

THE POTENTIAL OF THE PRIVATE SECTOR TO IMPROVE HEALTH OUTCOMES IN UGANDA



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Abbreviations and Acronyms

ADB	African Development Bank
AMREF	African Medical Research Foundation
ANC	Ante-natal clinic
CAO	Chief Administrative Officer
CME	Continuing Medical Education
CMR	Child Mortality Rate
CUAMM	Collegio Universitario Aspiranti Medici Missionari
DDHS	District Director of Health Services
DFID	Department for International Development
EPI	Expanded Programme on Immunization
EU	European Union
FGDs	Focal Group Discussions
GNP	Gross National Product
HC	Health Centre
HMIS	Health Management Information System
IHSP	International Health Systems Program
IHCAR	International Health Division of Karolinska Institute
IMR	Infant Mortality Rate
KI	Key Informant
MMR	Maternal Mortality Rate
MoH	Ministry of Health
MUIPH	Makerere University Institute of Public Health
NGO	Non Government Organization
OTC	Over the counter
PFP	Private for Profit
PNFP	Private not for Profit
PPPH	Public Private Partnership for Health
PSP	Private Sector Providers
RDC	Resident District Commissioner
SCF	Save the Children Fund
SIDA	Swedish International Development Agency
STI	Sexually Transmitted Infections
TB	Tuberculosis

TBAs	Traditional Birth Attendants
THs	Traditional Healers
THPs	Traditional Health Practitioners
THETA	Traditional and Modern Health Care Providers Together Against AIDS
UCG	Uganda Clinical Guidelines
UCMB	Uganda Catholic medical Bureau
UDHS	Uganda Demographic and Health Survey
UMMB	Uganda Muslim Medical Bureau
UPMB	Uganda Protestant Medical Bureau
USAID	United States of America International Development
VCT	Voluntary Counselling and Testing

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In Uganda, the collaborating institution is the Makerere University Institute of Public Health (MUIPH). Each institution prepared its own research project. For Uganda, the agreed research project was the “Potential of the Private Sector to Improve Health Outcomes in Uganda”.

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Executive Summary

The Potential Of The Private Sector To Improve Health Outcomes In Uganda

Background

In Uganda, as in many other developing countries, the rural poor shoulder a large share of the disease burden, but the mix and roles of the health providers accessible to local communities has not been fully documented.

Objectives

This study aimed to document the types of health providers available to rural communities and to quantify the relative importance of these health service providers.

Specific objectives

1. To carry out census mapping of both private and public health care providers so as to assess accessibility of services to the general public
2. To describe the health seeking behaviours of the population and outline how these are related to the findings of facilities mapping
3. To quantify the types and proportion of illness handled by the different providers
4. To assess the range and quality of services provided by the different providers
5. To identify the nature of public-private provider linkages, which include competition, collaboration and referral structures in the health care market
6. To study the effect of policy and regulation on the private health sector

Methods

The study was conducted in three Uganda districts, namely Iganga, Mpigi and Masaka. The research strategies included a household survey, a health facility survey, census mapping of all health service providers in 19 parishes, focus group discussions in the community and interviews with policy makers and selected stakeholders in the health sector.

Results

Census mapping

The census mapping revealed that in the mapped area the informal providers were the most numerous health care providers. Traditional healers made up 67.4% of all mapped health facilities while general merchandise shops that sold medicines made up 9.7%, making the informal providers' total fraction to be 77.1%. The next most common category is the private for profit category, which included private clinics and drug shops, contributing 17.4% of all mapped facilities. Among the formal providers the private for profit category is therefore the most common type of provider available to rural communities. The public facilities contributed 4.4% and the PNFP sector 1.6% of all mapped facilities. The informal providers, however, are usually one-person ventures, which offer a narrow range of services on an irregular basis.

Health seeking behaviour and access to care

Of 1097 sick persons who were studied 41.2% self-treated while 56% visited a formal health care provider and 6.7% visited a traditional healer. The most numerous providers are therefore not the most frequent providers of health services. The most commonly consulted biomedical providers were the PFP group comprising mainly private clinics and drug shops. Of patients who visited formal providers 45% went to the PFP providers, 42% to the public facilities, and 13% to the PNFP. Combining the PFP and with the PNFP as private sector providers (PSP), then the public sector takes 42% of ambulatory health care while the private sector takes 58%. The poor were more likely to go to public (free) facilities than to private facilities and the frequency of seeking health care increases with level of education.

The practice of buying drugs over the counter for self-medication is very common and the choice of where to buy the drugs from is largely influenced by convenience of the location, a reason that was given by 71% of the study group. Traditional healers are the most commonly occurring providers in Uganda but a majority of sick persons seek for health care from biomedical providers with less than 10% visiting traditional healers. Traditional healers are known for treating a narrow range of illnesses. Overall, convenient location was the main reason why persons chose to visit a particular provider, especially for providers in the private sector. On the other hand people visited public facilities when they perceived that an illness required management by personnel with high technical skills. The cost of treatment was not a major consideration when choosing a provider. Instead it appears to influence whether one seeks for treatment or not. The perception that an illness is minor was a major prohibiting factor to seeking treatment. Self-medication is quite common in the country, which calls for health education on the dangers of irrational self-medication. For hospitalisation, the leading choice is public facilities followed by PNFP facilities.

Linkages within and between sectors

Referral is a common practice and about 60% of formal facilities participate in the referral process either as recipients or as referring facilities. Most of this, however, is done informally in an undocumented manner. Sharing services is a less common practice with only 20% of facilities reporting sharing services such as x-rays or laboratory work. It mainly occurs within sectors. Sharing of personnel is quite rare. Only 8% of facilities reported doing it to some degree and it occurs mainly within sectors. Perceived competition is fairly common and occurs between and within sectors. Overall 40% of facilities reported this perception.

