* pseudo quality of clinical care constitute crucial factors. Their efforts are equally reflected in the business names of drugshops, for example "that people have good luck", "Life Guard" or "Family Life Clinic". In relation to other provider types, drugshops mainly compete by price, but also by providing credit. Rural NGO providers accuse drugshops of competition by slandering:

---

<sup>299</sup> Price differences between rural drugshops are small with only the less frequently prescribed drugs being priced differently. Profit margins are highest on antibiotics.

"The nurses at [rN-1] are good, but drugshops talk evil words about us, for example they say: 'The clinic is for the church only, they only treat church people, Moslems cannot be treated there'"(interview, HUMC member rN-1, 1999).

Private clinics are scattered in rural areas, so their main competition comes from drugshops, whereas in town competition among private clinics is strong given the higher number of health care facilities. In relation to all other health care providers, urban private practitioners compete on the basis of quality or rather by signalling quality. However, competition by quality does not necessarily lead to improvements in clinical care, as it is difficult for a layperson (the patient) to judge quality (cf. Kumaranayake 1998: 6). Further, as private providers compete for what patients want, they give way to the patients' unhealthy preferences; in fact, high quality providers who maintain standards may be competed out in rural areas. Among private practitioners (and NGOs), price levels or signalling lower prices are important competitive elements. Moreover, it is very difficult for a patient, who just came from the village, to understand the complicated price structure, which depends upon the seriousness of the disease, the drugs prescribed and the laboratory examinations. There is greater price transparency at drugshops in comparison to the private clinics, since it is much easier to compare drug prices.

In contrast to the public sector, private practitioners and drugshops have decision power over the input side – both in terms of staffing and salaries. Bennett et al.'s assessment of other developing countries equally holds true for Uganda, namely that most private practitioners have "a comparative advantage in terms of staffing, as they [are] tied neither to government pay scales nor to staffing norms, and tend to have lower labour costs" (1999: 16). Altogether, the competitive environment and the price mechanism foster technical efficiency, and as was demonstrated in Chapter 6.1, staff resource utilisation is most efficient among the private health care providers in Kamuli town. However, rural private practitioners are subsidised by the informal drain of public resources, such as drugs and staff time (cf. Chapter 6.2.1 and 6.2.4), because a very large proportion of government medical assistants, nurses and midwives practice privately. In contrast, none of the medical assistants and doctors that run a formal private clinic in Kamuli town are employed in the public sector, so there is no informal subsidisation by the public sector in these cases. Some Mission

health workers are employed in the private sector to increase their salaries. There are equally linkages, forward integration and personal overlaps between drugshops and the public sector, resulting again in the subsidisation of the former through staff time and drug leakage from the public sector.<sup>300</sup>

Furthermore, given the prevailing informational asymmetries in favour of the private providers, the latter can give way to perverse incentives. These translate into supplier-induced quality of care inefficiencies, such as inadequate or incomplete diagnosis, unhealthy and costly antibiotics and injection misuse, polypharmacy or unnecessary laboratory examinations, which also increase the patient's costs. Apart from the first point, these problems are also demand-induced in that they constitute explicit consumer preferences. In this way, although the availability of alternatives or substitutes increases competition and lowers prices, if there are too many drugshops in one area, quality does not increase, but it rather creates market failures and perverse incentives, in that commercial tendencies are fostered by adapting to people's preferences resulting in malpractice. These dangerous incentives have also been noted in other developing countries (Mackintosh/Tibandebage 2000: 8; cf. Bennett et al. 1994: 10). It must be emphasised, however, that private practitioners do have an interest in actively demonstrating process quality, such as friendly behaviour, provision of privacy, careful clinical examination, as well as the provision of some health education.

Trust plays an important role within the service delivery transaction and is enhanced through repeated interactions. Both the patient's and the provider's behaviour and choices are strongly embedded in social relations. The patient trusts the provider to cure him or her, whereas the latter will offer credit or concessions only if he or she is sure that the patient will pay at a later stage.

So, although the exit option is in principle available in a market with many providers, the need for both patients and providers to establish a social relationship with concomitant levels of trust, which are necessary to obtain credit, reduce the actual use of exit. At drugshops, 57 percent of the exit interview respondents were

---

<sup>300</sup> There was one case of horizontal integration found, but assumingly there are more. In this case, the drugshop owner (with no medical training) sends the clients in need of a laboratory test directly to the laboratory attendant at the government clinic, where they do not go through the official registration process. The latter examines and charges them on a private basis and sends the patient with the laboratory results back to the drugshop.

not first-time users, and the majority of those mentioned familiarity with and confidence in the drugshop as the reasons for utilisation. In other words, market competition is mixed with what Hyden (1989) conceptualised as the "economy of affection". Consequently, the exit option as a correction for failure in delivery and for strengthening competition is under-utilised, which then weakens competition. Yet exit does not change the prevailing dispensing practices and does not reduce the above-mentioned inefficiencies. It can be assumed for Kamuli that one finds what Hirschman (1970: 26) calls "competition as collusive behaviour", namely a situation where each drugshop garners some of the dissatisfied customers from other drugshops, while losing some of its previous customers to yet others.

In sum, as expected, there are considerable market imperfections and failures that weaken competition and thereby undermine financial responsibility. That said, the mechanism of financial responsibility is still much more functional in the private sector than in the public sector, which is also reflected in the better scores for staff resource utilisation efficiency and staff salary costs per patient (cf. Chapter 6.1).

### 7.3.2. Accountability

The accountability mechanism of the private sector is identical to that of financial responsibility, namely market competition, but it is again weakened by market imperfections, as discussed above. The market also fails in that those unable to pay are inherently excluded from taking part in market operations, and the market is unable to solve this access problem by itself. As said, the use of the exit option is limited and hence does not contribute to strengthening accountability, but neither is it supplemented by its alternative mechanism, that of voice. People do not express their dissatisfaction with private clinics directly, believing that "this is a business, where we cannot interfere." The large hierarchical gap between the layperson and the expert as well as the prevailing culture of subordination (cf. Section 7.2) also explains the reluctance to use voice. At drugshops, voice is hardly used either, and only 2 percent of the exit interviewees said that they would address again their issue to the drugshop owner in case they are dissatisfied. Although people are not satisfied with the poorly

qualified staff working in drugshops, they are seen as the least worst option or as an option that is better than having no nearby provider at all.<sup>301</sup>

Neither would people use voice and air their views at their local council, because, as mentioned in Section 7.2, they are generally reluctant to forward views, in the light of previous experiences or negative expectations that such an effort is in vain. Only in one extreme case, when a private practitioner had been accused of having killed several people due to lack of care, did the community call for the Subcounty authorities to intervene. Ogunbekun et al. (1999) point out the problem for Nigeria that consumers of health care are not organised into pressure groups, so that each patient is left to him- or herself when faced with malpractice. This is equally so in Uganda and constitutes a problem in relation to both the private and the public sector.

Internally, private clinics function as firms, and such an intra-firm principal-agent relationship between the employer and worker may give way to moral hazard and shirking. This raises the question of how employees are held accountable. Given the small number of employed health workers and the employees' interest in performance in order to get their salaries, shirking is much less of a problem than in government clinics. In addition, the owner closely supervises them, and in contrast to the government clinics, there is always the threat of being dismissed.

### 7.3.3. Incentives and Staff Equity

The prevailing incentive for performance is profit maximisation, such that private practitioners have an interest in attending to many patients and selling a large quantity of drugs, with the latter constituting the main source of income. But since private sector actors rely upon a good reputation in terms of quality and access, there is again a limit to unethical behaviour and charging excessive prices.

The private clinic owners' income is much higher than the salary of government health workers (cf. Table 7.1), and their efforts are clearly remunerated financially. The employed health workers (nurses, nursing aids, laboratory staff) do not earn more than their counterparts at government clinics, but they do receive other staff benefits such as free health care for the family, a (small) lunch allowance and sometimes a

---

<sup>301</sup> In cases of dissatisfaction, people either remain silent, choose to exit, usually to other drugshops or, depending upon the disease, go to higher-level providers.

housing allowance. More importantly, their salary is usually paid regularly and on time, which provides a secure income. Finally, the work environment is much more pleasant. Overall, performance is rewarded, while non-performance is sanctioned, and as salaries are flexible, it is easy to pay additional rewards.

The prevailing incentives within drugshops are very much the same as for private clinics. The drugshop owners' income is obviously much lower than that of private practitioners, thus not comparable, since drugshops can only charge for the sale of drugs. As the employees' salary depends upon the level of profit, there is a strong incentive for making large sales by meeting people's (unhealthy) preferences. Clearly, this is a perverse incentive.

Altogether, the market imperfections and failures and the low use of exit and voice weaken accountability and explain why the private practitioners' actions are not sufficiently guided by patients' real needs. As we have seen in Chapters 5 and 6, this results in a series of problems: high user charges; prescription patterns adjusted to the ability to pay (instead of being based on medical considerations); polypharmacy; and other forms of irrational use of drugs. There is therefore a pressing need for (better) regulation in the private sector, and it remains to be seen how state regulation and supervision impact on the operation of the private sector (see Chapter 8.2-3).

#### **7.4. The Voluntary Sector: Deficits in Participatory Accountability Mechanisms**

It was noted in Chapter 2 that the critical element of the voluntary sector is its value-drivenness and solidaristic concerns. Thus, the normative desire to maintain the solidarity with the group motivates performance and fosters competence (cf. Brett 1993: 276). Yet this is an ideal-typical conceptualisation and cannot be presumed for each voluntaristic organisation and employee, but requires critical and empirical validation. Further, the crucial determinant of performance is not only the compliance mechanism of solidarity, but the internal institutional structure and institutional mechanisms of the organisation. D. Leonard (2000) ascribes the NGOs' superior performance to their internal set-up. That is, accountability does not follow automatically from solidarity (Brett 1993: 278), but altruistic motivations may reduce the inclination of providers to exploit information asymmetries. As with the public

and private sectors, it is necessary to carefully examine the functioning institutional mechanisms for accountability, financial responsibility, personnel equity and the nature and extent of solidarity.

#### 7.4.1. Financial Responsibility

The assessment of financial responsibility must be differentiated according to whether the clinics have to recover their costs through user charges or whether they receive external support. The former group (uN-1, rN-3, hospital OPD<sup>302</sup>) operates like private clinics, as they have to compete for patients. Competition serves to keep input costs low, while the non-profit motif contributes to keeping prices at a cost-recovery level (even though prices are still high in relation to people's ability to pay, particularly at uN-1). In fact, for a clinic to register as an NGO facility under a religious medical bureau, the clinic must follow Christian principles and operate as a not-for-profit provider. Being exposed to market competition appears to be the major reason why drug supply management is more efficient in these clinics than in the subsidised ones.

The subsidised (Protestant) clinics (uN-2, rN-1 and 2) have to compete for patients if their utilisation rates are to satisfy their donors. Nevertheless, pressure on minimising inputs and improving outputs is weaker and there are no strong incentives for efficient drug supply management. The donor plans to gradually withdraw financial support and aims for the clinics to become self-reliant. This increases the pressure to recover costs and strengthens financial responsibility. Just like private practitioners, rural NGO clinics compete in terms of quality with other providers, although they have trouble in signalling their quality strengths. In town, NGO providers compete in terms of price and quality both with each other and with the private clinics. In cases of dissatisfaction, the people who exit usually go to the Mission hospital, although repeated social interactions and relations, embeddedness and the option of credit provision weaken the exit mechanism, as they do for the private sector.

---

<sup>302</sup> The Mission hospital receives delegated funds. However, in return in-patient user charges had to be similarly reduced.

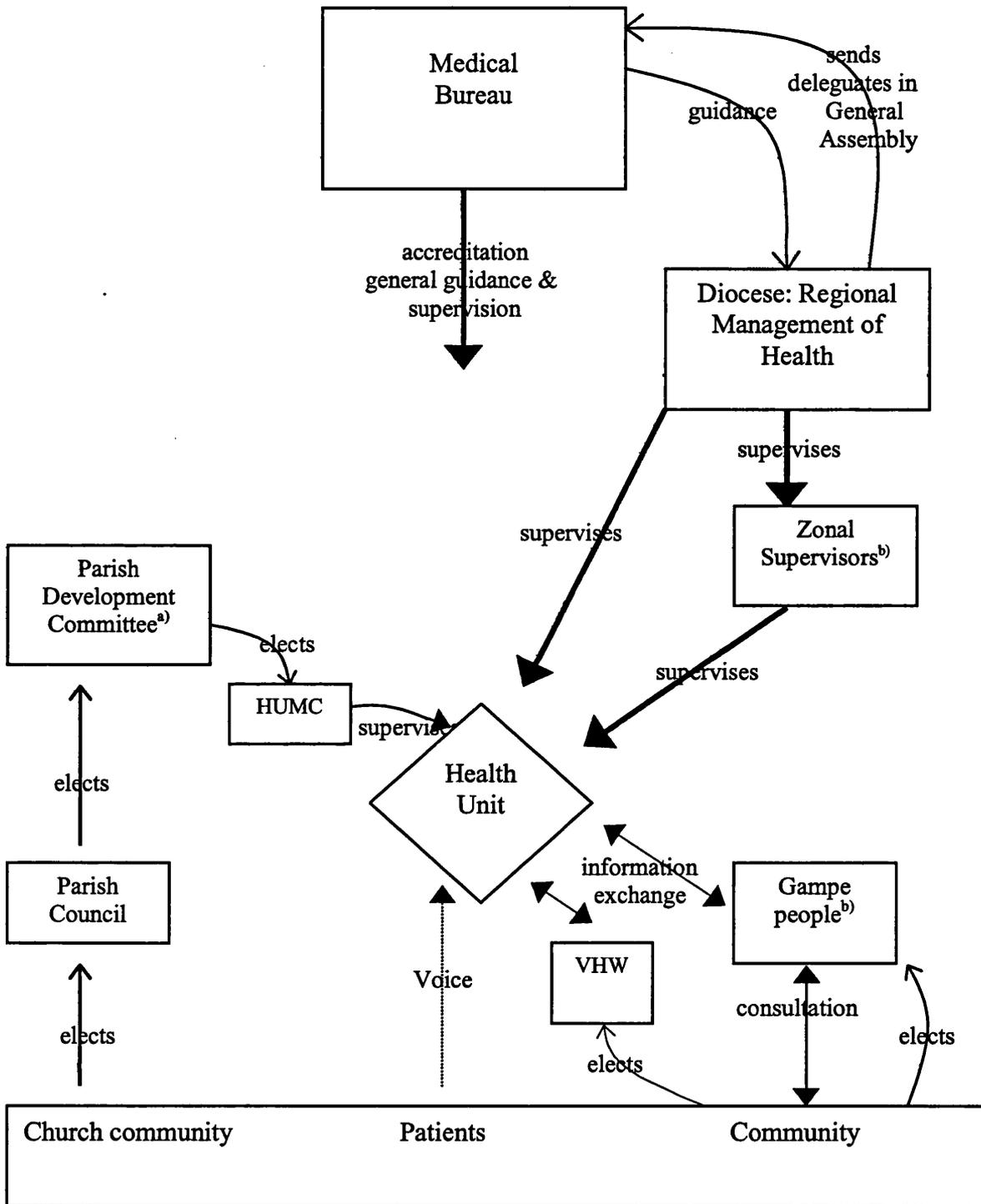
Decisions on inputs – drug management, staffing, medical and technical supplies – and user charge rates are decentralised to the facility level to a considerable extent. With regard to salaries, however, the NGO clinics do not have the same degree of discretion over staff salary rates, as does the private sector, since this is (co-)decided with the regional headquarters and influenced by the salary guidelines of the medical bureaux. But given the close contact and interaction between clinics and the headquarters, room for discretion is greater than in the public sector. The use of resources (staff time, drugs, user charge revenues) is, as we have seen in the previous two chapters, adequately and purposefully managed, with some small irregularities. Yet these irregularities are in no way comparable to the public sector practices.

Overall, financial responsibility is thus quite strong, which is also reflected in the better patient-throughput scores (cf. Chapter 6.1). As Mliga (2000) reveals for Tanzania, it is also found in Kamuli that NGO clinics have much stronger incentives to provide good quality care to their patients, when they must balance income and expenditures in order to remain open. That said, NGO clinics, especially in town, still give way to people's unhealthy treatment preferences, as do government and private clinics, resulting in supplier-induced inefficiencies (cf. Chapter 6.2.8). The following two sections will provide further insights into why information asymmetries are less exploited by health staff and why the degree of embezzlement of resources is minimal in the NGO sector.

#### 7.4.2. Accountability

There are various accountability and supervisory mechanisms in place that are supposed to ensure performance. Their rationale and structure (see Figure 7.2) is similar to that of the public sector and includes health unit management committees and headquarter staff in charge of administrative and technical supervision. Further stakeholders are the medical bureaux and donors. Finally, as said, NGOs have to compete on the health care market, so patients who choose to exit affect the clinics. This section will examine the functioning of these institutions.

**Figure 7.2: Formal accountability chains of rural clinics in the NGO sector**



<sup>a)</sup> For the Catholic clinics, this is the Parish Executive Council (cf. Chapter 4).

<sup>b)</sup> These two structures do not exist for the rural Catholic clinics.

7.4.2.1. Weak Health Unit Management Committees and Voice: Gaps in Community Involvement

HUMCs are elected by the church community leaders; for the Catholic Church this is the Parish Executive Council (Catholic clinics), while for the Protestant church election come through the development committee of the Busoga diocese's project area.<sup>303</sup> These bodies are in turn indirectly elected by the Parish church structure, in which committees at various levels represent the Christian community up to and including the diocesan level. The HUMC's duties are similar to those of the HUMCs of government clinics, namely monitoring the clinic, overseeing the financial management and providing a link with the community.

However, this supposed structure is not borne out by findings on the ground. Only two HUMCs (rN-1 and 2) out of the five rural units under study were functional, meeting on a regular basis with the members and looking after financial matters.<sup>304</sup> The other HUMCs did not function, since members were reluctant to meet without receiving a (large) allowance. As a consequence, meetings usually failed to take place or had a low attendance. This is a reflection of the strong "allowance culture" prevailing in Uganda, which has also penetrated to the voluntary sector and has suppressed or even suffocated voluntary action for the community. The willingness of the HUMC members to work voluntarily also seems to be related to levels of personal commitment. As was also found for the government clinics, the HUMC members of the NGO clinics often belonged to the better-off socio-economic groups.

NGO health workers are recruited by the NGO headquarters, but in legal terms they are employed by the church community, which is represented by the development committee. However, according to one headquarter staff, the link between health workers and the church community is very weak:

"The health workers take things for granted and for given; they work year after year, they think they can disappear when they want or they can eventually relax" (interview, NGO headquarter official, 1999).

---

<sup>303</sup> The two urban NGO clinics do not have a HUMC. At uN-2, a monthly patient exit audit is therefore carried out by external staff to find about the patients' satisfaction (interview, health workers uN-2, 1999).

The hospital is guided by a Board of Governors, whose main task is to decide upon the overall developments and future strategies. Its functioning has not been assessed.

<sup>304</sup> These were also the clinics that were found to be operating well. Yet it seems that a HUMC's non-functioning was the result of the clinic being improperly run rather than the other way around.

With one exception, staff-HUMC relationships are smooth, and the HUMCs are accepted by the staff, listened to and not pushed aside. Nonetheless, the HUMCs are rather weak when it comes to problem-solving. For example, one of the studied HUMCs has not been in the position to ensure the duty presence of the in-charge, who operates her own private maternity home. That said, in cases of severe malperformance, there are examples where action has been taken to dismiss staff.

The health workers and supervisors assume that the communities forward their views to the LC1s, to the (community-based) village health workers (at Protestant clinics), to the Parish Priest or to the nearest HUMC member. Table 7.4 shows people's awareness of and interaction with the HUMCs of NGO clinics and reveals marked differences between the Protestant and the Catholic clinics. These must be set against the corresponding scores of government HUMCs (cf. Section 7.2.2 and Table 7.1).

Table 7.4: Knowledge of and interaction with HUMCs of NGO clinics

	<u>Protestant clinics</u>		<u>Catholic clinic</u>	
	Household	Exit	Household	Exit
<b>Respondent is aware of existence of HUMC</b>	96%	80%	50%	33%
<b>Respondent knows someone on HUMC</b>	39%	42%	0%	14%
<b>Community was ever consulted</b>	43%	25%	0%	0%

At the Protestant clinics, the household and exit respondents' awareness of and consultation by HUMC members is much more widespread than at government clinics, where 0% of household respondents said that they had ever been consulted. Likewise, the focus group discussions confirmed that people are aware of the HUMCs. The higher score for the Protestant clinics is also due to the existence of the so-called "Gampe" people ("give me news"), who support the HUMCs in their role of

finding out about community views and needs.<sup>305</sup> By contrast, the Catholic clinic does not score better than the government clinics. Apart from a higher degree of mobilisation in the Protestant project areas, the lower score of the Catholic clinic may in part be due to the fact that many of the household respondents lived between the government and the rN-3 catchment area and therefore were not targeted by the HUMC as were possibly the other areas of the clinic.

Nevertheless, even when HUMCs are functional, they have rather little contact with the community, and the focus groups mentioned that the HUMCs do not really constitute a platform for voice. This is because people usually did not know how HUMC members were elected and stated that they had not elected these people. As a result, they did not feel participating in the accountability structure. Likewise, the focus groups hardly commented about the HUMC, which apparently were of little relevance to them. This is in line with Kassimir's assessment of the election of church leaders:

The election process does not guarantee a participatory leadership style; leaders of SCCs [Small Christian Communities] can be very directive even authoritarian, copying... what they have seen in the parish priest or in politics (AMECEA Documentation Service 1997 in Kassimir 1998: 71).

Because of time and resource constraints, it was not possible to analyse people's participation in the Parish councils and the parish communities. Kassimir points out that although lay members maintain loyalty with the church, they seek other forums for participation, and church leaders have not succeeded in fostering community mobilisation and socialisation (ibid.: 72, 76). This is confirmed by the focus group discussions during 1997-98, when one of the questions was what kind of organisations and groups operated in their community. None of the communities mentioned church-related groups.<sup>306</sup>

People usually exit in cases of dissatisfaction, just as they do at government clinics, but none of the respondents mentioned the use of the voice option. I only

---

<sup>305</sup> Another task of Gampe people is to inform the community about what is going in the clinic and to encourage them to utilise it. As they came into being two months prior to the data collection period, it was too early to assess them systematically, but it seemed that they have a positive impact.

<sup>306</sup> Another reason for this result may be that they were not sufficiently prompted during the focus group discussions.

heard of three cases of past abuses by health staff, where the communities expressed their concerns and took action. Yet, since staff-patient and VHW-community contact is much more informal and friendly and much less hierarchical, it is easier for patients to express their views and preferences. Despite this informality, the relationship to NGO VHWs is characterised by feelings that are similar to those reflected in the citizens' administrative culture (cf. Section 7.2.2):

"Since the VHW was not elected by the village, we fear to complain about her."

"The village people fear to be named wise [which is why they do not forward their complaints]" (FGDs, Subcounty B, 1999).

In sum, the NGO clinics have undertaken more efforts to increase participation and responsiveness and they do score better than the government clinics, but still, they do not fulfil all the claims made on their behalf.

#### 7.4.2.2. Adequate Supervision

Headquarter staff and field supervisors oversee NGO clinics for both clinical and administrative matters on a fairly regular basis, ranging from once a month up to once every three months. Headquarter staff also monitors whether field supervisors carry out their job. My impression was that NGO supervisors make more of an effort than their government counterparts. Also, the supervisory style is non-threatening, personal, co-operative and supportive which is assumed to have a stronger and positive effect on compliance. The supervisors are motivated, though lack of funds mean that in practice the supervision of Protestant clinics takes place half as often as planned.

The medical bureaux play an important role within the supervision system. Ultimately, they are the supervisors of the supervisors and their final sanction is to refuse or withdraw the NGO's accreditation under the medical bureau. Through the regional dioceses, they provide support supervision. UCMB, for example, checks the Mission hospital's drug stocks, drug dispensation and prescription patterns as well as the financial management. The bureaux also provide guidelines on the fee structures (interviews, hospital staff, health co-ordinator, UCMB official, 1999). As umbrella organisations, they offer services to their member organisations such as institutional support or advice on management and medical issues, and training and education.

Altogether, this assists the clinics in staying on the right track. In that sense, the medical bureaux in Uganda, as in other African countries, have, through self-regulation, taken over some of the tasks otherwise undertaken by governments (cf. Gilson et al. 1994: 22).

In sum, compared to the DMO's internal supervision practices at government clinics, NGO supervision is more intense and effective. This is similar to Tanzania, where it was found that missions offered much stronger supervisory systems than did the government and that staff control had a direct impact on quality (Mliga 2000). In addition to intra-NGO supervision, the state is supposed to supervise and regulate NGO clinics, which will be illuminated in Chapter 8.

#### 7.4.2.3. Donor Supervision: The Threat of Exit and Withdrawal

Regular evaluation and the constant threat of withdrawing funding are the key mechanisms of donor control over NGOs and their clinics. Donors are able to exit from an NGO given the fierce NGO competition for funding. That said, monitoring in remote areas is difficult, and it is costly to obtain independent information (Brett 1993: 294).

In Kamuli, the Protestant clinics are under direct donor control, even though they have considerable autonomy in running their services. Donors visited about twice a year to check up on the management, performance and utilisation rates. This direct donor dependence puts pressure upon the Protestant units to perform, as job employment is directly affected:

"If the money is not doing properly what it is supposed to do, the donor will cut money. In that case, we would lose our job. So this is why we are concerned" (interview, MA, 1999).

In contrast to the government clinics, NGO staff has no incentive to forge patient numbers, since high utilisation rates would result in high user fee revenues and hence sufficient income to run the clinic on a self-reliant, cost-recovery basis. This may accelerate the donor's financial withdrawal, and clinics therefore fare best by demonstrating their efforts in the most transparent way.<sup>307</sup> Too low utilisation rates, on the other hand, may result in closure of the clinic.

---

<sup>307</sup> Utilisation rates are not yet very high and hence do not yet make donor withdraw.

#### 7.4.2.4. Conducive Organisational Culture: Ethical Norms and Loyalty

As said in this section's introduction, we have to examine critically whether the NGO clinics under study constitute solidaristic groups that generate behaviour "dedicated to the common good and uncorrupted by... personal ... interests" (March/Olsen 1989, in Brett 1993: 276).

The religious affiliation of NGO clinics provides the starting point for their solidaristic concern. In general, the NGO health workers feel responsible towards the church and to the Parish community. NGO health workers were asked what they thought were the differences between NGO and government staff. According to my judgement, the statements below have much credibility and indicate that religious beliefs constitute a central component within the organisational culture of NGO clinics and play an important role in enforcing performance:

"[The clinics] work under church principles. Every practitioner is told about the mission to follow those guidelines." (interview, nurse uN-2, 1999).

"Staff knows that they are working for the church. There is a moral standard" (interview, supervisor of uN-2, 4, 1999).

"This is an NGO clinic. We have ethical standards to fulfil" (interview MA, uN-2, 1999).

The medical bureaux, the dioceses and headquarters provide an ethical code of conduct that includes behavioural guidelines. This translates into and strengthens a specific organisational culture, which is most pronounced in the leadership of the Mission hospital. The adherence (or at least a stronger adherence than at government clinics) to ethical standards is also reinforced by prevailing competition and rivalry over legitimacy and acceptability with the DMO. In this environment, NGO clinics attempt to distinguish themselves from the government clinics, ultimately strengthening their group identity.

Training by the NGO headquarter provides another opportunity to raise and strengthen ethical standards. Moreover, during the recruitment process, headquarters pay much attention to the staff's previous work record, their behaviour and their motivation to work for a church clinic (interviews, NGO headquarter officials, 1999). In sum, the church facilities succeed in nurturing and sustaining a considerable degree of loyalty to their organisation among their employees. This helps explain why

perverse incentives do not dominate in the way that they do in government clinics and why the overall levels of opportunistic behaviour among NGO staff are low.<sup>308</sup> While evidence is less clear for reciprocity as the basis for solidarity – i.e., the work for the Church may pay off in another way – it does seem that this also affects the staff's behaviour. Moreover, the Sisters' motivation in the Catholic facility and the Mission hospital appear to be based on altruistic concerns.

Yet, although solidaristic motivations may make the agent more reluctant to exploit the informational asymmetry within the principal-agent relationship, solidarity on its own is not sufficient to guarantee performance. Performance requires effective accountability mechanisms to ensure that solidarity is applied in the interest of the principals. So, only in combination with the relatively effective supervisory structures do these ethical codes succeed in upholding standards and establishing loyalty to the clinic by the clinic staff, thereby weakening withdrawal and their use of exit in the form of shirking or demanding informal payments. Performance is also ensured through mechanisms of exit and voice by clients, as these signals, though rarely used, are more likely to be translated into action; for example, incentive structures will be adapted or supervision will put particular attention on the respective problem. This explains why staff absence, drug leakage and informal charging hardly occur, with few exceptions at the hospital, where supervision is more difficult.

Overall, we find that the sum of accountability mechanisms, even though not perfect, are more functional than in government clinics. Nevertheless, the supervisory system does not adequately address the deficits in clinical quality of care.

#### 7.4.3. Incentives and Staff Equity

Salaries for rural NGO staff are slightly lower than at government units (cf. Table 7.1), however, these figures do not include the provision of uniforms and (partly better) housing on the clinic compound, which are highly valued by health workers. Urban NGO clinics pay salaries similar to the public sector (with one exception), but no lunch allowances are paid. In general, the remuneration includes an output-related

---

<sup>308</sup> This is not so much the case for nursing aids, who are not recruited by the headquarter. They do not obtain adequate remuneration, and their motivation seems to be guided by their interest in getting some training and job experience, after which they could look for better employment opportunities (usually at drugshops).

component, in that the salary classification is not only based on qualification but also related to experience and utilisation rates. The urban units also pay allowances from the user charge revenues, the amount depending on the clinic's performance. Most importantly, salaries are usually paid on time, with occasional delays, and in further contrast to the public sector, NGO staff can trust that salary arrears are cleared.

In order to generate additional income, a number of Mission hospital nurses and midwives practice on a private basis at their home or sell drugs in the village. But given better supervision, the health workers are always on duty during their shift. Several hospital workers are also employed in the private sector (having night shifts at the hospital and day shifts at a clinic or a drugshop, or vice versa), which in some cases has been agreed with the hospital administration. However, in other cases the administration was not informed. Even though this does not explicitly take time away from hospital duties, such double employment is problematic, in that it is difficult for staff to manage double shifts over long periods of time.

It is also important to take into account the non-material benefits. The working atmosphere is more pleasant and agreeable at NGO clinics, and staff relations overall were described in positive terms in contrast to what government health workers feel about their staff relations. The staff at the Protestant clinics attends refresher courses and as a result feel more confident in handling patients and providing quality care. Whether these aspects are based more on measurable outcome or mere perception, it does result in work satisfaction, which can only improve performance. Religious motives and beliefs among the Sisters at the Mission hospital seem to be much stronger than those of the other staff, but it still appears that in general, reciprocal motivations and loyalty to the church's principles contribute to assessing one's obligations in balance with one's benefits.

Finally, the NGO clinics relate rewards to performance (through salary rates and allowances) and tie sanctions to malperformance (decentralised control over staffing, dismissal and disciplinary measures). While NGO health workers are in principle guaranteed their salary, there is always the underlying threat that the clinic must perform if it is not to be closed down – an incentive that is absent at government clinics.

In sum, the most crucial institutional feature to ensure and enforce performance is the system of close supervision. Even though it has gaps, it is still more effective than the government's internal supervision. It succeeds in overcoming the non-functional HUMC structure and in providing a supportive framework for maintaining ethical standards. As a result, NGO facilities perform high in terms of process quality and are the best at taking into consideration people's ability to pay by offering exemption and extending credit (cf. Chapters 5 and 6).

## **7.5. Conclusion**

This chapter showed how the (non-)functioning of institutional mechanisms accounts for organisational (mal-)performance and how the performance differences among the provider types, as revealed in the previous two chapters, are clearly reflected in the differences in establishing financial responsibility, accountability and staff equity. (Only as regards access have we found institutional convergence, cf. Chapter 5).

In the public sector, malperformance is largely explained by lack of functional accountability mechanisms resulting in deviations from the public interest. Lack of supervision and disciplinary measures lead to a situation where perverse incentives dominate, allowing the staff to pursue their "privatisation" of public resources. This is related to the distorted local legitimisation process and the non-functional accountability chains between citizens, politicians and civil servants, which in turn undermines the capacity for financial responsibility. Further, the prevailing administrative culture characterised by people's fear to use voice cements this situation. In sum, the state operates a system on the basis of assumptions – professional standards, accountability and financial responsibility– that it cannot hold and is instead characterised by institutional degradation. This explains the serious deficits in relation to the three performance criteria of access, efficiency in the management and utilisation of resource inputs, and quality of care.

The problems of health care provision and the lack of accountability must be seen in light of the general gaps and problems of decentralisation and local

councils.<sup>309</sup> In fact, the Kamuli District administration's service delivery in other fields (education, agriculture, water and roads) has been equally inadequate and unsatisfactory for the communities (cf. Mathauer 1997). Malperformance of the public sector in the health care sector in Kamuli is thus in no way surprising, and part of a broader pattern that is in line with findings in other Ugandan Districts as well as other African countries, both for the health care sector and for other services.<sup>310</sup>

Thus, the crux of making effective local government a meaningful reality (and not only in formal-legal terms) is to strengthen the accountability of politicians and civil servants towards their citizens through a careful institutional capacity strengthening approach. In particular, this should support the functioning of the various committees, planning processes and intra-administrative procedures. In so doing, the informal institutions including the political-administrative culture have to be fully taken into account. Also, exit options must be strengthened, for example by providing vouchers to the poorest community members to allow them to use alternative providers. Voice options can be improved by making HUMCs and District and Subcounty Health Committees more functional (through training), by making HUMCs more representative (through direct elections) and by supporting NGOs that function as pressure groups for health care matters.<sup>311</sup> Furthermore, the LC system's inherent dysfunctional logic at the LC1 and LC2 level requires reform. It is also fundamental to inform the communities about their voice options and about administrative procedures in order to reduce the prevailing information and power asymmetries from which they suffer and which ultimately keep them quiet. This is what the action research undertaken in Kamuli District aimed at, leading to some encouraging results as regards the feasibility of improving accountability (cf. Mathauer 1998).

The private sector's malperformance is based on inefficiencies that are caused by market imperfections and failures and related thereto perverse incentives, which lead

---

<sup>309</sup> This is not to say that devolution has not led to improvements in planning, capacity, participation and the provision of services (cf. Chapter 3, cf. Kisubi/Mugaju 1999).

<sup>310</sup> For Uganda, cf. Batley (1996) for education, health, solid waste disposal; Golooba-Mutebi (1999) for health, education; Azfar et al. (2000) for health, education; Simonet (2000) for health in Zimbabwe; Mackintosh/Tibandabage (2000) for health in Tanzania; D. Leonard (2000) for health and veterinary services in a number of African countries.

<sup>311</sup> Cf. Howard-Grabham (2000) for ways of increasing accountability through community mobilisation approaches.

to supplier-induced inefficiencies and exclusion. Exit does not have a strong impact on improving services, and further the embeddedness of clients and providers in existing social relations undermines the use of the exit option, thereby weakening financial responsibility and accountability. This explains the low performance in clinical quality of care and access.

Market imperfections equally account for performance gaps in the voluntary sector. Moreover, the NGO facilities are not characterised by strong community involvement, in contrast to what was expected. However, strong internal supervision and supervision by the medical bureaux as well as solidaristic motivations help maintain norms and ethics and succeed in ensuring a satisfactory level of process quality of care and a relatively better level of efficiency. That said, the institutional mechanisms in this sector fail to address the inadequate quality of clinical care (by giving way to people's unhealthy preferences); this is partly due to the clinics' need for user fee revenues.

For the private and voluntary sector, this institutional account is not yet complete. Interorganisational relationships and governance mechanisms – the institutional mechanisms operating interorganisationally – equally affect performance, which will be examined in the next chapter. Only then can we evaluate the causes of performance and malperformance and identify entry points for the improvement of the private and voluntary sectors' performance. A final assessment on institutional pluralism and provider performance can then be provided in Chapter 9.

