People failed to mobilize to demand better services because they were afraid to be labeled enemies of the state, and they were unaware of their rights and the dynamics of politics associated with the rise of NSPs.

The Nonstate Provision of Health Services and Citizen Accountability in Uganda

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Why do citizens in Uganda choose nonstate health-care providers instead of free public health services? How does experience of the nonstate provision of health care strengthen or undermine citizen capacity to seek accountability? Based on original empirical data from Uganda, respondents rate private health-care services as being of much better quality than those found in the public sector. Study findings reveal little or no demand for accountability for better health services. This is associated not only with the rise of nonstate actors, but also with other factors, among which are the dictatorial tendencies of the current regime in power, which has prevented a potential coalition between urban elite private users and rural poor public users.

Introduction

Uganda is one of the many countries in the Global South where nonstate actors' involvement in delivering social services has grown in numbers, diversity, and importance. Indeed, nonstate provision plays a major role in the delivery of health services. As a result, nonstate providers (NSPs) have increasingly been recognized by governments and donors to be instrumental in helping realize the health-related Millennium Development Goals (MDGs).

Existing studies on the nonstate provision of social welfare have focused on technical and administrative concerns, particularly in developing countries, such as the relative efficiency of the public versus the private

provision of social services (Katusiimeh 2012; Ndandiko 2010). However, recent literature has concluded that nonstate provision can have profound effects on political life, particularly on equity (access to social welfare), state capacity, and accountability (Brass 2014; Cammett and MacLean 2011, 2014). To date, little empirical research explores the political consequences of the nonstate provision of social welfare, particularly in the context of sub-Saharan Africa.

In the healthcare sector, studies have focused on nonstate actors and their contributions to health service delivery (Nangendo and Kyaddondo 1997), but few have studied the political consequences[1] of the nonstate provision of health services and particularly its implications for accountability (Reinneka and Svensson 2003). Yet multilateral development agencies and bilateral donors are increasingly recognizing the value of accountability mechanisms in protecting the rights and obligations of democratic citizenship.

This study addresses two questions. *Why do citizens choose NSPs instead of free public health services? And what are the political consequences of the nonstate provision of health services?* In other words, how do the experiences of nonstate provisioning strengthen or undermine citizens' capacity to seek accountability? This article contributes to an emerging research agenda on the political consequences of nonstate provision of services.

The next section of the article explores the relevant theoretical literature. The third section highlights the methods of empirical data collection that inform the article's analysis. The fourth section presents and analyzes the findings. The conclusion highlights the implications of the study for theory and practice.

Theoretical Debates around the Politics of Nonstate Provision

NSPs are all providers outside of the public sector (Cammett and MacLean 2014). These may include national and international actors that are motivated by for-profit incentives or nonprofit, philanthropic missions (Moran and Batley 2004). In Uganda, these actors may include nongovernmental organizations (NGOs), faith-based organizations, private companies, small-scale informal providers, and individual practitioners.

The above discussion of public health services makes the lines between public versus private seem readily distinguishable, but in actuality, the health sector is complex, and the boundaries between the state and NSPs are frequently blurred (Brass 2014; Cammet and MacLean 2014). For instance, NSPs may receive significant levels of state financing or subsidies and even deliver services from state-owned offices and buildings. In some cases, civil servants may work in both private and public organizations.

In addition to describing the dynamics of the expanding nonstate sector in healthcare in Uganda, this article focuses on the political consequences,

specifically how nonstate provision affects accountability for citizens. Accountability with respect to social welfare entails citizens' ability to hold providers liable for the quality of services received and, more fundamentally, for the process and experience of seeking and obtaining services (Cammet and MacLean 2014).

Scholars on nonstate actors argue that the fragmented systems of social service delivery make it harder for citizens to locate appropriate providers and, if necessary, to assign blame to and seek compensation from specific entities (Post 2014). In other words, nonstate provision potentially diminishes providers' responsiveness to beneficiaries. However, two main sets of factors condition the political effects of nonstate provisioning, including the type of NSP and its relationship to the state; hence, NSPs may boost or undermine state accountability, depending on the type and goals of NSPs (Cammett and MacLean 2014).

Nonstate provision may affect citizens' everyday practices of political participation and relationships with their states. Encounters with NSPs may mobilize and empower—or demobilize and frustrate—citizens to new frequencies and intensities of political participation and may affect whether and how they demand accountability from their governments. Standard definitions of political participation emphasize voter registration and voting, but less sporadic and more everyday types of nonelectoral activities, such as attending a community meeting or contacting a politician for help with an issue, are also important modes of participation (MacLean 2011). If states neither provide nor receive credit for providing basic social services for their populations, their citizens may feel that their governments do not serve them and, as a result, will be less politically engaged and even trusting of public institutions and authorities when an issue arises.