Range and quality of services

The range of services provided by formal health facilities addresses the common problems in the community. The public and PNFP sectors provide more preventive services than the PFP sector. The quality of health care in PFP facilities is compromised by unqualified personnel, who have got no access to continuing medical education (CME). Regarding equipment, PNFP facilities were the best equipped while Public and PFP facilities were the worst equipped of all allopathic facilities. In all PFP facilities, lack of functional Health Information Management System or sound health record system was found to be undermining evidence-based management. The worst performers were traditional healers. Most private health service facilities provide services for longer hours than public health facilities, giving patients flexibility in accessing health services. Public and PNFP facilities were better supervised than PFP and TH facilities. The technical quality of formal clinical care in private health facilities is generally good except for the weak laboratory and counselling services

Policy and regulation

Laws have been introduced over the last 10 years to regulate the private health sector. These laws were also intended to promote the formal private sector. It was found that in spite of this the informal sector has larger numbers of facilities than the formal sector although the formal sector receives a much larger fraction of clients. Policies have increased formal private sector participation in health service delivery. There is now increased public awareness and the awareness of policy-makers on the importance of non-state institutions in health service delivery.

The recently enacted laws have been unable to curb professional malpractice because penalties for breaking the laws are not specified in these laws. In addition, the laws are not really enforced due to under-funding of the professional organisations, which are the bodies that are entrusted with ensuring standards. There is poor knowledge about specific policies and laws among the policy-makers and among the public. There seems to be a growing awareness that in the future the private sector will dominate health service provision and that public health services will continue to be dependent on external donors for some time to come. Quality is still a major concern among the PSP especially in those facilities manned by the less than fully qualified providers. This is an area that may benefit from specific intervention.

Conclusions and recommendations

Private health providers, in various forms, remain the closest health providers to most communities in Uganda. Their role in health service delivery needs to be further recognized and fully supported by government through proactive policies and interventions geared at supporting them to deliver high quality and affordable services. While informal health care providers are the most numerous type of provider, most health care is provided by the formal providers. Private providers look after more outpatients than public facilities, while the latter are more popular for admissions. In PFP facilities, the lack of a proper records system undermines the quality of their services. PHC services delivered by private health providers to communities should be strengthened in line with the National Minimum Health Care Package, through policy and interventions such as regular supervision, and affiliation to professional bodies.

Referral is a common practice both within and between the private and public health sectors. Effort needs to be made to ensure that this process is further strengthened by making it a formal documented process in all health facilities.

Traditional medicine practitioners are widely recognised in various communities in Uganda and have got a clientele for conditions that they are reputed to treat. Government should therefore continue to enact laws to regulate the practice of traditional medicine and to encourage sharing of knowledge and experiences amongst themselves and between traditional and biomedical practitioners.

The concept of Public Private Partnership for Health should be broadened to cover all the PFP providers, including private clinics, drug shops and traditional healers to address all their concerns. Quality is still a major concern among the private sector providers with regulations being poorly enforced. There is need to address this shortcoming.

CHAPTER 1: INTRODUCTION

1.1 Background

In all countries of the world, the private health sector is known to contribute to the health of populations through both service delivery and other interventions. In many developing countries, governments, for a long time, had the largest stake in health service delivery. Increasingly, however, decision makers in many of the middle and lower income countries are recognising the emerging significance of private sector providers (PSPs) in health care provision. Private providers are not only recognised by policy makers for the service delivery role alone, they are also getting increasingly involved in the policy making process. Governments in many countries are now increasingly purchasing services from PSPs, including both the “for profit” and the “not for profit”, through contractual arrangements. Many developing country governments were persuaded to change their attitude towards PSPs after recognising that they (governments) could no longer satisfy the health service needs and demands of their populations while continuing to ignore the role of the PSPs. There had to be some working together arrangement between governments and PSPs for the common good. While the roles of PSPs vary across countries, they are quite commonly a major source of health care for diseases of Public Health significance such as tuberculosis, malaria, HIV/AIDS, respiratory tract infections and diarrhoea. This is especially so at the ambulatory (out patient) level. Non-government providers are also often the main source of health care for the poor even in places with free or low cost public services. For example it has been reported that in India 60-80% of TB cases first seek treatment from private providers and two thirds of these stay with PSPs rather than change to public providers (Uplekar et al 1998). Another major finding from India is that 80% of consultations for childhood diarrhoea are with PSPs, most of whom are not fully qualified (Berman 2000).

Access to care

Given the limited resources that can be allocated to health, governments cannot simply establish health facilities to the extent of making them easily and conveniently accessible to all citizens in any location of the country. All countries report access bottlenecks to varying proportions of the populations. The health facility networks of PSPs could therefore become quite handy to ease the access problem, further providing a good rationale for some type of collaboration between public and private health sectors. To date many governments are moving towards this direction of reasoning by formalising linkages between public and private health care providers with the aim of improving access to health care.

Competition

In many communities the efficiency of running an enterprise commonly improves if there is some competition. Private providers in the health sector have demonstrated that they can offer good competition to the public sector. They managed to survive and in many instances even prospered through the periods when governments ignored them. By posing some level of competition with the public sector, private providers are likely to present an opportunity for improving efficiency in the public sector. In Uganda, many studies have demonstrated that there is a vibrant private health sector, which is expanding quite rapidly (Okello et al 1997). The two sectors apparently need each other in order to improve efficiency and for the

purpose of providing the best possible care to all the sick persons that need medical care. To date partnership between the public and private health sectors has become a priority policy of the Uganda government and the structures for implementing this are being formalised.