## Chapter 8

### **Deficient Interorganisational Relationships and Their Impact on Organisational and System (Mal-)Performance**

This chapter continues the institutional analysis of the previous chapter. Organisational performance and malperformance will be further explained through examining the interorganisational relationships and the way they influence organisational performance and the performance of the system as a whole or how they cause malperformance.

Interorganisational relationships are of relevance as regards system concerns. First, non-state providers come to deal with diseases of public health significance (such as communicable diseases). Second, the achievement of disease control objectives requires non-state providers to be integrated in the national health system (cf. Brugha/Zwi 1998: 108). Further, Uganda's multi- and intersectoral health care system is prone to duplication and fragmentation given the atomistic structure of the non-state sectors. The country's health policies seek to address these issues; one of its major objectives is to integrate non-state providers by "establishing appropriate instruments to facilitate the private sector " (RoU/MoH 1998b: 12). The policies also aim to make "the private sector [including NGOs] a major partner in Uganda's national health development by encouraging and supporting its participation in all aspects of the National Health Programme" (ibid.) (cf. Chapter 3).

Following the analytical-theoretical concepts for studying interorganisational relations (cf. Chapter 2), the first part of this chapter is concerned with governance mechanisms – competition, regulation and enabling, and network co-ordination, which govern and steer interorganisational relations and which thereby affect organisational performance and system concerns. Competition, which also operates as a compliance mechanism, has been dealt with already in the previous chapter, so the focus in this chapter will be on regulation and network co-ordination and how effective they are. To explain why the governance mechanisms function the way they do, one must examine the prevailing incentives and interests of the various actors involved, including the presence of informal institutions that may subvert formal institutions, as well as the actors' capacities to regulate and to engage in network coordination. Understanding the functioning of governance mechanisms allows us

then to derive their effectiveness, namely their impact upon performance and their appropriateness.

Section 8.1 provides some further methodological considerations. Regulation of the private practitioners, drugshops, and NGO clinics will be examined in Sections 8.2-4, respectively.<sup>312</sup> Section 8.5 will analyse network co-ordination as a governance mechanism and its impact. As outlined in Chapter 2, regulation can be broadly understood as the state's actions to manipulate prices, quantities, distribution and quality of services by using hierarchy or enabling measures (Maynard 1982 in Kumaranayake 1998: 8). Regulation is the predominant instrument applied to address market imperfections and failures, such as information asymmetries, exclusion and supplier-induced inefficiencies. In principle, regulation is about introducing incentives that need to be structured in such a way that it is in the interests of the regulator to regulate effectively and the providers to comply (Bennett et al. 1994: 12). Network co-ordination can be defined as a manifestation of "rules of the game negotiated and agreed by" interdependent actors within more or less stable patterns of social relations (Rhodes 1997: 7). Like regulation, network coordination aims to achieve integration and to address efficiency, in that coordination as to space, time and content optimises the use of resources and in that resources are pooled. It also addresses prices and thus access, quantities and related thereto location as well as coverage and last not least quality standards (cf. Chapter 2).

The second part of this chapter deals with interorganisational interactions, which also affect organisational performance and the performance of the system as a whole. In Section 8.6, the focus will be put on partnerships between the public sector and NGOs – both curative health care facilities and PPHC organisations – and their beneficial impacts.<sup>313</sup> Note that in contrast to Chapter 2, this chapter does not maintain the analytical separation between incentive-based schemes as a governance mechanism and partnership as a form of interaction, since in practice the one goes together with the other.

As it turns out, partnership arrangements entail many pitfalls. Section 8.7 therefore analyses the prevailing incentives of the organisational actors involved, the interaction structure and the interaction culture between the local administration and

---

<sup>312</sup> State supervision of government clinics was addressed in the previous chapter.

<sup>313</sup> Apart from business relations and double employment, there are no interactions between the private and the voluntary sector. Furthermore, the private sector is virtually not addressed through co-ordination and partnership initiatives.

the voluntary sector to explain the actual interactions found at the local level. Section 8.8 examines the functioning of the referral system. Section 8.9 concludes and sketches out some of the key interorganisational aspects that require reform in order to optimise organisational and system performance.

### **8.1. Methodological Considerations**

The structure of this chapter implies that regulation, incentive-based schemes, network coordination and partnerships exist independently of and unrelated to each other. In practice, they overlap and are intertwined. Incentive-based regulation, for example, often goes hand-in-hand with network co-ordination and partnerships or contracting (cf. Bennett et al. 1999). The chosen chapter structure thus serves analytical purposes to clearly identify the crucial issues.

For the study of interorganisational relationships, a network analysis was undertaken that focused on processes and structures. The core questions to each provider comprised the following: With which other organisation(s) does it interact? What is the nature of this interaction? Which resources are exchanged? Following an action research logic, the NGO clinics and community-based NGOs were also asked how interactions could be improved.<sup>314</sup> The network analysis examined interactions from 1995 to 1999 and was part of an action research that aimed to promote intersectoral co-operation and co-ordination. Further insights about the relationships between the NGOs and the local government/administration were gathered during the "action phase", specifically the networking workshops that followed the research phase.

The impact of interorganisational relationships will not only be assessed as to access, quality of care and efficiency, but also as to the extent to which interorganisational relationships foster integration and synergies, and increase output (cf. WHO 2000), as well as other inductively derived aspects. The assessment is qualitative and is also based on the perception of the various actors involved. Less is

---

<sup>314</sup> For the sake of obtaining a more comprehensive understanding of the nature of interactions, this network analysis also included the District departments of education, community development and agriculture, in addition to the DMO, as well as other community based NGOs beyond PPHC (cf. Chapter 1.4).

known about the performance level of PPHC providers (and other community-based NGOs), since it was impossible for time and resource constraints to undertake the same rigorous analysis of relative strengths for PPHC services as it was done for curative services in Chapters 5 and 6. Further, there are large methodological difficulties in studying output and outcome, given the "production technology" of PPHC services. However, a qualitative assessment, the results of which are not reported here (cf. Mathauer 1997) indicates that the majority of PPHC NGOs deliver services at a decent level of quality, at low costs, and they reach the rural communities (not necessarily the poorest people, however).<sup>315</sup> So, at the bottom line, they produce no harmful services. Hence, although they may not have optimised cost-effectiveness and technical efficiency and may not reach the poorest of the poor, their service delivery does serve the people's needs, so that it is worthwhile to foster their existence and support their services.<sup>316</sup> So, even without knowing the exact performance level, an impact study of interorganisational interactions is important and will reveal crucial insights into why organisations and systems perform or fail and how organisational performance can be promoted.

## **8.2. Regulation and Supervision of Private Clinics**

### **8.2.1. The Formal Regulatory Framework**

The private sector legislation was updated with the 1996 Ugandan Medical and Dental Practitioners Statute (UMDPS).<sup>317</sup> Figure 8.1 sketches the actors involved in regulation, supervision and enforcement and how their interplay is supposed to work in theory.

As spelled out in the 1996 UMDPS, a self-regulatory Council – the Ugandan Medical and Dental Practitioners Council (UMDPC) – was established in late 1998. It

---

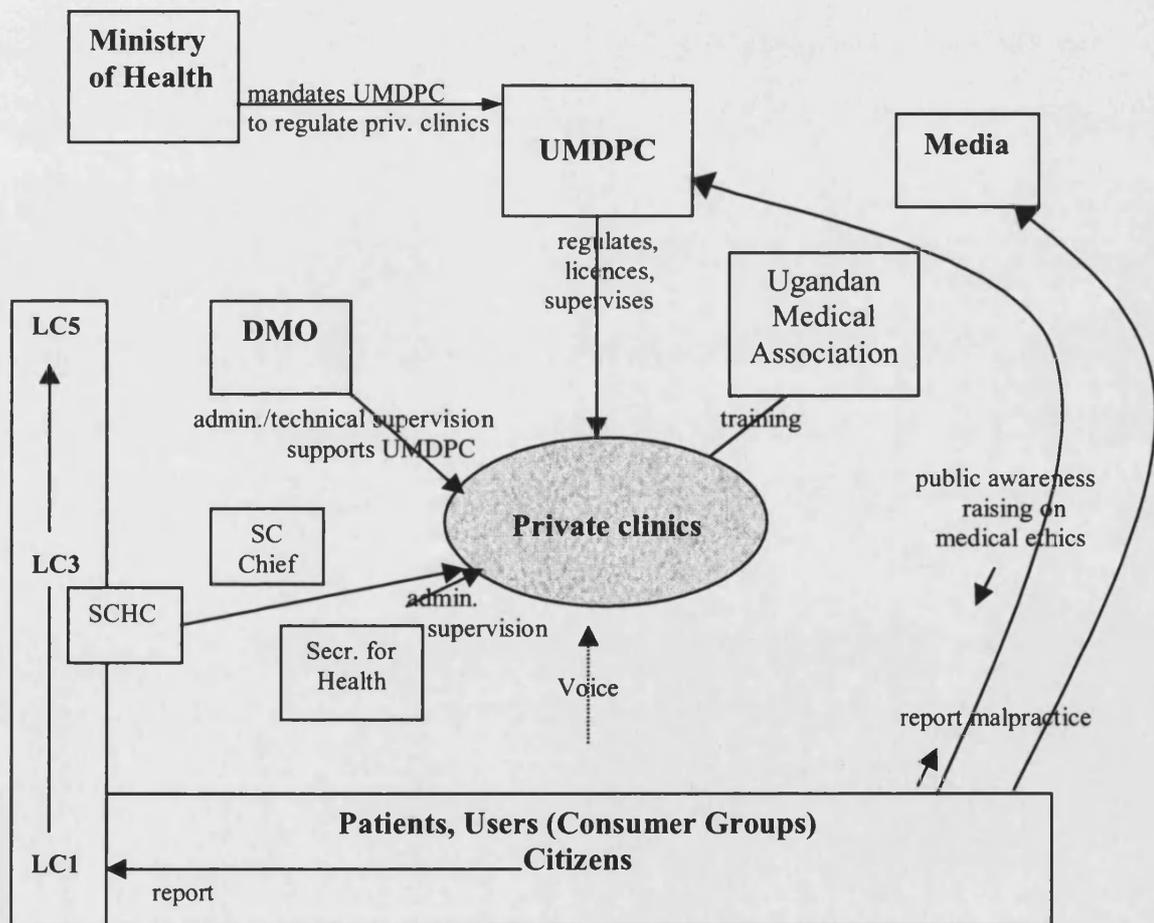
<sup>315</sup> This qualitative assessment is based on the 15 focus group discussions with LC1 Executive Committee members, 37 community focus group discussions, 15 focus group discussions with NGO target groups (1997-98), 12 community focus group discussions in 1999, numerous interviews and discussions with NGOs (see Annex 2 for the list of interviews and discussions) and some field visits and field observations of PPHC activities, e.g. the National AIDS day, AIDS awareness-raising stepping stone activities.

<sup>316</sup> There is one questionable exception to the NGOs' overall beneficial impacts. The Catholic church-associated NGO does not promote condoms for AIDS prevention; instead they advocate faithfulness and try to make people believe that condoms are useless for the protection against AIDS.

<sup>317</sup> Following the rationale of the UMDPS, similar legislation was also passed for allied health workers and nurses.

is composed of seven members, who are appointed by the Minister of Health upon the recommendation of various interest groups (faculties of medicine and professional associations). There are no provisions on the control of the council, except that members may be removed for inability to perform their functions. The Registrar assists in carrying out the Council's functions, including the maintenance and enforcement of professional medical and dental ethics as well as educational standards, and the exercise of general supervision and disciplinary control over medical and dental practitioners in order to ensure quality.

Figure 8.1: The formal regulatory and supervisory system of private clinics



priv. = private  
 admin. = administrative

Likewise, the Council should "disseminate to the medical and dental practitioners and to the public, ethics relating to doctor-patient rights and obligations" (UMDPS 1996, Section 4). Market entry – to guarantee that only qualified practitioners operate – is regulated by various licensing and registration provisions. However, quantity and prices are not regulated but are left to market forces, which raises serious concerns about access and supplier-induced oversupply, as we have seen in Chapters 5 and 6. Neither does the Statute regulate the location of providers in relation to each other, the result of which is unequal coverage (cf. Chapter 4). Finally, the legislation does not say anything about disease notification.<sup>318</sup> Hence, major market imperfections and failures remain unaddressed.

The District Medical Offices have agreed to assist and to carry out certain functions for the Council, most importantly, to supervise the quality of care at private clinics (interview, UMDPC official, 1999). The Statute does not mention the role of Subcounty chiefs, Secretaries for Health and health assistants, but in interviews, the latter two mentioned that they are in charge of supervision of private clinics. Likewise, the 1997 Local Government Act (LGA) suggests a role of the Subcounty chief in administrative supervision:

It shall be the duty of a Chief ... to carry out general administration in conformity with Government regulation... and to ensure implementation of District and Government policies ... (LGA 1997, Section 70, (3b), (5)).

### 8.2.2. Regulation in Practice

Based on the agreement between the UMDPC and the DMOs, the latter inspects private practitioners, but it only does so in the initial stage of the licensing process to provide approval. Yet this inspection concentrates on infrastructural matters rather than on quality of care issues. Apart from this inspection, none of the registered, formal clinics had ever been visited by the Council or the DMO. Okello et al. (1997: 16) notes the same failure in other parts of Uganda.<sup>319</sup> This can be attributed to the fact that the agreement between the UMDPC and the DMOs is only of an informal nature and not binding. Because of this non-interference, some private clinics are

---

<sup>318</sup> Disease notification is in general very poorly developed in developing countries (for the reasons, cf. Aljunid 1995: 344).

<sup>319</sup> Similarly, in Tanzania, providers complained of formalistic inspection that ignored support as regards clinical issues (Mackintosh/Tibandebage 2000: 10).

registered in the name of a doctor but actually run by a medical assistant who is not adequately monitored or supervised by the former – a problem that has also been observed in Zimbabwe (Hongoro/Kumaranayake 2000). Further, the UMDPC's and the DMO's records of private clinics are incomplete and only half of the (formal, visible) clinics in town had a license in 1999 or 2000. As a consequence, policy planning and regulation of the private sector is made virtually impossible. In that respect, Uganda is not different from other developing countries (Bennett et al. 1999: 14). The licensing and registration process is also undermined by the illegal practice of imposing a trading licence fee upon private practitioners by the Town Council authorities in order to raise local revenues.<sup>320</sup> Even though illegal, private practitioners find it difficult to refuse to make this payment but it obviously makes them even less willing to adhere to the government legislation in light of the latter's double standards. Needless to say this trading licence has no regulatory impact.

The DMO does not take action against the dual employment of government health workers in the private sector. Since a number of DMO staff owns private clinics (or drugshops) in rural areas, licensing private clinics is not in the DMO's interest, as this would openly acknowledge their double-employment and ask for a clear government statement on this matter. Ignoring the problem, thus, appears to be the more convenient strategy. The DMO bothers even less about the large number of rural informal clinics and nursing or maternity homes that are run by nurses, dispensers, midwives or medical assistants who are no longer employed in the public sector. Likewise, it is also remarkable that the DMO does not even have an interest in licensing the "official", visible town clinics owned by doctors and medical assistants who are not simultaneously employed in the public sector. While the legislation clearly regulates market entry through qualification requirements, this is, in practice, of no relevance, and the market is quite contestable.

The main problem in private clinics is the high frequency of polypharmacy and overuse of antibiotics and injections (cf. Chapter 6.2.8). According to the law, private practitioners should write a prescription and send the patient to a pharmacy. Yet they argue that they are forced to dispense and stock their own drugs in the absence of a

---

<sup>320</sup> Clinics do not constitute a business and are therefore not subject to trading licences (announcement in *New Vision*, 10-05-1999).

pharmacy in Kamuli District that sells class A and B drugs. Regardless, we know that drugshops in Kamuli sell all classes of drugs illegally. The true reason is that clinics mainly profit by dispensing and selling drugs, particularly as people are unwilling to just pay for advice and a "paper" (the prescription) (cf. Okello et al. 1997: 13).<sup>321</sup> In sum, law enforcement in relation to licensing and quality standards is inappropriate due to lack of supervision and monitoring. Ensuring adequate clinical quality of care is obviously very tricky, and the DMO fails to regulate and supervise not only the private sector, but also the government clinics (cf. Chapter 7.2). Accordingly, private sector actors accuse the government of applying double standards (Birungi et al. 1999: 10) – a similar complaint of non-state providers in Tanzania, for example (Mackintosh/Tibandebage 2000: 13).

Instead of actively seeking out low-quality providers, the current strategy is to wait passively for complaints, as can be derived from the 1996 UMDPS (Section 34). This is problematic, since it seems that the large majority of people are not aware of the existence and functions of the Council. On the question of what people could do in case they are dissatisfied with services, none of the exit and household respondents and focus group discussants mentioned the Council. Over 50 cases of alleged malpractice were reported to the Council from many parts of the country (but Kamuli is not mentioned), and "the majority have been investigated and appropriate action taken" (MoH 2001).<sup>322</sup> Up to August 1999, two cases of malpractice in Kampala were brought to media attention. Given people's known reluctance to complain, based on their fear, and in light of the LC deficits (as discussed in Chapter 7.2.2) and people's lack of trust in the judicial system, the UMDPC's strategy of passively waiting for complaints is inadequate, more so given the absence of consumer groups and a weak civil society. However, even in countries with a longer history of private sector regulation, the complaints system is not effective. In Thailand, which has a very long history of private sector regulation, only 10 to 20 complaints a year are received by the Medical Council regarding the behaviour of physicians (Roemer 1991 in Kumaranayake 1998: 28). Likewise, in Zimbabwe, the number of complaints is

---

<sup>321</sup> However, stricter enforcement may only result in vertical integration, i.e., collaboration with a pharmacy or a drugshop. I came across one example of a private clinic being linked to a drugshop in Kamuli town. There are presumably more cases, but they are difficult to detect.

<sup>322</sup> The source does not mention a time span, but it seems to refer to the time since the establishment of the Council.

slowly increasing, but as of yet, no case has been successfully followed through (Hongoro/Kumaranayake 2000: 376).

### 8.2.3. The Reasons for Inadequate Regulation and Implementation

The regulatory provisions are inadequate in that they do not cover all problem aspects of market failures and imperfections; that is, they do not regulate user charges, stop excess provision, or address poor quality of care and patient rights. So, Uganda's regulatory inadequacy is very similar to that found in Tanzania and Zimbabwe (Kumaranayake et al. 2000). Without having examined this empirically, the theory of regulatory capture offers a strong explanation, according to which the actual design of regulation is the result of an inherent political process and demands by various interest groups (the most strongest of which are doctors) to maximise their benefits (cf. Kumaranayake 1998: 13, 16). For example, doctors are strongly interested in a law that does not set price ceilings or establish strict systems of quality monitoring.

Where the law does spell out regulatory guidelines, the effective implementation is diluted for a number of reasons. Kumaranayake et al. (2000) name the critical aspects to be studied in order to understand the effectiveness of regulation. First, the Council lacks information on private clinics and these informational asymmetries make supervision difficult. Second, the Council is extremely underfunded and thus wants the resources to supervise (interview, UMDPC official, 1999; cf. Okello et al. 1997).<sup>323</sup> Third, the Council – qua regulator – is not supervised by a higher authority, and there is little pressure exerted upon it and no incentives provided for it to perform. Likewise, the Ugandan Medical Association (the professional association for doctors) has not been in a position to discipline their members during the past years. They only maintained a skeleton programme of meetings, and the attempts to continue education of doctors failed for lack of funds (Illife 1998: 165). Fourth, the DMO and the Subcounty Secretaries for Health do not assist in the supervision of private clinics, which is explained by the institutional weakness of the local government structure. Given the prevailing resource shortfalls at the District level, the DMO does not have the capacity in terms of personnel and funds to inspect and register the large number of private practitioners in rural areas, but there also appears

---

<sup>323</sup> This is a common problem in African states; cf. Ngalande-Banda/Walt (1995) for Malawi, Mackintosh/Tibandebage (2000) for Tanzania, Kumaranayake et al. (2000) for Zimbabwe and Tanzania, and Hongoro/Kumaranayake (2000) for Zimbabwe.

to be no interest in supervising the private sector. The DMO can afford not to fulfil its duties since there is no intra-administrative accountability that ensures performance, as was shown in Chapter 7.2. Instead, the DMO repudiates its responsibility by saying that the private clinics "are kind of independent" and that their supervision relies upon the public (interview, DMO official, 1999). In other words, it is the task of the political leadership and the councillors to perform this supervisory function.<sup>324</sup> Leaving this task to the politicians is problematic, as they proved to be weak and hardly accountable to the people (cf. Chapter 7.2). Fourthly, the communities have a strong interest in these clinics, so the Subcounty authorities and politicians would find it difficult to close down the unlicensed ones, especially in light of the failing government health services.

The non-existence of supervision is also due to a lack of professional authority. It is difficult for the District Medical Officer to monitor professionals who are at the same level as they are or even senior doctors and specialists. In addition, the DMO would be questioned about the legitimacy of its supervision, since it is widely known that government clinics perform much worse than private clinics in terms of attendance by qualified staff, ethics and commitment. There is a general problem with doctors supervising other doctors. The phenomenon of regulatory capture affects the *legislative* process, but it also refers to the inability and unwillingness to effectively *implement* regulation because of the close relation between regulator and regulatee (cf. Kumaranayake 1998), and this problem is also found in Kamuli District. For example, a doctor may hold the position of the District Director of Health Services (DDHS), and some time later he or she may quit and run a private clinic. Furthermore, as Bennett et al. (1994: 6) note, if there are competing priorities between different state actors (at the national and local level) involved in the implementation of regulation, the effectiveness of the proposed regulatory mechanisms is severely reduced. Clearly, the DMO is little interested in regulating, particularly as it is in charge of so many tasks.

Even more, there is a perverse incentive not to regulate. This is because of the double relationship between the DMO and the private sector, in that the DMO is supposed to regulate private clinics, but it also competes with them. As the DMO is

---

<sup>324</sup> As mentioned in Chapter 7.2, there was one example of public action that resulted in a private clinic being closed down. Yet after some time, this practitioner managed to open another clinic that was formally under NGO-ownership. This example reveals the lack of control.

primarily judged by the performance of the public sector, it may prefer to welcome private sector failure. So, implementation is weak, because the key factors critical to the government's ability to regulate – financial resources, information, capacity and appropriate organisational structures – barely exist. The same institutional weaknesses the state suffers from in providing services (cf. Chapter 7.2), which make private health care provision attractive, also undermine its capacity as a regulator.

Hence, the existing regulation does not have the desired effect on the behaviour of both regulator and regulatee, in that private practitioners do not comply with the regulations and the regulators do not fulfil their tasks. Cornwall et al. (2000: 2) emphasise that private practitioners are aware that the existing regulations are unlikely to be effectively enforced. This is also the case for Uganda given the many examples of open illegal practice. Needless to say, the current regulatory provisions do not successfully remedy the problems that initially called for regulation. Overall, regulation is inappropriate and not comprehensive, so that an undesirable gap exists between the law and the reality (cf. Birungi et al. 1999: 10). Likewise, the existing legislation is insufficiently implemented and enforced. Uganda is thus similar to other developing countries that also lack the capacity to enforce regulatory controls (cf. Brugha/Zwi 1998: 107; Moran/Wood 1993) and fits into Bennett et al.'s conclusion of a comparative study of developing countries:

Governments had failed in their duties and had neither monitored professional councils nor taken action to encourage them to regulate more effectively (1999: 14, cf. Kumaranayake 1998: 31).

#### 8.2.4. Ways Forward: Incentive-Based Regulation

In situations where hierarchical regulatory measures are doomed to failure and where regulation produces high transaction costs (cf. Kumaranayake 1998: 14), incentive-based approaches have more potential. However, despite the rhetoric on public-private partnership, this is barely realised in Uganda, as private clinics have not as yet enjoyed any substantial support from the government. Only one clinic reported that it receives FP methods occasionally. DISH (a USAID funded health programme) provides one of the few support activities and carries out quarterly support supervision on STD management at the private clinics that are run by medical

assistants.<sup>325</sup> Some privately employed nurses have been invited to training seminars, though these invitations were aimed mainly at filling empty spaces and were based on personal contacts, rather than on the DMO's systematic assessment of training needs. Private doctors outside government employment themselves are so far not integrated into the government's continuing medical education (CME) schemes. A CME implementation work plan for private practitioners is still in its developmental stages (MoH 2001). Finally, there are no incentives for disease notification.

The reasons for these gaps are several. First, because of competition, there are no linkages between private practitioners. Each health worker category is separately organised in different associations at the regional level above the District (Birungi et al. 1999: 10). Thus, information exchange, organisation among themselves and the aggregation of demands are more difficult. Second, private clinic practitioners described the relationship with government as non-existent or poor. They are seen as for-profit providers, and hence government officials argue that they cannot receive public funds for their aim to make profits (ibid.: 9). So, due to the previous isolation of the two sectors and spheres, in practice the government does not yet adequately recognise the private sector. Thirdly, there is a lack of interest to find out about the concerns of private practitioners, as well as a lack of an institutional framework at the District level (and previously at the national level) for the public sector and the private practitioners to interact with each other. For example, a doctor suggested semi-annual meetings with the DMO to discuss private clinic issues, but the latter has not taken this up. It seems that there is a general unwillingness at the local level to deal with and acknowledge the private sector. Under these circumstances, awareness of the problem or a consensus on how to establish supportive relationships cannot develop.

In sum, what is necessary is to begin to build a trusting relationship between government, professional organisations and the private sector, on the basis of which a "culture of regulation" (Mackintosh/Tibandebage 2000: 13) can develop. Moreover, training of staff on treatment guidelines has improved treatment practices in government and NGO clinics in Uganda (Kafuko et al. 1993). Based on a review of studies from Asia, Africa and Latin America, Brugha/Zwi (1998) also advocate that

---

<sup>325</sup> As in other countries, measures to facilitate the private sector tend to be donor-driven and financed (Bennett et al. 1999: 14).

this approach be applied in the private sector, which would equally contribute to overcoming their isolation. At the same time, it is crucial to strengthen accountability mechanisms at the local level and to set up incentives for the regulators to regulate and clear sanctions when they fail to do so. In order to get rid of the perverse incentives to not regulating, the functions of regulation and provision should be more clearly separated. In addition, whether through regulation or incentive-based schemes, location and prices must be addressed in order to improve geographical coverage and accessibility. To implement such regulatory provisions, the contribution and participation of the local administration would be useful. Finally, more research is required on the potential role of professional associations.

### **8.3. Regulation and Supervision of Drugshops**

#### **8.3.1. The Formal Regulatory Framework**

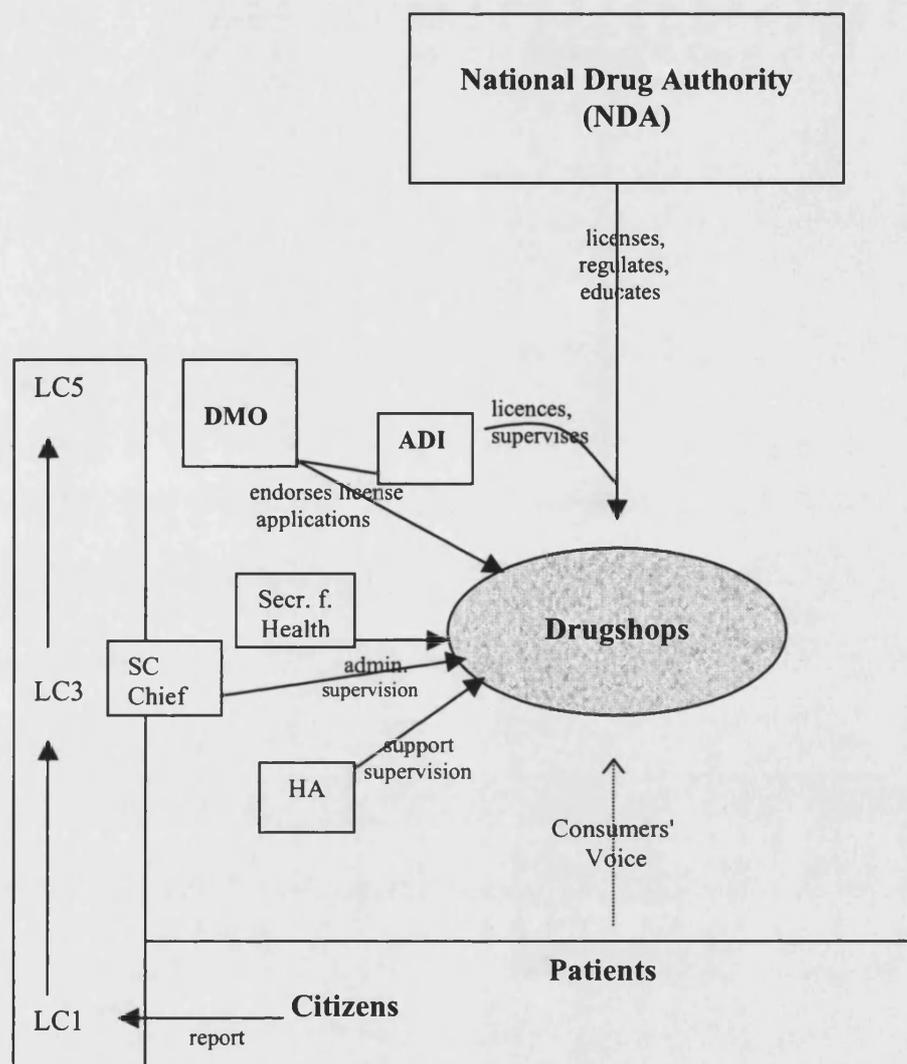
The boost of drugshops and the informalisation of health care services in the past decades were described in Chapter 3. The related problems, namely unqualified staff and the irrational use of drugs caused, could not be ignored anymore, so that the legislation was finally updated in the mid 1990s.<sup>326</sup> This legislation addresses a wide range of pharmaceutical issues, but this section focuses on drugshops. Figure 8.2 outlines the formal regulatory system and the actors involved in supervision

The legislation specifies the staff qualifications and premises requirements for obtaining a licence. It restricts the drugshops' use and sale of drugs to class C drugs. The National Drug Authority (NDA), a body corporate, whose members are appointed by the Minister of Health, is in charge of supervision and enforcement. The NDA has the power of entry into and investigation of drugshops and the right to inspect the records of all drugs procured by the seller. Some of these functions are delegated to the Assistant Drug Inspector (ADI) at the District level. These provisions and the entry regulations aim to ensure quality standards but, as Adome et al. point out, the legislation does not deal with ethical practice (1996: 20).

---

<sup>326</sup> These are the 1993 National Drug Policy and Authority Statute; the 1995 National Drug Policy and Authority (Certificate of Suitability of Premises) Regulations; and the 1995 National Drug Policy and Authority (Issue of Licences) Regulations.

**Figure 8.2: The formal regulatory and supervisory system of drugshops**



Nor does the legislation address prices or the location of drugshops except to forbid their location within a radius of 1.5 km kilometres from any existing retail pharmacy (unless already in existence before the legislation) (NDA Regulations on Premises 1995, Section 36). It is up to the discretion of the DDHS or the ADI to decide upon the location (interview, NDA official, 1999). After a licence applicant has obtained the approving signature of the LC3 chairperson, the DMO endorses the licence application. The 1997 LGA does not say anything on the role of the Secretary for Health, the health assistant or the Subcounty chief, but what has been said in relation to private clinics equally applies here. The latter issues (legal) trading licences to the drugshops, which could provide the ground for further administrative control.

### 8.3.2. Regulation in Practice

It appears that the DMO's discretion is not used to steer the location of drugshops, as we find 16 ±2 drugshops in the centre of Kamuli town (i.e. within a square of 300 x 300 metres) and about 5 or more drugshops in larger Subcounty trading centres. While competition in general has positive effects, this oversupply leads to a struggle for survival for the business. This lowers the standards of quality and medical ethics, in that drugshop attendants give leeway to people's unhealthy preferences, such as polypharmacy, combined with an underdose, injections and antibiotics.

Another large problem is that the majority of drugshops are not licensed and not run by qualified staff. The DMO record of 1998 listed only 44 out of the estimated 300 to 400 drugshops.<sup>327</sup> Few drugshops have applied for a licence since then. The DMO staff intentionally ignores the problem of inadequate qualification, as I witnessed when I looked at some applications that a DMO official showed me.

For example, one applicant for a drugshop licence had indicated that the nearest pharmacy and drugshop are in the next District capital, even though the DMO official knows that there are another four (non-licensed) drugshops within the same trading centre and many more in and on the way to Kamuli town. The endorsement of the DDHS on this application read: "He is the only one in the area. Let's give him a chance." The ADI assured me that this drugshop would be closed down if there were no qualified health worker found there. Yet, as the official knew, the applicant (an unqualified drugshop seller) had already been operating in the trading centre for years. There might have been bribing involved. But in any case, this suggests that there is no real interest in preventing the mushrooming of drugshops that are run by unqualified people. It may be the case that the DMO is satisfied with any licence application in order to improve the records of licensed drugshops, and moreover, rent-seeking is easier during the licensing process when the applicant approaches the DMO officials rather than the other way around.

The Subcounty authorities issue a trading licence to the drugshops. Even though this trading licence does not have a regulatory function in and of itself, the authorities could also assist in taking on regulatory tasks during the licensing process, for

---

<sup>327</sup> This is a nationwide problem, as there were only 2495 drugshops registered in 1999 (MoH 2001), i.e., an average of 60 drugshops per District.

example by identifying drugshops that are run by unqualified staff. Yet the Subcounty chief does not benefit from a drugshop being properly NDA-licensed, and hence there is no incentive to be concerned, other than about the trading licence that is an important source of local tax revenue. Nor are there any incentives for the Secretary for Health and the health assistant to follow up drugshops – this would only increase their workload.

The NDA-licensing process is easily subverted through rent-seeking (interview, NDA official, 1999). Drugshop owners also report that it is very difficult and takes a long time to procure the licence. They mentioned very different rates for the licence and the ADI's services in procuring the licence in Kampala. Despite validity concerns, the differing amounts (US\$ 60,000 – 110,000) that the drugshop owners paid to the ADI point to the informal payments.

One drugshop owner reported that he had paid US\$ 40,000 as a deposit to get the "go-ahead" from the ADI, and five months later, when the interview took place, he still did not have a licence. According to another DMO official, this was not a first instalment for the licence, but a bribe:

"The drugshop owner gives the Drug Inspector 10,000–30,000 Shillings and then says: 'You keep that money until I have got the full amount'. Now, has this person got a receipt? Do you think that the Drug Inspector is keeping the money for you? The Drug Inspector just takes that money and then keeps quiet. Drugshops pay to keep a friendly relationship" (interview, 1999).

In addition, supervision is not rigorously carried out, and as is the case in other countries, inspection tends to be prone to corruption (cf. Kumaranayake 1998). The drugshop attendants indicated that (unlicensed and licensed) drugshops pay some tribute in form of money, a lunch or a soda to the ADI on a more or less regular basis. This practice is well grasped with de Soto's (1992) concept of "informal costs" that serve to maintain the illegal status of their business or other wrongdoing. These costs can add up to about half of the official costs of the licence. That said, the following view is not untypical either for drugshop owners:

"The ADI is not corrupt, he does not ask for money, but you just give him, for example last time it was 5,000. At times, he greets us, so we give him a soda. This is for friendship; not paying does not have any effect, but it just creates a relationship, which is important, if any problem comes into the business. ... If there is no relationship with the ADI, there can be a problem. We are not supposed to give injections, but the community wants it. The ADI knows about it" (drugshop owner, Subcounty B, 1999).

As a result, the licensing system fails to uphold quality. For example, it is sufficient to simply put the name of a qualified person on the license (who earns money by providing the name), while the shop is run by a businessperson.

Another severe problem is the sale of class A and B drugs in drugshops that are licensed to dispense only class C drugs. People can buy any drugs over the counter without a prescription. Likewise, people are sent with a government clinic's prescription to the drugshops in order to receive antibiotics and other class A and B drugs, which are often not made available at the health unit (cf. Chapter 6.2.1). This demand in the villages is openly acknowledged by the ADI. Yet Kamuli District provides a paradoxical situation, since there is no pharmacy. So, if the law were fully enforced, people would not get access to drugs at all, and accordingly

Many people cannot see the sense of forbidding the sale of drugs by retailers who are the only dependable suppliers of life-saving medications in their community (Adome et al. 1996: 20).