This section of the article has thus far yielded insights into experiences of nonstate provisioning of services and how it affects accountability, but alternative explanations are available. First, decentralization has emerged as a goal of many developing countries since the 1980s (Agrawal and Ribote 1999). One of the objectives of decentralization is to enhance accountability. By bringing government decision making closer to citizens, decentralization is widely believed to increase public-sector accountability. However, if powers are decentralized to actors unaccountable to their constituents, or accountable only to themselves or superior authorities within the structure of the government, then decentralization is unlikely to accomplish its stated aims. Only when constituents come to exercise accountability as a countervailing power is decentralization likely to be effective. Second, globalization allows for new transnational mechanisms, like the transnational networks of accountability that enhance citizens' ability to seek redress. These networks have been formed in response to local problems, others coalesce around issues affecting many countries at once, and others still contribute to the development and spread of norms. These networks consequently affect the behavior of states (Keck and Sikkink 1998). Third, the nature of the regime shapes accountability. Fear of being arrested or killed forces citizens not

to demand accountability, as is witnessed in many developing countries. So do experiences of nonstate provisioning affect citizens' capacity to seek accountability, or are alternative explanations applicable? In the section below, I explore whether the experiences of nonstate provision of health services have strengthened or undermined citizens' capacity to demand for accountability in Uganda.

Research Design and Methodology

This investigation used a carefully selected case study design to reveal insights into the experience and meaning of nonstate provision in health-care on the ground. Most of the data collection was carried out in Mukono District and Kampala City in Uganda between May and September 2013. Mukono is an excellent case study because of the variation found along critical dimensions, such as degree of urbanization, level of infrastructure, and wealth; it lies close to Kampala, just twenty kilometers from the district headquarters. Its residents have access and have experiences with public and nonstate health facilities in not only Mukono Municipality, but also Kampala, where the best health-care services—whether public or private—are located. Mukono District contains both urban and rural parishes; the urban areas tend to be affluent, but the rural areas are predominantly poor.

This district thus reflects the general situation of other districts in the whole of Uganda. In general, the health situation in most districts across the country has deteriorated over time (EPRC 2010). For instance, the report of the Parliamentary Committee on Health on the ministerial policy statement for the health sector for the year 2012–2013 indicates the challenges that are "diminishing the state of health service delivery"[2] in the country as a whole and making health-service delivery almost a part-time activity. This is partly due to the low operational budget for the Ministry of Health, evidenced by the fact that "the per capita health cost has averaged USD 10 for over the last five years compared to the recommended per capita of USD 48 as per the minimum healthcare package."[3] This grave situation in turn promotes and benefits the expansion of private healthcare facilities. The choice of Mukono is therefore representative of the country situation overall.

The study mainly used qualitative methods of data collection, including interviews and focus-group discussions. These less structured methods of data collection allowed probing and in-depth inquiries in comparison to a standardized questionnaire. These data captured the experiences of different actors in health-service delivery as well as the political consequences of its nonstate provisioning for average citizens in Uganda. I targeted the local residents or the beneficiaries of public and private health facilities. I purposely selected one public health center (ten respondents), one private for-profit health center (ten respondents), and one private nonprofit (PNFP) health center (ten respondents). All these health centers were at a level of Health Center 1V in the categorization of health centers in Uganda. The

respondents were randomly selected from those who were waiting to be served or had already been served to find out their experiences of the public or private provision of healthcare. Whereas the original target was to get data that would be representative of Mukono, the realities on the ground during the process of data collection did not allow me to attain my objective fully. If the targeted respondent was not interested in being interviewed, I would move to the next in line. In total, I interviewed thirty people from these three types of health centers using a semistructured interviewer-administered questionnaire. The sampling strategy chosen therefore may not allow us to claim that the data collected are fully representative of Mukono.

I used focus-group discussions to elicit insights about the nature of state versus nonstate provision and accountability. Using an interview guide as a tool of data collection, I conducted five focus groups, composed of five to ten people each, selected from one parish (Kirowoza) in the district that is close to Mukono Municipality and one other rural parish (Nakisunga), far off from the city. I used the chairperson local council 1 (the political head of the lowest administrative unit in the district—the village) to mobilize respondents to constitute the focus group.

Finally, I conducted interviews with a range of key informants involved in the health sector, notably workers in health centers (5), members of Parliament on the Social Service Committee (both opposition and ruling party members) (5), journalists in Uganda who write on the politics of service provision (3), and academics teaching at universities (3). Local councilors of Mukono District (5) and other key opinion leaders (2) were also interviewed. Interviewees were purposively selected. Documentary information regarding the state of health-service provision in the country was reviewed from the Parliament of the Republic of Uganda, Mukono District local government headquarters, and think tanks and research organizations, such as ACODE and Makerere University Institute of Public Health.