Access to care in Uganda

For a long time, access to health care in Uganda has been difficult to measure and quantify in terms that all stakeholders will agree with. Officially, access is defined as living within a 5 kilo-meter radius, about one hours walking distance, of a health unit which can deliver both curative and preventive health services (MoH, 1992). Such facilities include both public and private not for profit (PNFP) facilities. The estimate of the proportion of the population living within this radius has varied between 50% and 75%. Many studies have demonstrated that populations both within and outside of this radius continue to get problems with access to health care. The gaps in health care for many people both within and outside of this radius are largely filled by private providers. This situation is not likely to change radically in the foreseeable future. This implies that the private health sector will continue to play a big role in service delivery and that it's potential to influence health outcomes is probably quite large.

1.2 The Uganda Private Health Sector

The private health sector in Uganda can be broadly categorised into Private for Profit (PFP) and Private Not for Profit (PNFP) providers. The PFP group contains both formal and informal providers. Informal providers mainly include general merchandise shops and traditional healers. There are also new (non Ugandan) systems of care such as the Chinese and Indian medical systems.

The PNFP providers

This category of providers is said to be motivated by concern for the welfare of the population. They can be categorised into facility based and non-facility-based providers. A majority of the PNFPs in Uganda are founded and run by religious organisations, while a few are owned and run by NGOs or other philanthropic organisations. The majority of the facility-based PNFP are religious-based falling under three umbrella organisations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB). The bureaux together own 78% of the 490 PNFP health units in the country, while the rest fall under other humanitarian organisations and community based health care organisations (MoH, 2002). The non facility-based PNFPs comprise the majority of local and international organisations working in the health sector commonly referred to as NGOs. They work with counterparts such as government, facility-based PNFP providers, private practitioners, and communities. Their contribution is in areas ranging from social awareness and advocacy to more specific aspects of service delivery. The area of emphasis tends to conform to agency expertise such as special disease programmes, technical assistance, training, capacity building, emergency and relief services and mainstream service delivery. The non facility-based PNFP providers include local ones such as the Uganda Red Cross and international ones such as AMREF, CUAMM, OXFAM and SCF (MoH, 2002). Facility based Private Not for Profit sector has got a large infrastructure base, comprising of a network of hospitals and health centres. It accounts for 42% of the 108 hospitals in the country, and 28% of the 1617 lower level units in the country with a considerable percentage of these units located in rural areas (MOH,

2005). The partnership between public and private sectors has led to strong support of PNFP hospitals from government. Some of them have even been contracted to carry out public roles including supervising lower level public facilities.

The Private for Profit Sector

According to the government (MoH) definition, this sector encompasses all cadres of health providers in the clinical, dental, diagnostics, medical, midwifery, nursing, pharmacy and public health categories who provide private health services outside the public, PNFP and the Traditional and complementary Medicine establishment (MoH, 2002). This definition includes only the formal private providers and, unfortunately, it completely excludes the informal providers. Similarly, Odedo (2001), in a study of PFPs in Uganda, categorises PFPs broadly into: Medical Clinics, Dental Clinics, Drug shops and Maternity Homes. Of these, drug shops account for the largest proportion of all facilities in the private health sector. The study shows that this is true of all districts except Kampala, which has more clinics than drug shops on record. This study however, only gives a picture of the legal PFPs since it was largely a review of records found at the Uganda Medical and Dental Practitioners Council, the National Drug Authority and District Medical Offices countrywide. Some studies in the country, however, have shown that most PFP facilities have got no professional license to practice (Orach 2001). This could be attributed, at least in part, to the finding that whereas the laws to regulate private practice are in place, their enforcement is poor (Konde-Lule et al 1998). A government of Uganda report states that the private health practitioners provide mainly primary level services and limited secondary level services. A few urban units offer tertiary and specialist care (MOH, 2002). Okello et al (1997) and Nuwagaba (2001) found that the private health providers mainly offered general curative services. The services include: treatment of common ailments such as bouts of malaria, colds, STI/STD and pneumonia. Okello et al (1997) found that the range of services provided were generally similar across the clinics and did not vary significantly in relationship to the highest qualification of the clinic managers. Specialists, general doctors, medical assistants (clinical officers), nurses and all others were virtually all providing the same range of services.

Informal providers

This category of providers thrives best in situations where formal providers, whether public or private, are scarce or not easily accessible. They generally operate outside of the law but since they are usually filling a gap in service delivery, they tend to become very popular in the areas where they operate. They appear in many forms and include general merchandise shop-keepers, village health workers, trained health care workers who offer services in their homes according to demand and unqualified persons who operate illegal facilities of different kinds. It also includes mobile health care providers of a wide range of competence, who commonly travel between villages and in market places to provide health services. In this study traditional healers were categorized as informal providers.

Traditional Healers

A traditional healer is one who is recognized by his community as a healer, and uses indigenous knowledge handed down from generation to generation, to alleviate diverse forms of human suffering. A study conducted by THETA showed that traditional healers acquire their knowledge over years mainly through apprenticeship. Some of the healers were trained directly by healers while other became healers through other means like possession by spirits as reported in 51% of the cases. The main traditional healing practices described include spiritualism, herbalism, bone setting, traditional birth attendants, and “false teeth” extraction. Although witchcraft was mentioned among the practices, all healers dissociated themselves

from it. The study revealed that the main proportions by type of healing practice are: herbalists (42.2%), spiritualists (44.9%), bonesetters (33%), and Traditional Birth Attendants (12.3%) (THETA, 2001)

Other systems of Traditional Medicine

Of late, a number of non-Ugandan Traditional Medicine systems have been introduced into the country. These include the Chinese and Ayurvedic practiced from China and India respectively. Other systems like Reiki, Chiropractice, Homeopathy and Reflexology are among later practices introduced into the country (MoH, 2002). There has as yet not been any move, on the part of government, to make any of these a partner with the public health care system.