### 8.3.3. The Reasons for Inadequate Regulation and Implementation

Given the 300 or so drugshops in the District, it is very difficult for one officer to carry out these regulatory and supervisory tasks given time and transport constraints. Further, the officer in charge does not face any sanctions from the DMO, and we have also seen that the DDHS does not stick to the regulatory provisions either as regards the licensing process. Neither is the officer in charge rewarded for doing a particularly good job. He would also lose out rent-seeking options if all drugshops adhered to the legislation. Yet there is not only lack of incentives but rather a perverse incentive structure. The current practice of drug leakage at the District and health unit level can only persist precisely with the existence of the high number of drugshops that provide drugs that are otherwise not available. Were the drugshop legislation fully enforced, many fewer drugshops would exist, thus endangering the system of drug embezzlement, which constitutes additional income sources and from which the DMO staffs and health professionals benefit.<sup>328</sup> At the same time, it is questionable whether the communities would still keep as quiet as they do at the moment if they had no options at all to obtain drugs at the local level.

---

<sup>328</sup> The widespread availability of class A and B drugs at drugshops is also due to leakage in the drug supply system at higher levels and the difficulties in controlling drug flows. Retail pharmacies, for example, do not ask whether a buyer has the respective licence for the types of drugs he or she buys (cf. Birungi 1994b: 64).

Rigorous enforcement of the legislation would imply that the DMO officials would also sanction a large number of government health workers, who sell drugs in their drugshops or through home treatment and who feel they can stay in the public sector only with some additional earnings. Their informal income contributes to stopping the public health system from further (or again) breaking down. It also suggests that there is an unspoken consensus and understanding among DMO officials that they should not be too strict. As with ineffective private clinic regulation, the officials' failure is not sanctioned in light of the inadequately developed intra-administrative accountability, which was discussed in Chapter 7.2.

Moreover, the scope of disciplinary action by the ADI is severely limited, since the communities and the lower LCs back up the drugshops. It is difficult for the ADI to simply close down a drugshop if it does not fulfil the requirements, since the LCs would support the owner in reopening the shop:

"It is impossible to close drugshops down; even LCs support them, because they cannot oppose them if they want to get votes. Also the Parish chiefs are dormant, they have no power anymore, they cannot enforce anything, as LC2s have overtaken" (interview, DMO official, 1999).

"The problem is especially with drugshops owned by LCs or their friends or relatives, so they defeat you. You come there to check, and then they quickly close the place for that day. But you cannot go there everyday to check" (interview, DMO official, 1999).

These two quotes illustrate again the fundamental structural problems within the LC system (cf. Chapter 7.2). Torn between the double functions as representatives and assistants to the law and order administration, LC1s and LC2s ultimately side with the community in order not to create enemies in their local environment. Further, the power struggle between the LC2s and Parish chiefs is unresolved. In addition, the links and personal overlap between economic power (the better-off and partly "big" people at the Subcounty and District level) and political power (LC councillors and members of the Executive Committee) makes those who have the capital to open a drugshop unassailable, and hence regulatory efforts futile.<sup>329</sup> Furthermore, the ADI may fear outbreaks of resistance by communities if he dares to close down a drugshop, which may culminate in the harassment of the official, as happened in a neighbouring District (Birungi 1994b: 70).

---

<sup>329</sup> One example is the medical assistants in the rural Subcounties who run their own private clinic and/or a drugshop. At the same time, they hold important Subcounty Council functions (cf. the examples in Chapters 6.2.2 and 7.2.2).

Finally, if there were cases of malpractice, it is questionable whether the community would take action, unless very severe incidents occurred. The reluctance in reporting malpractice on the part of a specific person is nurtured by the prevailing hierarchical administrative culture and local belief in witchcraft:

"People fear to report a death or a severe case. Also people fear revenge when you put somebody in problems, which is why people try to hide things" (interview, DMO official, 1999).

In sum, neither the community nor the councillors or the civil servants are interested in adhering to the regulatory provisions. So, both for private clinics and drugshops, the Ugandan regulatory practice corresponds to Kumaranayake's conclusion:

Despite the existence of a basic level of regulations in LMCs [low and middle income countries], the degree to which regulations are enforced and effective is low (1998: 27).

Hence, the state not only fails to produce services, but also fails to regulate. This notwithstanding, the services of informal health care providers constitute a crucial means of survival and a necessary part of the system in light of the inaccessibility of other providers. In this context, as Birungi et al. (1999) point out, what is right and wrong is difficult to define.

#### 8.3.4. Ways Forward: Incentive-Based Regulation

The NDA is in charge of promoting rational use of drugs through appropriate professional training and of establishing and revising professional guidelines and disseminating information to health professionals and the public (1993 National Drug Policy and Authority Statute, Section 6 (h), (i)). Yet few incentives are offered to drugshops to ensure performance apart from an annual educational seminar on the use of drugs, which is organised in each District and to which most of the licensed drugshops are invited. However, it is the unlicensed drugshops that need these seminars the most. As a result, local and informal adjustments take place, as the health assistant of Subcounty B stated:

"It is those with money that establish these shops. They are left to operate because they are providing services to the community. So instead, we [e.g. the HAs] advise them on how to give proper treatment (interview, 1997).

What is required, first of all, is to stop blaming and ridiculing informal health care providers (cf. Birungi et al. 1999: 11) and adequately recognise and formalise

their role in the system. This could involve more comprehensive drug education programmes for both drugshop owners, but also for communities as the consumers in order to shape their preferences, which proved to be successful in pilot districts of Uganda and other countries (cf. Adome et al. 1996 for Uganda; Kumaranayake 1998: 31 for Zimbabwe; Prof. Kaemthong Indaratna, personal communication 2000, for Thailand). In addition, consumer organisations, legal action and complaints procedures must be strengthened (cf. Kumaranayake 1998). For example, the NDA could intensify its efforts to disseminate information about its role in case of malpractice. Furthermore, there is need to introduce incentives for the ADI to perform regulatory and supervisory tasks. At the same time, drugshop owners must be better informed about the regulatory process in order to be able to resist rent-seeking practices. Ultimately, the effectiveness of any reform is contingent upon a functional and accountable local government and local administration so that people regain trust in the rule of law. Moreover, once the formal government health system improves and attracts patients, people's resort to drugshops will decline.

#### **8.4. Regulation and Supervision of NGO Providers**

##### **8.4.1. The Formal Regulatory Framework**

In contrast to the private sector, the NGO–public sector relationships are shaped much more by incentive-based schemes and by the provision of financial and technical support, so that the regulatory and supervisory practice overlaps and interlinks with support interactions. Yet, for reasons of analytical clarity, these issues are discussed separately (see Section 8.6).

NGO clinics are subject to the same regulations as private clinics (see Figure 8.1), but there is an exemption clause for clinics that have operated for more than 20 years, which is the case for some of the NGO clinics in Kamuli District. As elaborated in the previous chapter, the NGO sector is also self-regulated through the churches' medical bureaux and the respective NGO headquarters, but their operation is not linked to the structure and implementation of the state's regulatory practice.

#### 8.4.2. Regulation and Supervision in Practice

Given the exemption clause, the main role in accreditation is performed by the churches' medical bureaux. Other regulatory instruments are self-assessments through annual reports (Bennett/Ngalanda-Bande 1994: 47) and monthly reports to gather information on utilisation rates, immunisation and disease patterns for the MoH's Health Information Management System.

The rationale of the DMO's supervision is mainly based on its support interactions (see Section 8.6), in that they legitimise supervision to check whether financial and technical support has been used properly. The DMO's supervisory activities vary by facility type. The NGO clinics are visited three to six times a year, only the Mission hospital is not supervised. The DMO's supervision visits are not announced to or co-ordinated with the NGO headquarters. In the past, this has resulted in both the DMO and the NGO headquarter teams coming on the same day for supervision, which is ineffective for the supervisors and the supervised clinic and which results in resources being wasted. The DMO's main areas of concern are the conditions of the premises, hygiene and whether a qualified health worker runs the clinic, while less emphasis is placed on other aspects of clinical quality of care. But as at private clinics, the question is how the DMO can reduce the irrational use of drugs, since it has found no successful approach to address that problem in its own clinics. In addition, neither the LC3 authorities nor Health Committees of the Subcounty or the Town Council interact with the NGO clinics. In sum, this in line with Bennett/Ngalanda-Bande's observation (1994: 45) that quality regulation is weak in Uganda.

Even though the DMO's supervision may have an impact on cleanliness and hygiene, it results mainly in NGO clinics generally trying to work harder and in the internal supervision being carried out very carefully and rigorously. This is because of the unpleasant style of the DMO's supervision, as revealed in the following statements:

"When they find something wrong, they blame us. In government health units, it is often the nursing aid that runs the OPD [outpatient department], though if this happens with us, then we get yelled at. The DMO staff is very rude to us" (interview, NGO administrator, 1999).

"The language between us and the DMO is not good, we get easily rebuked. Otherwise, if there is no good performance, we would not get drugs donated by the DMO" (interview, NGO health worker, 1999).

As for the private sector, support supervision has to be intensified and improved in order to address issues of clinical quality of care.

### **8.5. Network Co-ordination**

A mere top-down regulatory approach is not considered as the (only) appropriate one. If it is impossible to achieve the desired result with competition or regulation, the state may undertake co-ordinative efforts or establish partnerships arrangements and incentive based schemes (for the latter, see the next section). Co-ordination refers to (mutual) adjustments of services and development activities in terms of space, time and/or the intervention (as regards the approach, the message or the technology). For that matter, the actors involved "exchange information about problems, preferences and means and trade off goals and resources" (Kickert et al.1997: 9; cf. Chapter 2.3.1).

The health policies, as outlined in Chapter 3.3, emphasise co-ordination with and integration of the voluntary sector (as well as the private sector). Yet there are few policy guidelines to specify or to support this, nor is there an institutional framework for doing so. The only section in the 1997 LGA on this subject states that

"The District Executive Committee shall monitor and co-ordinate the activities of non-governmental organisations in a District" (Section 18b; accordingly 27j for the Subcounty level).

It can be inferred that in particular the District Health Committee and the DMO are in charge of the co-ordination of non-state health care providers. Yet this section in the 1997 LGA is vague and does not provide further guidelines as to how to do so. Nor do the 1990 NGO Regulations provide further direction.<sup>330</sup> What was true for the early 1990s is still the case for the late 1990s:

The NGOs... complain about the lack of clear national health policy guidelines... [T]he government has never defined the role of NGOs and only 'hopes' that [they] will automatically fall into the National Health System (Asiimwe/Lule 1993: 12, cf. Giusti 1998: 12).

---

<sup>330</sup> Note that church facilities do not fall under the 1990 NGO Regulations. But if there were any specifications, they could have implications upon the church clinics.

It is thus impossible to assess the current practice of network co-ordination against a legislative reference or a policy norm. Policies and legislation on co-ordination and co-operation with NGOs are just beginning to develop.<sup>331</sup> Given the general competence and financial powers of local governments, there is, in principle, considerable scope for interaction.

There is no branch of the Ugandan Community-Based Health Care Association in Kamuli District to co-ordinate PPHC activities between the DMO and NGOs, the only institutionalised form of co-ordination at present being the quarterly planning meetings. The DMO gathers the majority of the health NGOs, but some of the smaller and weaker NGOs, or those that have had a conflict with the DMO, are not invited. Private practitioners are not included, either. The meetings aim at exchanging information, co-ordinating field-based PPHC immunisation activities in order to avoid service duplication at a specific location, and putting together the District health plan. In contrast, co-ordination (or at least information exchange) at the Subcounty level depends upon the commitment and interest of the health assistants in reacting to the NGOs' contact initiatives, whereas the Subcounty Health Committee or the Secretary for Health play no role at all in co-ordination.

The DMO meetings achieved some improvements in spatial coverage for immunisation, FP education and AIDS awareness-raising activities, which ultimately increases efficiency in resource use. The main achievement of the planning meetings has been information exchange; little as this is, it should be considered as an important step forward.<sup>332</sup> Despite these efforts, service duplication continues to prevail in some areas, so that resources are wasted, particularly in the field of AIDS awareness-raising, which is concentrated in the southern Subcounties. Resources are thus still used in a suboptimal way. Another problem is that the DMO's goal during these meetings is to get access to ideas from the NGOs by promising them funding.

---

<sup>331</sup> Cf. Riddell et al. 1998, MoA 1998; interviews, MoLG official, MFEP Aid co-ordinator, DENIVA official, and co-ordinator of the National NGO-Forum, 1998.

Given the policy gap and lack of guidelines, initial guidelines on how to establish co-operative and co-ordinative interactions were formulated at a networking workshop attended by Kamuli District Administration (KDA) officials and the Kamuli NGO Forum members during the action research process in 1998 (see Chapter 1.4).

<sup>332</sup> That said, there is still a lack of information and communication and this has a very direct and negative impact on the functioning of the system as a whole. For example, the Mission hospital administration regretted that it does not get informed or warned about epidemic outbreaks, which then come as a surprise, making it more difficult to react at the hospital level.

The NGOs resent this, but it does at least improve the government's programme design by spreading NGO innovations.

By means of individual co-ordination agreements, the DMO attempts to impose a spatial division of labour that is favourable to the DMO by allocating NGOs the more distant and inconvenient catchment areas, although their transport means and funds are even more scarce than the administration's. Some individual NGOs in the field are successful in co-ordinating the content and timing of their community development interventions, thereby increasing the effectiveness and efficiency of resource inputs. However, until recently, they have not succeeded in co-ordinating themselves on a wider scale, and attempts prior to 1998 to establish a Forum failed (see Section 8.7 for further elaboration).

Thus, co-ordination so far does not constitute an effective governance mechanism for managing service provision in a pluralistic system, particularly since it excludes the private sector. But it is important to keep in mind the constraints of further co-ordination, namely the sheer number of NGOs and their heterogeneity in terms of size, degree of professionalism and formality, funding, affiliation, approach, and so forth, as well as donor dependency (Bennett/Ngalanda-Bande 1994: 48). Often, donor conditions do not allow for autonomous decisions or adaptations to the local level. In such a situation, transaction costs for co-ordination are particularly high, so that it may be difficult to see and value the benefits of co-ordination gained through more effective and efficient services for the community (see Section 8.7 for further elaboration as to why co-ordination attempts are underdeveloped).

## **8.6. The Potential and Pitfalls of Partnerships**

There is a lot of rhetoric regarding partnership, yet its actual meaning is wide and elusive. There is not much more than donor programme specifications, and policies and guidelines on co-operation with NGOs are just beginning to develop, as mentioned. Here, the starting understanding of partnership is a "mutually beneficial relationship between consenting agencies, nurtured over time and leading to measurable results" (World Bank 2001a) and it comprises co-operation, co-production, enabling and contracting out.

### 8.6.1. Partnership Arrangements

The most recent and formalised form of enabling is the provision of delegated funds by the MoH to the Mission hospital since July 1997 on the basis of a service agreement between the KDA and the hospital. These funds are supposed to support hospital expenditure for salaries, drugs, equipment and renovation. In Kamuli, the provision of the delegated funds was linked to a contract that obliged the hospital to reduce user charges. Provided that non-state hospitals operate according to the regulation guidelines outlined for the whole country, government cannot directly interfere with their running (cf. MoH/PS 1998). The MoH has also begun to introduce PHC funds (as conditional grants) in order to increase the local government expenditure on health care. The Mission hospital and some of the Catholic clinics are included in this scheme, at least in theory. In the Subcounties studied, none of the NGO clinics had received any funds from the Subcounty budget, not even in those Subcounties where there is no government clinic.<sup>333</sup>

Apart from tax concessions on the imports of drugs and other medical equipment,<sup>334</sup> most of the NGO facilities receive financial and/or technical support from the DMO primarily for PPHC activities (see Tables 4.4 and 8.1). This includes STI kits, FP methods, training, vaccines, a refrigerator, cold boxes and other immunisation equipment. In case an NGO does not have a refrigerator, a nearby government clinic would store the vaccines for the NGO based on an informal agreement.

The other community-based PPHC NGOs also receive funds for transport and field worker allowances for specific activities (e.g. AIDS awareness-raising, nutritional education), IEC material, condoms for distribution, FP methods, and training. Occasionally, they can borrow the DMO's video equipment or the DMO's vehicles, but they must provide fuel and pay the driver.

---

<sup>333</sup> This is, however, not surprising, since not even the government clinics have benefited from Subcounty funding (cf. Chapter 7.2.2).

<sup>334</sup> Cf. MFEP (1993) and Adiin Yansaah (1995).

Table 8.1: Agreed financial and technical support for NGO clinics

	Funds	EDK	FP	Vaccines <sup>335</sup>	Allowances <sup>336</sup>	STI kits	Training
rN-1, 2, 4, 5	-	✓ (some clinics)	✓	✓	✓	✓ (some clinics)	✓
rN-3	PHC funds: 2.4m (plan)	✓	not carried out	✓	N/A	✓ (irregular)	✓
uN-1	-	-	✓	not carried out	N/A	-	✓
uN-2	-	-	✓	not carried out	✓	-	✓
<b>Mission hospital</b>	Delegated funds: 12 million/month  PHC funds: 8m/year (plan)		not carried out	✓	✓	✓ (3 to 4 kits)	✓

Source: interviews with DMO officials and NGO staff, and DMO work plan 1998/99

✓ = support provided

<sup>335</sup> This usually includes immunisation equipment, such as cold boxes, a refrigerator and paraffin.

<sup>336</sup> Allowances are provided for health education and outreach immunisation.

The financial and technical support is partly provided on the basis of the NGOs' requisitions and partly institutionalised on a quarterly basis, as long as accounting records are handed in. Most of the technical and financial support originates from programme-specific resources (usually donor programme funds such as DHSP, STIP, UNEPI, UEDMP or UECP). The funds are channelled from the central government through the Districts, which then allocate the funds to the NGOs.<sup>337</sup> They usually have to apply with a project proposal to spell out the objectives, the activities (e.g. the number of meetings with community groups, the number of households followed up) and the expected costs. This arrangement is similar to a cost-volume contract over a couple of months (cf. Mills 1997a).

The DHSP, which is funded by the World Bank, spells out technical, management and financial as well as epidemiological and geographic criteria for proposal selection, but they are vague. Moreover, it is questionable whether the District panels have the capacity to assess the NGOs, particularly in light of the lack of information about NGOs as a result of the previous low levels of interaction. In fact, I never heard of any meeting of the DHSP District panel or the District AIDS Commission (the programme being funded by UNDP) that were part of the programme implementation of these donor programmes and that aimed at integrating NGOs in the resource allocation process. In any case, these structures do not seem to be fully functional. Instead, it appears that the DMO makes the decision on which NGO proposals to fund and which ones not. As a result, the allocation of funds is open to manipulation and inappropriate use. Thus, although NGOs compete for funds, this contest appears to have no effect on quality and the costs of their services offered. Friendship and closeness to DMO staff and bribing come into play when it comes to the allocation of these funds (see below). This is even more the case for other technical support. For example, some NGO clinics receive EDKs while others still wait to be included in the programme.

Other forms of partnerships and collaboration among PPHC providers comprise information exchange and the transfer/referral of groups. For example, an NGO provides the DMO access to its organised and established beneficiary groups in the villages, which benefits both the DMO and the NGO. The former saves mobilisation costs, the latter is perceived as bringing additional services to its community groups.

---

<sup>337</sup> This is a very common World Bank approach.

A rather rare form of collaboration is co-production.<sup>338</sup> For example, the DMO and an NGO jointly undertook a Knowledge-Attitude-Practice study on AIDS awareness, and health education is jointly carried out by an NGO and DMO staff or Subcounty staff, such as government health workers or health assistants. All of these forms of interaction differ in terms of the degree of formalisation and collaboration, yet the differences are fluid.

The Mission hospital and its affiliated NGO is engaged in AIDS awareness-raising, excluding condom promotion or FP. This is not in line with the government approach and therefore is the source of constant friction between the two sides. FP and condom promotion are areas of frequent conflict between the government and church-related NGOs in other countries as well (cf. Green 1992: 85). In consequence, this NGO is not invited to the quarterly planning workshops and is also denied any other financial or technical support for such AIDS awareness-raising activities that are in line with the government approach. Other than this example, no other conflicts about approaches were identified.<sup>339</sup>

#### 8.6.2. The Benefits of Partnership Arrangements

The benefits and effects of these incentive-based schemes and support are numerous. This notwithstanding, discussions with NGO members revealed that many opportunities of collaboration are not realised, so that the full potential of interactions and the synergies and benefits related thereto are not exploited (for an account of these, cf. Mathauer 1997). Based on interviews, field documents and field observations, the following qualitative effects were noted as a result of partnership arrangements.

The provision of delegated funds enabled the Mission hospital to reduce fees substantially by 30 percent for adults and 50 percent for children. Financial and technical support for preventive services (immunisation, FP) allow the NGO clinics to increase spatial coverage and to extend and to bring services nearer to the people, which otherwise would not be offered by these clinics or would be offered with a higher user charge in the case of FP. This is, in principle, in the interest of the government in its efforts at ensuring the delivery of affordable and accessible

---

<sup>338</sup> Co-production comprises one or several joint actions (production steps) of problem analysis, planning, financing, implementation and reviewing (cf. Bebbington/Farrington 1993, Ostrom 1996).

<sup>339</sup> But this may also be due to the fact that NGOs adapt themselves to the dominant government approach in order not to lose out on funding.

services. In addition, the support makes the NGO clinics undertake more efforts, as they are criticised for the slightest wrongdoing, and yet they want this support to continue. The support for STI management (in the form of training and the supply of STI drug kits) improved the skills and treatment and hence quality of care. This reduces what is often referred to as "voluntary sector failure", such as lack of professionalism (Salamon 1995). Similarly, the financial and technical support to the PPHC NGOs allows them to make use of their strengths, namely their elaborate member group structure, their strong community links, a participatory approach and their focus on empowerment. Also, they could not have had the same geographical coverage without these additional resources.

The few cases of group transfer and referral clearly fostered service integration and allowed for cost savings. For example, group transfer and referral saved on the costly process of social mobilisation and group identification; hence the number of field trips and transport costs could be reduced, in that a provider is able to begin working with an already organised group. This increases efficiency and effectiveness.

Finally, in the few cases of co-production, resources could be pooled and allowed for a better use of each organisation's relative strengths. Thus, again it increased effectiveness and efficiency.<sup>340</sup> This also allowed for mutual control. And again, it enabled each side to carry out activities that they otherwise could not have undertaken alone (cf. Mathauer 1997: 43-45 for examples).

In sum, these interactions have a beneficial and developmental impact, even though they are of low profile, formality and intensity. They allow the NGOs to offer services that they otherwise could not have delivered to the same extent in terms of geographical expansion, quality, quantity and accessibility. The empirical evidence hence confirms the existence of what Huxham (1996) calls "collaborative advantages" and the importance of these synergistic forms of interaction. Such interaction benefits have been observed in other developing countries as well (Bennett et al. 1999, Ostrom 1996, Robinson/White 1997, Tandler 1997). This said, although the support contributed to service extension, the prevailing incentive structure of these partnerships arrangements did not affect quality aspects except as

---

<sup>340</sup> Ostrom (1996) also provides examples of co-production in which each side could make use of its relative strengths.

regards the effects of training activities (cf. Bennett/Ngalande-Banda 1994: 45). In addition, there are no monitoring and control mechanisms in place to check upon quality standards; or if they are, they are not functional. Therefore, as McPake/Ngalande-Banda (1994: 28) emphasise in their review of country experiences of contracting-out health services, these types of arrangements have to be based on trust, given the inevitability of imperfect information. It also became evident that the prevailing partnership arrangements cannot be readily and more precisely categorised as incentive-based schemes because their actual regulatory impact is marginal and because the facilitation provided is hardly specified in terms of the expected outcomes.

### 8.6.3. Face-to-Face Interaction in Practice: The Pitfalls of Partnerships

While the interactions between the public and voluntary sector produce benefits, a closer look reveals that they also suffer from many pitfalls. All the NGO facilities and PPHC NGOs experienced difficulties in obtaining the promised support. Some NGOs reported that their transport allowances for health education had been withheld. The NGO staff that participated in the National Immunisation Days was entitled to allowances for their outreach activities, but these were not always paid on the basis of flimsy explanations. Several NGOs planned to show AIDS awareness video clips, but the DMO often did not lend out its video equipment, even though it was not needed by the DMO at that time. Again, unconvincing excuses were given, and it seemed as if the obstruction was intentional. Virtually all NGOs reported at least once that the promised funds were not paid out by the DMO. In addition, the acquisition of these funds was usually very time-consuming and bureaucratic, not least because the civil servants in charge were often not found in their office. These bureaucratic constraints were already reported for the early 1990s (cf. Asimwe/Lule 1993, MFEP 1993, Gilson et al. 1994). Even though some external factors beyond the District level account for the non-availability of funds, the non-payment is largely to be blamed on the District.<sup>341</sup> These problems are very similar to findings in Senegal, where the MoH withheld the NGO funds that were provided by the World Bank's Integrated Health Sector Development Programme (Mathauer 2001).

---

<sup>341</sup> External factors comprise embezzlement at the central government level (interview, MoH official, umbrella NGO official, 1999), financial constraints due to the government's cash budget, and the bank crashes in 1999, which equally affected donor funding.

Another delaying and obstructive tactic of the CAO and DMO was to lose or forget about NGO requisitions (e.g., for vaccinations and FP), so that the NGOs eventually gave up on the request. It was also found that some NGOs had to pay back about 25 percent of their funds to some of the District authorities, either directly at the DMO, or in a more informal way and in instalments, as follows:

"After the Deputy CAO had found out about our funds provided through the local administration, he stopped at our office and said: 'I'm broke, you help me', so eventually I had to give him something" (interview, NGO staff, 1999).

Donor funds for NGOs have become a very lucrative income for civil servants. As a result, many NGOs stop calling for the funds they are entitled to. Withholding allowances or other forms of support promised to NGOs demoralises the staff, lowers their performance and, in the worst case, impedes their task fulfilment. Furthermore, difficulties and obstruction encountered in relation with PPHC services, which are the main focus of support, can also negatively influence the provision of curative services, since the service integration, utilisation and credibility of the facility are affected.

While the Mission hospital has always encountered delays in obtaining its delegated funds, the new administrative head that came into office in 1999 was particularly obstructive and made the transfer of funds very tricky and complicated:

"For each requisition, you go several times to get the three signatures, and so it depends on the CAO's, CFO's and DDHS' presence in the office. And for the cheque again: you go there three to four times for chasing the same issue. So, we go there fifteen times in a month if you have two to three requisitions."

"... And then they toss you up and down and tell you: 'This [application form] is not correct, you rewrite this and come tomorrow'. The following day, there is something else which they don't like."

"We now made a requisition for [US\$] 6.5 million to buy drugs, but probably we will not get it, even last time, it was very difficult. He [CAO] asked 'Why do you need that much? Last time, you asked only for 6 million'" (interviews, hospital administrators, 1999).

The CAO has been very creative in coming up with various barriers every other week, and it seemed as if he spent a lot of time thinking about how to make things difficult. In return, the Mission hospital administration then had to sit down and reflect on how

to react.<sup>342</sup> Because of the CAO's unjustified bureaucratic requirements, the hospital once had to travel three times to Kampala (instead of the usual one trip) to buy drugs, the costs for which amounted to a tenth of the actual drug purchase. It also led to a delay of two weeks, during which the hospital had run out of lifesaving drugs. During this time, the hospital account stood at the equivalent of two monthly payments of delegated funds, since none of the requisitions had been accepted. Thus, the CAO violates the guidelines on delegated funds by interfering in the spending autonomy of the hospital and by not providing his signature for certain requisitions. Likewise, the District authorities have refused to transfer the PHC funds, so that the money rests in the account.

During the negotiation of the service contract between the administration and the hospital, the latter had to make large informal payments to some of the District authorities (interview, key informant, 1999). The hospital also had to pay something to get the District officials' signatures for the hospital's requisitions, as the following hints suggested:

"Here, you have to go with money to get things."

"You do not get money without giving them something. They always tell you: 'You are not co-operative' [which is a synonym for bribing]" (interviews, key informants, 1999).

Likewise, government auditors requested their share. Meanwhile, the relationship is tensioned, since the hospital resists paying such bribes (interview, key informant, 1999). The hospital is clearly obstructed and the "partnership" creates more problems than assistance. It must be noted that these difficulties encountered by non-state providers are not unique to Uganda, as such examples of interference are also found in other countries (cf. Russell et al. 1999: 773).

In sum, this section revealed that partnerships have their pitfalls and produce negative impacts. Most of the NGOs have experienced and suffered from irregular and unreliable government support, which undermines secure planning, smooth

---

<sup>342</sup> Once the CAO sent the ADI and an auditor with the hospital staff to control the drug purchase at the Joint Medical Store (JMS) in Kampala. The hospital administration reacted in the following way: "I just left and dumped them at the store; they wanted to get a ride to town [the centre], but I told them: 'No, you are on duty'. So they stayed there the whole day without lunch, they were hungry. They went from room to room and computer to computer to check what the JMS gave us. In the evening, I told them: 'You are still on duty, now we load down the drugs and you check the state of the drugs and whether they are alright.' Eventually though, I let them go, since they said: 'This is really too much. It is okay with the drugs.' It seems they won't do that again (interview, hospital staff, 1999).

operation and the implementation of activities. A large part of the problem of unreliable government support is rooted at the District level, in that the District authorities do not comply with the agreements and obligations, rendering such efforts at co-ordination futile. At the same time, by granting support, the DMO is in a position to play off the NGOs against each other, thereby creating competition and division.

Finally, these funding arrangements also create dependency and affect the NGOs' autonomy and innovation potential – a problem, which Gilson et al. (1994) and Green (1987, 1992) observe in other countries as well. Ultimately, what we find are unequal relationships, in which one side dominates and manipulates the other. This negatively impinges on organisational and system performance. Hence, it must be questioned whether the term partnership is actually appropriate for what happens in practice. The next section will look at the reasons why these partnerships fail. Each side's incentives and the rationales behind them will be analysed by drawing upon various context factors, such as the funding situation, the nature of the local state, power structures between state and NGOs, and the NGO policy environment.

## **8.7. Explaining Interaction Patterns: Perverse Incentives and an Impeding Interaction Culture and Structure**

### **8.7.1. The NGOs' Set of Incentives to Co-operate**<sup>343</sup>

In the context of withdrawing donors, NGO facilities are struggling to recover costs, whilst still keeping prices at an affordable level. The medical bureaux have hence long called for stronger recognition of their work and for support in order to reduce the cost-recovery pressure (interview, UCMB official, 1999). Likewise, most PPHC NGOs are highly dependent upon external resources, so that the majority of them have a strong interest in interacting and co-operating with the local administration. The financial and technical support strengthens the NGO's presence in the field and makes their services more comprehensive, and the synergies and beneficial impacts

---

<sup>343</sup> The historical developments of NGOs and church facilities and hence the historical legacies within the present relationships are different. That said, the nature of the daily interactions appears to be very similar. Thus, the discussion will be of the two in combination.

of co-operation contribute to organisational performance. This increases the NGO's standing, reputation and legitimacy in the eyes of the people. Furthermore, there are incentives that operate on a personal level, as the financial support is most often spent as allowances for field volunteers, which is an important income source for many of them.

Usually, NGOs initiate the contact with the administration in their search for support and co-operation, but this often results in one of the following patterns. Either the administration rejects the NGO's requests on the grounds that strong donors support them or NGOs (mainly PPHC organisations) are considered "beggars" and treated as such, which puts them in a weak bargaining position. This is because the relationships between NGOs on the one hand and the DMO and the local administration on the other are characterised by unequal power structures, so that the latter are in a position to manipulate the NGO activities.

In fact, while partnership arrangements that are negotiated on an equal basis would be the desirable form of interaction, in practice, NGOs are often merely instrumentalised as cheap implementing agents for state programmes and clientelised – a problem that is common elsewhere (Dicklitch 1998, Kasumba 1998, MFEP 1993, Therkildsen/Semboja 1995 for Uganda; cf. Bebbington/Farrington 1993 and Hulme/Edwards 1995 for examples in other countries) and one I also observed in Senegal among PPHC actors. As a result, some of the NGOs attempt to avoid any interaction with the state in order to keep their autonomy and are reluctant to provide any information, for example, on their donors or financial position. This has also been observed in other Districts (Kwagala 1997, Birungi et al. 1999).

The PPHC NGOs do not defend themselves against the District administration's practices of withholding money or requesting a 25% share of funds. Instead, fear of personal consequences makes them remain quiet and passive (interview, NGO headquarter official, 1998) and reflects closely the features of the administrative culture of citizens (cf. Chapter 7.2.2). One NGO field worker explains why NGOs keep silent about the administration's trimming of NGO funds:

"This sharing of the money is the order of the day, it is now just normal. The official puts it back in his safe, as if it were official money. It is like a law. If you do not give the money, next time, you are left out; you are put from the list. This is what happened to [another NGO].

We do not have a voice.... We could go to the LC5 and tell him, but then, one is afraid, because those people might lose their job. And then you have an enemy, which is bad, it is a danger, they might use these African herbs and kill you. So

you are afraid and you just keep quiet....In the end, you make up receipts, our bosses make us [the field workers] sign for field allowances and for work which we did not do. This is how it happens... These people at the administration just put it in their own pocket."

The Mission hospital and a church-affiliated PPHC NGO resist these informal payments given the Diocese's backing and the hospital's size and importance in the District. In relation to the hospital, the District authorities have therefore been much less successful in their manipulation attempts. Across all 20 NGOs in Kamuli, it appears that those NGOs with more educated staff that has experience beyond Kamuli District and the larger, more established NGOs are more likely to resist. In general, these patterns of interaction seriously undermine trust in the government. As in other countries, NGOs feel torn between the attempt to retain autonomy versus the need for resources and support and thus some interaction with the administration (cf. Bratton 1989, Fowler 1991a, Robinson/White 1997). This is particularly the case for smaller and young PPHC NGOs, which have fewer contacts with national NGOs or donors. Applying for some funds through the local administration is hence less complicated. Despite the considerable trouble that NGOs encounter they perceive the possible benefit as higher. Section 8.7.3 will address the question of why the NGOs of Kamuli are currently unable to address the problems encountered with the administration through the local democratic process.

#### 8.7.2. Perverse Incentives for the Administration Not to Co-operate

The starting problem is that the role of NGOs has yet to be clarified; in fact, NGOs are still not fully acknowledged and accepted as equal service providers (cf. MFEP 1993). So far, there is little guidance on NGO-DMO interaction. Second, the DMO is not assessed or monitored on its performance or its interaction and co-operation with NGOs (or the private sector), just as the DMO's performance is poorly controlled in general, as was demonstrated in the previous chapter. There are thus no incentives or rewards for the local administration or the DMO to co-operate and interact with the NGOs in a legal, legitimate and effective way to produce synergies for the ultimate benefit of the communities. Given the accountability deficits, the incentives for non-co-operation or self-interested co-operation are dominant, so that donor funds or

MoH and District resources for NGO activities can be turned into a lucrative income source for the highest District authorities to add to their salary.<sup>344</sup>

Moreover, given the small budget of departments (cf. Chapters 3.4 and 7.2.1), there is a reluctance to share funds with NGOs. As local governments are extremely dependent upon central government and donor funds and as NGOs are "inserted" into public provision by donor pressure and conditions, the lack of co-operation can be explained as competition for scarce resources. This forced "partnership" leads to resentment and therefore obstruction and unwillingness of the local administration/government to co-operate.<sup>345</sup> For example, the loss of NGO requisitions and applications for funds within the administration constitute a conscious attempt to sabotage the NGOs' activities. Accordingly, an NGO health worker stated:

"You really get the impression that they want to give you a hard time. Also, they make you wait on purpose" (interview, 1999).

As the donor funds for NGOs are based on the assumed NGOs' performance, the DMO staff may prefer the NGOs to perform badly in order to undermine their ability to attract funds:

"They want a report from us to make us show what we are doing. They actually cannot accept that we are working so much. They think that we have money. That is why they do not help us. The reason for this reluctance and bad relationship is their fear that our clinics might get famous. They do not see that we are actually serving the people. There is envy" (interview, NGO health worker, 1999).

The same rationale explains why information about programme funds and how to apply for them is concealed from NGOs, so that they are hampered in getting access to them.