Understanding the Political Context in Uganda

In Uganda, the National Resistance Movement (NRM), led by Yoweri Museveni, came to power in 1986 after more than two decades of civil war and political instability (Rubongoya 2009), with a promise of total commitment to democratic reform and improved service delivery. The first two decades or so of NRM rule brought order and commitment to service delivery until 2006, when the constitution was extensively amended to enable the president to stand for another term, popularly known as a third term. Measures were introduced to centralize power, among them reduction of the power and independence of the local councils, with the abolition of the graduated tax, increased powers of the resident district commissioners (representatives of the president at the local level), and the creation of more and more districts—which meant increased expenditures on public administration, with

local governments relying increasingly on the central government to fund the provisioning of social services (Ulriksen and Katusiimeh 2014).

A growing number of Ugandan scholars, including Makara, Rakner, and Svasand (2009), Mwenda (2007), and Rubongoya (2007), have demonstrated how Museveni has manipulated the population, state institutions, and government in a bid to hang on to power. He has brought the state virtually under his total control, to the extent that it runs as he wishes (Wild and Domingo 2011). He has maneuvered what would have been genuine efforts toward democratization and economic reform so as to concentrate power in the executive and himself. Freedoms have been curtailed, especially with the passing of the Public Order Management Bill, which political commentators interpret as a move to limit the space for demonstrations and public assemblies. Meanwhile, cases of corruption involving high-profile government executives seem to be on the increase. Some independent media organizations still function, but there are also reports of increasing crackdowns, including through proposed new legislation. Although a large number of civil-society organizations exist, many focus on service delivery and remain relatively immature in their roles as accountability actors (Katusiimeh 2004).

The Health System in Present-Day Uganda

Nonstate provision has a long history in Uganda. In the colonial period, religious missions were the dominant source of healthcare provision in the country, primarily catering to the health needs of the indigenous population, especially in rural areas (Robinson and White 1997). These religious groups believed they had a distinctive role to play in service provisioning as an extension of their evangelical work. For example, the first hospital established in Uganda was Mengo Hospital, founded in 1897 by Anglican missionaries, and Rubaga Hospital was founded by Catholic missionaries in 1899.

Colonial authorities adopted a fairly relaxed attitude toward faith-based organizations in the absence of their own concerted efforts to develop health facilities for Africans. It was only in the later stages of colonial rule that state investments were made in health facilities, for the most part building hospitals in urban areas for the benefit of civil servants, traditional elites, and Europeans, partly as a means of securing political legitimation in response to the growing popularity of emerging nationalist movements. For example, the national referral hospital was completed in 1960, two years before Uganda became independent from British rule.

After the end of British colonial rule, the first independence government of Milton Obote expanded public healthcare provision by building twenty-two large hospitals, distributed in almost every region of Uganda. Despite these initiatives, the nonstate sector remained dominant in health provisioning, even in the postcolonial era (Kaija andOkiira Okwi 2003).

The political and military turmoil of the 1970s and 1980s meant the government retreated from funding and providing public goods and services

of many types. In healthcare, the burden was taken up by the private, for-profit sector and religious nonprofit providers. The latter mobilized external resources from outside donors to sustain their activities (Republic of Uganda 2001). Despite efforts by the private for-profit and nonprofit sectors, health indicators fell dramatically over this period.

Structural adjustment programs, implemented in the 1980s, worsened the situation as emphasis was put on the reduction of government expenditures and cost sharing was introduced in government health facilities (Kaija and Okiira Okwi 2003). Following the restoration of peace in the late 1980s and during the subsequent economic recovery, the Ugandan government implemented a major program of infrastructure rehabilitation in the public health sector. Generally, the mid-to-late 1990s were a period of institutional reform in the health sector. The government initiated the process of preparing a national health policy and a health sector strategic plan (Tashobya, Ssengooba, and Oliveira-Cruz 2006). The sector-wide approach was officially launched in August 2000, its blueprint being the health sector strategic plan of 2000–2001 to 2004–2005. This document contains a clear statement of the health sector's mission. Other reforms in the health sector included abolishing user fees, which subsequently led to an increase in demand for health services, and devolution, which led to limited recurrent funding for health facilities as districts prioritized areas other than healthcare (Nsibambi 1998). While the health infrastructure has improved, the quality of public services has not improved at the same pace, now reflected in the continued high demand for privately provided care.

Today, the modern health sector in Uganda is composed of four types of facilities: hospitals and health centers 1V, 111, and 11. These facilities can be government, private for-profit, or PNFP operated and owned. These actors (including private) operate under the policy and institutional framework set by the Ministry of Health under the relevant laws and the associated health-sector strategic plans. The challenge is weak state capacity in ensuring that laws be implemented and health services be regulated to ensure effectiveness across the board (Taylor 2011).

In all public health facilities, curative, preventive, rehabilitative, and promotive health services are free, the Ugandan government having abolished user fees in 2001 (Health Sector Strategic and Investment Plan 2010). A notable exception, however, is that user fees remain in the private wings of public hospitals.