1.3 Problem Statement and Study Rationale

Problem Statement

The private health sector is apparently making a very big contribution to health service delivery in Uganda. The comprehensive picture of this contribution, however, is neither well understood nor fully documented. Also lacking is an understanding of how best its performance can be further improved to positively impact health outcomes in Uganda. Several studies have documented that most of the people who seek health care in the country have their first contact with private providers. Private providers play an essential role in service provision, particularly in ambulatory care, which is for the most part treatment of acute personal illness for diseases of public health importance, such as acute respiratory infections (ARI), diarrhoeas (mainly affecting children), tuberculosis, sexually transmitted infections (STD), infections associated with HIV/AIDS, and malaria. The burden of these diseases tends to be more heavily concentrated among the poor. An understanding of the health seeking behaviours of the Uganda population can only be achieved if it is based on a comprehensive understanding of the service providers. There is a mix of both public and private health service providers, whose contributions need to be better understood in the context of the different socio-demographic and rural-urban settings in the country. There are, unfortunately, still many unanswered questions especially with regard to the private health sector. For example: who the private health care providers are and what their capabilities are; what are the available options for the different types of health problems and in the different urban-rural settings; how accessible are the options and what is the quality of services provided? What type of providers do the Ugandans prefer and what is the nature of provider competition, linkages, collaborations or referral structures in the health care market? There have been previous attempts to address some of these questions and this study will aim to build on these efforts to close the gaps in knowledge and to provide a comprehensive picture regarding health care and health service delivery in Uganda.

Rationale for Study

Following an increasing recognition of the need to involve the private health sector in the task of improving primary health care, Uganda has identified partnership between the public and private health sectors to be a priority policy area. Moving this partnership forward is now recognised to be an essential step in the struggle to improve the various health indicators for the country, including the Maternal Mortality Rate (MMR), the Infant Mortality Rate (IMR), the total fertility rate (TFR), and the Childhood Mortality Rate (CMR), whose improvement had slowed down or stagnated in recent years. There is a need to establish the role of the private sector at this stage in order to be able to project its potential as the policy

environment changes. It is important to fully understand who the private providers are, what they do, their strengths, their weaknesses, who their clients are, what quality of service they provide and the type of competition they provide to the public sector. This was the motivation for conducting this study. The private health sector includes many players but the providers of interest in this study were mainly those who provide health care to the rural population, which makes up the largest part of the Ugandan population (about 90%), and includes the less privileged and those recognised to be poor.

1.4 Study Objectives

Study Goal and Overall Objective

The goal of this study is to improve basic health services and to enhance the collaboration between different providers so as to improve the quality of health services.

The overall objective was to study the private health care providers' role in health care provision in Uganda and assess their potential to improve care at the primary and ambulatory level.

Specific Objectives

1. To carry out census mapping of both private and public health care providers so as to assess accessibility of services to the general public
2. To describe the health seeking behaviours of the population and outline how these are related to the findings of facilities mapping
3. To quantify the types and proportion of illness handled by the different providers
4. To assess the range and quality of services provided by the different providers
5. To identify the nature of public-private provider linkages, which include competition, collaboration and referral structures in the health care market
6. To study the effect of policy and regulation on the private health sector

CHAPTER 2: METHODS

2.1 Country profile

Uganda is an agricultural land locked country located in East Africa. Its population is about 24 million people with a high annual population growth rate of over 3%. Prior to the political upheavals and civil strife that beset the country between the mid 1960s and mid 1980s, Uganda had some of the best health indicators in the region. The period of decline led to the collapse of most sectors including health and the economy. This led to a reversal of the health indices, which are now among the worst in the region. While health status remains poor, there have been significant improvements recorded in most indices since 1986.

For example, between 1991 and 1995 the Infant Mortality Rate decreased from 122 to 97 and Total Fertility Rate from 7.3 to 6.9. During this period there has been a big increase in government spending on health. Government allocation to the health sector increased from 2.5% in 1987/88 to about 10% of the national budget in 2005. Uganda's economy has been growing at about 6% per annum for the past 10 years, but it still remains one of the poorest countries in the world with a GNP per capita of about US\$ 300. The economy of the country is based on subsistence agriculture making it vulnerable to climatic changes.

Uganda is divided into over 70 administrative districts. Each of these is divided into counties, which are themselves divided into sub-counties, and then into parishes, and finally villages, which are the smallest administrative units. A district has got an average population of 400,000 people, a county about 100,000, a sub-county 30,000 (20,000 – 50,000), a parish 5,000 and most villages have got 500 - 1,000 people.

2.2 Methodological strategies

The following methodologies were employed to address the broad range of study objectives:

- Census mapping of private providers
- Household survey
- Focus group discussions with community leaders and traditional healers
- Health facility survey
- Interviews with policy-makers and stakeholders

Census mapping of private providers

Census mapping of health care facilities in defined parishes in each of the 3 study districts was undertaken with the objective of assessing the accessibility of various health care services to the general public. In each study district, 2 parishes were randomly selected per sub-county that had participated in the household survey. Since 3 sub-counties per district were recruited in the household survey, a total of 18 parishes were targeted to participate in the facility mapping exercise for the entire study. Both public and private health care facilities were mapped. Mapping of private health care facilities encompassed private clinics, nursing homes, maternity homes, pharmacies, drug shops, and any designated treatment facilities of traditional healers. A health care provider had to be acknowledged by the local community as a regular provider in order to be mapped. The mapping exercise involved recording of GPS coordinates by well-trained research assistants, to describe the location of each healthcare facility in the participating parish. The GPS data enabled us to generate maps showing the distribution of different types of healthcare facilities in each mapped sub-county.

The numbers of different types of healthcare facilities that were mapped are presented and the relative frequency of the different providers is shown.