Similarly, the administration's resentments and its attempts at obtaining informal payments explain its obstructive behaviour towards the Mission hospital. The higher authorities have an interest in making the Mission hospital fail. They try to undermine its reputation by accusing it of poor management and poor patient care. Several key informants claimed that some individuals of the District leadership wished for the collapse of the Mission hospital in order to obtain discretion over the MoH delegated

---

<sup>344</sup> It appears that NGO funds are treated as money that can be easily "eaten" more legitimately than government funds.

<sup>345</sup> Bebbington/Farrington point out that programme resources allocated for NGOs have always been a cause for resentment, leading to administrative contractual relationships (1993: 46).

funds for a District-owned hospital that the District is in the process of building. But since the District is doing this without the support and agreement of the MoH, the lack of funds have stopped its completion. The District's efforts are a prime example of Niskanen's (1971) theorising, who notes that office holders always try to increase their budget. In the case of the delegated hospital funds, this would also enormously increase opportunities for embezzlement. These motivations explain why the administration has never shown any concern about the regular power cut at the hospital every second or third night that result in emergency operations being carried out with a torch.<sup>346</sup>

In sum, there has been little political commitment to partnership at the local level. It must also be noted, however, that this obstruction was primarily fostered by the CAO who, as a leader, set a standard and institutionalised a norm. Although the prevailing incentives are perverse and not supportive of partnerships, the outcome is in no way deterministic. Ultimately, the level of obstruction is limited. While competition and resentment motivate attempts to make NGOs fail, there is the danger that if NGOs failed completely or if the administration's obstruction became too obvious, funds for NGOs would be withdrawn, so that no money would be channelled through the administration anymore.

### 8.7.3. Impeding Interaction Culture and Structure

The interaction culture, which both shapes and is shaped by the incentives illuminated above, refers to cognitive, affective and evaluative attitudes among the public, private and voluntary sector actors in relation to each other.<sup>347</sup> The interaction culture provides a norm of behaviour that is reproduced in the context of the prevailing incentives. Today's interaction culture in Uganda also entails the legacy of the previous animosities and suspicion between the state and the NGOs and the churches respectively (cf. Riddell et al. 1998, Dicklitch 1998, Kasumba 1998).

---

<sup>346</sup> Because of power shortages, power supply rotates each evening through the different parts of the town, whereas certain parts of the town are always supplied with electricity as a result of bribing the Ugandan Electricity Board. However, a direct hospital line would not constitute a complicated technical undertaking and it would not interrupt the power saving rotation scheme within the other parts of town.

<sup>347</sup> The term is derived from the concept of "administrative culture" (cf. Chapter 7.2) and can be considered as a component of the administration's organisational culture and the citizens' administrative culture. Similarly, Weichselgärtner (1996) identifies the administrative culture as an important condition for "co-operative administrative action".

The majority of NGO staff perceives civil servants as egoistic, greedy and not socially oriented. From their point of view, the relationship is poor, and the language is often rude and abusive. On the other hand, the NGOs' reluctance to reveal their funding sources is negatively assessed by the administration, which perceives them as rigid and non-transparent, but it must be noted that NGOs have become more transparent over the past few years. This has led to misperceptions and misunderstandings over time and both sides speak badly about each other. As a consequence, there is a tremendous information gap between the two.

Apart from unwillingness, effective communication between the administration and NGOs is undermined by organisational-cultural barriers due to differences in size, structure, organisational ethos, professional qualification and salary (cf. Wellard/Coperstake 1993: 301). The information gaps also result from the lack of an interorganisational structure that allows for and fosters regular contact, information exchange and discussion, and interaction. In Kamuli, however, there had never been a culture of coming together in light of the past animosities between the state and NGOs. Nor does the prevailing interaction culture foster integration of NGOs into the District planning process or take their contributions into account.<sup>348</sup> These patterns are very similar to what I observed in Senegal. In consequence, awareness about possible entry points for co-operation and more so willingness to co-operate is difficult to develop.

#### 8.7.4. A Weak Civil Society: Lack of Impact upon the Local State

It remains to ask what role the local civil society plays in demanding accountability and addressing the pitfalls of partnership. Civil society can be understood as

The realm of organised social life that is voluntary, ... autonomous from the state, and bound by a legal order or set of shared rules.... It is distinct from society in general in that it involves citizens acting collectively in a public sphere to express their interests... (Diamond 1994: 5).

The role of civil society is *inter alia* to contribute to creating channels for articulation, aggregation and representation of interests, redefine the rules of the political game along democratic lines, make demands on the state, and ultimately

---

<sup>348</sup> Other Districts have progressed more in this respect (Bagambisa 1995, Kwagala 1997, Riddell et al. 1998, Azfar et al. 2000). However, Azfar et al.'s point is crucial to understand the administration's behaviour, namely that district administrations may fear that the disclosure of information on NGO contribution or donor funds may lead to cuts in block grants (2000: 62).

make local government respond to the citizens' needs (Schmitter 1993, Diamond 1994, White 1994).

However, most local NGOs in Kamuli are understood and understand themselves mainly as service providers and they have not exerted control and demanded accountability and transparency over the financial and technical support that is not provided to them. Thus, the NGOs have not been able to take up the role of a local civil society. This is also confirmed by Kassimir's (1998) study of the Catholic church and its role in social mobilisation in Uganda and Waliggo's (1995) and Dicklitch's (1998) analysis of the role of NGOs in the Ugandan democratisation process. In fact, NGOs suffer from a lack of transparency and accountability within the local administration, just like the individual citizens, and they do not succeed in balancing out the lack of local legitimisation. This is because it is very difficult to address their concerns and make them public through the democratic process given the deformations of the LC system both in structure and process, as described in Chapter 7.2. Further, the NGOs are told to stay non-political and warned not to interfere in politics or link up with councillors.<sup>349</sup> In addition, the no-party regime limits participation to the local council system to an individualised and localised approach rather than one based on collective action and issue-orientation (cf. Mamdani 1994: 553; Carbone 2001).

NGOs are also constrained in addressing their concerns with the authorities, because the District and Subcounty administration have not allowed for their participation or even passive attendance in the local discussion and policy making process in that they have not fostered attendance of local NGOs in the Technical Planning Committee or the Sectoral Committees of the District Council. This lack of structural entry points reduces the NGOs' options and capacity to take up the political roles of civil society. Finally, NGOs have not succeeded in organising themselves (until 1998) due to low social capital, that is, mistrust, competition, lack of mutual recognition and power struggles about leadership among each other (cf. MFEP 1993: 22), thereby weakening their position and their ability to speak with one voice.

In sum, the prevailing nature of interactions has hindered the NGOs from operating as civil society actors, and their interactions have had a limited positive

---

<sup>349</sup> The rationale of NRM-supporters is the attempt to avoid political parties using NGOs as their mouthpiece and their organisational link to the communities (interview, umbrella NGO official, 1998).

impact on the local state in terms of accountability and transparency. Instead, the partnership arrangements and support measures have provided opportunities for the administration to seek illicit rents and bribes and to manipulate the relationships according to their own interests. It must be noted, however, that the degree of interaction and co-operation varies between Districts according to the beginning of their decentralisation process, donor engagement and the strength of local civil society. Another important factor is visionary leadership. Thus, the degree of co-operation and partnership is rather poor in Kamuli in comparison with some other Districts.<sup>350</sup> The findings of Kamuli District hence seem to be comparable only with more deprived and isolated Districts.

Yet the relationships have changed with the establishment of the NGO Forum in 1998 in Kamuli District as a result of an action research that aimed at promoting intersectoral co-operation (Mathauer 2000). This will be further discussed in Chapter 9, which examines the scope for "constructability" to overcome these institutional barriers.

## **8.8. Interorganisational Relations and Their Effect on the Functioning of the Referral System**

A functional referral system is one of the most important pillars in any multi-levelled and multisectoral health care system. The referral system inherently consists of interorganisational (and interpersonal) relations; hence effectiveness is linked to the nature of these relationships as well as the way it is co-ordinated. In the past, as a consequence of the general decline of health care services, the referral as well as the transfer system had also broken down (Okello et al. 1994: 603; cf. Omaswa et al. 1997). This section addresses the question of how today's referral system operates and in which way it is affected by the interorganisational relationships.<sup>351</sup>

In theory, referral is guided by medical judgement, i.e., patients first report to a lower level unit; then they are referred to higher-level units if need be. In practice,

---

<sup>350</sup> Interviews, co-ordinator of the National NGO Forum, 1998; Jochen Becker, DED NGO liaison officer, 1998, 1999; NGO headquarter staff, 1999; and personal communication, Mary Mulusa, World Bank, 2001.

<sup>351</sup> There is no transfer system in Kamuli due to a lack of resources. Inter-District referral (for patients living in areas that are closer to the health facilities of a neighbouring District) and referral to the tertiary level will not be considered here.

referrals are made to facilities and not to individuals, whereby the diagnosis and the treatment of the referred patient are not passed back to the referring facility. What Leonard/Leonard (1999) described for Tanzania, namely that the referral network is depersonalised and creates few incentives for lower-level providers to refer, is also the case for Kamuli. Pride is another reason to refer only reluctantly, leading to serious quality of care deficits, especially when a patient's state suddenly deteriorates and the treatment required exceeds the resources and competence of the lower facility (interview, Almeda, 1998; Kristen, 1999, DED health professionals).

Referral discipline appears to be better in the NGO clinics, because NGO health workers face sanctions if they are found to refer too late. In contrast, private practitioners do not refer as promptly, since their profit maximisation interests dominate.<sup>352</sup> Nevertheless, formal private clinics are more responsible in referring cases than informal ones or drugshops are, due to the higher degree of professionalism and medical ethics, as well as their better knowledge. The formal clinics are always afraid of losing their reputation; thus they refer rather than risk having a patient die in their clinic.<sup>353</sup> In contrast, apart from lack of knowledge and their desire for profit, lower-level informal providers have to worry about being accused of a mistake, so that their informal and illegal status stops them from officially referring and from providing a referral note. They would just tell their patients to "go to town" or "go to the hospital". Moreover, since patients get abused by higher-level staff for having gone to or stayed too long with lower-level providers, they are not interested in getting a referral note, either. However, the referral note is crucial to provide the higher-level provider with the necessary information about the course of the disease and the previous treatment. This said, when informal practitioners see that they cannot manage the case, some of them do refer early and in so doing increase their reputation as responsible providers.

The functioning of the referral system is furthermore undermined by the high degree of self-referral by patients who, after having used drugshops, go straight to the urban clinics instead of utilising rural government clinics. 86 percent of the exit

---

<sup>352</sup> Similarly, for Tanzania, Mackintosh/Tibandebage (2000: 8) note the private practitioners' reluctance to refer when cases were beyond their competence.

<sup>353</sup> The hospital suffers from the private clinics' practice of referring patients very late, when he or she is just about to die. If the patient dies, it is blamed on the hospital (personal communication, Krötz, DED doctor in the hospital, 1998).

respondents at higher-level providers had done so.<sup>354</sup> As Leonard/Leonard point out, the extent of self-referral may be the result but not the cause of non-functioning referral networks (1999: 17). Moreover, poorer people fear the high expenditures at higher facilities (including the costs of transport to Kamuli Town) and the anonymity there, so that they often do not follow the providers' advice and referral; they rather turn to and beg another local provider to obtain treatment.<sup>355</sup> As a consequence, patients often arrive at the hospital in a very critical state when it may be too late. It must be noted, however, that the delegated hospital funds helped to reduce user fees considerably and therefore contributed to re-establishing the referral system.

In sum, the referral system is underdeveloped and reflects the fragmentation of the health care system, the lack of communication and interactions, and the bad relationships between the providers. This is aggravated by regulatory failure and lack of supervision.

## 8.9. Conclusion

This chapter has shown that regulatory provisions are insufficient and that the state also lacks the institutional and financial capacity to implement them. Market imperfections and failures are not addressed adequately, so that poor clinical quality of care, unequal coverage and difficulties in financial access persist. The private sector has not been fully integrated into the national health system and planning, which prevents the public-private mix from being streamlined and promoted. The potential of making use of the private sector to provide PPHC services has not been tapped into at all.

State regulation and supervision of the NGO sector equally fail to address clinical quality of care. Network co-ordination of PPHC services is practised in an initial stage, but its co-ordinative impact is still marginal, other than as regards information exchange. In contrast, partnerships arrangements are more advanced. Yet

---

<sup>354</sup> In calculating this figure, it was not taken into account that direct public transport to Kamuli is available in some places, and hence going to Kamuli may be as (in-)convenient as going to a rural clinic by bicycle. This figure may thus be a slight overestimation. Yet, Leonard/Leonard report similar high figures (1999: 32).

<sup>355</sup> This is in principle similar to what Withworth et al. (1999) found in south-west Uganda as regards people's referral behaviour for ophthalmology clinics.

these partnerships have serious pitfalls, in that the actual interactions are impaired by the administration's obstructive behaviour. This is the result of its perverse incentive structure in the context of the accountability gaps of the local government. The interaction pattern of the administration is also shaped by and shapes the prevailing impeding interaction culture and thus explains the large number of missed opportunities for further interactions. This obstruction undermines the NGOs' organisational performance as well as the performance of the system as a whole, so that Uganda's health care system does not achieve the level of performance it could with its available resources. Furthermore, the prevailing partnerships patterns prevent NGOs from taking up civil society functions, namely articulating and representing interests, demanding accountability and making local government respond to the people's need. In sum, the findings suggest that the smoothening rhetoric of partnership is inadequate and counterproductive in the long term, as it hides the pitfalls. Instead, the government and donors should recognise that the relationships are unequal and antagonistic. Being more clear about the starting point and the context will in the long term allow for more realistic arrangements and more appropriate support to overcome these problems.

Many of the deficits in Uganda as regards both regulation and partnerships are also encountered in other African and Asian countries. So for Uganda, as for other countries, the indirect roles of the state (regulatory and enabling) are weakly adopted (Batley 1999b: 762; cf. Russell et al. 1997 for Zimbabwe). In fact, since none of the governance mechanisms or the partnership arrangements functions properly and effectively, the question is whether Uganda employs the right mix of governance mechanisms and partnership arrangements, or whether these failures are related to capacity deficits in applying and implementing them and whether the latter is fundamentally due to unmet assumptions and preconditions for the governance mechanisms to function. The answer to this question is even trickier, since it simultaneously requires an answer to a second question about the right sector mix, which must equally take into account the deficits of intra-organisational institutional mechanisms.

The evidence suggests that the answer to the first question is to move both ways. First of all, government must clarify the role of the private and voluntary sector as well as its own role. It also calls for a shift in the mix of governance mechanisms as

well as for strengthening the capacities to apply them. This constitutes, secondly, a step towards meeting the preconditions and assumptions for the functioning of the governance mechanisms.

For the provision of curative services, healthy competition must be fostered, which necessitates comprehensive and effective regulation and its implementation as to quality of care, location and prices. This requires an approach that promotes the state's institutional capacities to regulate, supervise and monitor. In addition, adequate incentive-based schemes must be developed in order to address those aspects that are difficult to rectify through hierarchical regulation. At best, these incentive-based schemes are developed together with the other two sectors in a co-operative way. As regards PPHC services, a focused shift towards network coordination has to take place. This implies enhancing both the capacities of actors to network as well as the actors' willingness and awareness. The partnership arrangements have proved beneficial, but in order to exploit their full potential, these arrangements must further evolve into contracts that specify the services and the quality more explicitly than they have done so far. This should take place on the basis of a fair and equal negotiation process and also requires a great degree of trust (cf. Mills 1997a). Likewise, the competitive element within the application process for funds needs strengthening, while it must be equally ensured that the selection process and criteria be more transparent. For example, NGOs should be included in panel committees not only on paper but in practice, and more facilitation should be provided to local governments during this process. Alternatively, donors may consider other organisational-institutional options to channel funds to NGOs, such as regional or District NGO forums.

In order to avoid the pitfalls of partnership, focus must be put on fostering the actors' capacity to interact as well as their willingness to do so, by improving the interaction culture and establishing an interaction framework that allows for regular and constructive interaction. It is also necessary to specify guidelines and performance indicators to facilitate, monitor and evaluate partnerships between NGOs and the local government. A starting point is to clarify responsibilities of who is in charge of dealing with NGOs, to set up office hours for NGO matters, institutionalise consultative meetings that are participatory and moderated by neutral actors, and establish voice mechanisms for NGOs. This is surely a difficult undertaking in a context of co-optation, patronage and clientelism and, thus, also calls

for strengthening NGOs in their role as civil society. But it is a feasible aim, as the promising results of the action research in Kamuli District showed (see Chapter 9).

Ultimately, all of these strategies will require a functional local government. Hence, strengthening local legitimisation and bottom-up accountability is fundamental. This also calls for extending the people's voice and exit options in relation to all three sectors. The next and final chapter will elaborate on some theoretical and practical implications resulting from the empirical findings of Chapters 5-8.

## Chapter 9

### **Conclusion: Institutionalised Pathologies or Healing Organisations?**

#### **9.1. The Potential and Pitfalls of Institutional Pluralism**

This chapter draws together the empirical data described in the previous chapters and recapitulates the analysis of institutional pluralism and interorganisational relationships. The starting point was the recognition that performance and relative strengths are context-specific. Which provider type and which governance mechanism is best can therefore not be determined a priori, but requires empirical analysis. Chapter 2 discussed the methodological difficulties involved in defining relative strengths; it was noted that there is always a normative component to it. By combining people's views with the observer's, an adequate understanding of relative strengths has been derived that is based on the performance criteria: access, efficiency (in staff resource utilisation) and quality of care.

The background chapters (3 and 4) examined the local government developments, the previous organisational changes and the context of Uganda's health care system in order to illuminate the prevailing legacies with which it is faced today. These include deficits in local government accountability (which did not become institutionalised in the previous decades), the informalisation process (which resulted in a huge informal, unregulated private sector), the privatisation of public resources, and related thereto the fragmentation of the health care system. As a result, the roles, responsibilities, ownership and loci of decision-making changed and transformed. Given the nature of the health policy-making process of the past decade, however, the inherited problems could not be quickly solved. Likewise, the identified shortcomings within the decentralisation process after 1986 continue to constrain health care provision at the local government level.

An analysis of people's medical-pluralist notions revealed the numerous paths of health care seeking and the treatments available. The examination of people's utilisation behaviour and the rationale behind helped interpret the results of the comparative performance analysis. The factors influencing utilisation comprise qualitative, financial/economic and cultural aspects. Choice of treatment is thus contingent upon availability, affordability and acceptability. As active health care seekers, people's main

criterion for choosing a provider is quality, although people's notion of quality does not necessarily coincide with a biomedical understanding of quality of care. As in other countries, people (both providers and users) have developed a strong preference for injections and antibiotics, which they believe to be the most powerful means of restoring and maintaining health.

Chapters 5 and 6 were devoted to a comprehensive comparative performance analysis: public, private and voluntary sector health care providers were assessed in terms of access, efficiency in staff resource utilisation and quality of care. It was shown that urban private and NGO clinics are more efficient in the utilising staff resources. Accessibility to all providers is contingent upon the patient's ability to pay, but there is a trade-off in terms of losses of quality, such as partial doses for partial payments or inferior treatment, when patients do not have enough money to pay, although this is not that extensive at NGO clinics. Drugshops constitute the least expensive option; on the other side of the coin, the unqualified staff completely gives way to people's unhealthy preferences. Out-of-pocket user charges are very high at urban private and NGO clinics, as well as at government clinics, because of the high extent of informal charges and the patients' need to buy drugs at drugshops. Furthermore, exemption practice is very rare and hence does not contribute to counterbalancing inability to pay. Ultimately, exclusion and self-exclusion are the result.

Process quality, which includes drug availability, staff behaviour, waiting time, opening hours, presence and attendance of qualified staff, and appropriate consultation and examination, is overall adequate at NGO and private clinics, but extremely poor in the public sector. That said, clinical quality of care – measured as a clinical examination provided, the fit between diagnosis and treatment, a correct treatment, the rational use of drugs and the use of adequately sterilised syringes – is inadequate everywhere. Overall, the hypothesis is confirmed that the public sector performs worst. In fact, it has no relative strengths at all at present, whereas the NGOs deliver relatively better services, even though user charges are quite high and as such reduce access. In sum, the comparative performance analysis illustrated the numerous problems in service provision, which are by no means unique for Uganda, but reflect the overall difficulties and challenges in health care provision of developing countries (Bennett et al. 1999). Despite the significant performance differences, the question of relative strengths, as a

matter of fact, turned into which provider type is least worst, since none of the provider types performed satisfactorily overall.

In Chapter 7 and 8, (mal-)performance was explained by means of an institutional account that demonstrated the importance of the intraorganisational institutional mechanisms and interorganisational relationships.

In the public sector, as hypothesised, malperformance is the result of the lack of functional accountability mechanisms and distorted local legitimisation processes, thereby simultaneously disrupting financial responsibility. Deficits in supervision and disciplinary mechanisms lead to a situation where perverse incentives dominate, deviating the service providers from the public interest. The staff is thus in a position to privatise public resources. For example, the logic of informal charging is based on bad performance, particularly as regards behaviour and drug availability, which can then be improved by such informal payments. As informal charging generates more additional income, health workers give way to the perverse incentive for bad performance. Moreover, the prevailing administrative culture is characterised by people's fear for negative consequences when using voice. This, in turn, cements a situation in which nobody is accountable. In sum, the state operates a system on the basis of assumptions that it cannot hold. Instead, it succumbs to institutional degradation that creates the serious deficits in relation to the performance criteria access, efficiency (in staff resource utilisation) and quality of care. These systemic problems affect not only government health care provision but other social services as well. Drawing upon other case studies has shown that many African countries suffer from similar and in part identical institutional deficits.

Private and NGO clinics are exposed to market competition because of the cost-recovery requirement, which exerts pressure on their performance. However, market imperfections cause supplier-induced inefficiencies (lower quality than under perfect competition) and also make access problematic. For the NGO clinics, this is counterbalanced, however, not so much by participatory structures and solidaristic motivations per se, as expected, but above all by the existence of strong supervision and top-down accountability that succeed in upholding a certain level of solidaristic motivations and loyalty, thus offsetting perverse incentives. Furthermore, the extent of the hybridisation of the public and voluntary sectors was not expected. Both sectors show some distinct features of the private sector, in that patient exit is the main bottom-

up accountability mechanism for users (even though this has no effect on the performance of government clinics) and in that access is contingent upon direct out-of-pocket payments, which raises serious accessibility concerns. Given this hybridisation, the usefulness of the sector conceptualisation is also in question, as the sector boundaries are blurred.

Chapter 8 showed the importance of interorganisational relations in explaining performance and malperformance, as hypothesised. It demonstrated that market failures and imperfections are not adequately addressed due to regulatory gaps and the state's inability to implement these regulations. These problems are also found in other African countries (Kumaranyake et al. 2000). Nevertheless, the existence of state clinics as some form of benchmark for competition and the DMO supervision – even though more limited to infrastructural aspects – exert pressure upon NGO facilities and make them perform better in the context of their prevailing antagonistic relationship. Further, the hypothesis was confirmed that partnership arrangements are beneficial in that they improve or extend the NGO services and allow NGOs to take advantage of their relative strengths. Yet the potential of these support interactions is undermined by the administration's obstructive practices that make it difficult or even impossible for the NGOs to obtain the financial and technical support they were promised. The channelling of NGO funds through the local governments has produced perverse incentives in the context of the severe accountability deficits of the local government, since these funds could be turned into an additional lucrative income source for the highest District authorities. There are no incentives for the administrative actors to achieve the intended interaction benefits, such that their personal interests of appropriating NGO funds dominate. On the other hand, the lack of co-operation can be explained as competition for scarce resources. As such, the forced "partnership" upon the local government authorities has led to resentment. Their obstruction offsets the positive effects of NGO clinics competing with and being supervised by the DMO. The situation is worsened by the impeding interaction culture and structure, as well as the NGOs' inability to make the local government accountable. At the same time, this has prevented the NGOs from taking on the role of a local civil society. Thus, there is a vicious circle, in that the collective action of a local civil society is required to establish (constructive) interactions in order to promote good governance and strengthen the devolved local state by

supporting a capacity-building process. Again, the literature indicated at various points that these problems are not unique to Kamuli or Uganda.

Institutional pluralism has much potential, and some of its benefits are realised in Kamuli, but at the same time it suffers from huge pitfalls. In fact, what we find is a situation of institutional weaknesses. This is manifested in huge accountability gaps in the public sector, lack of patient participation in all three sectors, poor state regulation, a particularly imperfect health care market and low professional and ethical standards. As a result, perverse incentives for public, private and voluntary sector health workers are not fully counterbalanced and lead them to overprescribe and underdrug at varying degrees. In combination, the identified deficits constitute severe pathologies within the health care system and explain the low organisational and system performance. These pathologies are institutionalised in the sense that they are deeply ingrained as norms for organisational and individual behaviour that determine future behaviour and expectations and in that these norms are constantly reproduced within the prevailing system. This is particularly the case in the public sector where stakeholders are interested in their reproduction and resist their dissolution.

## **9.2. Wider Implications and Reflections**

### **9.2.1. Weak Intellectual Thrust of Institutional Pluralism? Or: The Importance of Preconditions and Informal Institutions**

The institutional set-up of the three sectors is quite diverse, so that failure occurs in various degrees and due to different causes. In a situation, in which all provider types perform inadequately and in which the question of relative strengths turns into which provider type is least bad, one may question the intellectual thrust of institutional pluralism, since what we have to explain is a situation of failure and specifically institutional and organisational pathology.<sup>356</sup> However, as was noted in Chapter 1, theory and the validity of its predictions are contingent upon preconditions and assumptions. Obviously, the assumptions of institutional pluralism, namely functional sectors with

---

<sup>356</sup> It must be noted that the term "failure" is used in relative terms. Obviously, in comparison with previous decades or imploding states, today's Uganda is doing much better and the achievements during the past 15 years must be clearly acknowledged.

their respective (inherent) strengths (and weaknesses) for making it a superior social order, are not met in Kamuli, and we have found that all three sectors perform below the theoretical expectations.

In Kamuli, there are particularly severe market imperfections and failures due to poverty and deprivation, as there usually are in rural African settings. Markets are not in equilibrium because of locked supply, information asymmetries, the relatively long travelling times and the high costs to reach providers (D. Leonard 2000b: 260, 264). Another market imperfection is the "economy of affection" that acts as one of the strongest informal institutions. In many instances, markets are able to create the institutions or other markets required on their own to overcome market failure and imperfections. As regards health, one of these is professional associations, which ensure quality of care and ethics. Another one is insurance markets and other community-based financing schemes to increase market access. Yet both of these types of institutions are very poorly developed in Uganda. As regards insurance markets, this is due to the absence of collective action, the incompatibility between rural household structures and formal insurance requirements, as well as high levels of illiteracy (ibid., cf. Abraham/Platteau 2000 on the reasons for the failure of community insurance systems).<sup>357</sup>

Voluntary sector performance is based on very specific assumptions, such as the prevalence of collective action, solidarity, a participatory structure and functional accountability chains. These requirements are not sufficiently explicated in the voluntary sector discussion, but it is a mistake to take the existence of these factors for granted (cf. Abraham/Platteau 2000, Larmour 1997). Likewise, the state fails in direct service delivery and indirect provision since its institutions are underdeveloped and weak. As was shown in Chapter 7, the central cause is rooted in the severe accountability gaps, such that the most fundamental assumption of the Weberian model is not met. At this point, there is no scope for providing a detailed explanation of why these assumptions do not prevail; moreover this would require a detailed empirical study on its own. However, based on my observations and elaboration of some of the points made in Chapter 7, the

---

<sup>357</sup> Also, for the poorest, even community-based financing schemes are often unaffordable (Preker et al. 2001 for a review of 45 community-based financing schemes).

following aspects appear to be critical in understanding the roots of this lack of accountability and collective action.

First, the prevailing administrative culture makes people suppress their demands out of fear for negative consequences. Strong trust in hierarchies (Mathauer 1997; Golooba-Mutebi 1999), a leadership culture ("personalissimo"), and the acceptance of inequalities (Munene 1991, Munene et al. 2000) raise the threshold for taking action against the authorities' wrongdoing. Further, people's level of information about their rights or regarding where to address their views is low and they are not experienced in asking for that information.

Second, while there is a strong sense of community in African societies, my impression of Uganda in comparison with other African countries I have worked in is that the society is relatively more individualised, possibly as a result of the despotic regime of Idi Amin and the civil war. This impression was confirmed in various conversations with persons who worked in other parts of Uganda. During the focus group discussions, the communities themselves complained about this. Related thereto are low levels of social co-operation and low capacity for collective action (cf. Mathauer 1997, 1998; Mutebi-Golooba 1999).<sup>358</sup> Triandis (1976) conceptualised this as "ecosystem distrust", whereby one's wider environment is perceived as hostile rather than benign (in Munene 1991: 456). As a result, problems are solved individually through patron-client relationships. The vicious circle is not interrupted by the local NGO sector, since it has not yet reached Korten's (1987) "third generation" of system development but remains in the "second generation" of promoting small-scale development.

The effect of informal institutions is enormous and is particularly strong in the public sector. They subvert the assumptions on which the sector conceptualisations are based, especially when formal institutions are already weak. In turn, the preconditions for the adequate functioning of the three sectors and hence for institutional pluralism do not fully exist. This questions the appropriateness of the (Weberian) state model for a context like rural Uganda, as Simon (1993) does for developing countries, or the adequacy of the private sector, as does D. Leonard (2000). The resulting policy question is thus whether a health care system should use other provider types and other

---

<sup>358</sup> As a vicious circle, this is also undermined by the contradictory logic of the LC system; for example, the indirect elections of the LC2 level as the critical gate to the directly elected LC3 level.

institutional arrangements, notably NGOs, which are the remaining category. This then brings the rationale of institutional pluralism into question. If not, is the solution to change the preconditions, specifically the political and social conditions that inhibit successful public and private provision? Or are there other solutions? The following sections address these questions.

### 9.2.2. Which Provider Type to Set On?

The government (and donors) endeavour to extend and improve health care services. In light of each sector's failure, the question of which provider type to promote and invest in becomes difficult. The comparative performance analysis indicated a relatively superior performance on the part of NGO clinics given their strong internal supervision system, even though severe performance gaps remain. D. Leonard also argues that NGOs perform better since church missions in particular have high-powered incentives through their institutionalised set of values, thereby substituting for system-wide organised professional (self-)regulation (2000: xxxvii). He therefore recommends an expansion of the role of NGOs. However, the mere extension, replication and scaling up of NGO services is not unproblematic, because NGOs may lose their flexibility, their "small is beautiful" advantage and their unbureaucraticness. Furthermore, extending the number of NGO facilities also raises funding questions and, as we have seen in Chapter 8, the provision of funds is accompanied by numerous problems, which affects their performance and endangers their autonomy.

Apart from these considerations, it is ultimately crucial to note again that the performance of NGOs is also related to the DMO's supervision and the antagonistic relationship as well as the prevailing competition, which puts added pressure on them. The existence of institutional pluralism, specifically the presence of private and public sector health care providers, and not only the state in its function as regulator, is critical, in that the other providers constitute a benchmark and an incentive for NGOs to perform better. In consequence, an extension of the number of health clinics should prioritise the NGO sector and secondly the well-regulated private sector, but this should not lead to an active down-sizing of the government clinics, since their existence is equally needed as a distinct type of service delivery, though with a rather different internal institutional set-

up (see below). This argument is also based on the fact that current experiences in contracting out are not fully promising and convincing.<sup>359</sup>

### 9.2.3. Is Institutional Pluralism Superior?

This point brings us back to one of the hypotheses of this research, namely that institutional pluralism is a superior social order for providing services and governing service provision and hence is a means to provide *better* services. Moreover, an effective pluralistic system allows for appropriately addressing the issues of access and equity. The empirical findings have demonstrated the actual achievements and the potentials of institutional pluralism. One of the advantages is the existence of competition, which ideally yields improved process quality if the health market is regulated. Other advantages are the increased availability of drugs, physical proximity of providers in rural areas and some degree of provider choice, as well as the benefits of partnerships, including the use of relative strengths.

That said, it is evident that institutional pluralism per se is not the solution, since it may also entail numerous problems and pitfalls, particularly when the state is too weak to overcome these deadlocks. In fact, in Uganda, as elsewhere, the move towards institutional pluralism has not been accompanied by the development of strong (formal) institutions. As D. Leonard puts it,

The expansion of markets has exposed the absence or weakness of the institutions required for their efficient operation. [Thus], the market has not yet worked any miracles (2000b: 260).

Also, because of the substitution processes that take place from the public to the (rural) private sector, there is always the danger that the increase in private provision may not fully add to the total activity of the health care sector (McPake 1997: 33). This also appears to hold true for Uganda, as the overall health budget has stagnated (Oloka-Onyango 2000: 24) and as the increase in private sector activities is linked to informally "privatised" state resources (mainly drugs and staff time).

Further, in Uganda, the shift to a pluralistic system was not managed and governed properly and hence resulted in fragmentation, duplication and eventually sub-optimal use of scarce resources, so that overall health goals have become more difficult to achieve.

---

<sup>359</sup> Cf. for example Gilson et al. 1997, Bennett et al. 1997, Palmer/Mills 2000, MCPake/Ngalande-Banda 1994.

Likewise, in an environment characterised by weak formal institutions, the potentials of partnerships are undermined. Institutional pluralism requires strong functioning governance mechanisms, but we have seen that they do not function effectively either. It puts higher governance demands on the system and particularly on the state, while paradoxically, in Uganda, institutional pluralism emerged because of state service delivery failure and governance failure. This is why the shift to institutional pluralism was accompanied by institutional weakening, resulting in the pathologies described in the previous chapters.

It is difficult to prove directly that institutional pluralism, despite all its pitfalls, is still potentially superior to an approach that uses only one sector. However, having gained an understanding of how the system functions at the moment, one can assume that a system based on solely one provider type would perform much worse today, precisely because of the lack of competition among different provider types.<sup>360</sup> Ultimately, a one-sector model is not a viable alternative and institutional pluralism is the only remaining policy alternative. The practical question is how to make it functional.

### **9.3. Making Institutional Pluralism Work: A Multi-Dimensional Approach to Reform**

Institutional pluralism is potentially superior, but also much more complex to manage, especially because of the two-way interrelation of the intra- and interorganisational institutional mechanisms.<sup>361</sup> On the one hand, it requires the functioning of the intra-organisational institutional mechanisms of all provider types. System improvement will hence not primarily come about by changing the division of labour, although a role specification is necessary, but by reducing intraorganisational deficits. On the other, institutional pluralism requires functional governance mechanisms and conducive interorganisational relationships. For this institutional pluralism to be healthy and

---

<sup>360</sup> In fact, the decentralised organisational change occurred because of the failure and breakdown of the previous health care system in the 1970s.

<sup>361</sup> Managing institutional pluralism is made even more challenging through cross-linkages with other policy fields (agriculture, sanitation, water, nutrition).

beneficial in Uganda, the right balance and combination of *more* competition, and therefore *more effective* regulation, but also *more* co-ordination and *more* partnership arrangements are necessary, as each of these are relevant. The right balance will also make it possible to reset intraorganisational institutional mechanisms and incentives and to address system concerns.

For developing countries, finding the optimal institutional-organisational arrangements for service provision at the local level is not simply a matter of determining the relative strengths of each service provider in order to reorientate the division of labour, as initially assumed. Instead, it requires a simultaneous assessment of the potential institutional capacity of the actors in delivering services and in governing interorganisational relationships in order to correct institutional deficits. This implies a move from a static notion of relative strengths to a dynamic one. As said, the providers' relative strengths – also vis-à-vis their institutional and organisational capacity – are situational and they can be influenced and promoted (Mathauer 2000). For example, although the public sector in Kamuli District currently does not have the institutional and organisational capacity to deliver services in an efficient and effective manner, or the capacity to contract or regulate, it may so in the future with the appropriate support. Under such a scenario, relative strengths will have to be reattributed to the providers.

It is therefore central to improve both the functioning of intra-organisational institutional mechanisms and interorganisational relationships, including the mix of governance mechanisms and beneficial partnership arrangements. This also serves to bring the required preconditions and assumptions about institutional pluralism into existence through capacity strengthening. In finding the least worst option, such a capacity-strengthening approach must equally take into account the relationship between formal and informal institutions and the way they are subverted. These recommendations seem to be very ambitious in light of the many institutionalised pathologies, and a comprehensive and multi-dimensional approach to promoting healthy institutional pluralism is therefore needed. Only this will make it possible to address the interrelated performance criteria (access, efficiency and quality of care) and hence to raise their scoring in order to improve overall organisational performance.