The private sector plays an important role in the delivery of health services in Uganda today. The private health system is comprised of PNFPs, private health practitioners (PHPs), and the traditional and complementary medicine practitioners (TCMPs), who may also work for profit. The contribution of each subsector to the overall health output varies widely. The PNFP sector is more structured and prominent in rural areas. The PHP sector is growing fast, and most of its facilities are concentrated in urban areas. TCMPs are present in both rural and urban areas, even if the services provided are not consistent and vary from traditional practices in rural areas

Table 1. Healthcare facilities in Uganda, 2006–2010

Year	2006				2010			
Indicator	GOVT	PNFP/ Private Not-for-profit	PRIVATE	Total	GOVT	PNFP	PRIVATE	TOTAL
Hospitals	59	46	8	114	64	56	9	129
Health Centre 1V	148	12	1	161	164	12	1	177
Health Centre 111	762	186	7	955	832	226	24	1082
Health Centre 11	1332	415	261	2008	1562	480	964	3006
Total	2301	659	277	3237	2622	774	998	4394

Source: Health Sector Strategic and Investment Plan, 2010.

to imported alternative medicines, mostly in urban areas. The government recognizes the importance of the private sector by subsidizing the PNFPs, a few private hospitals, and PNFP training institutions (Orem et al. 2011).

In urban municipalities and Kampala, private health facilities outnumber public facilities. This is not a reality in rural Uganda, where few private health centers exist, and those that are private are characterized as drugstores. Most Ugandans live in rural areas. The rural percent of the national population was last reported at 86.70 in 2010, according to a World Bank report published in 2012. According to the national statistics, the government runs 60 percent of the hospitals and health centers. Not-for-profit organizations (mostly faith-based) run just under 20 percent. Private for-profit organizations run just over 20 percent, mainly in urban areas (Health Sector Strategic and Investment Plan 2010). Unrecognized small private units are innumerable.

Why People Choose Nonstate Actors in Health-Service Delivery in Uganda

With the availability of free health services since 2001 in all public health facilities, it is surprising that some Ugandans still shun them in preference for NSPs. Focus-group discussions with Mukono residents reveal that not only do Ugandans prefer private health centers, but many have not frequented a public health facility for quite a number of years. One said, "I don't know when I last visited a public health center; probably when I was taking my son for immunization four years ago." Another expressed disdain for public clinics in terms of the costs incurred to avoid them: "I stay very far from where private clinics are in town, but I'd rather incur costs of transport and medical care than go to public health facilities."

Another talked about how rare visits to public health facilities were: "I come to public health facilities rarely, when I don't have money, but given a choice, I wouldn't come."

Our data from the fieldwork reveal several reasons why Ugandans prefer private health facilities. First is good customer care. One respondent said, "There's good customer care in private healthcare facilities. Health workers smile at you, and that heals psychologically, and it motivates [you] to come back when you aren't feeling well." The second reason is the availability of drugs. One respondent said, "The major problem I face in public health facilities is [the] nonexistence of drugs. While the medical personnel at times may be available, it's by luck that you're prescribed medicine, and you find it there." Still, patients may not mind how expensive services are, as long as they meet satisfactory standards: "While private healthcare facilities are expensive, one is assured of better services." By better services, respondents are making comparisons with other services, especially those provided by private health facilities. This is in terms of customer care, existence of drugs, and availability of health personnel, including medical doctors, as already indicated by other respondents.

The responses quoted above were common. More than 90 percent of the thirty respondents interviewed at the health center waiting to be served, or who had already been served, had similar views.

In addition to these observations, my interviews with health workers reveal that they operate under demotivating terms and conditions. Their lack of morale undoubtedly contributes to the low popularity of public health facilities from the viewpoint of patients. A newly hired medical officer in a public health facility, for example, earns less than UGX 2,000,000 per month (approximately US$800). This is little money compared to other agencies of government, like Kampala Capital City Authority, which pay the same salary to lower categories of staff, like drivers.[4] Incomes earned by doctors in private facilities are almost the same as those of their government counterparts. This is why many health workers trained on Ugandan taxpayers' money are migrating to Rwanda and other neighboring countries, where they receive substantially more pay. It explains why 54 percent of the doctors in the private sector also work in the government sector (Health Sector Strategic and Investment Plan 2010–2015), as they have to supplement their incomes.

Our field observations and interviews reveal that health workers in public health facilities share a poor work ethic, which manifests itself in absenteeism, tardiness, rudeness to patients, fewer hours worked, and informal solicitation of bribes from patients.[5] All in all, respondents preferred private healthcare facilities because of high-quality services compared to the services offered by their public healthcare counterparts. In the public health facilities, low-quality services are reflected in poor infrastructure, lack of medicines and other supplies, shortage of human resources in the public sector, low salaries, lack of accommodation at health facilities, and other factors that further constrain access to high-quality service delivery. The

poor quality of the public sector facilities has in turn spurred the expansion of private facilities. It remains to be seen how this affects citizens' accountability capacity.

Explaining the Political Consequences of Providing Nonstate Health Services

With the challenges experienced in health-service delivery outlined and explained in the previous section, one might expect citizens to be up in arms, holding health providers accountable, individually or as a group, so I asked respondents: "What actions have people employed to hold government or public servants or health workers accountable for the poor state of health services in the country?" I categorized the range of responses from the focus-group discussions. After mentioning the form of accountability, the respondents were charged with reaching a consensus on whether this mechanism of accountability was common, rare, or possibly not at all used.