Household Survey

The objective of the household survey was to find out people's perception of ill health, identify health needs at household level and identify health-seeking behaviors. The survey instrument also attempted to track pre-determined diseases through therapeutic paths from earliest perception or detection of problem to health seeking practices. This was a cross sectional study that employed both quantitative and qualitative data collection methods. The study was conducted in three rural districts of Uganda namely: Iganga, Mpigi and Masaka. The 3 study districts of Iganga, Mpigi and Masaka were selected to be complimentary to the needs of the Ministry of Health to generate a national picture on the health care providers.

In each selected district, 3 sub-counties were purposively selected to be representative of the rural-urban divide of the district: one sub-county had to be adjacent to the Town Council (this was considered to be urban), one remote sub-county and finally the third one was located midway between the remote and the urban sub-counties. Therefore a total of 9 sub-counties were studied. In each of the selected sub-counties, 2 parishes were selected randomly giving us a total of 6 parishes per district and 18 parishes for entire study. From each selected parish, two villages were randomly selected to provide a total of 12 villages per district and 36 villages for the entire study. Each village formed a cluster, and a total of 12 households were selected from each village, making 144 households per district and total of 432 households. The research team identified the starting point of the cluster randomly from a list of households in the village that was obtained from the village Chairperson. After identifying the first household, every fifth household on the list was enrolled into the study until 12 households were enrolled. In situations where a selected household declined to participate, the next eligible household on the village list obtained from the chairperson was enrolled. The research teams included a local guide in each village. When a selected household declined the interview, the next eligible household on the village list was enrolled.

Eligibility Criteria: All households that had been residents for at least one year in the sampled areas were eligible for the study. A minimum of 1 year was chosen because some of the study aspects inquired into health seeking behaviors over the last one year. However, migration in the rural areas of Uganda is very rare, and therefore none of the selected households were eliminated on this criterion. Child headed families where none of the children were at least 15 years old were not eligible to participate. Luckily we did not come across any of such households in this study.

Respondents: Respondents in each household included the head of household and all those household members that were 15 years old and above. The household head or mother responded on behalf of children below 15 years old. The household head was always interviewed first, followed by the spouse, then the rest of the household members in descending order of age.

Data Collection Methods: Through face-to-face interviews conducted by trained research assistants, a semi-structured questionnaire was used to collect information on people's perception of ill health, health needs at household level and health-seeking behaviors.

Research team: The study team recruited research assistants with experience in conducting surveys. These were constituted into three interviewer teams comprising each of 4 interviewers and 1 supervisor. The investigators conducted the training of the research teams for a period of 1 month. The interviewer teams were walked through the objectives, methods and tools of the study to enable them grasp the details of the study requirements.

Subsequently explanations, question and answer sessions and mock interviews were held. After completion of the training of the research teams, the instruments of the household survey were pre-tested by the study and research teams in Nangabo sub-county, a rural area in Kampala district.

Field work and data quality: The investigators oversaw the entire data collection exercise. The supervisors, with the help of the village leaders, identified the households to be included in the sample and then allocated them to interviewers. The supervisors edited completed questionnaires before the interviewers left the field. At the end of each day, the supervisors together with their interviewers reviewed the data collected to correct mistakes and look out for missing data. The supervisors ensured that where there was any missing data, the interviewers returned to the households with the supervisors to collect the missing information.

Data Management and Analysis: The collected data was coded and entered into a computer by trained and experienced data entry clerks. The data was then cleaned, and analyzed using the Epi Info 2002 and SPSS 12.0 statistical packages. The data was tested for normality and transformation was done where necessary. Odds ratios, chi-square and t-tests were used to test for significant associations. Qualitative data was analyzed manually using matrices and summarized thematically. Data is presented in the form of tables, text, and graphs. All findings that have a bearing on policy will be discussed with policy makers in the Ministry of Health and policy briefs will be drafted and submitted to the appropriate officials.

Focus groups: Focus group discussions were conducted in each sub-county upon completion of the household survey to try and find explanations and answers to enrich the findings of the household survey. These were conducted after completion of the household survey to try and find explanations and answers to enrich the findings of the household survey. Four focus group discussions were held in each sub-county, 2 with community leaders and 2 for traditional healers, making a total of at least 36 focus groups.

Health facility survey methodology

The objective of the Health Facility Survey was to assess the professional competence of each type of facility and quality of services provided. This was achieved by recording the qualifications of the providers, diagnostic equipments available, range of services offered and types of diseases handled. Another objective was to identify the nature of public-private health care provider competition, linkages, collaborations and referral structures in the health care market. The survey enrolled public, private not for profit (PNFP) and private for profit (PFP) facilities. The perceived quality of services, as assessed by the clients was obtained from the focus group discussions in the community and complemented by the household survey. Clinical competence was assessed using case scenarios, where a provider was presented with a specific case scenario and his/ her approach to diagnosis, investigations, treatment and advice including referral was evaluated against the national treatment guidelines also known as Uganda Clinical Guidelines (UCG) from the Ministry of Health. Common disease presentations were used including fever, acute respiratory illnesses and diarrheal disease among children and diabetes mellitus among adults as case scenarios.

Sampling of health facilities for the facility survey: Health care facilities of different categories of health care providers were purposely sampled in the 3 selected districts where the household survey was conducted. This was done for public and private providers.

Public Sector facilities: Public Sector Health facilities were purposively sampled from the three study districts. In each study district, all the public facilities situated in the 3 sub-counties where the household survey was conducted were recruited into the study. Mpigi District had 9 public facilities, Masaka had 5 while Iganga 8, which gave a total of 22 public sector facilities.

Private not for profit: The same procedure used for selecting Public Sector facilities was employed for selecting PNFP facilities. In Mpigi, 2 PNFP facilities were recruited; 5 for Masaka and 6 PNFP facilities were identified in Iganga district, giving a total of 13 PNFP facilities for the entire study.