Increasingly, the New Public Management (NPM) model for the governance of institutional pluralism, or elements thereof, is being propagated and its suitability is

being scrutinised. Its core features are the reduction of government's *direct* role in providing services to citizens and greater reliance on markets, communities and individuals to manage themselves. It also aims at extending government's role in the *indirect* management of other actors and calls for management reforms in the remaining areas of government action (such as internal markets, performance-related salaries, establishing a service culture) in order to create new pressures and incentives for efficiency and effectiveness.<sup>362</sup> These different aspects reshape the relationships of accountability between officials and politicians and between the public administration and society (Batley 1994a, 1999a). Country experiences are promising, but have so far not been very far reaching, as the introduction of NPM elements "require not only changes in organisational structure but also organisational culture" (Batley 1999b: 773; similar Grindle 1997).<sup>363</sup>

Nevertheless, the system's functioning still requires some hierarchical regulation for licensing and ultimate health safety enforcement, either by an independent self-regulatory body or by a state institution. For those tasks (now reduced to a minimum), the conventional state model of hierarchy has still practical relevance. The state's different roles of regulating, monitoring, enabling, co-operating, contracting, financing and co-ordinating are not easily accommodated with each other (Batley 1994a). Enabling and co-ordination are particularly challenging when state services also compete with other provider types. While the different roles (regulatory versus enabling) are difficult to combine, this can be eased by organisationally separating these opposite functions. Ultimately, the success of these reforms – strengthening the conventional roles of the state and pursuing a NPM approach – depends upon two crucial measures: (1) establishing accountability and (2) fostering the willingness and capacity of all actors to interact and co-operate.

Promoting administrative and political accountability at the local level serves to break up the vicious circle of a weak state failing in delivery, which then tries in vain to regulate an underdeveloped market that grew out of state failure. Apart from institutional changes and in particular changes in procedures of decision-making and control over resources, it is also necessary to "enhanc[e] the capabilities of communities to exercise

---

<sup>362</sup> For a detailed account on NPM measures, cf. Walsh 1995, Osborne/Gaebler 1992, Osborne/Plastrik 1997.

<sup>363</sup> Similarly, Bennett et al. note the importance of organisational culture (1999: 27).

their new rights and responsibilities" (Cornwall et al. 2000: 3).<sup>364</sup> In light of the numerous deficiencies that characterise the local government system in Kamuli, this appears to be a great challenge. While this is not easy, it is not insurmountable. This is confirmed by the action research process undertaken in Kamuli District, which aimed at strengthening people's voice options and providing information about decentralisation. The communities' strategies were focused on making structures and institutions more functional and increasing community awareness and capacity. The communities aimed to create and strengthen voice options and accountability mechanisms by requesting to be involved in local decision-making and planning processes. A small but notable change took place in that people started to use voice and to take action against the wrongdoing of office-holders (cf. Mathauer 1998 for the results of the action research).

The second key reform is to promote the willingness to interact and collaborate in order to establish the conditions necessary for intensified networking co-ordination and partnership arrangements. This calls for reshaping the incentive structure at the local level to make civil servants co-operate with non-state service providers. At the same time, this requires interorganisational trust and a change in the interaction culture, since it will be impossible to implement the partnership policy if the current central-local-civic constellation remains the way it is.<sup>365</sup> Instead of a bureaucratic machinery, a "co-operative administration" and a co-operative administrative culture are required, which allow for "two-sided, open and results-oriented co-operation rather than one-sided hierarchical rules application" (Simon 1993: 69, translated). Again, this points to the fundamental importance of strong accountability mechanisms, as partnerships can be successful only if voice options and accountability mechanisms are functional so as to avoid the pitfalls of partnership; this also holds true for contracting. The approach must also comprise the promotion and strengthening of NGOs and civil society in order for them to play a central role in ensuring accountability.

The positive and encouraging action research experiences of promoting interorganisational co-operation and the establishment of the NGO Forum in Kamuli

---

<sup>364</sup> The field of institutional development of local government has only begun to emerge in the development literature since the late 1980s (Montiel 1997: v).

<sup>365</sup> As a matter of fact, the promotion of interaction entails per se (re-)shaping the relationships (cf. Hanf/O'Toole 1992: 170).

indicate the potential of such an approach (cf. Annex 1.6 for the proceedings). The NGO meetings led to improvements in the interaction culture among them. Similarly, there was an increase in resource sharing and pooling (transport sharing, borrowing office equipment, exchange of educational material, etc.) among them. Altogether, these were low-profile improvements at a small scale. Nonetheless, this was a crucial starting point, as it reduced mistrust and envy and created a basis for speaking univocally and acting collectively.

Moreover, the existence of the Forum meant that the administration had to take the NGOs more seriously. The NGOs asked for the appropriate recognition as gap-fillers and complementary service providers. The interaction culture began to change as NGOs started to actively shape their relations with the public sector. As a result of the NGOs' advocacy, two NGO representatives were allowed to attend the District Management Team meetings, and the NGOs were also invited to the Sectoral Committee meetings<sup>366</sup> and in the District Council, although the latter is open to the public anyway. The NGOs' behaviour and tone has changed from the previous one of caution to one of being more aware and confident of their importance. Likewise, collectively, NGOs have been less afraid of addressing their problems and views to the administration. These are critical steps in taking on some of the roles of civil society (cf. Mathauer 1998, 2000).

#### Specific policy recommendations

Only in addressing those two main issues in combination – local accountability and conducive interorganisational relations – can more specific reform measures be pursued in order to avoid their being captured and subverted by individual self-interest and perverse incentives.

One crucial reform is reducing the prevailing rent-seeking options of government health workers. As McPake et al. argue, "there is no option to 'unlearn' the strategies they have devised" (1999: 864). As long as the large consumer surplus and the much better income opportunities in the private sector exist, it must be clearly acknowledged that from the point of view of health workers, the balance between incentives/rights and obligations is not satisfactory. Nevertheless, the prevailing patterns (diverting staff time for private practice, drug leakage and staff misbehaviour) could be considerably

---

<sup>366</sup> However, some of the NGO envoys did not attend the meetings, presumably because they would not receive a sitting allowance.

diminished if there was more supervision and pressure upon health workers to ensure staff attendance and responsible behaviour and if the health workers received at least the officially agreed upon salaries. At the same time, health workers' private practices should be more openly acknowledged, while staff attendance during core duty hours needs to be strictly enforced. Moreover, a new work culture must be introduced, especially among the young health workers, that expects health workers to behave appropriately (cf. Asiimwe et al. 1997b). Likewise, a clear and rewarding performance system, training opportunities and a supportive supervision scheme are required to strengthen professional values and to make staff feel valued again (cf. Mackintosh/Tibandebage 2000: 18).

In addition to the attempt at introducing and strengthening a work culture that promotes process quality, it is vital to address clinical quality of care by supervising health units more closely in order to implement the national treatment guidelines. This support supervision should include educating health workers, drugshop attendants and communities on the rational use of drugs, since intervention studies have shown that appropriate awareness can considerably enhance the rational use of drugs (Le Grand et al. 1999).

All these efforts should equally contribute to increasing access for those unable to pay and hence make health care more redistributive. In addition to lowering cost by reducing the degree of polypharmacy, and apart from a new consensus that puts equity high on the agenda, a range of specific measures should be pursued. These include a rigorous implementation of exemption, a shift from user fees for registration to user charges for drugs and the officialisation of informal charges (cf. Chapter 6). Ultimately, however, further thinking as to how to implement prepayment and community-based financing schemes beyond mere community involvement in user charge management is required. Although the prevailing conditions for introducing a social insurance system are less favourable than in other neighbouring countries (cf. Griffin/Shaw 1995), there are some prepayment pilot projects in Uganda. These call for further analysis to examine their replicability and options for upscaling.

#### **9.4. From Institutionalised Pathologies to Healing Organisations**

In sum, we have seen that the health care system, and particularly the public sector, suffers from many pathologies and that these are, in part, strongly institutionalised, in that informal institutions determine the logic of the system's functioning. Many of these pathologies are legacies from previous decades, but this is not to say that these pathologies cannot be rectified. In comparison to what the health care system looked like after the NRM took over, the past years have clearly constituted a substantial recovery process for the various types of organisations to be healed; for example in terms of drug supply management, staffing and salary payments, the introduction of formal accountability mechanisms (even though not yet functional) and increased financial responsibility.

While the system is performing badly, it is clearly no longer as appalling as it was in the 1970s and 1980s, when no care at all was better than the care that was delivered. Today, clinical quality of care was found to be low at all provider types but, nonetheless, the organisations are overall somehow healing and curing people. In fact, this may be the case exactly because of some of the existent institutionalised pathologies, namely the incentives that foster the high extent of polypharmacy and the overuse of antibiotics in order to cover for insecurity in diagnosing. (This has, however, severe consequences both on the system-level as regards drug resistance and on the efficient utilisation of resources.)

There is potential for organisations to be healed themselves and to heal. In fact the move to this stage, i.e., organisations to be healed and healing, would accelerate, once the crucial institutional bottlenecks are addressed. The state's capacity as a service producer and also as a regulator and enabler must be strengthened if the health care system wants to benefit from institutional pluralism and a private and voluntary sector expansion. This notwithstanding, I argue that the potential of local government has not yet been tapped sufficiently both as a service producer and a provider in charge of regulation, enabling, contracting and other forms of governance. Before laying down the public sector as a service producer, we should attempt to rectify some of the institutional pathologies and heal the local government. As was outlined above, the critical reform is to establish effective accountability mechanisms, to reset the civil servants' incentives for

partnerships and to introduce a conducive interaction culture and structure in order to take advantage of the potentials of partnerships and to avoid their pitfalls. So, once the right incentives are provided, the public sector as well as the other provider types can potentially perform much better. In fact, these reforms also encourage the installation of some of the preconditions for the formal institutions to function. This would allow to break up the vicious circle of weak formal institutions that contribute to persistent deprivation and hence to the inability of developing and setting up some of the preconditions for institutional pluralism to function. The action research results showed that this is a feasible undertaking if capacity programs actually do go down to the community level. It also demonstrates, however, that external actors and donors may be required to trigger such processes at the local level.

## Bibliography

- Abel-Smith, B. (1994). An Introduction to Health: Policy, Planning, and Financing. London, New York, Longman.
- Abel-Smith, B. and A. Dua (1988). "Community-financing in developing countries: the potential for the health sector." Health Policy and Planning 3(2): 95-108.
- Ablo, E. Y. and R. Reinikka-Soininen (1998). Do budgets really matter? Evidence from public spending on education and health in Uganda. Washington, D.C., World Bank Africa Region Macroeconomics 2.
- Abrahmam, A. and J.-P. Platteau (2000). The central dilemma of decentralised rural development, Paper prepared for the conference on "New Institutional Theory, Institutional Reform and Poverty Reduction", Development Studies Institute (DESTIN), London School of Economics, September 2000.
- Adiin Yansaah, E. A. (1995). An Analysis of Domestic Legislation to Regulate the Activities of Local and Foreign NGOs in Croatia, Kenya, Rwanda and Uganda. Oxford, Centre for Socio-legal Studies.
- Adome, R. Odoi et al. (1996). Popular Pills. Community Drug Use in Uganda. Amsterdam, Het Spinhuis Publishers.
- Akin, J. S. and P. Hutchinson (1999). "Health-care facility choice and the phenomenon of bypassing." Health Policy and Planning 14(2): 135-151.
- Aljunid, S. (1995). "The role of private medical practitioners and their interactions with public health services in Asian countries." Health Policy and Planning 10(4): 333-349.
- Aljunid, S. and A. Zwi (1997). Public and private practitioners in a rural district of Malaysia: complements or substitutes? Private Health Providers in Developing Countries. Serving the Public Interest? S. Bennett, B. McPake and A. Mills. London, New Jersey, Zed Books: 40-53.
- Allen, T. (1991). The quest for therapy in Moyo District. Changing Uganda. H. B. Hansen and M. Twaddle. London, James Currey: 149-160.
- Allen, T. (1992). Upheaval, affliction and health: a Ugandan case study. Rural Livelihoods: Crises and Responses. H. Bernstein. Oxford, Oxford University Press.
- Allen, T. (1998). Understanding health: Biomedicine and local knowledge in Northern Uganda. London School of Economics, Development Studies Institute, mimeo.
- Alnwick, D. J. et al. (1985). Morbidity and mortality in selected Ugandan hospitals, 1981-1982. Crisis in Uganda. The Breakdown of Health Services. C. P. Dodge and P. D. Wiebe. Oxford et al., Pergamon Press: 79-86.
- Amooti-Kaguna, B. and F. Nuwaha (2000). "Factors influencing choice of delivery sites in Rakai district of Uganda." Social Science and Medicine 50: 203-213.
- Anell, A. and A. Norinder (2000). "Health outcome measures used in cost-effectiveness studies: A review of original articles published between 1986-1996." Health Policy 51: 87-99.
- Arrow, K. (1963). "Uncertainty and the welfare economics of medical care." American Economic Review 53: 941-973.
- Asiimwe, D. and J. L. Lule (1993). The public/private mix in financing and provision of health services in Uganda. Proceedings from the Workshop on the Public/Private Mix for Health Care in Developing Countries. Health Policy Unit Report. S. Bennett and A. Mills. London: London School of Hygiene and Tropical Medicine.
- Asiimwe, D. et al. (1997a). Informal Markets and Formal Health Financing Policy. Kampala, MISR.
- Asiimwe, D. et al. (1997b). The private-sector activities of public-sector health workers in Uganda. Private Health Providers in Developing Countries. Serving the Public Interest? S. Bennett, B. McPake and A. Mills. London, New Jersey, Zed Books: 141-157.

- Atkinson, S. et al. (2000). "Going down to the local: Incorporating social organisation and Political culture into assessments of decentralised health care." Social Science and Medicine 51: 619-636.
- Azfar, O. et al. (2000). Making Decentralisation Work: An Empirical Investigation of Governance and Public Services in Uganda. IRIS Center, University of Maryland, December 2000.
- Bagambisa, G. (1995). Health services delivery and decentralisation, Paper presented at the World Bank Workshop at the International Conference Centre, Kampala, Uganda on 6th November, 1995.
- Baker, J. L. and J. van der Gaag (1992). Equity in Health care and health care financing: Evidence from five developing countries. Equity in the Finance and Delivery of Health Care: An International Perspective. E. van Doorslaer et al. Oxford, Oxford University Press.
- Barker, C. (1996). The Health Care Policy Process. London et al., Sage.
- Batley, R. (1994a). "The consolidation of adjustment: implications for public administration." Public Administration and Development 14: 489-505.
- Batley, R. (1994b). The role of government in adjusting economies: A survey of issues related to the research. The Role of Government in Adjusting Economies. Paper 1 - Literature Review. DAG. Birmingham, DAG: 1-19.
- Batley, R. (1996). "Public-private relationships and performance in service provision." Urban Studies 33(4-5): 723-751.
- Batley, R. (1999a). "Introduction." Journal of International Development 11: 755-760.
- Batley, R. (1999b). "Policy arena. The New Public Management in developing countries: Implications for policy and organisational reform." Journal of International Development 11: 761-765.
- Bayart, J.-F. (1993). The State in Africa: the Politics of the Belly. New York, Longman.
- Beall, Jo (1997). A City for All. Valuing Difference and Working with Diversity. London, Zed Books
- Bebbington, A. and J. Farrington (1993). "Governments, NGOs and agricultural development: Perspectives on changing interorganisational relationships." The Journal of Development Studies 29(2): 199-219.
- Becker, Hans-Joachim (1998). EO-Bericht 1996 – Uganda. Kampala, DED
- Bennett, A. (1998). "Sustainable public/private partnerships for public service delivery." Natural Resources Forum 22(3): 193-199.
- Bennett, J. et al. (1995). Meeting Needs. NGO Coordination in Practice. London, Earthscan Publications.
- Bennett, S. (1991). The Mystique of Markets. Public and Private Health Care in Developing Countries. Department of Public Health and Policy, London School of Hygiene and Tropical Medicine.
- Bennett, S. (1994). The health sector. The Role of Government in Adjusting Economies. Paper 1 - Literature Review. DAG. Birmingham, DAG: 28-32.
- Bennett, S. (1997a). Health-care markets: defining characteristics. Private Health Care Providers in Developing Countries. Serving the Public Interest? S. Bennett, B. McPake and A. Mills. London, New Jersey, Zed Books: 85-101.
- Bennett, S. (1997b). Private health care and public policy objectives. Marketising Education and Health in Developing Countries. Miracle or Mirage? C. Colclough. Oxford, Clarendon Press: 93-123.
- Bennett, S. and E. Ngalande Banda (1994). Public and private roles in health: a review and analysis of experience in Sub-Saharan Africa. Geneva, WHO.
- Bennett, S. et al. (1994). "Carrot and stick: state mechanisms to influence private provider behaviour." Health Policy and Planning 9(1): 1-13.
- Bennett, S., S. Russell, A. Mills (1995). The Role of Government in Adjusting Economies. Paper 4. Institutional and Economic Perspectives on Government Capacity to Assume New Roles in the Health Sector: A Review of Experiences. London, ODA.

- Bennett, S., B. McPake, A. Mills (1997). The public / private mix debate in health care. Private Health Providers in Developing Countries. Serving the Public Interest? S. Bennett, B. McPake and A. Mills. London, New Jersey, Zed Books: 1-18.
- Bennett, S. and X. Muraleedharan (1998). The Role of Government in Adjusting Economies. Paper 28. Reforming the role of government in Tamil Nadu health sector, London, ODA.
- Bennett, S., S. Russell, A. Mill (1999). The Changing Role of Government in Adjusting Economies. Health Sector - Summary Paper. Paper 3. London, Final draft February 1999, Health Economics and Financing Program, LSHTM.
- Benz, A. (1994). Kooperative Verwaltung: Funktionen, Voraussetzungen und Folgen. Baden-Baden, Nomos.
- Berg-Schlosser, D. and R. Siegler (1990). Political Stability and Development: A Comparative Analysis of Kenya, Tanzania, and Uganda. Boulder, L. Rienner Publishers.
- Biehl, D. (1987). Dezentralisierter Föderalismus als Lösungsansatz. Dezentralisierung des politischen Handelns (III). Konzeptionen und Handlungsfelder. F. Schuster. Melle: 58-78.
- Bigsten, A. and S. Kayizzi-Mugerwa (1999). Crisis, Adjustment and Growth in Uganda: A Study of Adaptation in an African Economy. Basingstoke, Macmillan; New York, St. Martin's Press.
- Bitrán, R. (1995). "Efficiency and quality in the public and private sectors in Senegal." Health Policy and Planning 10(3): 271-283.
- Birdsall, N. and R. Hecht (1997). Swimming against the tide: strategies for improving equity in health. Marketising Education and Health in Developing Countries. C. Colclough. Oxford, Clarendon Press: 347-366.
- Birungi, H. (1994a). Injections as household utilities: injection practice in Busoga, Eastern Uganda. Medicines: Meanings and Contexts. N. Etkin and M. Tan. Manila, Health Action Information Network: 125-135.
- Birungi, H. (1994b). The Domestication of Injections: A Study of Social Relations of Health Care in Busoga, Eastern Uganda. Ph.D. Thesis. University of Copenhagen.
- Birungi, H. (1996). An Assessment of Gender Gaps in the Decentralisation Policy and Decentralisation Secretariat Programs. Kampala, DANIDA.
- Birungi, H. (1998). "Injections and self-help: Risk and trust in Ugandan health care." Social Science and Medicine 47(10): 1455-1462.
- Birungi, H., D. Asiimwe, S. Whyte (1994). Injection Use and Practices in Uganda. Geneva, WHO/DAP/94.18.
- Birungi, H. et al. (1999). The Policy for Public-Private Mix in Uganda: Catching up with Reality. Kampala, MISR/MOH, mimeo.
- Bloomington, J. (1994). "Managing the health care market in developing countries: prospects and problems." Health Policy and Planning 9(3): 237-251.
- Bossert, T. (1998). "Analysing the decentralisation of health systems in developing countries: Decision space, innovation and performance." Social Science and Medicine 47(10): 1513-1527.
- Bradach, J. L. and R. G. Eccles (1991). Price, authority and trust: from ideal types to plural forms. Markets, Hierarchies and Networks. J. Frances et al. London et al., Sage: 277-292.
- Brady, H. and D. Collier (2000). Rethinking social inquiry: diverse tools, shared standards. Paper presented to the DESTIN research seminar series, LSE, October 2000.
- Bratton, M. (1989). "The politics of government-NGO relations in Africa." World Development 17(4): 569-587.
- Brett, E. A. (1973). Colonialism and Underdevelopment in East Africa: The Politics of Economic Change, 1919-1939. London, Heinemann.

- Brett, E. A. (1992). Providing for the Rural Poor: Institutional Decay and Transformation in Uganda. Brighton, University of Sussex Institute of Development Studies.
- Brett, E. A. (1993). "Voluntary agencies as development organisations: Theorising the problem of efficiency and accountability." Development and Change 24: 269-303.
- Brett, E. A. (1994). "Rebuilding organisational capacity in Uganda under the National Resistance Movement." Journal of Modern African Studies 32(1): 53-80.
- Brett, E. A. (1995). Creating the basis for democratic transition in Uganda: the problem of governance. Uganda. Landmarks of Rebuilding a Nation. P. Langseth, J. Katorobo, E. A. Brett and J. Munene. Kampala, Fountain Publishers: 209-228.
- Brett, E. A. (1996a). "The participatory principle in development projects: the costs and benefits of cooperation." Public Administration and Development 16: 5-19.
- Brett, E. A. (1996b). Uganda. Limits of Adjustment in Africa. The Effects of Economic Liberalisation, 1986-94. P. et al. Engberg-Pedersen. Centre for Development Research, Copenhagen in association with James Currey/Oxford and Heinemann/ Portsmouth (N.H.): 309-346.
- Brett, E. A. (1998a). Managing Organisational and Interorganisational Relationships. Development Studies Institute, London School of Economics, mimeo.
- Brett, E. A. (1998b). "Responding to poverty in Uganda: Structures, policies and prospects." Journal of International Affairs 52(1): 313-337.
- Brett, E. A. (2000a). "Development theory in a post-socialist era: Competing capitalisms and emancipatory alternatives." Journal of International Development 12: 789-802.
- Brett, E. A. (2000b). Participation and accountability in development management, Paper prepared for the conference on "New Institutional Theory, Institutional Reform and Poverty Reduction", Development Studies Institute (DESTIN), London School of Economics, September 2000.
- Brett, E. A. (2000c). Understanding organisations and institutions. Managing Development. Understanding Inter-Organisational Relationships. D. Robinson et al. London, Thousand Oaks, New Delhi, Sage: 17-48.
- Brugha, R. and A. Zwi (1998). "Improving the quality of private sector delivery of public health services: challenges and strategies." Health Policy and Planning 13(2): 107-120.
- Bulmer, M. (1993a). General introduction. Social Research in Developing Countries. Surveys and Censuses in the Third World. M. Bulmer and D. P. Warwick. London, UCL Press: 3-26.
- Bulmer, M. (1993b). Sampling. Social Research in Developing Countries. Surveys and Censuses in the Third World. M. Bulmer and D. P. Warwick. London, UCL Press: 91-100.
- Burgess, R. G. (1984). In the Field. An Introduction to Field Research. London, Routledge.
- Burke, G. F. (1964). Local Government and Politics in Uganda. Syracuse, NY, Syracuse University Press.
- Burkey, I. (1991). People's Power in Theory and Practice: The Resistance Council System in Uganda. Unpublished Research Paper, Yale University, mimeo.
- Cannon, C. (1996). "NGOs and the state: a case study from Uganda." Development in Practice 6(3): 262-264.
- Carbone, G. M. (2001). Non-Party Democracy? Political Organisation and the Movement Democracy in Uganda 1994-2000. University of London, PhD Thesis.
- Carley, M. (1980). Rational Techniques in Policy Analysis. London, Heinemann Educational.
- Carroll, T. F. (1992). Intermediary NGOs: the Supporting Link in Grassroots Development. West Hartford, Connecticut, Kumarian Press.
- Cassels, A. (1995). "Health sector reform: Key issues in less developed countries." Journal of International Development 7(3): 329-347.

- Cassen, R. and Associates (1995). Does Aid Work? Report to an Intergovernmental Task Force. Oxford, Clarendon Press.
- Castells, M. and A. Portes (1989). World underneath: The origins, dynamics, and effects of the informal economy. The Informal Economy - Studies in Advanced and Less Developed Countries. A. Portes, M. Castells and L. A. Benton. Baltimore, London: 11-37.
- Cernea, M. M. (1988). Nongovernmental Organisations and Local Development. Washington, D.C, World Bank.
- Chambers, R. (1983). Rural Development: Putting the Last First. London, Longman.
- Chambers, R. (1994). "Participatory Rural Appraisal (PRA): Analysis of experience." World Development 22(9): 1253-1268.
- Chawla, M. and R. Ellis (2000). "The impact of financing and quality changes on health care demand in Niger." Health Policy and Planning 15(1): 76-84.
- Chazan, N. (1988). Patterns of state-society incorporation and disengagement in Africa. The Precarious Balance: State and Society in Africa. D. Rothchild and N. Chazan. Boulder, Westview Press: 233-264.
- Chazan, N. (1992). Politics and Society in Contemporary Africa. Boulder, Colorado, L. Rienner Publishers.
- CIETinternational (1998). National Integrity Survey Uganda. Final Report. [www.undpc.org/adhoc/crime/corruption\\_uganda\\_survey98.pdf](http://www.undpc.org/adhoc/crime/corruption_uganda_survey98.pdf). (May 2001).
- CIHI (1995). Uganda. Country Health Profile 1995. CIHI Country Health Profile Series, Centre for International Health Information, [www.cihi.ca/eindex.htm](http://www.cihi.ca/eindex.htm). (January 1997).
- Cohen, J. M. (1995). "Capacity building in the public sector: a focused framework for analysis and action." International Review of Administrative Science 61: 407-422.
- Colclough, C. (1997). Education, health, and the market: An introduction. Marketising Education and Health in Developing Countries. C. Colclough. Oxford, Clarendon Press: 3-36.
- Collins, C. and A. Green (1994). "Decentralisation and primary health care: some negative implications in developing countries." International Journal of Health Services 24(3): 459-475.
- Commonwealth Secretariat (1988). Mechanisms for Collaboration between Government and NGOs with Special Reference to Universal Child Immunisation. Regional Workshop in the Health Field, Apia, Western Samoa 15-17 March 1988, Commonwealth Secretariat.
- Cornwall, A. et al. (2000). "Introduction: Accountability through participation. Developing workable partnership models in the health sector." IDS Bulletin 31(1): 1-13.
- Corry, D., R. Radcliffe, et al. (1997). Public-Private Partnerships: A Marriage of Convenience or a Permanent Commitment? London, Institute for Public Policy Research.
- Coulibaly, S. and B. Diallo (2000). Financement de la santé et équité dans l'accès aux soins dans les communes "V" et "VI" du district de Bamako. Paper presented at the conference "Health System Financing in Low-Income African and Asian Countries, 30 November - 1 December 2000, Clermont Ferrand.
- Crabtree, B. et al. (1993). Selecting individual or group interviews. Successful Focus Groups: Advancing the State of the Art. David Morgan. Newbury Park, California, Sage: 137-152
- DANIDA (1995). Review of the DANIDA Decentralisation Program. June 1995, DANIDA, Kampala.
- DANIDA (1997). Uganda Country Study. Kampala.
- Dayton, J. (1998). World Bank HIV/AIDS Interventions. Ex-ante and ex-post evaluation. Background paper for 'Confronting AIDS. Public priorities in a global epidemic'. World Bank Discussion Paper No. 389, World Bank.

- Ddungu, E. (1989). Popular Forms and the Question of Democracy: The Case of Resistance Councils in Uganda. Kampala, Centre for Basic Research.
- de Hann, A. (1999). Social exclusion: towards a holistic understanding of deprivation. London, Department for International Development  
[http://www.dfid.gov.uk/public/what/advisory/group7/pdf/sdd\\_socex.pdf](http://www.dfid.gov.uk/public/what/advisory/group7/pdf/sdd_socex.pdf) (June 2001).
- de Janvry, A., E. Sadoulet, E. Thorbecke (1993). "Introduction." World Development 21(4): 565-575.
- de Soto, H. (1989). The Other Path: The Invisible Revolution in the Third World. New York, Harper&Row.
- Deininger, K. and A. Crommelynck (2001). Did User fees Reduce Access to Health Care by the Poor? Evidence from Uganda. Washington, D.C., World Bank, July 2001.
- Devereux, S. and J. Hoddinott, Eds. (1992). Fieldwork in Developing Countries. New York et al., Harvester Wheatsheaf.
- DFID (1999). Better Health for Poor People. London, DfID.
- Diamond, L. (1994). "Rethinking civil society. Towards democratic consolidation." Journal of Democracy 5(3): 4-17.
- Dicklitch, S. (1998). The Elusive Promise of NGOs in Africa: Lessons from Uganda. New York, St. Martin's Press.
- Dodge, C. P. and P. D. Wiebe (1985). Crisis in Uganda: The Breakdown of Health Services. Oxford, Pergamon Press.
- Drummond, M. F. et al. (1987). Methods for the Economic Evaluation of Health Care Programs. Oxford et al., Oxford University Press.
- Enns (1985). The clocks have stopped in Uganda. Crisis in Uganda: The Breakdown of Health Services. C. P. Dodge and P. D. Wiebe. Oxford et al., Pergamon Press: 53-56.
- Esman, M. J. and N. T. Uphoff (1984). Local Organisations: Intermediaries in Rural Development. Ithaca, Cornell University Press.
- Evans, P. B., Ed. (1997). State-Society Synergy: Government and Social Capital in Development. Research series / University of California at Berkeley, International and Area Studies; no. 94. Berkeley, California, University of California at Berkeley International and Area Studies.
- Evans, P. B. (1997a). Government action, social capital, and development: reviewing the evidence of synergy. State-Society Synergy: Government and Social Capital in Development. P. B. Evans. Berkeley, Calif., University of California at Berkeley International and Area Studies: 178-210.
- Evans, P. B. (1997b). Introduction: Development strategies across the public-private divide. State-society Synergy: Government and Social Capital in Development. P. B. Evans. Berkeley, Calif., University of California at Berkeley International and Area Studies: 1-10.
- Fabricant, S., C. W. Kamara, A. Mills (1999). "Why the poor pay more: Household curative expenditure in rural Sierra Leone." International Journal of Health Planning and Management 14: 179-199.
- Fallers, L. A. (1965). Bantu Bureaucracy: A Century of Political Evolution among the Basoga of Uganda, Chicago U.P.
- Fals-Borda, O. (1987). "The theory and practice of participatory action research." EADI Bulletin 1: 41-47.
- Farrington, J., A. Bebbington, et al. (1993). Reluctant Partners? Non-Governmental Organisations, the State and Sustainable Agricultural Development. London, Routledge.
- Filmer, D. and L. Pritchett (1998). The Effects of Household Wealth on Educational Attainment: Demographic and Health Survey Evidence. Washington, D.C., World Bank, September 1998.
- Finsterbusch, K. and W. van Wicklin (1987). "The contribution of beneficiary participation to development project effectiveness." Public Administration and Development 7: 1-23.

- Fisher, C. M. (1998). Resource Allocation in the Public Sector: Values, Priorities and Markets in the Management of Public Services. London, Routledge.
- Flessa, S. (1998). Das Konzept der Nachhaltigkeit in kirchlichen Krankenhäusern in Tansania. Evangelische Fachhochschule, Erlangen, unpublished paper.
- Flynn, N. (1993). Public Sector Management. Hemel Hempstead, Harvester-Wheatsheaf.
- Fowler, A. (1990). "Doing it better? Where and how NGOs have a "comparative advantage" in facilitating development." University of Reading, Agriculture Extension and Rural Development Department, AERDD Bulletin 28: 11-20.
- Fowler, A. (1991a). "The role of NGOs in changing state-society relations: Perspectives from Eastern and Southern Africa." Development Policy Review 9: 53-84.
- Fowler, A. (1991b). "What is different about managing non-government organisations (NGOs) involved in Third World Development." RRA-Notes 11: 75-81.
- Fowler, A. (1998). "Authentic NGO partnerships in the new policy agenda for international aid." Development and Change: 137-159.
- Frances, J. et al. (1991). Introduction. Markets, Hierarchies and Networks. J. Frances et al. London et al., Sage: 1-20.
- Frey, J.H. and A. Fontana (1993). The group interview in social research. Successful Focus Groups: Advancing the State of the Art. David Morgan. Newbury Park, California, Sage: 20-34
- Gilson, L., P. D. Sen, M. Shirin (1994). "The potential of health sector non-governmental organisations: policy options." Health Policy and Planning 9(1): 14-24.
- Gilson, L. et al. (1997). Should African governments contract out clinical health services to church providers? Private Health Providers in Developing Countries. Serving the Public Interest? S. Bennett, B. McPake and A. Mills. London, New Jersey, Zed Books: 276-302.
- Girard, J. E. and V. M. Ridde (2000). L'Equité d'accès aux services de santé pour les indigents dans un contexte africain de mise en oeuvre de l'initiative de Bamako, Paper presented at the conference "Health System Financing in Low-Income African and Asian Countries, 30 November - 1 December 2000, Clermont Ferrand.
- Giusti, D. (1998). "Not for profit. What is it?" Newsletter of the Uganda Catholic Medical Bureau Bulletin 1(1): 11-13.
- Golooba-Mutebi, F. (1999). Decentralisation, Democratisation and Development Administration in Uganda, 1986-1996: Limits to Popular Participation. Ph.D. Thesis, University of London.
- GoU (1987). Report of the Commission of Inquiry into Local Government System. Entebbe, Government Printer.
- GoU/MoH (1997). Draft Health Policy 1997. Ministry of Health, Entebbe.
- GoU/MoLG (1993a). Decentralisation in Uganda. The Policy and its Implications. No. 2. Kampala, Ministry of Local Government/Decentralisation Secretariat.
- GoU/MoLG (1993b). Decentralisation: The Policy and its Philosophy. No. 1. Kampala, Ministry of Local Government/Decentralisation Secretariat.
- Green, A. (1987). "The role of non-governmental organisations and the private sector in the provision of health care in developing countries." International Journal of Health Planning and Management 2: 37-58.
- Green, A. (1990). "Health economics: are we being realistic about its value." Health Policy and Planning 3(3): 274-279.
- Green, A. (1992). An introduction to health planning in developing countries. Oxford, Oxford University Press.