The forms of accountability that they mentioned include strikes, public demonstrations, boycotts, civil disobedience, public interest litigation, writing letters to the press, using suggestion boxes at health facilities, writing directly to the local and national political representatives, and direct complaints to management. Most respondents did not know how to respond to the question and were unsure of whether they had been engaged in one way or another in holding the government accountable for the poor state of services. Further probing (i.e., mentioning the possible forms of seeking accountability) showed that citizens rarely used the avenues of seeking accountability in health-service delivery, especially in public health facilities. In contrast, in private health facilities, the beneficiaries tend to complain more directly to management or through a suggestion box (table 2).

Below, I discuss the dynamics of contention (or lack of protest) for several different forms of accountability, and thereafter I explain the link between NSPs and state accountability.

Strikes, Boycotts, Demonstrations, and Civil Disobedience

Strikes, boycotts, demonstrations, and civil disobedience are common forms of accountability normally employed when things have gotten out of hand. In a country like Uganda, which is experiencing a crisis in the healthcare system, one might have expected people to engage in strikes, boycotts, and demonstrations or engage in acts of disobedience.

Evidence in the field indicates the contrary. For boycotts, it is only for those who have money and have boycotted going to health facilities where there are poor services, especially public health facilities; in other words, they shun public hospitals and choose to go to private ones. This applies mainly in urban areas, where a variety of NSPs can be found. However, most

Table 2. Forms of accountability used in public versus private health facilities in Uganda

	Public health facilities			PNFP			PFP		
Accountability mechanisms	Common	Rare	Not at all	Common	Rare	Not at all	Common	Rare	Not at all
Strikes, boycotts, and civil disobedience		✓				✓			✓
Public interest litigation		✓				✓		✓	
Engaging the media		✓				✓			✓
Mob violence		✓				✓			✓
Suggestion boxes		✓		✓			✓		
Complaining directly to managers or proprietors		✓		✓			✓		
Community meetings		✓				✓			✓
Engaging local and national politicians		✓				✓			✓

Source: focus-group discussions.

respondents interviewed indicated that they fear to take on the state machinery and its repercussions by engaging in strikes, riots, demonstrations, and civil disobedience. They say those actions are too dangerous, as people who have repeatedly engaged in such protests end up losing their lives or getting blacklisted and are then unable to benefit from other desirable government programs, such as the National Agricultural Advisory Services. Some participants expressed fear at being labeled enemies of the state. A case in point was a protest at a government health facility against the lack of basic services,[6] whose repercussions were reflective of the general political situation in Uganda. The fear of an oppressive and vengeful regime may explain the lack of engagement in strikes, demonstrations, and boycotts.

Public Interest Litigation

Public interest litigation is an effective mechanism for amplifying the voice of citizens and their quest for accountability in public administration, especially when public criticism tends to fall on deaf ears. Litigation is a powerful tool because it can help clarify the obligations of the state and transform them into legal duties that the state must implement. Asked why citizens do not think of using public litigation, most were unaware, and those who were aware considered it to be too expensive and time consuming. In one focus group discussion, a resident of Kirowoza said this about public interest litigation:

> I'm getting to know of this mechanism now after explaining it to me, but how can I sue the state for the poor state of health services? Is it possible? Can anyone sue [the] government anyway in any form? In any case, it must be very expensive. People sell their pieces of land to take a case in court, and I guess I wouldn't dare.

This quote highlights why many Ugandans consider public litigation to be too expensive. However, despite evidence for the dominance of this general view in our focus group discussions, recent newspaper reports have described how some NGOs have assisted citizens in taking health workers to court over negligence.[7] The Centre for Health, Human Rights, and Development, a Ugandan nonprofit group, has tried without success to take up issues against the Ugandan government's neglect of the health sector that has resulted in the deaths of many. One of its strategies has been to present constitutional petitions or cases in court.[8] The cases have not succeeded, as the state has been able to argue against the petitions as speculative. Its other line of defense had been that there are other competing fundamental rights which the state has to make provision for from its meager resources. People's ignorance of the use of public litigation and the perception of the expensiveness and bureaucratic process explains the lack of action to seek accountability for health services.

Engaging the Media

The role of the press as a forum for public discussion and debate has been recognized. The notion of the media as watchdog, guardian of the public interest, and conduit between governors and the governed remains deeply ingrained. Uganda has had a vibrant press.[9] A good number of people own a radio, and they listen to what is being said. However, only a small percentage of the population can afford to buy newspapers and watch television. Even "those who listen to the radio cannot effectively participate in the talk shows, as most have no money to buy air time to call."[10] Participating in radio talk shows and writing in newspapers is for urban elites. As one key respondent said, "A few urbanites write letters in the newspapers and call in live talk shows on radios complaining about the poor state of health services." Poverty is therefore partly responsible for the lack of action to seek accountability, and the consequence is that issues that focus on accountability for public funds and health-service delivery are little discussed.