Sample Sizes of Public and PNFP health facilities

District	Public	PNFP	Total
Mpigi	9	2	11
Masaka	5	5	10
Iganga	8	6	14
Total	22	13	35

Private for profit health facilities: The following categories of PFP facilities were enrolled for the study:

Maternity: Two were enrolled per district to give a total of 6 maternity homes for the study.

Private clinics: Private clinics were categorized by ownership as follows:

- (i) Doctor's private clinic
- (ii) Clinical officer's private clinic
- (iii) Nurse's / Midwife's private clinic
- (iv) Nursing Assistant's / Nursing Aid's private clinic
- (v) Private clinics of untrained owners (Business personnel)

One private clinic per category of ownership per sub-county was enrolled giving a total of 15 private clinics per district. Overall, 45 private clinics were supposed to be recruited for this study but the actual numbers were smaller. Community leaders and drug inspectors (DADIs) guided the study team in selecting clinics according to ownership. The selection of private clinics was not influenced by the legal registration status of the facility.

Drugs shops: 5 drug shops per sub-county were targeted giving a total of 15 per district and 45 for the entire study. Like private clinics, selection of drug shops was independent of the legal registration status of the facility, but the number of drug shops that was recruited was lower than the targeted number.

Traditional healers: These were classified into four different categories:

- Herbalists
- Spiritualists
- Bone setters
- Traditional birth attendants (TBAs)

Three traditional healers per category of practice (a total of twelve traditional healers per district) were enrolled for the study in each district. Hence, 9 of each category were recruited for the entire study. Overall, 36 traditional healers were studied in this study.

Informal health care providers: This category consisted of general merchandise shop-keepers that also sell medicines or condoms. All shops that were selling drugs were selected in each sub-county in all study districts.

Qualitative procedure: The qualitative approach that was employed with various providers is the key informant (KI) interview. An appropriate KI interview guide was developed for the purpose and it was designed to cover market structure, reasons for entering private practice and attitudes or experiences related to government regulations. Individual private providers will be identified and interviewed in private.

Data collection team: The same data collection teams used in the household survey were used for the health facility survey.

Review of Policy and Regulation Documents and KI Interviews

The study of the effect of policy and regulation on the private health sector in Uganda was done through a documents review and key informant interviews with policy makers and other stakeholders. Themes covered during interviews with policy makers included:

- How public policy affects the private sector: specifically looking at overall economic framework, regulation/laws, effectiveness of policy/law implementation
- How policies are made: Normative process, Actual process, Who makes decisions, What causes the difference between normative and actual process
- Problems impeding the health sector reform
- How does the private sector contribute to these problems
- The desired role of the private sector
- Actions that have been identified and are being supported to increase private sector contribution to health sector performance
- Implementation and evaluation of policies
- Perceived and actual policy implementation

The target group for this interview included:

- a) Policy-makers: decision-makers and advisors: These were limited to: Permanent Secretary, Directors, Commissioners, Assistant Commissioners, and Technical Advisors in the ministries of Health, Finance, Local Government, Justice and Labour Gender and Social Development. These ministries were selected upon realizing that policies affecting the private sector for health include those made in other ministries which were listed above.
- b) Donor agencies: World Bank, USAID, DFID, DANIDA, SIDA, ADB, EU.
- c) District Authorities: RDC, CAO, District Chairman, and DDHS.
- d) Non-Government Organizations

2.3 Ethical Issues

Approval for the study was obtained from the Makerere University Institute of Public Health Higher Degrees Research and Ethics Committee, and the National Council for Science and Technology. Permission to undertake the study in the selected districts was sought from the District Local Council Authorities particularly the offices of the Chief Administrative Officer, and the District Director of Health Services. Written informed consent was obtained from each respondent and their confidentiality ensured throughout the data collection exercise, data entry, analysis and dissemination of findings.

CHAPTER 3: STUDY FINDINGS

This section of the report presents findings from the different surveys and interviews that were conducted in the 3 districts (Mpigi, Masaka, Iganga) and at national level. The implications of the findings are discussed where they are presented.

The findings cover:

- Census mapping of health providers
- Household survey
- Health facility survey
- Interviews with policy makers

3.1 Census Mapping of Health Facilities

The purpose of the census mapping was to capture the relative frequency of the different types of health facilities in the study areas. All categories of health care providers were included without any limitation. A total of 18 parishes were mapped from the three study districts and these were sampled from the sub-counties in the study. There were 7 parishes from Masaka District, 6 parishes from Mpigi and 5 parishes from Iganga District. The facilities mapped by category were: 19 public facilities, 7 PNFP facilities; 76 PFP facilities, mainly clinics and drug shops; 300 traditional healers comprising of herbalists, bone setters and spiritualists and 43 general merchandise shops, selling medicines or condoms in the mapped area. The public facilities comprised one hospital and the rest were health centres while all the PNFP facilities were health centres. With an average parish population of 5,000 people, the total population in the mapped parishes was estimated at 100,000 people. Table 1 shows the types of facilities that were mapped by district.

Table 1: Numbers of health facilities mapped by district and type of provider

District	Public	PNFP	PFP	Traditional Healers	General Shops	Total
Masaka	5	3	44	224	20	295
Mpigi	9	2	18	35	11	75
Iganga	5	2	14	41	12	75
Total	19	7	76	300	43	445
<i>Percentage of total facilities</i>	<i>4.4</i>	<i>1.6</i>	<i>17.1</i>	<i>67.4</i>	<i>9.7</i>	<i>100</i>

Traditional healers are the most numerous, making up 67.4% of all mapped units.