- Green, A. and A. Matthias (1995). "NGOs - A policy panacea for the next millenium?" Journal of International Development 7(3): 565-573.
- Gretschmann, K. (1985). Solidarity and markets. Guidance, Control, and Evaluation in the Public Sector: the Bielefeld Interdisciplinary Project. F. X. Kaufmann, G. Majone and V. Ostrom. Berlin, New York, W. de Gruyter: 387-406.
- Griffin, C. C. (1988). User Charges for Health Care in Principle and Practice. An EDI Seminar Paper No. 37, Washington, D.C., World Bank.
- Griffin, C. C. and P. Shaw (1995). Health insurance in Sub-Saharan Africa: Aims, findings, policy implications. Financing Health Services through User Fees and Insurance. Case Studies from Sub-Saharan Africa. P. Shaw and M. Ainsworth. World Bank Discussion Papers, No. 2944, Africa Technical Department Series, Washington D.C., World Bank: 143-167.
- Grindle, M. S. (1997). Getting Good Government. Capacity Building in the Public Sectors of Developing Countries. Harvard, Harvard University Press.
- Grindle, M. S. (2000). New rules of the game: Theory, practice, and poverty, Paper prepared for the conference on "New Institutional Theory, Institutional Reform and Poverty Reduction", Development Studies Institute (DESTIN), London School of Economics, September 2000.
- Grindle, M. S. and M. E. Hildebrand (1995). "Building sustainable capacity in the public sector: What can be done?" Public Administration and Development 15: 441-463.
- Gwatkin, D. R. et al. (2000). Socio-Economic Differences in Health, Nutrition, and Population in Uganda. Washington, D.C., HNP/Poverty Thematic group, World Bank, May 2000.
- Haddad, S., et al. (1998). "What does quality mean to lay people? Community perceptions of primary health care services in Guinea." Social Science and Medicine 47(3): 381-394.
- Hall, R. H. et al. (1977). "Patterns of Interorganisational Relationships." Administrative Science Quarterly 22: 457-474.
- Hanf, K. and L. J. O'Toole (1992). "Revisiting old friends - networks, implementation structures and the management of inter-organizational relations." European Journal of Political Research 21(1-2): 163-180.
- Hegner, F. (1985). Solidarity and hierarchy: Institutional arrangements for the coordination of actions. Guidance, Control, and Evaluation in the Public Sector: the Bielefeld Interdisciplinary Project. F. X. Kaufmann, G. Majone and V. Ostrom. Berlin, New York, W. de Gruyter: 407-429.
- Hentschel, J. (1999). "Contextuality and data collection methods: A framework and application to health service utilisation." The Journal of Development Studies 35(4): 64-94.
- Hewitt, T. (2000). A hybrid or a third Way? Contemporary thinking on inter-organisational relationships. Managing Development: Understanding Inter-organisational Relationships. D. Robinson, T. Hewitt and J. Harriss. London et al., Sage: 49-66.
- Hill, W., R. Fehlbaum, P. Ulrich (1989). Organisationslehre: Ziele, Instrumente und Bedingungen der Organisation sozialer Systeme. Band 1. Bern et al.
- Hirschman, A. O. (1970). Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States. Cambridge/Mass, London, Harvard University Press.
- Hiscock, J., A. LaFond, J. White (1993). Sustainability in the health sector, part I: Uganda Case Study. London: Save the Children Fund.
- Hofstede, G. (1980). Culture's Consequences: International Differences in Work-Related Values. Beverly Hills, London.
- Hofstede, G. (1991). Levels of culture and national cultures in four dimensions. Cultures and Organisations: Software of the Mind. G. Hofstede. London, McGraw-Hill.

- Hollingsworth, J. R. et al. (1994). Governing Capitalist Economies: Performance and Control of Economic Sectors. New York, Oxford University Press.
- Hongoro, C. and L. Kumaranayake (2000). "Do they work? Regulating for-profit providers in Zimbabwe." Health Policy and Planning 15(4): 368-377.
- Howard-Grabham, L. (2000). "Bridging the gap between communities and service providers. Developing accountability through community mobilisation approaches." IDS Bulletin 31(1): 88-96.
- HRW (1999). Hostile to Democracy. The Movement System and Political Repression in Uganda. New York, Human Rights Watch.
- Hulme, D. and M. Edwards (1997). NGOs, States and Donors: Too Close for Comfort? Basingstoke, Macmillan in association with Save the Children.
- Hutchinson, P. (1999). Health Care in Uganda. Selected Issues. World Bank Discussion Paper No. 404, Washington, D.C., World Bank.
- Huxham, C. (1996). Creating Collaborative Advantage. London, Thousand Oaks, California, Sage.
- Hyden, G. (1989). Reciprocity and governance in Africa. The Failure of the Decentralised State. Institutions and Self-Governance in Africa. J. Wunsch and D. Oluwu. Boulder, Westview Press: 245-269.
- Hyden, G. and M. Bratton (1992). Governance and Politics in Africa. Boulder, Colorado, L. Rienner.
- Iliffe, J. (1998). East African Doctors. A History of the Modern Profession. Cambridge, University Press.
- Israel, A. (1987). Institutional Development: Incentives to Performance. Baltimore, London, John Hopkins University Press.
- Jakab, M. and C. Krishnan (2001). Community Involvement in Health Care Financing: Impact, Strengths and Weaknesses. A Synthesis of the Literature. Washington, D.C., World Bank, HDNHE, mimeo, June 2001.
- Jann, W. (1983). Staatliches Handeln und Verwaltungskultur. Baden-Baden, Nomos-Verlag.
- Jansen, D. and K. Schubert (1995). Netwerkansätze, Netzwerkforschung und Politikproduktion: Ansätze zur 'cross-fertilisation'. Netzwerke. D. Jansen and K. Schubert. Opladen, Westdeutscher Verlag: 9-23.
- Janzen, J. M. and W. Arkininstall (1978). The Quest for Therapy in Lower Zaire. Berkeley, University of California Press.
- Jessen, B. (1995). Einleitung. Von der Fremdsteuerung zur Selbststeuerung - Alternativer Interventionismus asiatischer NGOs. B. Jessen. Hamburg: 7-34.
- Jing, F. (2000). "Participation. A way to better health outcomes?" IDS Bulletin 31(1): 37-42.
- Jitta, J. (1996). Children's illnesses. Mothers' definition and management of 'serious enough' symptoms. Kampala Women Getting By. Wellbeing in the Time of AIDS. S. Wallman. London et al., James Currey: 152-165.
- Joensson, B. and P. Musgrove (1997). Government financing of health care. Innovations in Health Care Financing. G. J. Schieber. Proceedings of a World Bank Conference, March 10-11, 1997, Washington, D.C., World Bank.
- Kafuko, J. et al. (1993). Rational Drug Use in Rural Health Units of Uganda: Effect of National Standard Treatment Guidelines on Rational Drug Use. Kampala, MoH
- Kaharufa F. et al. (1996). Private disease. Kampala Women Getting By. Wellbeing in the Time of AIDS. S. Wallman. London et al., James Currey: 166-188.
- Kasekende, L. A. and M. Atingi-Ego (1999). "Uganda's experience with aid." Journal of African Economics 8(4): 617-649.
- Kassimir, R. (1995). Catholics and political identity in Toro. Religion and Politics in East Africa. H. B. Hansen and M. Twaddle. London, James Currey: 120-140.

- Kassimir, R. (1998). "Social power of religious organisation and civil society: The Catholic Church in Uganda." Journal of Commonwealth and Comparative Politics 36(2): 54-83.
- Kasumba, D. G. (1998). "Enhancing the decentralisation process in Uganda - The Role of NGOs." DENIVA News(January-March 1998): 222-4.
- Kaufmann, F. X., G. Majone, et al. (1985). Guidance, Control, and Evaluation in the Public Sector: the Bielefeld Interdisciplinary Project. Berlin ; New York, W. de Gruyter.
- Kaufmann, F. X. (1985). The relationship between guidance, control, and evaluation. Guidance, Control, and Evaluation in the Public Sector: the Bielefeld Interdisciplinary Project. F. X. Kaufmann, G. Majone and V. Ostrom. Berlin, New York, W. de Gruyter: 211-228.
- KDA (1991). Baseline Data. Kamuli District Administration, Planning Unit.
- KDA (1997). Kamuli District Baseline Data. Kamuli District Administration, Planning Unit.
- KDA (1998). District Health Committee Report to Kamuli District Local Council Meeting. Kamuli District, 12th March 1999.
- Kenis, P. and V. Schneider (1991). Policy networks and policy analysis: Scrutinising a new analytical tool. Policy Networks. Empirical Evidence and Theoretical Considerations. B. Marin and R. Mayntz. Frankfurt, Campus.
- Kickert, W. J. M., E.-H. Klijn, et al. (1997). Managing Complex Networks: Strategies for the Public Sector. London, Thousand Oaks, California, Sage.
- Killingsworth, J. et al. (1999). "Unofficial fees in Bangladesh: price, equity and institutional issues." Health Policy and Planning 14(2): 152-163.
- King, M. (1966). Medical Care in Developing Countries: A Primer on the Medicine of Poverty and a Symposium from Makerere. Nairobi, Oxford University Press.
- Kipp, W. A. Kielmann, E. Gwered (1991). "Postwar Uganda: A review of health services in Kabarole District." International Journal of Health Planning and Management 6: 221-228.
- Kipp, W. et al. (1994). "Monitoring of primary health care services: an example from Western Uganda." Health Policy and Planning 9(2): 155-160.
- Kironde, E. (1985). A village perspective of health services in Buganda. Crisis in Uganda: The Breakdown of Health Services. C. P. Dodge and P. D. Wiebe. Oxford et al., Pergamon Press: 65-68.
- Kisubi, M. and J. Mugaju, Eds. (1999). Rural Health Providers in South-West Uganda. Kampala, Fountain Publisher.
- Kjaer, M. (1999). "Fundamental changes or no change? The process of constitutionalising Uganda." Democratisation 6(4): 93-113.
- Klempp, L. (1997). "Ein Volk bricht nicht auf - Entwicklungspolitische Überlegungen zur Zivilgesellschaft in Tanzania." Aus Politik und Zeitgeschichte(B9): 19-29.
- Klijn, E.-H. (1997). Policy networks: An overview. Managing Complex Networks: Strategies for the Public Sector. W. J. M. Kickert, E.-H. Klijn and J. F. M. Koppenjan. London, Thousand Oaks, Sage: 14-34.
- Kooiman, J. (1993). Modern Governance: New Government-Society Interactions. London, Sage.
- Koppenleitner, R. and A. T. Mpabulungi (1997). Evaluation of DED Interventions in two Health Districts in Uganda. Kampala, Deutscher Entwicklungsdienst.
- Korten, D. C. (1987). "Third generation NGO strategies: A key to people-centered development." World Development 15(Supplement): 145-159.
- Korten, D. C. (1990). Getting to the 21st Century: Voluntary Action and the Global Agenda. West Hartford/Connecticut.
- Kostansjek, N. (1997). District Health Management under the Decentralised System. A Case Study of Tororo District. DED, Kampala.

- Krause, G. et al. (1999). "Rationality of drug prescription in rural health centres in Burkina Faso." Health Policy and Planning 14(3): 291-298.
- Krueger, R. (1998). Moderating Focus Groups. Focus Group Kit 4. Thousand Oaks et al., Sage.
- Kruesselberg, H.-G. (1985). Markets and hierarchies. Guidance, Control, and Evaluation in the Public Sector: the Bielefeld Interdisciplinary Project. F. X. Kaufmann, G. Majone and V. Ostrom. Berlin, New York, W. de Gruyter: 349-386.
- Kumaranayake, L. (1998). Economic Aspects of Health Sector Regulation: Strategic Choices for Low and Middle Income Countries. London, Department of Public Health and Policy. Health Policy Unit.
- Kumaranayake, L. et al. (2000). "How do countries regulate the health sector? Evidence from Tanzania and Zimbabwe." Health Policy and Planning 15(4): 357-367.
- Kwagala, B. (1997). The Role of NGOs in the Delivery of Health and Water Services in Uganda. The Quest for Good Governance: Decentralisation and Civil Society in Uganda. Research Project, MISR, Kampala.
- Kwesiga, J. (1995). The challenges of indigenous NGOs and CBOs in Uganda, Paper presented at the Regional Conference of the German Development Service on 16 June 1995, Kampala.
- LaFond, A. K. (1995). "Improving the quality of investment in health: lessons on sustainability." Health Policy and Planning 10(Supplement): 63-76.
- Langseth, P. and J. Mugaju (1996). Towards reconstruction. Post-Conflict Uganda: Towards an Effective Civil Service. P. Langseth and J. Mugaju. Kampala, Fountain Publishers: 17-33.
- Larmour, P. (1997). "Models of governance and public administration." International Review of Administrative Sciences 63: 383-394.
- Lavy, V. and J.-M. Germain (1994). Quality and Cost in Health Care Choice in Developing Countries. Washington, D.C, World Bank.
- Le Grand, A. et al. (1999). "Intervention research in rational use of drugs: a review." Health Policy and Planning 14(2): 89-102.
- Leonard, D. K. (1983). Interorganisational linkages for decentralised rural development: Overcoming administrative weaknesses. Decentralisation and Development: Policy Implementation in Developing Countries. G. S. Cheema and D. A. Rondinelli. Beverly Hills. 271-293.
- Leonard, D.K., Ed. (2000). Africa's Changing Markets for Health and Veterinary Services: The New Institutional Issues. London, McMillan Press.
- Leonard, D. K. (2000a). Introduction. Africa's Changing Markets for Health and Veterinary Services: The New Institutional Issues. D. K. Leonard. London, McMillan Press: 1-39.
- Leonard, D. K. (2000b). Lessons from the New Institutional Economics for the structural reform of human health services in Africa. Africa's Changing Markets for Health and Veterinary Services: The New Institutional Issues. D. K. Leonard. London, MacMillan Press: 260-292.
- Leonard, K. D. (2000). African traditional healers and moral hazard in the supply of medical effort, Paper presented at the conference "Health System Financing in Low-Income African and Asian Countries, 30 November - 1 December 2000, Clermont Ferrand.
- Leonard, K. D. (2001). 'Active patients' in rural African health care: Implications for welfare, policy and privatisation, Paper presented at the Annual Bank Conference for Development Economics, World Bank, Washington, D.C., May 2001.
- Leonard, K. D. and D. K. Leonard (1998). Institutional solutions to the principal-agent problem in African health care. Columbia University, Department of Economics, Discussion Paper Series No. 9899-02, October 1998.

- Leonard, K. D. and D. K. Leonard (1999). Asymmetric information and the role of NGOs in African health care. Columbia University, Department of Economics, Discussion Paper Series No. 9899-09, July 1999.
- Leonard, K. D. and D. K. Leonard (2000). The Political Economy of Improving Health Care for the Poor in Rural Africa: Institutional Solutions to the Principal-Agent Problem. Paper prepared for the conference on "New Institutional Theory, Institutional Reform and Poverty Reduction", Development Studies Institute (DESTIN), London School of Economics, September 2000.
- Leonard, K. D. and G. Mliga (2000). Bypassing health centres in Tanzania: Revealed preferences for quality, Paper presented at the conference "Health System Financing in Low-Income African and Asian Countries, 30 November - 1 December 2000, Clermont Ferrand.
- Lingnau, H. (1996). Lean Management als Konzept zur Reform öffentlicher Verwaltungen in Afrika südlich der Sahara. Überlegungen am Beispiel Benins und Uganda. Berlin, DIE.
- Livingstone, I. and R. Charlton (1998). "Raising local authority revenues through direct taxation in a low-income developing country. Evaluating Uganda's GPT." Public Administration and Development 18(5): 499-517.
- Loewenson, R. (2000). "Public participation in health systems in Zimbabwe." IDS Bulletin 31(1): 14-20.
- Lubanga, F. X. K. (1996). The Process of decentralisation. Democratic Decentralisation in Uganda. S. Villadsen and F. X. K. Lubanga. Kampala, Fountain Publishers: 47-59.
- Mackintosh, M. (1992). Questioning the state. Development Policy and Public Action. M. Wuyts. Oxford: 61-90.
- Mackintosh, M. (1999). Informal regulation: a conceptual framework and application to decentralised mixed health care systems. Economic Decentralisation and Public Management Reform. M. Mackintosh and R. Roy. Cheltenham Northampton, MA, Edward Elgar: 149-175.
- Mackintosh, M. and P. Tibandebage (2000). Sustainable redistribution with health care markets? Rethinking regulatory intervention in the Tanzanian context, Paper prepared for the conference on "New Institutional Theory, Institutional Reform and Poverty Reduction", Development Studies Institute (DESTIN), London School of Economics, September 2000.
- Macrae, J., A. Zwi, H. Birungi (1994). A Healthy Peace? Rehabilitation and Development of the Health Sector in a 'Post'-Conflict Situation: The Case of Uganda. London, LSHTM, research report.
- Macrae, J., A. Zwi, L. Gilson (1996). "A triple burden for health sector reform: 'Post'-conflict rehabilitation in Uganda." Social Science and Medicine 42(7): 1095-1108.
- Maddick, H. (1993). Democracy, Decentralisation and Development. London, Asia Publishing House.
- Mahal, A., V. Srivastava, D. Sanan (1997). Decentralisation and Public Sector Delivery of Health and Education Services: The Indian Experience. ZEF-Discussion Papers on Development Policy No. 20, Centre for Development Research, ZEF, Bonn, January 2000.
- Majone, G. (1985). Mutual adjustment by debate and persuasion. Guidance, Control, and Evaluation in the Public Sector: the Bielefeld Interdisciplinary Project. F. X. Kaufmann, G. Majone and V. Ostrom. Berlin, New York, W. de Gruyter: 445-458.
- Makara, S. (1997). Institutional Relationships between Political and Administrative Leaders in the Decentralisation Process. Kampala, MISR.
- Mamdani, M. (1994). Pluralism and the right of association. Uganda. Studies in Living Conditions, Popular Movements, and Constitutionalism. M. Mamdani and J. Oloka-Onyango. Vienna: 519-563.
- Mamdani, M. (1995). The politics of democratic reform in Uganda. Uganda. Landmarks of Rebuilding a Nation. P. B. Langseth et al. Kampala, Fountain Publishers: 229-239.
- Mamdani, M. (1996). Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism. Princeton, N.J, Princeton University Press.

- Mangold, W. (1973). Gruppendiskussionen. Handbuch der empirischen Sozialforschung. Band 2: Grundlegende Methoden und Techniken der empirischen Sozialforschung, Erster Teil. R. König. Stuttgart: 228-259.
- Marshall, A. (1991). On markets. Markets, Hierarchies and Networks. J. Frances et al. London et al., Sage: 24-34.
- Martineau, T. (2000). Health reforms and human resources: understanding the incentives, Paper presented at the conference on "Health sector reform: equity, efficiency, sustainability", Dhaka, 3-6 July, 2000.
- Mathauer, I. (1997). Ansatzpunkte für Selbsthilfeförderung nach dem Subsidiaritätsprinzip durch den DED. Subsidiaritätsförderung Länderbericht Uganda. Teil I. Berlin, ded.
- Mathauer, I. (1998). Entry Points for the Promotion of Subsidiarity. Country Study Report Uganda. Part II. Berlin, ded.
- Mathauer, I. (2000). Zur Suche nach komparativen Vorteilen in Interaktionsbeziehungen auf lokaler Ebene am Beispiel des Subsidiaritätsförderungsprojekts in Kamuli District, Uganda. Subsidiaritätsprinzip, Dezentralisierung und local government - Konzeptionelle Fragen und Fallbeispiele aus drei Kontinenten. Beiträge des Arbeitskreises "Entwicklung und Verwaltung". K. Bodemer. Hamburg, Institut für Iberoamerika-Kunde: 29-53.
- Mathauer, I. (2001). "Institutional Capacity Assessment and Ways of Strengthening. Report on the Pre-Appraisal Mission of the Nutrition Enhancement Program, March 15-30, World Bank, HDNHE, Washington D.C., April 2001."
- Mathauer, I. and S. Ng (1997). Urban management through decentralisation. A City for All. Valuing Difference and Working with Diversity. J. Beall. London, Zed Books: 240-251.
- Mathiowetz, N. (2000). Retrospective recall: A review of the effects of length of recall on the quality of survey data, Proceedings of the 4th International Conference on Methodological Issues in Official Statistics, Stockholm, October 12-13, 2000, [www.scb.se/omsch/proceedings.asp](http://www.scb.se/omsch/proceedings.asp). (December 2000).
- McCord, M. J. (2001). "Health care micro-insurance - case studies from Uganda, Tanzania, India, and Cambodia." Small Enterprise Development 12(1): 25-38.
- McKay, R. B. et al. (1996). Translating survey questionnaires: lessons learned. Advances in Survey Research. New Directions for Evaluation. M. T. Braverman et al. San Francisco, Jossey-Bass.
- McPake, B. (1997). The role of the private sector in health service provision. Private Health Providers in Developing Countries. Serving the Public Interest? S. Bennett, B. McPake and A. Mills. London, New Jersey, Zed Books: 102-123.
- McPake, B., K. Hanson, A. Mills (1993). "Community financing of health care in Africa: An evaluation of the Bamako Initiative." Social Science and Medicine 36(11): 1383-1395.
- McPake, B. and E. E. Ngalande-Banda (1994). "Contracting out of health services in developing countries." Health Policy Planning 9(1): 25-30.
- McPake, B. et al. (1998). The Economic Behaviour of Health Workers in Uganda: Implications for Quality and Accessibility of Public Health Services. PHP Departmental Publication, No. 27. London School of Hygiene and Tropical Medicine.
- McPake, B. et al. (1999). "Informal economic activities of public health workers in Uganda: implications for quality and accessibility of care." Social Science and Medicine 49: 849-865.
- Meng, Q., X. Liu, J. Shi (2000). "Comparing the services and quality of private and public clinics in rural China." Health Policy and Planning 15(4): 349-356.
- Messner, D. (1995). Die Netzwerkgesellschaft. Wirtschaftliche Entwicklung und internationale Wettbewerbsfähigkeit als Probleme gesellschaftlicher Steuerung. Köln, Weltforum Verlag.
- MFEP (1992). The 1991 Population and Housing Census (District Summary Series), Kamuli District. Statistics Department, MFEP, Entebbe.

- MFEP (1993). Realising the Development Potential of NGOs and Community Groups in Uganda. MFEP, Kampala.
- Mills, A. (1994). "Decentralisation and accountability in the health sector from an international perspective: what are the choices?" Public Administration and Development 14: 281-292.
- Mills, A. (1997a). Contractual relationships between government and the commercial private sector in developing countries. Private Health Providers in Developing Countries. Serving the Public Interest? S. Bennett et al. London, New Jersey, Zed Books: 189-213.
- Mills, A. (1997b). Improving the efficiency of Public health services in developing countries: Bureaucratic versus market approaches. Marketising Education and Health in Developing Countries. C. Colclough. Oxford, Clarendone Press: 245-274.
- Mills, A., S. Bennett, B. McPake (1997). Future research directions. Private Health Providers in Developing Countries. Serving the Public Interest? S. Bennett, B. McPake and A. Mills. London, New Jersey, Zed Books: 303-312.
- MISR (1997). Study on the Effects of the Decentralisation Reform in Uganda. MISR, Kampala.
- Mitchell, J. (1991). Hierarchies. Introduction. Markets, Hierarchies and Networks. J. Frances et al. London et al., SAGE Publications: 105-107.
- Mliga, G. R. (2000). Decentralisation and the quality of health care in Tanzania. Africa's Changing Markets for Health and Veterinary Services: The New Institutional Issues. D. K. Leonard. London, McMillan Press: 203-223.
- MoA (1998). Guidelines for Integrating NGO Activities into Governmental Agricultural Programs. Stakeholders Task Force, Ministry of Agriculture, Entebbe, February 1998.
- Mogedal, S., S. S. Hogden, G. Mpelumbe (1995). "Health sector reform and organisational issues at the local level: Lessons from selected African countries." Journal of International Development 7(3): 349-367.
- MoH (1997). Draft Health Policies for Uganda 1997 - 2001. Entebbe, MoH.
- MoH (1998a). Government statement on the health sector at the pre-consultative group session of the consultative group meeting. Kampala, MoH.
- MoH (1998b). Uganda National Health Policy, Draft. Kampala, MoH.
- MoH (2001). Programs and Policies. [www.health.go.ug/policies.html](http://www.health.go.ug/policies.html) (May 2001).
- MoH/Permanent Secretary (1997). Overview of Decentralisation in Health, Paper presented at the National Conference for All District Medical Officers and Medical Superintendents at the International Conference Centre, 17-19 July, 1997.
- MoH/Permanent Secretary (1998). Guidelines on the use of delegated funds for PNFP hospitals, 1998/99. Entebbe, Ministry of Health.
- MoLG/Decentralisation Secretariat (1995). Decentralisation and the Block Grants System. Ministry of Local Government, Kampala.
- MoLG/Decentralisation Secretariat (1996). Decentralisation and the Block Grants System. Ministry of Local Government, Kampala.
- Montgomery, J. D. (1988). Bureaucrats and People: Grassroots Participation in Third World Development. Baltimore, London, Johns Hopkins University Press.
- Montiel, L. (1997). The Institutional Development of Local Government in Less Developed Countries: A Literature Review. Development Administration Group, Papers in the Administration of Development, No. 62.
- Moore, M. (1992). "Competition and pluralism in public bureaucracies." IDS bulletin 23(4): 65-77.

- Moore, M. (1996). Public Sector Reform: Downsizing, Restructuring, Improving Performance. Geneva, WHO, Forum of Health Sector Reform, Discussion Paper No. 7.
- Moran, M. and B. Wood (1993). States, Regulation and Medical Professions. Buckingham, Philadelphia, Open University Press.
- Morgan, D. L. and R. A. Krueger (1993). When to use focus groups and why. Successful Focus Groups: Advancing the State of the Art. Newbury Park, California, Sage: 3-19
- Müller, N. (1993). Rechtsformenwahl bei der Erfüllung öffentlicher Aufgaben (Institutional Choice). Köln et al.
- Mugaju, J. (1996). The road to collapse. Post-Conflict Uganda. Towards an Effective Civil Service. P. Langseth and P. Mugaju. Kampala, Fountain Publisher: 1-16.
- Mugaju, J. (1999). On the eve of the rural health programme. Rural Health Providers in South-West Uganda. M. Kisubi and J. Mugaju. Kampala, Fountain Publisher: 1-15.
- Mukyala Makiika, R. (1997). The Quest for Good Governance: Decentralisation and Civil Society in Uganda, and the Role of Traditional Leaders in the Promotion of Good Governance and Democratisation. Kampala, MISR.
- Munene, J. C. (1991). "Organisational environment in Africa - a factor analysis of critical incidents." Human Relations 44(5): 439-458.
- Munene, J. C. (1993). Organisational Pathology and Accountability in Health and Education in Rural Uganda. Kampala, Makerere University, Department of Psychology, December 1993.
- Munene, J. C. (1995). Organisational pathology and accountability in health and education in rural Uganda. Uganda. Landmarks in Rebuilding a Nation. P. Langseth, J. Katorobo, E. A. Brett and J. Munene. Kampala, Fountain Publisher: 133-154.
- Munene, J. C. et al. (1997). Exploration into the cultural dimensions of African productivity. Draft, First Paper presented at OSSREA Conference on Africa in the Year 2000, University of Western Cape, South Africa on 3-10 November, 1996, Kampala.
- Munene, J. C., S. H. Schwartz, P. B. Smith (2000). "Development in Sub-Saharan Africa: Cultural influences and managers' decision behaviour." Public Administration and Development 20: 339-351.
- Musau, S. N. (1999). Community-Based Health Insurance: Experiences and Lessons Learned from East and Southern Africa. Technical Report No. 34, Bethesda M.D., Partnerships for Health Reform. Abt. Associates Inc.
- Mutibwa, P. M. (1992). Uganda since Independence: A Story of Unfulfilled Hopes. London, Hurst.
- Nabuguzi, E. (1995). Popular initiatives in service provision in Uganda. Service Provision under Stress in East Africa. The State, NGOs and People's Organisations in Kenya, Tanzania and Uganda. O. Therkildsen and J. Semboja. London, James Currey: 182-208.
- Naschold, F. (1998). Zur Neubestimmung öffentlicher Aufgaben. Modernisierung des Staates. F. Naschold. Baden-Baden, Nomos-Verlag: 37-64.
- Ndyomugenyi, R., S. Neema, P. Magnussen (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.
- Neema, S. (1999). Women and rural health: The gender perspective. Rural Health Care Providers in South-west Uganda. M. Kisubi and J. Mugaju. Kampala, Fountain Publisher: 96-118.
- Neubert, E. (1997). Zivilgesellschaft in Ostafrika. Opladen, Westdeutscher Verlag.
- Ngalande-Banda, E. and G. Walt (1995). "The private health sector in Malawi: opening Pandora's box?" Journal of International Development 7(3): 403-422.
- Nicholls, L. (1998). From Paradigm to Practice: The Politics and Implementation of Sustainable Human Development in Uganda. Ph.D. thesis, University of London.

- Niskanen, W. A. (1971). Bureaucracy and Representative Government. Chicago, Aldine.
- North, D. (1989). "Institutions and economic growth: A historical introduction." World Development 17(9): 1319-1332.
- North, D. C. (1990). Institutions, Institutional Change, and Economics Performance. Cambridge, Cambridge University Press.
- Nsibambi, A. (1995). Facilitators and inhibitors of decentralisation in Uganda. Strengthening African Local Initiative: Local Self-Governance, Decentralisation and Accountability. D. Rothchild. Institut für Afrikakunde, Hamburg: 109-120.
- Nsibambi, A. (1997a). Making democratic decentralisation an instrument of poverty eradication: Uganda's challenge. Paper presented at the UNDP's Development Forum, 4 April, 1997, Kampala.
- Nsibambi, A. (1997b). The Financing of Decentralisation for Good Governance in Uganda. The Quest for Good Governance. Decentralisation and Civil Society in Uganda - Research Project. MISR, Kampala.
- Nugent, J. B. (1993). "Between state, markets and households: A neoinstitutional analysis of local organisations and institutions." World Development 21(4): 623-632.
- Nwankwo, S. (1997). "State and market partnership for development: A review of development strategy for Sub-Saharan Africa." Review of Policy Issues 3(4): 3-23.
- Obbo, C. (1991). Women, children and a 'living wage'. Changing Uganda. H. B. Hansen and M. Twaddle. London, James Currey: 98-112.
- Ocaya-Lakidi, D. (1982). From local governments to mere local administrations, 1949-1972. Uganda: The Dilemma of Nationhood. G. N. Uzoigwe. New York et al., NOK Publishers International: 299-312.
- Ogden, J. and G. Bantebya-Kyomuhendo (1996). Home treatment. Kampala Women Getting By. Wellbeing in the Time of AIDS. S. Wallman. London, James Currey: 142-151.
- Ogunbekun, I., A. Ogunbekun, N. Orobato (1999). "Private health care in Nigeria: walking the tightrope." Health Policy and Planning 14(2): 174-181.
- Ojanuga, D. N. and C. Gilbert (1992). "Women's access to health care in developing countries." Social Science and Medicine 35(4): 613-617.
- Ojo, K. et al. (1998). Costing Minimum Health Care Package in Uganda. Kampala, MoH/WHO, November 1998.
- Okello, D. et al. (1994). "Low bed occupancy rates in Uganda's peripheral health units: Is it a policy problem?" East African Medical Journal 71(9): 601-603.
- Okello, D. O. et al. (1997). Aspects of the Private For-Profit Health Sector in Uganda: An Appraisal of Scope and Impact. Kampala. Final Report of Phase II of the Health Policy Analysis and Development Group (HPADG), April 1997.
- Okello, D. O. et al. (1998). "The challenge to restoring basic health care in Uganda." Social Science and Medicine 46(1): 13-21.
- Okullo, B. A. (1998). Speech by the Guest of Honour at the Opening of UCBHCA's 13th Annual General Meeting, Hon. Betty Akech Okullo, Minister of State for Health in Charge of Primary Health Care, 26th November 1998. Kampala, UCBHCA.
- Okuonzi, S. A. and J. Macrae (1995). "Whose policy is it anyway? International and national influences on health policy development in Uganda." Health Policy and Planning 10(2): 122-132.
- Oloka-Onyango, J. (2000). "Poverty, human rights and the quest for sustainable human development in structurally-adjusted Uganda." Netherlands Quarterly of Human Rights 18(1): 23-44.
- Omaswa, F. et al. (1997). "Introducing quality management into primary health care services in Uganda." Bulletin of the World Health Organisation 75(2): 155-161.

- Osborne, D. and T. Gaebler (1992). Reinventing Government: How the Entrepreneurial Spirit is Transforming the Public Sector. Reading, Mass, Addison-Wesley Publishing Company.
- Osborne, D. and P. Plastrik (1997). Banishing Bureaucracy. The Five Strategies for Reinventing Government. Reading et al., Addison-Wesley.
- Ostrom, E. (1996). Crossing the great divide: Co-production, synergy, and development. State-Society Synergy: Government and Social Capital in Development. P. Evans. Berkeley, California, University of California at Berkeley International and Area Studies: 85-118.
- Ostrom, E., L. D. Schroeder, S.G. Wynne (1993). Institutional Incentives and Sustainable Development: Infrastructure Policies in Perspective. Boulder, Westview Press.
- Palmer, N. and A. Mills (2000). Serious contractual difficulties? A case study of contracting for PHC in South Africa. Paper presented at the conference "Health System Financing in Low-Income African and Asian Countries, 30 November - 1 December 2000, Clermont Ferrand.
- Pannarunothai, S. and A. Mills (1997). "The poor pay more: Health-related inequality in Thailand." Social Science and Medicine 44(12): 1781-1790.
- Paul, S. (1988). Governments and grassroots organisations: From co-existence to collaboration. Strengthening the Poor: What Have We Learned? J. P. Lewis. New Brunswick, Oxford, Transaction Books: 61-71.
- Paul, S. (1992). "Accountability in public services: Exit, voice, and control." World Development 20(7): 1047-1060.
- Paul, S. (1994). Does Voice Matter? For Public Accountability Yes. Washington, D.C., World Bank, Policy Research Department.
- PCGM/Donor statement (1998). Donors Statement on the Health Sector. Kampala, Pre-consultative group meeting, December 8, 1998.
- Pearson, M. (1997). Hospital costing: A comparison of the efficiency of government and NGO facilities. Paper presented at the National Conference for All District Medical Officers and Medical Superintendents at the International Conference Centre, 17-19 July, 1997, Kampala.
- Perrot, J. (2000). Un partenariat basé sur des relations contractuelles: une option stratégique pour améliorer la performance des systèmes de santé. Paper presented at the conference "Health System Financing in Low-Income African and Asian Countries, 30 November - 1 December 2000, Clermont Ferrand.
- Perrot, J. and O. Adams (2000). Applying the Contractual Approach to Health Service Delivery in the Developing Countries. A Discussion Paper. Geneva, WHO, Department of Health Services Delivery.
- Pfeffer, J. and G. R. Salancik (1978). The External Control of Organizations: a Resource Dependence Perspective. New York, London, Harper & Row.
- Powell, W. W. (1991). Neither market nor hierarchy: Networks forms of organisation. Markets, Hierarchies and Networks. J. Frances et al. London et al., Sage: 265-276.
- Powell, W. W. and P. DiMaggio (1991). The New Institutionalism in Organizational Analysis. Chicago, University of Chicago Press.
- Preker, A. S., A. Harding, N. Girishankar (1999). The economics of private participation in health care: New insights from institutional economics. Paper submitted to the International Social Security Association, August 1, 1999.
- Preker, A. and A. Harding (2001). The Economics of Public and Private Roles in Health Care: Insights from Institutional Economics and Organisational Theory. Washington, D.C., HNP, World Bank, June 2000.
- Preker, A. et al. (2001). Social Inclusion and Financial Protection through Community Financing. Initial Results from Five Household Surveys. Discussion Paper, World Bank, HDNHE, Washington, D.C., July 2001.

- Puentes-Markides, C. (1992). "Women and access to health care." *Social Science and Medicine* 35(4): 619-626.
- Ranger, T. (1983). The invention of tradition. *The Invention of Tradition*. E. J. Hobsbawm and T. O. Ranger. Cambridge, Cambridge University Press.
- Rhodes, R. A. W. (1997). *Understanding Governance: Policy Networks, Governance, Reflexivity and Accountability*. Buckingham, Open University Press.
- Richards, A. I. (1982). Changing local government policy, 1950-1970. *Uganda's First Republic: Chiefs, Administrators and Politicians, 1967-1971*. A. F. Robertson. African Studies Centre: Cambridge University.
- Riddell, R. (1990). *Judging Success: Evaluating NGO Approaches to Alleviating Poverty in Developing Countries*. London, Overseas Development Institute.
- Riddell, R. and M. Robinson (1993). *Working with the Poor: NGOs and Rural Poverty Alleviation*. manuscript, London (ODI).
- Riddell, R. and M. Robinson (1995). *Non-Governmental Organizations and Rural Poverty Alleviation*. Oxford, New York, Clarendon Press: Oxford University Press.
- Riddell, R., Z. Gwiyo, H. Mwesigye (1998). Review of National Policy on NGOs in Uganda. Kampala, August 1998, MFEP.
- Robertson, A. F., Ed. (1982). *Uganda's First Republic: Chiefs, Administrators, and Politicians, 1967-1971*. African Studies Centre: Cambridge University.
- Robinson, D., T. Hewitt, J. Harriss, Eds. (2000). *Managing Development. Understanding Inter-Organisational Relationships*. London, Thousand Oaks, New Delhi, Sage.
- Robinson, M. and G. White (1997). *The Role of Civic Organisations in the Provision of Social Services. Towards Synergy*. UNU/WIDER.
- Rogers, D. L. and D. L. Whetten, Eds. (1982). *Interorganisational Coordination: Theory, Research, and Implementation*. Ames, Iowa State University Press.
- Rondinelli, D. A. and G. S. Cheema (1983). Implementing decentralisation policies. An introduction. *Decentralisation and Development: Policy Implementation in Developing Countries*. G. S. Cheema and D. A. Rondinelli. Beverly Hills: 9-34.
- Rothchild, D. (1995). The debate on decentralisation in Africa: An overview. *Strengthening African Local Initiative: Local Self-Governance, Decentralisation and Accountability*. D. Rothchild. Institut für Afrikakunde, Hamburg: 1-12.
- RoU (1987). *Report of the Health Policy Review Commission*. Republic of Uganda, Kampala.
- RoU (1998). Health Sub-Districts in Uganda. Concept Paper. Draft III. Kampala, MoH, May 1998.
- RoU/MoH (1998a). National Health Strategic Plan, 1997/98 - 2001/02. Kampala, MoH, June 1998.
- RoU/MoH (1998b). Ten Year National Health Policy. Kampala, MoH, November 1998.
- Russell, S. (1996). "Ability to pay for health care: concepts and evidence." *Health Policy and Planning* 11(3): 219-237.
- Russell, S. and L. Gilson (1995). User Fees at Government Health Services: Is Equity Being Considered? London Health Research Unit, Department of Public Health and Policy, LSHTM.
- Russell, S. et al. (1997). *The Role of Government in Adjusting Economies. Paper 20. Zimbabwe: Reforming the Health Sector: Does Government Have the Capacity?*, London, ODA.
- Russell, S., S. Bennett, A. Mills (1999). "Policy arena. Reforming the health sector: towards a healthy New Public Management." *Journal of International Development* 11: 767-775.