Mob Justice

Mistrust of courts leads people to resort to extrajudicial mechanisms, like mob justice. My findings show that people have sometimes, though rarely, taken the law into their hands. Respondents indicated that they had never witnessed mob violence related to poor health-service delivery, but they had heard of it in health centers elsewhere, or had read about such actions in the newspapers. For example, the *Daily Monitor* reported that people had lynched health workers in Kamuli District when an operation had gone wrong and the patient had died, but the health workers had demanded a bribe. As a Member of Parliament explained, "These cases are not many. They are just a drop in the ocean. There are a few instances here and there."[11] Cases of mob violence may increase if the delivery of health services does not improve. Nevertheless, mob justice is a rude way of seeking the accountability of health services.

Suggestion Boxes

Most private health facilities have suggestion boxes, in which people may put their complaints. This is especially true in the private health facilities, particularly missionary-founded hospitals, popularly called NGO hospitals. According to one health worker in the nonprofit health facility:

> Church members of Mukono Cathedral go directly to the diocesan offices to complain about what they see that is not good. Those who personally know members of hospital management, they directly go to them and complain. Some even come here at the administration desk and complain to us.

Interviews reveal the ineffectiveness of this form of accountability. According to the administrator of Mukono Church of Uganda Hospital, "Suggestion boxes are grossly abused and as a result are never taken seriously."[12] The interviews show that personal engagement with hospital administration does bring about change, especially when influential members of society are involved. In public health centers, the absence of suggestion boxes indicates the unwillingness of the staff and management to encourage openness for clients to seek accountability.

Complaints to Management or Proprietors

Direct complaints to management over service delivery are critical to improving the provision of social services. While the clients of health centers mentioned that it is rare for citizens to complain directly to the management of healthcare facilities, as they feel nothing much will result, a few respondents, especially health workers, said that members of the public do exert pressure on them, in one way or another. A medical doctor who has worked in both public and private health centers explained:

> Sometimes, in private hospitals, they will air their views directly to the administrators. You see those who come to private hospitals are learned, unlike those who go to the public hospitals. They know their rights."

Clients' failure to engage proprietors and managers directly may also explain the lack of action to seek accountability in health services.

To promote community participation, the government established health-unit management committees (HUMCs) at each government health unit.[13] These committees were largely to provide oversight and link management and communities; however, they worked for only a short time and now are not functional. This was revealed in several interviews and corroborated by focus group. A key informant had this to say.

> In [the] 1990s, these health-unit management committees were very functional, meeting regularly, and health unit in-charges were secretaries and kept minutes of meetings. A health center would not be closed during working hours, and health workers knew these committees were their bosses. The motivation for these committees and staff was the [*sic*] mainly user fees charged on patients and used at facility level.
>
> As you will recall, in [the] 2001 elections, Jim Muhwezi, the then Minister of Health, panicked due to constant maternal mortality rates, infant mortality rates, and child mortality rates. The president was told during campaigns that user fees were denying women and children access to health services, and that's why maternal and children [*sic*] death was constant.

> Museveni politically responded by removing these fees in order to win elections. Dr. Kizza Besigye was then mounting pressure. Graduated tax also went in [the] same vein.
>
> User fees were replaced by primary healthcare conditional grants, and these funds would be managed by chief administrative officers or district health officers, and facilitation for health-unit management committees stopped, whereas user fees would be managed at [the] health facility level to buy additional supplies or drugs, repair or maintain infrastructure or equipment, [and] pay allowances for staff overtime, fuel, meeting allowances, et cetera. Primary healthcare grant [*sic*] only covers limited costs. Because of [the] centralization of funds and management, these committees lost morale and interest. Now they are there in name, but no work is done. No wonder health facilities are rotting away!

These views are consistent with the findings of Hutchinson, Habte, and Mulusa (1999) in the World Bank discussion paper that found that the link between the HUMCs and their communities was often undeveloped, the members of the HUMCs did not know their responsibilities, and community members did not know that HUMCs existed. The failure to make the HUMCs functional may explain the lack of citizens' participation in the management of health services—which in turn has hampered citizens' capacity to seek accountability.

Community Meetings

Community meetings are another of way of demanding accountability. The most famous are barazas, which resulted from a presidential initiative adopted in 2009 to create space for citizens' advocacy. Barazas are spearheaded by the office of the resident district commissioner. They bring together stakeholders from three sectors: government officials who make policies; people who, as public service providers, implement policies; and the public, the consumers or beneficiaries of services. Barazas provide an opportunity for local communities and their leaders to share public information, with a focus on effectively monitoring the provision of public services (on the leaders' part) and demanding accountability and transparency (on the local population's part).Unfortunately, however, barazas have become vulnerable, hijacked by the political elites, especially the resident district commissioners, chief administration officers, and local members of parliament in localities that are strongholds of the ruling National Resistance Movement (NRM).[14] This means that the opposition views barazas as NRM platforms, which are not fit for them. This could explain their lack of popularity. According to many interviewees, few have attended barazas because they think nothing can be achieved. Fear of the regime may explain their lack of attendance. Alternatively, many are unaware of why barazas were instituted.