The government target is to have at least one public or PNFP facility per parish and it appears to have been realised in the mapped areas. The two combined, however, make up only 6% of all the mapped facilities. The average number of facilities per parish is: Public 1 per parish; PNFP 0.37 per parish; PFP 4.0 per parish; traditional healers 16 per parish; and general merchandise shops 2.3 per parish. It is important to note, however, that traditional healers are actually informal providers usually practicing part time and in many instances without designated structures for their practice. It was later found during the household survey that traditional healers were not commonly consulted for the commonest illnesses. They tend to be approached for specific conditions at which their competence is recognised. The relatively high frequency of traditional healers may therefore not provide a satisfactory solution to the access problem in rural areas.

3.2 Household Survey

Characteristics of households visited

A total of 434 households were recruited in this study and they contained 2,580 household members. Average household size was 5.9 members, (with a minimum of 1, maximum of 21, mode of 1). The average household size in this study is higher than the national average of 4.8 persons that was reported in the 2000-2001 Uganda Demographic Health Survey (UDHS). This was attributed to the fact that our study area was largely rural where households are larger than in urban areas. There were an equal number of female and male household members.

Age distribution

Table 2 shows the age distribution of the household members studied. The overall age distribution of the household members is similar to that of the national demographic composition of the 2002 census, indicating that our sample had an age structure similar to the national one. Fifty three percent (1367/2580) of the household members were below 15 years of age, 7% (177/2580) were in the 15-17 year age group while 40% (1031/2580) were adults (18 years and above).

Table 2 Distribution of Household members by age group

Age (Years)	Frequency (n=2580)	Percentage
0-4	427	16.6
5-9	450	17.5
10-14	481	18.7
15-19	285	11.1
20-24	166	6.4
25-29	128	5.0
30-34	137	5.3
35-39	88	3.4
40-44	95	3.7
45-49	57	2.2
50-54	58	2.3
55-59	30	1.2
60+	164	6.4
Age not stated	14	0.5

Marital status

Of the adults (18+ years), 64.8% (668/1031) were currently married, 19.9% (205/1031) never married, 8.2% (85/1031) widowed, and 5.4% (56/1031) separated or divorced while 1.6% (17/1031) did not respond to this question.

Occupation

We investigated the kind of work that household members aged 10 years and above were engaged in. This was done in order to enable us to make inferences about the household incomes and to provide a basis for assessing the purchasing power of the households. Income is relevant when one needs to purchase health care. A cut off age of 10 years was used because in this setting persons of this age or above are effectively working or in school. Findings are presented in table 3. The category of technician included mechanics, carpenters, painters, metal and wood workers and machine operators. The category of "other" included drivers, commercial motorcyclists, tailors and casual labourers.

Table 3: Occupation of Household members aged 10 years and above

Marital status	Frequency (n=1689)	Percentage
Peasant	668	39.6
Student	630	37.3
Trader	102	6.0
Salary earner	58	3.4
Unemployed	45	2.7
Technician	26	1.5
Housewife	11	0.7
Other	118	7.0
Not stated	31	1.8

On the basis of the occupations that were provided during the interviews, we categorised the respondents among those with regular or irregular source of income. We found that most people, to the tune of 80.5%, have got no regular source of income (table 4). Only 19.5% receive some regular income. It is therefore apparent that the studied communities may be categorised as being generally poor because even those who were categorised as having a regular income get very low levels of income when compared to urban dwellers. The low levels of income are likely to strongly influence the health seeking behaviours in these study communities.

Table 4: Occupation status of respondents out of school and aged 18+ years

Occupation	Age (Years)			Total
	18-30	31-45	46+	
	No. (%)	No. (%)	No. (%)	
Irregular income earners	294 (79.0)	209 (75.7)	247 (87.3)	750 (80.5)
Regular income earners	78 (21.0)	67 (24.3)	36 (12.7)	182 (19.5)
Total	372 (100.0)	276 (100.0)	283 (100.0)	932 (100.0)

Most adults in the studied communities (80.5%) have got no regular source of income and this is the case across all age groups.

Education

Table 5 shows the highest level of education attained by household members that were at least 6 years old at the time of this survey. A cut off age of 6 years was used since the government policy (Ministry of Education policy) is for children to enrol into primary school when they are at least 6 years old. Household members were categorised into children (below 18 years) and adults (18+ years). Among children, 80.3% (817/1018) reported “primary” as the highest level of education that they had attained. For the adults, 58.2% reported primary school as the highest level of education attained, indicating improving opportunities for education. This can be attributed to the introduction of the universal primary education in Uganda in 2001, which has registered a big increase in primary school enrolment.

Table 5: Education attainment for Household members aged 6+ years

Education level	Children (<18years)		Adults (18+ years)	
	Frequency (n=1018)	Percentage	Frequency (n=1031)	Percentage
None	56	5.5	144	14.0
Kindergarten	29	2.8	1	0.1
Primary	817	80.3	600	58.2
Secondary	113	11.1	237	23.0
Tertiary	1	0.1	48	4.7
Not stated	2	0.2	1	0.1
Total	1018	100	1031	100

Among adults 18+ years old 14% never attended school.

Characteristics of heads of households

The detailed findings are shown in table 6.

Table 6: Characteristics of the Heads of Households

Characteristic	Frequency (n = 434)	Percentage
Gender	Male	320
	Female	104
Age	15-24	17
	25-34	111
	35+	302
	Unknown	4
Marital status	Married	319
	Widowed	64
	Separated	16
	Divorced	11
	Never married	16
	Unknown	8
Education level	Primary	253
	Secondary	84
	Tertiary	22
	None	73
	Unknown	2
Occupation	Peasant	274
	Trader	69
	Salary earner	30
	Technician	20
	Unemployed	19
	Other	22

Most heads of household are married males, have got primary level of education and are peasants without a regular income.