- Salamon, L. M. (1987). Partner in public service: the scope and theory of government-nonprofit relations. The Nonprofit Sector. A Research Handbook. W. W. Powell. New Haven, Yale University Press: 99-117.
- Salamon, L. M. (1995). Partners in Public Service: Government-Nonprofit Relations in the Modern Welfare State. Baltimore, MD, Johns Hopkins University Press.
- Samoff, J. (1990). "Decentralisation: The politics of interventionism." Development and Change 21(3): 513-530.
- Sandberg, E. (1994). Introduction: The changing politics of non-governmental organisations and the African state. The Changing Politics of Non-Governmental Organisations and the African State. E. Sandberg. Connecticut, London: 1-31.
- Sathyamurthy, T. V. (1982). Central-Local Relations: the Case of Uganda. Manchester, University of Manchester.
- Scharpf, F. W. (1993). Games in Hierarchies and Networks. Frankfurt/Main, Campus Verlag.
- Scheyer, S. and D. Dunlop (1985). Health services and development in Uganda. Crisis in Uganda: The Breakdown of Health Services. C. P. Dodge and P. D. Wiebe. Oxford et al., Pergamon Press: 25-42.
- Schieber, G. and A. Maeda (1997). A Curmudgeon's guide to financing health care in developing countries. Innovations in Health Care Financing. Proceedings of a World Bank Conference, March 10-11, 1997. G. Schieber. Washington, World Bank: 1-38.
- Schmitter, P. C. (1993). Some Propositions about Civil Society and the Consolidation of Democracy. Institut für Höhere Studien, Reihe Politikwissenschaft, No. 10, September 1993.
- Schuppert, G. F. (1994a). Institutional Choice im öffentlichen Sektor. Staatsaufgaben. D. Grimm. Baden-Baden: 647-683.
- Schuppert, G. F. (1994b). Die Erfüllung öffentlicher Aufgaben durch die öffentliche Hand, private Anbieter und Organisationen des Dritten Sektors. Privatisierung öffentlicher Aufgaben. Private Finanzierung kommunaler Institutionen. J. Ipsen. 4. Bad Iburger Gespräche, Köln et al., Carl Heymanns Verlag: 17-35.
- Silva, T., S. Russell, C. Rakodi (1997). The Opinions of Health and Water Service Users in Sri Lanka. Birmingham, Development Administration Group, School of Public Policy, University of Birmingham.
- Simon, K. (1993). Subsidiarität als Rahmenbedingung für Entwicklung durch Armutsbekämpfung in Selbsthilfe. Subsidiarität in der Entwicklungszusammenarbeit: Dezentralisierung und Verwaltungsreformen zwischen Strukturanpassung und Selbsthilfe. K. Simon, A. Stockmayer and H. Fuhr. Baden-Baden, Nomos-Verlag: 45-83.
- Simon, K. (1994a). Lokale Selbstverwaltung in der Dritten Welt. Kommunalwissenschaftliche Analysen. O. W. Gabriel and R. Voigt. Bd. 13: Mobilität und Normenwandel. Bochum: 279-318.
- Simon, K. (1994b). Partner für Subsidiarität. ded Berlin.
- Simon, K., J. Fritz, N. Kostansjek (1993). Kommunalverwaltung und Selbsthilfe in der Dritten Welt: Zur Kooperation zwischen Kommunen und Selbsthilfeorganisationen. Subsidiarität in der Entwicklungszusammenarbeit: Dezentralisierung und Verwaltungsreformen zwischen Strukturanpassung und Selbsthilfe. K. Simon, A. Stockmayer and H. Fuhr. Baden-Baden, Nomos-Verlag: 323-361.
- Simon, K. et al. (1997). Ansatzpunkte für Selbsthilfe nach dem Subsidiaritätsprinzip durch den Deutschen Entwicklungsdienst. Studie im Auftrag des DED. Ergebnisbericht. Universität Konstanz.
- Simonet, M. (2000). Decentralising health services in Zambia: District choices and performance trends in nine case studies. Paper presented at the conference "Health System Financing in Low-Income African and Asian Countries, 30 November - 1 December 2000, Clermont Ferrand.

- Sinanovic, E. et al. (2000). Performance of private GPs under contract in South Africa: A comparative study of the cost and quality of primary care services provided by the public sector and private GPs under contract to the state. Paper presented at the conference "Health System Financing in Low-Income African and Asian Countries, 30 November - 1 December 2000, Clermont Ferrand.
- Smith, B. C. (1985). The Territorial Dimension of the State. London.
- Smith, S. and J. Sander (1987). Poverty, Class and Gender in Rural Africa. A Tanzanian Case Study. London, Routledge.
- Smithson, P. (1993). Sustainability in the Health Sector. Part 2: Financial Constraints to Health Sector Sustainability in Uganda. London, Save the Children Fund.
- Steinich, M. (1997). "Erst wenn wir unseren Kopf in unsere eigenen Hände nehmen können..." Subsidiaritätsförderung als Beitrag zur Armutsbekämpfung in Entwicklungsländern. Muenster, LIT-Verlag.
- Stockely, D. (1985). Primary health care in Teso, 1980-1984. Crisis in Uganda. The Breakdown of Health Services. C. P. Dodge and P. D. Wiebe. London, Pergamon Press: 221-226.
- Streeck, W. and P. Schmitter (1985). Community, market, state - and associations? The prospective contribution of interest governance to social order. Private Interest Government. Beyond Market and State. W. Streeck and P. Schmitter. London, et al., Sage Publications: 1-29.
- Sülzer, R. and A. Zimmermann (1996). Organisieren und Organisationen verstehen. Opladen, Westdeutscher Verlag.
- Sydow, J. (1992). Strategische Netzwerke. Evolution und Organisation. Wiesbaden, Opladen.
- Tendler, J. (1997). Good Government in the Tropics. Baltimore, Johns Hopkins University Press.
- Therkildsen, O. and J. Semboja (1995). A new look at service provision in East Africa. Service Provision under Stress in East Africa. The State, NGOs, and People's Organisations in Kenya, Tanzania, and Uganda. O. Therkildsen and J. Semboja. London, James Currey: 1-43.
- Tibandebage, P. and M. Mackintosh (1999). Institutional cultures and regulatory relationships in a liberalising health care system: A Tanzania case study. Paper submitted for publication in a book based on the WIDER workshop in Group Behaviour and Development, Helsinki, September 10-11 1999, December 1999.
- Tidemand, P. (1994). New local state forms and "popular participation" in Buganda, Uganda. The New Local-Level Politics in East Africa: Studies on Uganda, Tanzania and Kenya. P. Gibbon. Uppsala, The Scandinavian Institute of African Studies: 22-49.
- Tidemand, P. (1995). Popular versus state provision of local justice. The Resistance Councils in Uganda. Service Provision under Stress in East Africa. The State, NGOs, and People's Organisation in Kenya, Tanzania, and Uganda. O. Therkildsen and J. Semboja. London, James Currey: 223-237.
- Tizio, S. (2000). Les implications de l'économie neo-institutionnelle pour la régulation des systèmes de santé en Afrique subsaharienne: un nouveau paradigme? Paper presented at the conference "Health System Financing in Low-Income African and Asian Countries, 30 November - 1 December 2000, Clermont Ferrand.
- Toye, J. (1995). The new institutional economics and its implications for development theory. The New Institutional Economics and Third World Development. J. Harriss et al. London, Routledge.
- Tripp, A. M. (1994). "Gender, political participation and the transformation of associational life in Uganda and Tanzania." African Studies Review 37(1): 107-131.
- Tripp, A. M. (2000). Women and Politics in Uganda. Madison, University of Wisconsin Press.
- Tukahebwa, G. (1997). The Quest for Good Governance: Decentralisation and Civil Society in Uganda - Research Project: The Role of District Councils in the Decentralisation Program in Uganda. Kampala, MISR.

- Uganda Yearly Review (1993).
- ULAA (1996). Position Paper of Uganda Local Governments on the National Budget 1996/7. Kampala, ULAA.
- ULAA (1997). Position Paper of Uganda Local Governments on the National Budget 1996/7. Kampala, ULAA.
- UNDP (1997). Human Development Report. New York, Oxford University Press.
- Unom, S. (2000). "Whose accountability? Participation and partnership in a disabling environment." IDS Bulletin 31(1): 78-87.
- Uphoff, N. (1993). "Grassroots organisations and NGOs in rural development: Opportunities with diminishing states and expanding markets." World Development 21(4): 607-622.
- van de Ven, A. H. and D. L. Ferry (1980). Measuring and Assessing Organizations. New York, Chichester, Wiley.
- van der Geest, S. et al. (1990). "Planning for essential drugs: are we missing the cultural dimension?" Health Policy and Planning 5(2): 182-185.
- van der Geest, S. et al. (2000). "User fees and drugs: what did the health reforms in Zambia achieve?" Health Policy and Planning 15(1): 59-65.
- van der Heidjen, H. (1988). The role of the private voluntary sector: A historical perspective. Approaches that Work in Rural Development. Emerging Trends, Participatory and Local Initiatives. J. Burbidge. Muenchen et al.: 36-44.
- Vaughin, M. (1991). Curing Their Ills: Colonial Power and African Illness. Oxford, Polity Press.
- Villadsen, S. (1995). Implementing democratic decentralisation in Uganda. Principles and challenges for management. Uganda: Landmarks in Rebuilding a Nation. P. B. Langseth et al. Kampala, Fountain Publishers: 316-332.
- Villadsen, S. and F. X. K. Lubanga, Eds. (1996). Democratic Decentralisation in Uganda. Kampala, Fountain Publisher.
- von Prittwitz, V. (1998). Leistungsresponsivität und Verfahrenssteuerung - Modernisierungskonzepte des öffentlichen Sektors. Modernisierung des Staates. F. Naschold. Baden-Baden, Nomos-Verlag: 115-144.
- Wagstaff, A. (2000). Research on Equity, Poverty, and Health Outcomes: Lessons for the Developing World. Washington, D.C., HNP, World Bank, October 2000.
- Waliggo, J. M. (1995). The role of Christian Churches in the democratisation process in Uganda 1980-1993. The Christian Churches and The Democratisation of Africa. P. Gifford. Leiden et al., E. J. Brill: 205-224.
- Wallman, S. (1996). Kampala Women Getting By. Wellbeing in the Time of AIDS. London, James Currey.
- Walt, G. et al. (1999). "Managing external resources in the health sector: are there lessons for SWAPs." Health Policy and Planning 14(3): 273-284.
- Wang'ombe (1997). Cost-recovery strategies in Sub-Saharan Africa. Innovations in Health Care Financing. Proceedings of a World Bank Conference, March 10-11, 1997. G. Schieber. Washington, World Bank: 155-162.
- Warwick, D.P. (1993). On Methodological Integration in Social Research. Social Research in Developing Countries. Surveys and Censuses in the Third World. M. Bulmer and D.P. Warwick. London, UCL Press: 211-262
- Waters, H. R. (2000). "Measuring equity in access to health care." Social Science and Medicine 51: 599-612.

- Watt, D., R. Flanary, R. Theobald (1999). "Democratisation or the democratisation of corruption? The case of Uganda." Commonwealth and comparative politics 37(3): 37-64.
- WCW (1997). Engaging in Bilingual/Bicultural Research. Research Report. [www.wellesley.edu/WCW/spring97\\_feat3.htm](http://www.wellesley.edu/WCW/spring97_feat3.htm) (December 2000).
- Wegener, A. (1995). Typisierung von Organisationen im Spannungsfeld institutioneller Pole zwischen Staat, Markt und Gemeinschaft. Neuer Institutionalismus in der Entwicklungspolitik. Perspektiven und Rahmenbedingungen der Verwaltungsentwicklung im Sueden und Osten. R. Pitschas and R. Suelzer. Berlin, W. de Gruyter: 213-233.
- Wegner, R. (1993). Nicht-Regierungsorganisationen als entwicklungspolitische Hoffnungsträger? Eine Studie zur Wirksamkeit privater Entwicklungshilfe auf den Philippinen. Muenster et al.
- Weichselgärtner, B. (1994). Verwaltungskultur als Bedingung für Kooperatives Verwaltungshandeln. Dissertation, Universität Konstanz.
- Weisbrod, B. A. (1977). The Voluntary Non-Profit Sector. Lexington/Mass., Lexington Books.
- Wellard, K. and J. G. Copestake (1993). NGOs and the State in Africa: Rethinking Roles in Sustainable Agricultural Development. London, New York, Routledge.
- Werna, E. (1993). Healthy Institutions for Healthy Cities: Trends in Local Government, Urban Management and Service Delivery in Developing Countries. Urban Health Programme, London School of Hygiene and Tropical Medicine, unpublished paper.
- White, G. (1993). "Toward a political analysis of markets." IDS Bulletin 24(3): 4-11.
- White, G. (1994). "Civil society, democratisation and development (I): Clearing analytical ground." Democratisation 1(3): 375-390.
- WHO (1995). Uganda: Geopolitical and Socioeconomic Features. WHO Global Program on AIDS, [www.who.ch/ctryprof/uga.htm](http://www.who.ch/ctryprof/uga.htm) (January 1998).
- WHO (1996). Integration of Health Care Delivery. Geneva, WHO Technical Report Services/86.
- WHO (2000). The World Health Report 2000 - Health Systems: Improving Performance. Geneva, WHO.
- Whyte, S. R. (1991). Medicines and self-help: The privatisation of health care in Eastern Uganda. Changing Uganda. H. B. Hansen and M. Twaddle. London, James Currey: 130-148.
- Whyte, S. (1992). "Pharmaceuticals as folk medicine: Transformations in the social relations of health care in Uganda." Culture, Medicine and Psychiatry 16(2): 163-186.
- Whyte, S. R. (1997). Questioning Misfortune: The Pragmatics of Uncertainty in Eastern Uganda. New York, Cambridge University Press.
- Wiebe, P.D. and C.P.Dodge (1987). Beyond Crisis: Development Issues in Uganda. London, Pergamon Press
- Wilkesmann, U. (1995). Macht, Kooperation und Lernen in Netzwerken und Verhandlungssystemen. Netzwerke. D. Jansen and K. Schubert: 52-73.
- Williams, P. (1985). Medical education in Uganda today. Crisis in Uganda. The Breakdown of Health Services. C. P. Dodge and P. D. Wiebe. London, Pergamon Press: 247-252.
- Withworth, J. et al. (1999). "Determinants of attendance and patient satisfaction." Health Policy and Planning 14(1): 77-84.
- Wolf, C. (1988). Markets or Governments: Choosing Between Imperfect Alternatives. Cambridge, Massachusetts, London, MIT Press.
- World Bank (1993). World Development Report 1993: Investing in Health. Oxford, Oxford University Press.

- World Bank (1994). District Health Service Pilot and Demonstration Report. Report No 13515-UG. Staff Appraisal Report RoU, December 28, 1994, Eastern African Department. Population and Human Resources Operations Division.
- World Bank (1997a). Sector Strategy: Health, Nutrition, and Population. Washington, D.C., World Bank, Human Development Network.
- World Bank (1997b). World Development Report 1997: The State in a Changing World. Washington, D.C., World Bank.
- World Bank (1998). District Health Services Pilot and Demonstration. Mid-Term Review: October 12-28, 1998. Final aide-mémoire. Washington, D.C., World Bank.
- World Bank (2000). Private and Public Initiatives: Working Together in Health and Education. [www.worldbank.org/html/extrdr/hnp/health/ppi/pubpri2n.htm](http://www.worldbank.org/html/extrdr/hnp/health/ppi/pubpri2n.htm) (October 2000).
- World Bank (2001a). Development Forum World Bank: Partnering with Civil Society. Discussion group, 7-12-2001. [www2.worldbank.org/hm/participate/0028/html](http://www2.worldbank.org/hm/participate/0028/html) (April 2001).
- World Bank (2001b). Uganda National Household Survey 1999. Household Medical Expenditure Data. Unpublished Results, Washington D.C., World Bank, DEC.
- Wunsch, J. S. and D. Olowu, Eds. (1990). The Failure of the Decentralised State. Institutions and Self-Governance in Africa. Boulder, Colorado State University Press.
- Wunsch, J. S. (1994). "Institutional Analysis and Decentralisation: Developing an Analytical Framework for effective Third World Administration Reform." Public Administration and Development 11: 431-451.
- Yach, D. (1992). "The use and value of qualitative methods in health research in developing countries." Social Science and Medicine 35(4): 603-612.
- Zeitz, G. (1980). "Interorganisational dialectics." Administrative Science Quarterly 25: 72-88.
- Zwi, A. and A. Mills (1995). "Health policy in less developed countries: Past trends and future directions." Journal of International Development 7(3): 299-328.

## **Laws**

- Constitution 1995
- Local Government Act 1997
- Local Governments (Resistance Councils) Statute 1993
- Resistance Council Statute 1987
- National Drug Policy and Authority (Certificate of suitability of Premises) Regulations, 1995 National Drug Policy and Authority (Issue of licences) regulations, 1995.
- National Drug Policy and Authority Statute 1993
- Non-Governmental Organisations Registration Statute No. 5, 1989
- Non-Governmental Organisations Regulations, Statutory Instruments No. 9, 1990
- Allied Health Professionals Act 1996
- Nurses and Midwives Act, 1996
- Ugandan Medical and Dental Practitioners Statute 1996

**Reports, internal documents, minutes and other publications**

Reports of DED health professionals (Uganda), 1996-1999

Supervision reports of 10 government health facilities, Kamuli District, Dr. Müller-Stöver, 1999

Kamuli District Administration budgets 1995/96-1999/00

Selected Subcounty budgets 1997/98 – 1999/00

Financial Committee Minutes 1997-1999

Minutes of District Council meetings, 1998-99

District Medical Office Records for Drugshops, 1998

District Medical Office Workplan 1998/99

Ethical Code Guidelines for Hospitals and Health Units under the Catholic Church in Uganda

Uganda Protestant Medical Bureau, Information Brochure

National Drug Authority: Scale of Licence and Permits Fees applicable

Roles of Health Unit Management Committees (at government)

Service Agreement between Kamuli District Administration and the Kamuli Mission Hospital, 1997

**Newspapers**

The Monitor

The New Vision

## **Annex 1: Further Methodological Issues**

### **Research Design, Data Collection Methods and Sample Selection**

Chapter 1.4 has outlined the research design in its broad features. This Annex discusses the methodological and technical proceedings, the sampling, and the difficulties encountered as well as reliability and validity concerns in further detail.

#### **1. Selection of the Research Location**

Kamuli District was chosen, since the German Development Service (DED), under whose auspices the action research project was undertaken, had been operating in Kamuli District for several years. The DED helped establish the contact with a local NGO, the Kamuli District Women Development Association (KADIWODA), which provided access to communities and community groups. Furthermore, the DED's support of the District health services facilitated the access to government health care providers and also allowed me to benefit from the expertise of and collaboration with DED health professionals, particularly as regards clinical aspects.

#### **2. Interpreters and Facilitators**

From the beginning, I had decided to work with interpreters, because my previous experience in learning Kiswahili had made me realise that I would be unable to reach a mastery of the language sufficient of conducting focus group discussions and interviews on my own within a few months' time. I therefore decided to take some language training in Lusoga, the language spoken in the kingdom of Busoga, to which Kamuli District belongs, in order to be able to broadly follow conversations. Research assistants played an important role by acting as simultaneous translators for interviews (household, exit, and other), where necessary, but also as facilitators during the focus group discussions with communities.

Even though a language barrier creates the potential losses of information, the involvement of research assistants had also many advantages. They helped me in finding the right terms for complex concepts, such as accountability. Moreover, their cultural

familiarity allowed me to get access to people, i.e., to make them comfortable feel in talking to us and airing their views. Even if I had commanded the language, I would not have been able to interact so closely with the people as I did through the help of the research assistants.

For the action research, I worked with six facilitators. They were all Basoga and grew up in Kamuli District. Four of them had very long work experience in community development in Kamuli District; the other two were social scientists who had recently graduated. The facilitators were trained for 20 days on the rationale of the action research, and on interviewing, facilitation and recording skills, as well as the discussion of the thematic aspects. Continuous review and monitoring sessions were carried out (practising facilitation and interviewing).

### **3. Focus Group Discussions**

One of the research methods used in the communities was the focus group discussion. A focus group discussion is a qualitative research technique involving a group of people brought together to discuss a particular topic. This discussion is led by a "moderator" who keeps the participants "focused" on that topic (Frey/Fontana 1993: 29). The decisive element distinguishing focus groups from one-to-one interviews is the presence of group interaction. Thus, in addition to the respondent-interviewer relationship, group interviewing takes advantage of this group interaction and dynamic, which provides a stimulus to elaboration and expression and which thus produces new and additional data (ibid.: 32). This was particularly the case for the rather abstract and complex nature of the research topics investigated, such as decentralisation, accountability, transparency and provider choice. Also, it seemed that some women felt more comfortable in elaborating on a topic if other group members had already discussed it. That said, even though they often had to be explicitly encouraged to give their view, the women did not simply repeat what had been said, but also expressed different perceptions.

A great advantage of the focus group is that the interaction and non-verbal actions of the participants can tell us a great deal about the underlying social relations and the social context that exist beyond the group (Morgan/Krueger 1993: 32). Focus groups can also generate new ideas outside the actual research aspects. Above all, they can give

insight into shared cultural understandings (Crabtree et al. 1993: 143). For example, the sitting arrangements and who talks and who does not (unless not explicitly encouraged and asked by the facilitator) provided insights into the different degrees and the gendered nature of access to and participating in the public sphere (for the question about what sort of people actually came to the meetings, see below). Furthermore, by means of the focus group discussions, insights could be gained into how people perceive their efforts and problems as regards collective action and self-help.

The focus group technique generates a good degree of external validity, because focus groups constitute a more natural setting. This point, however, equally endangers validity. Communication in a focus group is a social process, in that opinions and respondents' behaviour are shaped by compliance, conformity or social desirability, and identification or internalisation (Morgan/Krueger 1993). Group responses can be influenced by the group members' view of the interview purpose, the size of the group or the role of the interviewer in the group, face-politeness and low levels of trust. It was therefore crucial to clearly state what the intentions of this research were.

Chairpersons of NGO groups, Executive Committee members of the LC 1, and other local elites (schoolteachers, for example) dominated the discussions. In response, the facilitators constantly encouraged the more silent people to talk about their experience. Usually, these people seemed a little bit more cautious about what they were saying. Yet across the zones, similar responses with the same delicate content came up, whether dominant or more silent persons had spoken first on that particular issue. The fact that people also expressed different views on some topics gives me confidence that the above influences were rather minimal. Nevertheless, not all statements can be taken as face value; the interpretation has to be related to the context in which the statements were made. Hence, after each focus group discussion, the research team went through the notes and discussed the issues that had pricked our concern. However, it seemed that people took the chance to talk about their problems. They appreciated it that somebody came to them and listened to their problems.

Focus group discussions should be held with homogenous groups (Morgan/Krueger 1993: 12). This was guaranteed to the extent that women, men and youth from one

village were met separately.<sup>367</sup> The unit of analysis was the group, with the results (i.e., the data) constituting the shared understanding of groups (cf. Crabtree et al. 1993: 144), but this does not necessarily mean that there was only one opinion.

#### **4. Action Research**

Action research is a research process that involves the communities in analysing the "research problem". A solution-finding process follows the joint problem analysis, so that participants can make use of the generated information and to rectify some of the analysed problems. People are subjects and owners of the research; action research is therefore more likely to guarantee people's willingness to participate. This, in return, makes discussants more comfortable in talking about delicate issue, and thus may provide more insight than the conventional empirical-analytical research method. Action research is empowering by virtue of the fact that it provides people the chance to develop problem-solving capacities. Instead of extracting data from a community, action research ideally leaves the data within the community for their own use (Fals-Borda 1987).

The related data collection method of action research is the focus group discussion. The ultimate objective of this is to trigger collective action, which is facilitated through a group-based problem analysis. Chambers argues that group discussions rather create the atmosphere for "collective and creative enthusiasm" being a crucial element for action (research) (1994: 1263). The back and forth bouncing of opinions and statements during group discussion contributes to making people aware of things they may not have thought about before and allows them to exchange experiences. Focus groups are a means to provide information not only by the researcher, but also by the group itself (Morgan/Krueger 1993: 17). Finally, focus group meetings and communication correspond to a more natural setting in contrast to the rather artificial one-to one-interviews. It is mainly the social group in which opinions are formed and problems about community issues discussed and solved.

---

<sup>367</sup> The focus group discussions during 1999 were held with mixed groups due to time and resource constraints.

### The action research process

During the 1997 and 1998 research phase, one research focus was on local government issues, administrative culture and service delivery (public, private, NGO, and community-based), health care being the main focus. 15 communities (LC1s) took part in the action research. They were located in four Parishes (two in Subcounties A and B, respectively, which are within the same County). The locations were chosen in agreement with local councillors and KADIWODA representatives, based on the following criteria: (1) a Subcounty within feasible reach and medium travel distance to Kamuli town (20-25 km) given the costs and time constraints; (2) presence of a KADIWODA women group and/or other NGO target groups operating in the zone; (3) interested and co-operative communities; and (4) adjacent LC1s for joint community action. In each of the zones, focus group discussions were carried out with the LC1 Executive Committee, and a group of men, women and youth respectively.<sup>368</sup>

The moderated discussions, using key questionnaires, focused on the service provision deficiencies of the different providers as people encountered them, whether and how people were involved in the decision-making of the service provision, how the degree of decision-making involvement affected the service provision quality, etc. The community discussions also served to identify people's preferences as regards the service provider types, whereby a particular focus was placed on health care. These preferences constitute a core component in the definition process of relative strengths (comp. Chapters 2.4 and 4.5.4).

The men, women and youth groups were attended by 15-25 people, with a mean of 20. It was not possible or desirable to dictate the exact number of people in each group. Reflecting on the scope of the focus group discussions, the research team assumed that the people in attendance were those who also usually came to LC meetings, namely the "better-off", the active community members, and "those who had time" (as the group discussants said themselves), while the poorest were much less likely to come.<sup>369</sup> One research assistant facilitated the groups, and another took notes or translated for me. In order to avoid biases, we refrained from tape recording. A few days after these group

---

<sup>368</sup> The youth (young unmarried adults) constitute a social group on their own within the LC system.

<sup>369</sup> Yach points out that local status hierarchies cause a certain degree of self-selection, which leads to groups comprising higher status members (1992: 607).

meetings, all the groups were invited to come together for a joint discussion and reflection process on possible solutions to the previously identified problems. Eight communities that had shown great interest and self-initiative in the action research were then selected and revisited two to three times to follow up on their solution finding process and implementation activities.<sup>370</sup>

### Problems encountered

While it was planned to conduct three separate meetings with men, women and youth (a total of 45 FGDs), this schedule could not be realised in all 15 communities. A large number of meetings had to be rescheduled because of rain,<sup>371</sup> burials or poor mobilisation (particularly of the youth groups). Because of costs and time constraints, the youth group discussions then often had to be left out or it was combined with the men's groups. A total of 37 FGDs with communities and 15 FGDs with LC1 Executive Committee members were thus realised.

Sometimes, in the course of discussing a particular issue, people became quite angry and grumbled about the "government". People started recounting similar incidents and became very repetitive. In order not to lose the group dynamics, we felt that it was necessary to allow the discussion to continue along these lines before getting back to the key questionnaire, and thus some other questions had to be left out.

Additional focus group discussions were carried out with 16 member groups from ten NGOs (see Annex 2 for a list of the groups) to extend on the above research issues. On the basis of discussions with the NGO staff, an active, well co-operating group and, where a second group was met, a less active group for each NGO were chosen in the same two Subcounties. These focus groups gathered 18 group members on average (ranging from 8-30).

In order to deepen the analysis on people's views and their assessment of health care services, 12 focus group discussions were carried out in the same catchment areas where

---

<sup>370</sup> For reasons of scope, the action research activities and results are not reported here (cf. Mathauer 1997, 1998).

<sup>371</sup> The focus group discussion phase had been scheduled for the dry season, but the seasons had changed, so that the scheduled phase fell in the rainy season.

the household interviews took place (see below). The chairpersons of the respective zones were asked to gather about 15 women and men who were active village residents.

### **5. Qualitative Interviews Based on Key Questionnaires**

The above research issues were further followed up by interviews based on key questionnaires with LC2, LC3 and LC5 Executive Committee members, Parish and Subcounty Chiefs, Subcounty Accountants, the Chief Administrative Officer and the Deputy, the Chief Financial Officer and Deputy, the heads of the service departments (health, education, agriculture, community development, water), seven section heads of the DMO, health assistants, community-based service officers, and agricultural extension officers. An additional gender perspective on the above issues was collected through interviews and focus group discussions with women leaders, namely Secretaries for Women at the LC1, LC2, LC3 and LC5 levels, Women Council chairpersons and KADIWODA Subcounty representatives.

To collect data on the health care providers' performance, individual interviews (with some exceptions) were carried out with at least two health workers at each of the selected health care providers, except at drugshops, where one interview only was carried out at some places. Further information on health care planning and facility management was collected by interviewing Health Unit Management Committee members, Secretaries for Health at the Subcounty and District level, Chairpersons of Subcounty Health Committees and the District Health Committee, as well as supervisors, namely staff of the District Medical Office and the Assistant Drug Inspector, as well as NGO Headquarter staff. These interviews usually lasted about one hour, or longer, if the respondents were interested and willing (see Annex 2 for a list of interviews).

District top officials would sometimes attempt to hide information that could put them in a bad light, but two senior officials in the Finance Department had a strong interest in telling me about the intra-administrative happenings and served as valuable key informants. Furthermore, one former civil servant was especially willing to reveal insider information. Lower (Subcounty) civil servants were sometimes afraid of making negative statements about the District leadership, but the re-emphasis on my

confidentiality and my interest in identifying the problems that lower civil servants had to deal with as well as my follow-up visits, which established a trusting relationship, helped to overcome their hesitation.

## 6. Network Analysis

For the network analysis of interorganisational relationships, action research-oriented discussions (using key questionnaires) were held individually with NGO staff and civil servants during 1997 and 1998.<sup>372</sup> The network analysis comprised the heads and Subcounty civil servants of the District departments of health, education, agriculture and community development as well as 20 NGOs, that is, all Ugandan NGOs operating in Kamuli District with an office in Kamuli Town<sup>373</sup> (see Table 4.7 for their activities). The rationale behind including other non-health related organisations was to get the full spectrum of interactions, which do not only take place within health care but also across other fields. Thus, the analysis will not suffer from being dislocated from its context.

The individual discussions with NGO staff and civil servants revealed a great need and demand for greater communication and networking, so that we – the KADIWODA executive committee and myself (under the auspices of DED) – organised and moderated six workshops during a period of three months. The first three workshops were tailored for the NGOs, while the departments joined thereafter. These meetings aimed to initiate a joint discussion on the interaction problems between the administration and the NGOs, followed by a discussion of solutions. This solution finding process was further pursued in three working groups on AIDS/health, women and agriculture that took place fortnightly.<sup>374</sup> One of the results of this action research process was the establishment of a District NGO forum in 1998.

---

<sup>372</sup> With most, two formal interviews/discussions were carried out, one in 1997, the other in 1998. More informal talks took place in 1999.

<sup>373</sup> I have come across only two NGOs that are not based in Kamuli town. The focus was on NGOs based in Kamuli Town, since interaction is more likely to occur where there is physical proximity. Moreover, District authorities (and not Subcounty authorities) are the main state actors that shape interorganisational interactions by distributing and allocating resources and exerting power. In contrast, the scope of NGO-Subcounty relationships is still very limited, and only a full coverage of all Subcounties, which was impeded by time and cost constraints, would have generated sufficient data material for a substantial analysis.

<sup>374</sup> Some District civil servants attended these meetings.

Another series of interviews and informal talks with the NGOs and DMO staff was held during 1999. To assess the progress and the ways forward, a review workshop was facilitated. My attendance and participation at another two forum meetings in 1999 provided further opportunities to study the relationships between the local administration and the NGOs.

## 7. Exit Interviews

For the comparative performance analysis of health care providers, the patients' (or their attendants') views were gathered by 146 exit interviews at the providers of the core sample.<sup>375</sup> As some providers have very low daily utilisation rates, the desired number of 10 exit interviews per provider could not be fulfilled within the scheduled sessions, which explains the odd number of 146 (see Annex 4 for the distribution of exit interviews).

The exit interviews lasted approximately 20 minutes each (up to 30 minutes), and took place between nine o'clock in the morning and one o'clock in the afternoon. When patients and attendants walked out, they were told the purpose of the study and asked whether they were willing to participate.<sup>376</sup> We did not ask individuals who, from our lay perspective, seemed to be severely ill patients who were suffering pain and were taken home quickly. Thus, the most severe cases may be underrepresented. At the drugshops, customers were excluded when they only came to buy some drugs for home storage. Instead, the focus was on those patients or customers who had a patient at home. In many instances, it was the attendant of a patient who answered the questions.

Exit interview respondents were classified into three socio-economic groups (ultrapoor, medium and "better-off"<sup>377</sup>) by using a range of indicators: clothing and shoes, schooling, occupation of the patient and spouse, means of transport used to reach the clinic, other "features" (such as a watch, the type of handbag, jewellery, glasses, hairdressing) and general appearance, both of the patient and the attendant.

---

<sup>375</sup> This was preceded by a pre-testing phase.

<sup>376</sup> The refusal rate was less than 5%. Reasons given for refusal were other urgent business to do or the severity of the patient's illness.

<sup>377</sup> Cf. Chapter 1.4 for the same qualifications to be made on this term and the categorisation process.

## 8. Household Interviews

Given the strong research interest in understanding how and whether the very poor access health services, the target was to identify at least 50 percent of household respondents who belonged to the poorest section. The original plan aimed for a random sampling process using the LC tax register, but it was found that almost every household was classified into the lowest graduated tax rate, while those exempted were not in the list. Thus, the tax register was not useful for a random sampling process.

The next attempt was to ask the LC1 chairperson to provide the names of the poorest households in the zone, taking into account income, number of children not attending school<sup>378</sup>, the housing type and state (roof and walls), the size of the land owned and female-headed households.<sup>379</sup> The search for these pre-selected households proved to be very difficult given the scattered settlement structures in rural Uganda, while directly asking for a specific individual raised too much attention and made the respondent suspicious. Ultimately, it was found that the households that had been selected by the LC1 chairperson did not seem to be part of the poorest section. The chairperson may have suggested names of friends or relatives, hoping that our visit would produce direct benefits for him or them. Presumably, this would also be the case when asking other key informants, such as village elders, school headmasters or religious leaders, to select poor households. Therefore, it was decided to select the respondents ourselves; following the methodology that was discussed in Chapter 1.4, 9-10 household interviews were undertaken in the 12 areas chosen.