Engaging Local and National Politicians

Citizens' engagement with politicians is critical because politicians are expected to represent the masses and act as a channel for their grievances. The clients of private health centers mentioned that it is rare for citizens to complain directly to the local and national politicians, as they feel nothing much will result, but a few respondents, especially health workers, said that the public exerts pressure on them in one way or another. A medical doctor who has worked in both public and private health centers explained:

> In public hospitals, whenever clients have issues, they run to politicians. They write to politicians, and in turn they come to embarrass us. They come shouting and quarreling. They also insult us. They think we are the ones who are taking away drugs. In private hospitals, it is different: they may insult, but will not go to politicians, and they will vote with their feet and go to other facilities for healthcare services.

This assertion agrees with Liebowitz et al. (2015), who find evidence that Ugandans are placing increasing demands and expectations on their leaders in relation to service delivery; however, with commercialization of elections, in which many Ugandans ask politicians for personal favors before and after elections, this is not likely to lead to people's increased expectations of service delivery.

Instead of using public interest litigation or demonstrations or strikes or other forms of accountability explained above, respondents said that they have paid bribes—what they normally call *kasiimo*[15]—to workers in public health facilities to get health services. Asked why they have to pay a gift or a direct bribe to a public health servant for a service and not complain about the poor state of services, most responded by saying there was no alternative. One said, "If you don't pay, you will not get served, as there is always a long line waiting to be served, so you have to give something." In any case, in a context where respondents think everyone is corrupt, including their bosses and the police, the supposed guardians of the public good, no one will take action.

The discussion above clearly indicates a lack of an actively united citizenry to demand better health services in Uganda, either individually or as a group. Failure to demand better health services is not entirely surprising. Olson has argued (1965) that collective action is rare. The basic problem is that within the scope of his model, individuals acting in an economically rational way does not contribute to the provision of a public good. This is even the case when people can utilize the good after it has been obtained. The findings are consistent with the expectations of collective action theory.

The findings of this study suggest other observations. First, there is a disconnect between urban elites, who have access to private healthcare services, and the rural poor, who mainly access government healthcare

facilities. If no private-sector providers of health services existed, the urban rich and the rural poor would probably join together to demand the improvement of public health services, since they all would be affected the same way. Thus, one can say that NSPs have undermined citizens' capacity to demand accountability; however, effective accountability mechanisms work under dictatorial regimes only with difficulty. Fear of oppression keeps the urban-based political opposition from connecting with the rural populace to build a coalition to demand accountability. This finding is consistent with the findings of Escribà-Folch (2013), to the effect that dictatorial regimes advocate for restrictions on civil rights to prevent coordination, thereby hampering collective action from within the population. This means that even if the NSPs were absent, it would be difficult to have effective accountability in Uganda under Museveni's regime.

Demands for accountability for service delivery were weakened by the abolition of the graduated personal tax in 2005, a direct tax, which every able-bodied man must pay.[16] It was an attempt to tax the informal sector, and it had wide coverage in rural and urban areas (Kjaer and Katusiimeh 2012). Currently, it is only the salaried, working class, especially in the urban areas, that pays a direct tax. With the abolition of the graduated personal tax, every service received comes like a gift. According to the view of an MP who sits on the Social Services Committee in parliament, this makes it extremely difficult for the illiterate, rural majority to relate tax payment and service delivery, as opposed to their educated counterparts in the urban areas.[17] With the majority—the rural poor, who access low-quality health services—unable to team up with the urban elite, this tax splits and undermines the potential coalition that might mobilize and demand accountability from the government.

As a result, rural people are generally unaware of the roles of local council leaders and other politicians, like members of parliament. In the focus-group discussions in Nakisunga Parish,[18] community members were shocked when researchers enumerated the roles and responsibilities of the councilors, especially regarding the need to meet and exchange views with the electorate and monitor the delivery of services. People were unaware of their right to hold councilors accountable on these issues and had almost given up hope of advocating change from a grassroots level. This supports what Muyomba-Tamale et al. (2010) found in Goma Subcounty, whose perpetual water problem the local area councilor influenced the council to solve by providing taps. In the citizens' view, the councilor had done them a favor, yet that was his job: the community was entitled to councilor support as a means of increasing the effectiveness of local services. Participants in most focus groups perceived a breakdown in the delivery of political services chain, thinking the president is better equipped to improve local services than their own councilors.

In sum, there is lack of mobilization for an active united citizenry to demand better services because of fear of being labeled enemies of the state,

lack of awareness of beneficiaries regarding their rights, and dynamics of politics associated with rise of the nonstate providers.

Conclusion

This article has sought to establish and analyze the causes and the consequences of NSPs of healthcare in Uganda. Specifically, it studies how the experiences of nonstate provisioning strengthen or undermine citizens' capacities to seek accountability. Overall, experiences of nonstate provision of health services undermine the accountability capacity of citizens related to the failure to build a coalition of rural and urban citizens to demand better health services; however, poverty, a lack of awareness of citizens' rights, and other factors undermined this capacity. In addition, this study shows that the dictatorial nature of the government in power, by restricting political freedoms, makes accountability for delivery of health service almost nonexistent. In developing countries under somewhat authoritarian rulers, the climate of fear as a result of undemocratic tendencies undermines citizens' capacity to seek accountability. The article therefore makes a contribution to theoretical debates about how citizens of countries that have conditions similar to those of Uganda exercise their political rights in a variety of arenas and how enhancing service delivery through accountability may be difficult.

This article's analysis has implications for both theory and practice. Scholars, politicians, practitioners, policy makers, and citizens need to reflect more systematically and deliberately on the experiences of the nonstate provision of services. This study concentrates on the health sector of the Ugandan economy. A need remains to investigate conditions under which nonstate provisioning promotes or undermines accountability in other settings and sectors, so lessons can be learned to improve life in Uganda and elsewhere in the developing world. In addition, the issues raised invite further study with a bigger sample and quantification for better understanding of these issues in Uganda and elsewhere.

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NOTES

1. The political consequences of NSPs relate to equitable and sustainable access to welfare, accountability for citizens, and state capacity (Cammett and MacLean 2014). This study focuses on accountability for citizens.
2. *The Parliament of Uganda: Report of the Parliamentary Committee on Health on the Ministerial Policy Statement for the Health Sector for the Financial Year 2012/2013,* p. 5.
3. The New Kampala Capital City Authority Structure, February 2012.
4. See also Cook (2014) on the solicitation of informal payments by public sector health workers in Russia.
5. According to the *Daily Monitor* ("Iganga MP Arrested over Hospital Demonstrations," 30 July 2013), activities on 29 July 2013 at Iganga District Hospital were paralyzed after a demonstration by the Municipality MP Peter Mugema, who was protesting a month-long lack of water at the government health facility. Police arrested him and dispersed the demonstrators.
6. The *Sunday Monitor* reported on 19 May 2013 that a widower whose wife had died at Nakaseke Hospital after she had allegedly been neglected for more than ten days while in labor, had blamed the health facility for the incident and sued the district local government since it had been directly in charge. David Mugerwa told Kampala High Court Judge Benjamin Kabiito that his wife, Irene Nanteza, should still be alive. He said that two doctors attached to the hospital had gone to Kampala and Nakasongola districts, leaving the hospital in nurses' hands. He testified, "I believe my wife would have not dies [*sic*] if there was a readily available doctor to attend to her when she went into labour. . . . I pray [the] court finds that my wife's right to life was violated[,] for which I am demanding damages. I also want [the] court to send out a warning that such an unfortunate scenario does not happen to any other woman."
7. Constitutional Petition 16 of 2011 is a story of two women, Sylvia Nalubowa, who died in Mityana Hospital on 19 August 2009, and Jennifer Anguko, who died in Arua Hospital on 10 December 2010. After Sylvia Nalubowa had delivered a baby at Manyi Health Centre III, a government healthcare facility in Mityana, it was discovered that she was to have twins and required emergency obstetric care to deliver the second baby. She was transferred to Mityana Hospital, where she and the second baby died; at the hospital, the mother's attendant had had to pay for three bottles of rehydrating water. In another case, on 10 December 2010, Jennifer Anguko checked into Arua Hospital, a regional referral government facility. She received no medical treatment for more than ten hours. Valente Inziku, her husband, claimed that even when she was at the point of death, the midwives had rebuked him for interrupting their conversation.
8. HRNJ-Uganda released a report, "Impact of Liberalization and Commercialization of the Media in Uganda," in Kampala on 2 May 2012, one day after World Labour Day and hours before World Press Freedom Day. The report, a result of a study carried out in various media houses, established that commercial interests were overriding the quality, content, and working environment of media outlets.
9. Interview with a journalist (who asked to remain anonymous) working for the *Daily Monitor,* an independent newspaper.
10. Interview with the Sheema District woman Member of Parliament, 2 May 2013.
11. Interview with the administrator of the Mukono Church of Uganda Health Center.

12. See details on these committees at http://www.health.go.ug/docs/Guidelines%20on%20Health%20Unit%20management%20committees%20for%20Health%20Centre%20III%20%282003%29.pdf.
13. "Barazas' [*sic*] the Replacement of 'Bimeza' Not an Effective Option," *Uganda Picks,* posted on 22 March 2012.
14. The strategic and investment plan of the Ministry of Health calls it unofficial fees.
15. Interview with the Sheema District woman Member of Parliament, 2 May 2013.
16. Interview with the Member of Parliament for Mbarara Municipality, 3 May 2013.
17. Focus-group discussion conducted on 22 August 2013.

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