The households were classified into two categories – the poorest and the "better-off" (i.e. less poor) – by means of an index of inhabitants' assets and wealth, as listed in Chapter 1.4. Household interviews were conducted in the afternoon, when people would no longer be working in their gardens. The interviews lasted about 60 to 75 minutes. There was sufficient room left at the end of each interview to provide the respondent

---

<sup>378</sup> With the introduction of Universal Primary Education, by which parents do not have to pay school fees for up to four children, they have been strongly encouraged to send their children to primary school. While UPE reduced the financial burden, parents still have to pay an average of US\$ 7,000 for uniforms, books, feeding etc. (cf. Azfar et al. 2000). Consequently, the primary school rate is not 100% (Deininger 2001). Thus, the number of children not going to school is a valid indicator of the household's socio-economic situation.

<sup>379</sup> Cf. Smith/Sander (1987) for Kenya, who asked local leaders to identify their respondents.

with the opportunity to raise other issues as he or she wished. This allowed us to get a sense of the more general problems and concerns that people had. Interviewees were asked to recall events within the previous two months. This period is considerably long and therefore subject to unintentional extension or shortening by the respondent. Further, remembering specific facts may be difficult over that period. However, any recall period beyond two weeks is endangered by recalling mistakes and inaccuracies. It is for these reasons that the exit interviews gained relevance for triangulation purposes.<sup>380</sup> That said, the chosen period meant that a reasonable amount of health care seeking events could be gathered and discussed. Related to this, a longer recall period increases people's representativeness in judging performance (Mathiowetz 2000).

## **9. Other Data Collection Methods**

Another important way of examining the health care providers' performance was a "healthy patient test". A healthy Ugandan aged 25 was instructed to visit all urban facilities (government, private, NGO clinics and the hospital OPD) within two days and to pretend to suffer from the same diffuse combination of symptoms. These records illuminated the examination procedures, staff behaviour, the diverse range of diagnosis and the different prescribed treatment options for the patient's symptoms, and so forth.

The drugshop observation study provided further insights into the transactions that were taking place. Most of the drugshop attendants or owners were co-operative and quite open about the drugs they were selling, but two drugshop sellers kept some of their drugs (those they are not supposed to sell) behind the counter, so that it was impossible to get information about all types of drugs sold.

During my research, five DED health professionals (doctors, nurses and midwives) were working in Kamuli. We usually met at least once a week on an informal basis and to talk about the daily experiences in the hospital and the government clinics or related clinical and organisational matters of health care. Their anecdotes and the discussions allowed me to gather many small facts and also eventually extended my lay medical understanding, thus increasing my awareness and attention during observation. I could

---

<sup>380</sup> However, a number of research findings suggest little to no difference in the quality of retrospective recall as a function of the length of the recall period (Mathiowetz 2000).

always come back and consult with them on medical-clinical aspects that I had observed. Ultimately, their observations provided many further insights into what was going on, while I could simultaneously get an understanding of the DED health professionals' framework, namely how they perceived "their" reality, which allowed me to assess their statements.

Apart from the formal interview situations, numerous informal conversations with the research assistants, who became crucial as valuable key informants as well as with other acquaintances (mainly NGO staff) provided important insights.

Finally, an important data collection method was observation at council meetings, at electoral meetings preceding the local government elections, at the District Administrative Headquarter and the District Medical Office, where the time spent waiting to interview officials afforded me the chance to observe first hand how citizens and lower-level civil servants of rural areas were treated. Likewise, as the KADIWODA office is located in one of the district administration headquarters (Department of Education, Community Development and Labour), the work with the research assistants there provided numerous opportunities to observe what was going on there.

## **10. Reliability and Validity**

Patient records at all three provider types provided information on the patient numbers, user charges, diseases and diagnoses, and treatment. It is known that government health staff forge health unit records by recording ghost patients in order to record drug dispensing, while the drugs are actually channeled into private pockets (McPake et al. 1999). Any government records therefore must be treated with caution. However, observation allowed us to get a realistic view for example of utilisation rates. Given a different incentive structure and tighter control (see Chapters 7 and 8), it was found that the number of patients at NGOs and private clinics are usually reliably recorded.

The reliability of the focus group discussion results is assumed to be high given the "investigator triangulation" (Burgess 1984: 143), in that different teams of research assistants consistently found the same patterns. Likewise, as these patterns corresponded to my observations, the interview data and the focus group discussions results of the 1997 DED evaluation, which had some overlapping questions, I am confident of the

FGD data validity. One incident in a village was particularly indicative of this. When a government extension officer showed up during a focus group discussion, the respondents' behaviour suddenly changed and they started giving us answers that were the opposite of what they had said a minute before his arrival. In general, both in FGDs and during household interviews, people expressed their dissatisfactions very strongly.

Various forms of triangulation ensured or at least increased the reliability of the key questionnaire interviews. One was, as said, the use of different data collection methods (interviews, reports, focus group discussions and observation). Another form was what is called "person triangulation" (Burgess 1984) by talking to a large number of different persons at different levels and in different settings. Household and exit interviews are equally subject to verification and validity concerns because of people's own "truth" and recalling mistakes. Again, triangulation with other sources (observation, patient records, interviews with key informants, etc.) and "investigator triangulation" (Burgess 1991: 143) is therefore key to identifying possible distortions.

Construct validity (i.e., the researcher actually measures what he or she claims to measure) was enhanced by using similar questions in consequence and several indicators to measure the same phenomenon. The validity of data can suffer from a number of factors that influence the data collection. One severe one was the fact that my being white and often associated with the DED raised expectations for technical or financial support among communities as well as health professionals. I therefore made it clear from the beginning that I had no funds to bring, but that I was strongly interested in the problems of health care provision. On the other hand, for Ugandans, I appeared to be in the early twenties, so that it was easy to believe what I was saying, which gives me confidence that social desirability responses could be reduced to a minimum.

While my being an outsider surely made some people cautious in what they were telling me, as one does not like to tell visitors "bad things", most people appreciated it that somebody from outside sat down on a mat and came to listen to their concerns and grievances in order to hopefully forward them to a higher level.

## 11. Household and exit respondent distribution

### Household Survey

Table 1: Distribution of poor vs. better-off respondents

	Poor	Better-off	Total
Rural area	35	40	75
Urban area	25	12	37
<b>Total</b>	<b>60</b>	<b>52</b>	<b>112</b>

Table 2: Distribution: Female and male respondents

	Female	Male	Both	Total
Rural	37	28	10	75
Urban	19	18	0	36
<b>Total</b>	<b>56</b>	<b>46</b>	<b>10</b>	<b>112</b>

### Exit Interview Survey

Table 3: Distribution of poor vs. better-off patients

	Poor	Medium	Better-off	Coding gap	Total
Women	13	31	11		55
Men	6	10	2		18
Child/children	23	25	15	10	73
<b>Total</b>	<b>42</b>	<b>66</b>	<b>28</b>	<b>10</b>	<b>146</b>

## Annex II

### List of Interviews and Focus Group Discussions

#### Interviews at the National Level

Organisation	Position	Location	Date
AMREF	- Program Manager	Kampala	4 June 1999
AVSI	- Director	Kampala	21 April 1999
Decentralisation Secretariat / MoLG	- Planning Officer	Kampala	9 February 1998
Decentralisation Secretariat / MoLG	- Senior Official	Kampala	9 April 1998
DENIVA	- Program Manager	Kampala	17 October 1997
GTZ	- Health Coordinator	Kampala	23 April 1999
MFEP	- Director of Aid Coordination	Kampala	7 April 1998
Ministry of Agriculture	- Senior Officials	Kampala	6 April 1998
Ministry of Health	- Planning Unit, expatriate	Entebbe	9 February 1998
Ministry of Health	- Planning Unit	Entebbe	8 April 1998
Ministry of Health,	- Officer in charge of DHSP	Kampala	3 September 1999
National Drug Authority	- Senior Drug Inspector	Kampala	4 June 1999
National NGO Forum	- Coordinator	Kampala	24 April 1998
Red Cross	- Program Manager for Health	Kampala	3 September 1999
UCBHCA	- Program Manager	Kampala	2 September 1999
UCMB	- General Secretary	Kampala	26 April 1999
UMDPC	- Registrar	Kampala	18 June 1999
UPMB	- General Secretary	Kampala	22 April 1999 6 September 1999

### Interviews with the District Medical Office

<b>Position</b>	<b>Location</b>	<b>Date</b>
<b>Assistant Drug Inspector</b>	Kamuli	20 May 1999
<b>District Medical Officer</b>	Kamuli	23 September 1997
<b>District Medical Officer, Deputy</b>	Kamuli	17 February 1998
<b>District Director of Health Services</b>	Kamuli	17 June 1999 9 July 1999
<b>District Health Educator</b>	Kamuli	9 September 1997
<b>District Health Educator Assistant</b>	Kamuli	31 March 1998
<b>District Health Inspector</b>	Kamuli	31 March 1998 3 May 1999
<b>District Health Visitor</b>	Kamuli	23 September 1997 30 March 1998 3 May 1999
<b>District Nursing Officer</b>	Kamuli	24 September 1997
<b>Senior Health Assistant Subcounty A</b>	Subcounty A	3 October 1997
<b>Health Assistant Subcounty B</b>	Subcounty B	6 October 1997
<b>Health Assistant Subcounty surrounding Kamuli town</b>	Kamuli Town	9 July 1999

### Interviews with Health Professionals

Facility Type	Qualification of Interviewee	Location	Date
Urban government uG-1	- Medical Assistant, I/C - Registered Nurse - Nursing Aid	Kamuli	17 August 1999 12 August 1999 12 August 1999
Rural government clinic, rG-2	- 2 Nursing Officers - Nursing Officer	Subcounty A	31 May 1999 13 August 1999
Rural government clinic, uG-3	- Medical Assistant, I/C  - Senior Nurse - Midwife - 2 Senior Nursing Aids	Subcounty C	28 July 1999 29 July 1999 26 July 1999 29 July 1999 29 July 1999
Rural NGO clinic rN-1	- Nursing Aid - Midwife	Subcounty B	13 May 1999 15 May 1999
Rural NGO clinic rN-2	- Midwife - Nursing Aid	Subcounty B	7 May 1999 26 May 1999
Rural NGO clinic rN-3	- Nurse-midwife, I/C - Midwife	Subcounty C	27 July 1999 26 July 1999
Rural NGO clinic rN-4	- Nursing Aid	Subcounty B	21 May 1999
Rural NGO clinic rN-5	- Nursing Aid	Subcounty C	29 July 1999
Urban NGO clinic UN-1	- Medical Assistant - Nurse	Kamuli	10 August 1999 10 August 1999
Urban NGO clinic UN-2 Medical Assistant	- Medical Assistant - Nurse - Nurse-Midwife	Kamuli	9 August 1999 9 August 1999 13 August 1999
Mission Hospital	-Medical Superintendent -Medical Superintendent  - Hospital Administrator  - Bursar  - Nurse (Registration) - Nurse - Nurse - Pharmacist	Kamuli	13 January 1998 25 May 1999 28 May 1999 7 June 1999 (short talk) 17 June 1999 22 August 1999 8 July 1999 24 August 1999 18 August 1999 26 August 1999 27 August 1999 18 August 1999
Rural private clinic 1	- Medical Assistant	Subcounty A	9 June 1999
Rural private clinic 2	- Dispenser	Subcounty C	14 August 1999
Private clinic A**	- Medical Assistant and Nurse - Nursing aids (informal talk)	Kamuli	24 August 1999 25 August 1999
Private clinic B	- Medical Assistant - Laboratory Assistant - Nurse (informal talk)	Kamuli	23 June 1999 23 June 1999 23 June 1999
Private clinic C	- Doctor - Nursing Aid - Midwife	Kamuli	24 June 1999 7 August 1999 7 August 1999
Private clinic D	- Doctor - Nurse - Senior Nurse	Kamuli	6 August 1999 6 August 1999 9 August 1999

\*\* For anonymity reasons, the A-B-C-D names do not correspond to the P-1, P-2, P-3, P-4 codes.

### Interviews with Drugshops Attendants

Drugshop	Qualification	Owner of Drugshop	Location	Date
Drugshop 1	- Nurse	Business person	Kamuli	26 August 1999
Drugshop 2	- Dispenser - Nursing Aid - Nursing Aid	Lab assistant	Subcounty A	1 June 1999 24 June 1999 10 July 1999 **
Drugshop 3	- Med. Assistant, Nursing Aid - Nursing Aid	Medical Assistant	Subcounty A	3 June 1999 10 July 1999 **
Drugshop 4	- Trained on the job - Nurse	Nurse *	Subcounty A	1 June 1999 10 July 1999 **
Drugshop 5	- Nurse	Nurse	Subcounty A	3 June 1999
Drugshop 6	- Nursing Aid	Health Assistant	Subcounty A	10 July 1999 **
Drugshop 7	- Trained on the job	Nurse	Subcounty B	16 May 1999
Drugshop 8	- Midwife	Midwife	Subcounty B	7 May 1999 (short talk)
Drugshop 9	- Trained on the job	Business person	Subcounty B	7 May 1999 14 May 1999
Drugshop 10	- Trained on the job	Laboratory assistant	Subcounty B	21 May 1999
Drugshop 11	- Trained on the job	Business person	Subcounty Naminage	7 May 1999 (short talk)

**cont.**

<b>Drugshop</b>	<b>Qualification</b>	<b>Owner of Drugshop</b>	<b>Location</b>	<b>Date</b>
<b>Drugshop 12</b>	- Traditional Birth Attendant	Business person	Subcounty B Naminage	7 May 1999
<b>Drugshop 13</b>	- Nursing Aid	Nurse	Subcounty B	7 May 1999
<b>Drugshop 14</b>	- Nursing Aid	Nurse	Subcounty C	26 July 1999
<b>Drugshop 15</b>	- Trained on the job	Business person	Subcounty C	28 July 1999
<b>Drugshop 16</b>	- Trained on the job	Business person	Subcounty C	14 August 1999

\*\* These interviews were carried out by Patrick Mwigo

### Interviews with Non-government Supervisors

Facility Affiliation	Position	Location	Date
Jinja Diocese	- Health Coordinator	Jinja	7 June 1999
Busoga Diocese,	- Program Manager for Health	Jinja	1 October 1997 10 February 1998 19 June 1999
Busoga Diocese	- Zonal Manager (Supervisor)	Kamuli	19 August 1999
Busoga Diocese	- Zonal Manager (Supervisor)	Kamuli	19 August 1999
Busoga Diocese	- Supervisor	Kamuli	19 August 1999
Fellowship, Jinja Headquarter	- Manager	Jinja	15 July 1999

### Interviews with Members of HUMCs and Health Subcounty Committees

Position	Location	Date
Subcounty Health Committee A Chairperson	Subcounty A	16 June 1999
Subcounty Health Committee B Chairperson	Subcounty B	21 May 1999
Subcounty Health Committee C Chairperson	Subcounty C	30 July 1999
HUMC, rG-2 Chairperson and Vice	Subcounty A	31 May 1999
HUMC, rN-1 Treasurer	Subcounty B	14 May 1999
HUMC, rN-2 Zonal Representative Treasurer LC1 Chairperson	Subcounty B	26 May 1999 29 May 1999 29 May 1999
HUMC, rN-4 Treasurer	Subcounty B	22 May 1999
HUMC, rG-3 Chairperson LC1 Chairperson	Subcounty C	30 July 1999 31 July 1999
HUMC, rN-3 Vice Chairperson	Subcounty C	29 July 1999
Hospital Board of Governors member	Kamuli	13 January 1998 6 March 1998

### Interviews with Staff of PPHC NGO in Kamuli<sup>1</sup>

NGO	Position	Location	Date
AEGY	- Program Coordinator - Program Coordinator - Program Coordinator	Kamuli	13 September 1997 21 January 1998 1 May 1999
CCF	- Management team - Program Coordinator - Program Coordinator	Kamuli	15 September 1997 **23 January 1998 23 August 1999
FFWP	- Chairperson - Chairperson	Kamuli	6 February 1998 20 August 1999
IMAU	- 3 members of Executive Committee and Coordinator	Kamuli	5 February 1998
KAASFA	- PWA members - Field worker	Kamuli	30 January 1998 14 August 1999
KADIWODA	- Executive Member - Executive Member	Kamuli	20 August 1997 25 October 1997
KAMASO	- Program Coordinator - Program Coordinator - Program Assistant	Kamuli	23 January 1998 29 April 1999 3 May 1999
NACWOLA	- Chairperson - Chairperson	Kamuli	21 March 1998 23 August 1999
NASCRUD	- Assistant Fieldworker	Kamuli	17 September 1997
Red Cross	- Volunteer - Volunteer	Kamuli	2 October 1997 30 January 1998

<sup>1</sup> This list does not include the many, more informal talks with the majority of the NGOs at various occasions.

cont.

NGO	Position	Location	Date
UCOBAC	- Chairperson - Vice Chairperson - Program Officer	Kamuli	12 September 1997 *** 29 September 1997 5 February 1998
UTHA	- Program Officer	Kamuli	18 September 1997
Don Bosco	- Program Managers	Kamuli	15 October 1997
KAEA	- Executive Committee Member - 4 Execut. Committee Members - Program Coordinator - Executive Committee Member - Program Coordinator	Kamuli	22 August 1997 2 September 1997 28 January 1998 12 February 1998 23 August 1999
Kiribawa Rural Women Development Network	- 3 Execut. Committee Members	Kamuli	8 September 1997
KREDA	- 2 Program Officers	Kamuli	19 February 1998
Maria's Care	- Program Manager - Staff	Kamuli	11 October 1997 26 March 1998
SAFA	- Program Officer - Program Officer	Kamuli	29 September 1997 20 February 1998
UNFA	- 5 Execut. Committee members - Program Coordinator - Program Officer	Kamuli	3 September 1997  13 February 1998 23 August 1999
USSIA	- Coordinator - Coordinator	Kamuli	23 January 1998 21 August 1999
UWFCT	- Program Officer	Kamuli	21 August 1999

\*\* Interview was carried out by Annie Alimuwa and Fredrick Ssali

\*\*\* Interview was carried out by Paul Bukuluki and Fredrick Ssali

Execut. = Executive

### Interviews with other District Departments

Department	Position	Location	Date
District Agricultural Department	- Veterinary Officer and County Extension Officer	Kamuli	9 September 1997 **
	- M+E Officer	Kamuli	24 March 1998
	- Agriculture Extension Officer	Subcounty A	2 October 1997
	- Assistant Agricultural Extension Officer	Subcounty B	6 October 1997
District Community Development Office	- Senior Community Development Officer	Kamuli	10 September 1997 ** 15 October 1997
	- Community Development Officer	Kamuli	10 September 1997 **
	- Subcounty Community Based Service Officer	Kamuli	16 March 1998
District Education Department	- District Education Officer	Kamuli	18 September 1997
	- Complementary Primary Education, Field worker	Kamuli	11 March 1998

\*\* interview carried out by Paul Bukuluki and Fredrick Ssali

### Interviews with Women Leaders

Position	Location	Date
Women Council 5, Chairwoman	Kamuli	29 October 1997
LC5 Secretary for Women	Kamuli	5 October 1997
Women Councillors, LC3 5 members	Subcounty A	24 October 1997
Women Councillor, LC3	Subcounty B	22 October 1997
LC2 Secretary for Women	Subcounty A	21 October 1997
LC2 Secretary for Women	Subcounty B	24 October 1997

### Interviews with District Administration Authorities

Position	Location	Date
LC5 Chairperson	Kamuli	26 September 1997
LC 5 Vice Chairperson	Kamuli	25 August 1999
Chief Administrative Officer	Kamuli	30 September 1997
Chief Administrative Officer, Deputy	Kamuli	14 October 1997 27 January 1998
Chief Administrative Officer	Kamuli	5 May 1999
Chief Finance Officer	Kamuli	23 September 1997
Chief Finance Officer Deputy	Kamuli	30 September 1997
Finance Officer	Kamuli	1 October 1997
Finance Officer	Kamuli	8 October 1998
Clerk to the LC5 Council	Kamuli	22 September 1997
RDC, Deputy	Kamuli	23 October 1997
Secretary for Health	Kamuli	6 May 1999
District Health Committee Chairperson	Kamuli	7 June 1999
District Service Commission	Kamuli	13 March 1998
District Tender Board Chairperson	Kamuli	11 March 1998
Planning Officer	Kamuli	4 February 1998 18 March 1998
Former civil servant	Kamuli	2 March 1998 11 March 1998 10 April 1998 17 April 1998
<b>Meetings attended</b>		
LC5 Council	Kamuli	October 1997 February 1998 June 1999
DMO Nutrition Planning Seminar	Kamuli	20 March 1998

### Interviews with Authorities at the Subcounty level and below

Position	Location	Date
Subcounty Accountant	Subcounty A	2 October 1997
Subcounty Chief	Subcounty A	26 February 1998
Subcounty Chief	Subcounty A	31 May 1999
LC3 Executive Committee (4 members)	Subcounty A	10 October 1997
LC3 Secretary General	Subcounty A	9 June 1999 (shorter talk)
Secretary for Health	Subcounty A	9 June 1999
3 Parish Chiefs	Subcounty A	3 October 1997
LC2 Executive Committee (6 members)	Subcounty A	3 October 1997
LC3 Executive Committee (5 members)	Subcounty B	6 October 1997
4 Parish Chiefs	Subcounty B	24 September 1997
LC2 Executive Committee (5 members)	Subcounty B	7 October 1997
Acting Subcounty Chief (Parish Chief)	Subcounty B	13 May 1999
Subcounty Chief	Subcounty B	7 October 1997 with Annie notes
<b>Subcounty C</b>		
LC3 Chairperson	Subcounty C	28 July 1999
Subcounty Accountant	Subcounty C	28 July 1999
<b>Kamuli</b>		
Secretary for Health, Town Council	Kamuli	26 August 1999
Secretary for Health, Subcounty Nabwigulu	Kamuli	27 June 1999
Subcounty Health Committee Chairperson	Subcounty surrounding Kamuli Town Council	9 July 1999
<b>LC1 Chairpersons in 12 villages**</b>		
LC1 Chairpersons in 12 villages**	Subcounty A, B, C, Kamuli Town Council	June – August 1999

\*\* These were the same communities where the Focus Group Discussions took place in 1999.

### Interviews with DED Staff

Position	Name	Location	Date
Country Director	Klaus-Dieter Seidel	Kampala	12 May 1997
Liaison Officer	Jochen Becker	Kampala	16 October 1997 12 January 1998 21 April 1999
Health coordinator	Cornelia Grade	Kampala	21 April 1999
NGO Coordinator, Mbale	Helen Fielding	Kampala	23 April 1998
NGO Coordinator, Fort Portal	Karin Eckert	Kampala	23 April 1998
NGO Coordinator, Soroti	Kerstin	Kampala	24 April 1998
Development Worker	Dr. Georg Kopf	Kampala	3 September 1999
Development Worker	Nenad Kostansjek	Kampala	13 May 1997 4 March 1998
Health Professional	Marianne Schmücker	Kampala	2 June 1997
Health Professional	Dr. Ulrich Schmeidl	Kamuli	12 August 1997
District Health Planner, Kamuli	Helmut Weigt	Kamuli	30 June 1997 20 August 1997
Health Professionals	Teresa Almeda Elske Rasenack	Kamuli	throughout field stay in 1997 and 1998
Health Professionals	Hannelore Kristen Dr. Bernhard Krötz Dr. Müller-Stöver Annerose Beer Manuela Bülow	Kamuli	throughout field stay in 1998 and 1999

### Focus Group Discussions with NGO Target Groups

<b>NGO</b>	<b>Location</b>	<b>Date</b>
AEGY	Subcounty A	27 September 1997
AEGY	Kamuli Town	13 October 1997
CCF	Kamuli Town	16 September 1997
KAEA	Subcounty B	17 September 1997
KADIWODA	Subcounty A	26 September 1997
KADIWODA	Subcounty B	14 October 1997
KADIWODA	Subcounty B	25 September 1997
NAWOLA	Kamuli Town	5 February 1998
KAMASO	Kamuli Town	30 January 1998
Kiribawa	Subcounty A	19 September 1997
Kiribawa	Subcounty A	19 September 1997
Nascrud	Subcounty B	29 September 1997
UCOBAC	Subcounty A	20 September 1997
UNFA	Subcounty A	15 September 1997
UNFA	Subcounty B	15 September 1997

### Focus Group Discussion with Communities

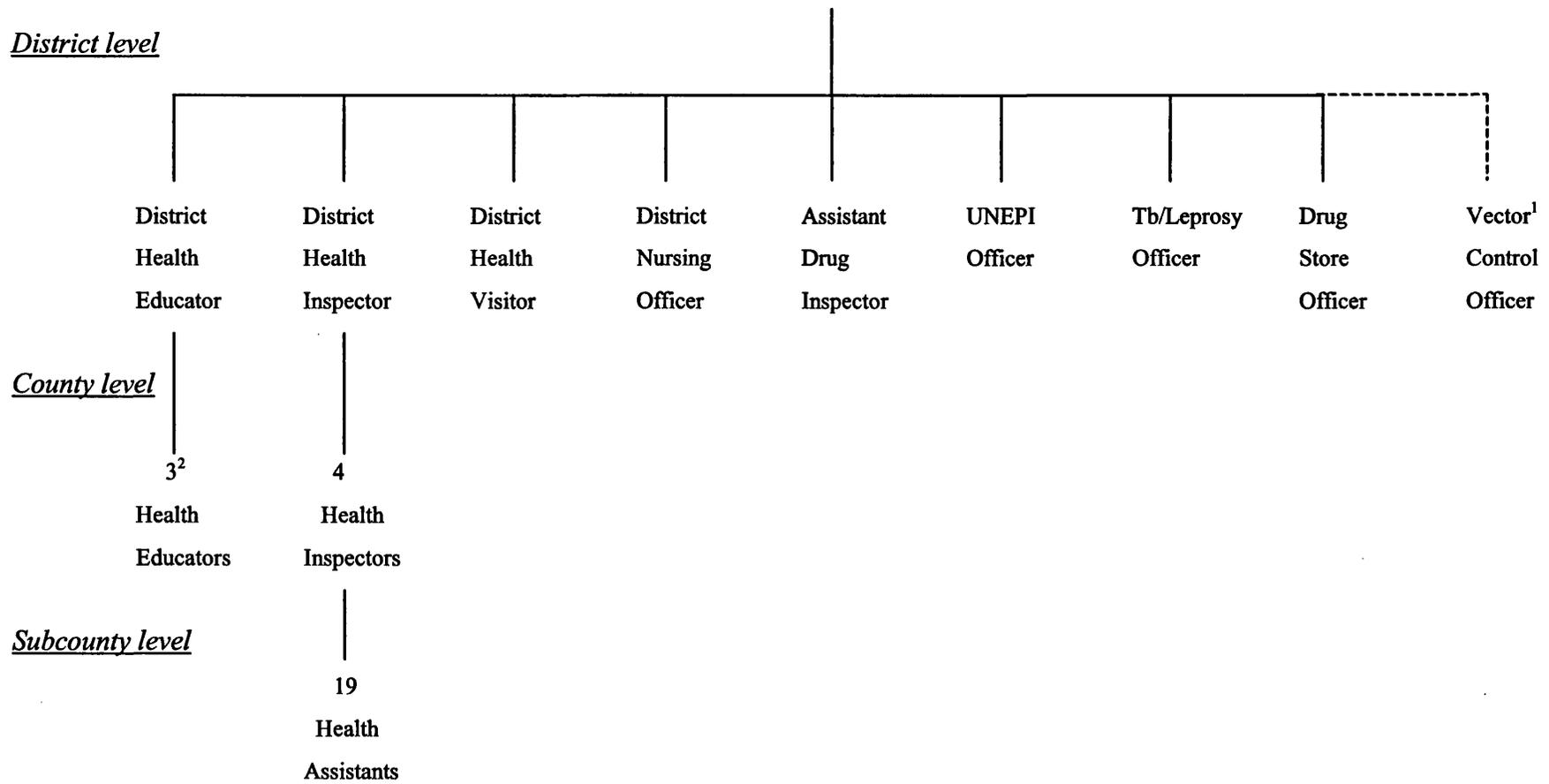
Activity	Number of Communities and Location	Date
<b>15 FGDs</b> with 15 LC1 Executive Committees	- 7 communities in Subcounty A - 8 communities in Subcounty B	July – September 1997
<b>37 FGDs</b> with 15 communities (LC1s) (same as above) <ul style="list-style-type: none"> <li>• 12 FGDs with men</li> <li>• 15 FGDs with women</li> <li>• 10 FGDs with youth</li> </ul>	- 7 communities in Subcounty A - 8 communities in Subcounty B	July – September 1997
<b>16 solution finding FGDs</b> with 8 communities (selected from the 15 communities)	- 4 communities in Subcounty A - 4 communities in Subcounty B	February, April 1998
<b>12 FGDs</b> with 12 health catchment areas	- 3 communities in Subcounty A - 3 communities in Subcounty B - 3 communities in Subcounty C - 3 communities in KamuliTown	June – August 1999

### Observation of NGO Forum Activities

Activity	Date
<b>7 meetings</b> - 3 NGO meetings - 4 NGO Forum-local administration meetings	February – May 1998
<b>2 NGO Forum meetings</b>	July, September 1999
<b>8 meetings with sectoral NGO working groups</b> - AIDS/health; - Agriculture; - Community development	March – May 1998
<b>10 meetings of the NGO Forum Task Force</b>	March – May 1998
<b>4 meetings of the NGO Forum Task Force</b>	July – September 1999

**Annex III, Figure 1: Organisational Diagram of the DMO and task division**

**District Medical Office:  
District Director of Health Services**



<sup>1</sup> not directly under the DMO

<sup>2</sup> These numbers refer to Kamuli District.

## Annex IV

### Distribution of Exit Respondents

	Poor	Medium	Better-off	Coding gap	Total
<b>uG1</b>	4	8	2		14
<b>rG2</b>	4			7	11
<b>rG3</b>	5	4			9
<b>P1</b>	2	4	5		11
<b>P2</b>	4	4	2		10
<b>P3</b>	3	4	5		12
<b>P4</b>	1	7	1		9
<b>uN1</b>		4	5		9
<b>uN2</b>		4	6		10
<b>Hospital</b>	4	9	2		15
<b>Prot. NGOs</b>	3	3		1	7
<b>Catholic clinic</b>	5	2			7
<b>3 Drugshops</b>	7	13		2	22
<b>Total</b>	42	66	28	10	146

## Annex V

### User Charges for Malaria Treatment

Table 1:

User charges for oral malaria adult treatment at rural health care providers (in US\$)

<b>rG-1</b>	<b>rG-2</b>	<b>rN-1</b>	<b>rN-2</b>	<b>rN-3</b>	<b>Drugshops</b>
800** (including laboratory test)	500	350 for drugs + some 200 for consultation	300 for drugs + some 200 for consultation	700	300

Source: User charge lists, interviews, facility records

Table 2:

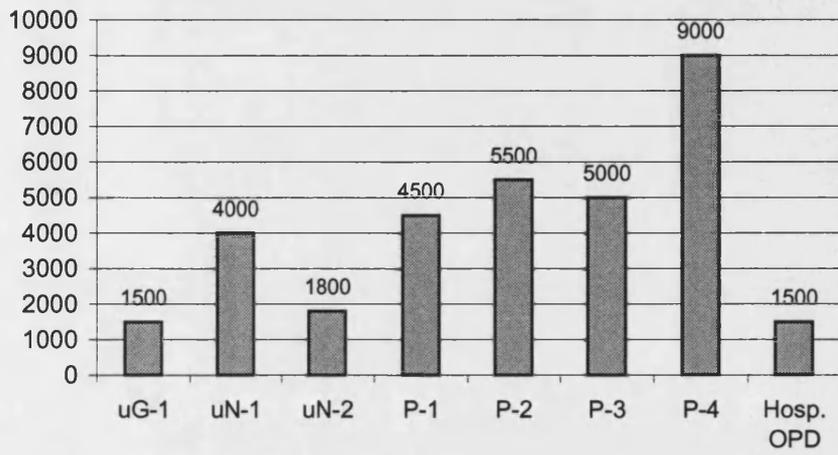
User charges for oral malaria adult treatment at urban health care providers, including laboratory test (in US\$)

<b>Drug-shops</b>	<b>uG-1</b>	<b>uN-1</b>	<b>uN-2</b>	<b>Hosp OPD</b>	<b>P-1</b>	<b>P-3</b>	<b>P-2</b>	<b>P-4</b>
400	1,500**	2,500	1,800	1,500	2,000	5,000	4,500	2,500

Source: User charge lists, interviews, facility records

\*\* These are the official costs, but ultimately may not include additional costs for drugs, such as informal charges, or by purchasing drugs at a drugshop.

Figure 1: Costs for Malaria Treatment [in US\$]



Source: "Healthy Patient" test

## Annex VI

### Chi Square Test Scores for Chapters 5.6 and 5.8.

#### 1. Method of partial payment in relation to wealth group

	Poor	Medium	Well-off	Total
N	22	37	22	74
% of patients w/ credit or partial payment	6 27.27%	7 18.91%	3 13.63%	16 21.62%
% of patients with credit	1 4.5%	1 2.70%	0 0%	2 2.70%
% of patients with no deferment	16 72.73%	30 81.09%	19 86.37%	58 78.38
Chi Square p-value	0.11			

#### Utilisation patterns in relation to wealth group (household respondents)

##### 2. Home treatment

	Poor N	Better-off N
Low use of home treatment (0-1 times)	46	45
Higher use of home treatment (>1 times)	8	2
Chi-Square p-value	.073	
Gamma	-.593 (.062)	

Two-sided significance levels are shown in brackets

##### 3. Rural government clinics

	Poor	Better-off
Low use of rural government clinics (0-1 visits)	22	28
Higher use of rural government clinics (>1 visits)	7	7
Chi Square p-value	.330	
Gamma	-.120 (.692)	

4. Drugshops

	Poor N	Better-off N
Low use of drugshops (0-3 visits)	34	33
Higher use of drugshops (>3 visits)	20	14
Chi Square p-value	.289	
Gamma	-.162 (.439)	

5. Drugshops, (peri-)urban households

	Poor N	Better-off N
Low use of drugshops (0-3 visits)	17	10
Higher use of drugshops (>3 visits)	8	2
Chi Square p-value	.285	
Gamma	-.404 (.286)	

6. Catholic clinic

	Poor	Better-off
No utilisation	4	1
Utilisation (>1)	5	1
	-	

7. Protestant clinics

	Poor N	Better-off N
No utilization	8	6
Utilisation (> 0 visits)	3	5
Chi Square p-value	.330	
Gamma	.379 (.367)	

8. Rural private clinics

	Poor N	Better-off N
No utilization	48	39
Utilisation (>0 visits)	6	8
Chi Square p-value	.411	
Gamma	.269 (.327)	

9. Urban government, rural households

	Poor N	Better-off N
No utilization	29	31
Utilisation (>0 visit)	0	4
Chi Square p-value	.082	
Gamma	1 (.034)	

10. Urban government clinic, (peri-)urban households

	Poor N	Better-off N
No utilization	16	6
Utilisation (>0 visits)	9	6
p-value	.438	
Gamma	.254 (.409)	

11. Urban government clinic, all households

	Poor N	Better-off N
No utilization	45	37
Utilisation (> 0 visits)	9	10
Chi Square p-value	.368	
Gamma	.149 (.556)	

12. Urban NGO clinics, rural households

	Poor N	Better-off N
No utilisation	29	35
Utilisation (>1 visit)	0	0
	-	

13. Urban NGO clinics, (peri-)urban respondents

	Poor N	Better-off N
No utilization	22	10
Utilisation (> 0 visits)	3	2
Chi Square p-value	.53	
Gamma	.189 (.711)	

14. Private clinics, rural households

	Poor N	Better-off N
No utilization	29	33
Utilisation (> 0 visits)	0	2
Chi Square p-value	.295	
Gamma	1.00 (.146)	

15. Private clinics, (peri-)urban households

	Poor N	Better-off N
No utilisation	22	4
Utilisation (> 0 visit)	3	8
Chi Square p-value	.003	
Gamma	.874 (.001)	

16. Private clinics, all households

	Poor N	Better-off N
No utilization	51	37
Utilisation (> 0 visits)	3	10
Chi Square p-value	.019	
Gamma	.644 (.02)	

17. Hospital OPD

	Poor N	Better-off N
No utilisation	38	34
Utilisation (> 0 visits)	18	13
Chi Square p-value	.345	
Gamma	-.133 (.535)	