Three in every four households visited were headed by males, consistent with the 2000/2001 UDHS findings. This study was interested in the highest level of education attained by the household heads because education is an important factor in social development; strongly associated with contraceptive use, low fertility, good health, and low levels of morbidity and mortality among children. Tertiary education was not subdivided because in the Uganda

setting both diploma and degree holders tend to fare equally well socially, as they both belong to the small advantaged group.

Reported health problems not resulting in admission in the last one month

Household members were asked whether they had had any health problems (not resulting into admission) in the last one month preceding the survey. Of the 2580 members in the 434 households visited, only 2347 (91%) responded to this question. The explanation for this is because data was not obtained for adult household members aged 15 years and above that were absent at the time of interview. Forty seven percent (1097/2347) of the household members experienced a health problem (not resulting in hospitalisation) in the preceding month. As shown in table 7, the most commonly reported illness was fever, affecting 65.6% of the respondents that reported having had a health problem in the preceding month. This was followed by cough, which was reported by 14.1% of the household members. It should be noted that these illness prevalence levels represent self-reported morbidity.

Table 7: Health Problems reported by the household members

Health Problem	Frequency (n=1097)	Percentage*
Fever	720	65.6
Cough	155	14.1
Headache	68	6.2
Body ache	62	5.7
Diarrhoea/vomiting	59	5.4
Flu	50	4.6
Sexual/Reproductive health problem	25	2.3
Dental problem	23	2.1
Eye problem	23	2.1
Stomach-ache	20	1.8
Measles	20	1.8
Others	134	12.2

* Total percentage is greater than 100 because of multiple responses

At 47% the rate of illness episode in this study is quite high, contrasting with previous surveys, which reported that the national proportion reporting illness in the past 30 days prior to the survey was 22.5% in 1992, 27.7% in 1999 and 29.4% in 2002 (Ssewanyana et al, 2004). Our study only asked about health problems that had not resulted in hospitalisation, information on persons that had been hospitalised in the month preceding the interview was as a result missed. Therefore, the findings of our study may be an under estimate of the actual level of morbidity in the study area. However, our finding suggests a rising trend in the proportion reporting illness in the last 30 days. Regarding disease pattern, our findings are consistent with the Uganda Ministry of health (MOH) surveillance reports, which show that malaria and upper respiratory tract infections are the leading causes of morbidity in the health facility out- patient departments nationwide. A study conducted by Ssewanyana et al (2005) revealed that more than 56% of the total burden of disease in Uganda was due to malaria, followed by respiratory infections that accounted for 12%. Malaria accounts for 14% of all inpatient deaths in Uganda (World Bank, 2005). A study in Nigeria also reported malaria as the leading cause of illness in the one month preceding the survey (Uzochukwu and

Onwujekwe, 2004). These results indicate that communicable diseases remain the leading cause of morbidity in the Ugandan population.

Effect of illness on school or labour force

We investigated the effect of illness on school or the labour force by asking respondents that reported having a health problem in the last one month preceding the household survey whether they had missed work or school due to the illness. To analyze this question, we only used data collected from persons aged 10 years and above. Among the 1097 members that reported having had a health problem, 738 were at least 10 years old. Sixty three percent (468/738) of persons aged 10+ years reported missing work or school due to a health problem. Average number of days missed from work or school due to ill health was 8.6 days (median 7.0, range of 1-30 days).

Further analysis was done to establish the difference between children and adults regarding effect of illness. Out of the 468 respondents that reported having missed work or school due to illness, 194 (41.4%) were children while 274 (58.5%) were adults. The average number of days missed away from work by children was 7.8 days (median 5.0, range 1-30 days) while that for adults was 9.1 days (median 7.0, range 1-30 days). It was concluded that sick children spent fewer days away from school or work than sick adults.

Table 8: Comparison of the effect of illness on work among children and adults

	Days missed away from work/school		
	Average	Median	Range
Children (10-17years) n= 194	7.8	5.0	1-30
Adults (18+ years) n=274	9.1	7.0	1-30

Fever was the commonest cause of missing work or school. Of the 720 persons that had had fever, 487 (67.6%) were in the 10+ year age group. Sixty three percent (306/487) of persons with fever missed their daily activities due to illness. Average number of days missed from work/school due to fever was 7.4 days (median 5.0, range of 1-30 days). Missing work or school due to a health problem shows the seriousness of a health problem. The fact that on average a sick individual missed work or school for 8 days indicates that the morbidity of health problems experienced was severe. Further still, considering that this finding only represents persons aged 10 years and above, the impact of illness on households in this study was probably higher, considering that mothers or care takers may have had to miss work to take care of sick children (less than 10 years old).

3.3 Health Care Seeking Behaviour

One of the specific objectives of this study was to describe the health seeking behaviour of the study population. This subsection of the report describes the health seeking behaviour of our study population and relates this behaviour to the findings of the health facilities mapping exercise.

Health care seeking behaviour for illnesses not resulting in hospitalisation

Household members were asked the different types of health care they sought for the illness that they had experienced in the month preceding the survey. Table 9 shows the type of health care and treatment options that household members received.

Table 9: Type of Health Care Received

Type of health care received	Frequency (n=1097)	Percentage*
Self Treatment	452	41.2
Visited a biomedical Health Care Provider	614	56.0
Visited a Traditional Healer	73	6.7
None	130	11.9

**Total percentage greater than 100, because of multiple responses*

Self-treatment

Persons who reported having had a health problem in the month preceding the survey were asked whether they had self treated the problem at any one time. Out of the 1097 persons that had experienced a health problem, 41.2% (452/1097) self treated the problem. The most common form of self-treatment was use of medicine that was available at home 60.4%, (273/452). The other form of self-treatment was homemade medicine (included roots, oils, herbs) and this was used by 50% (225/452) of the respondents. The prevalence of self-medication in our study population seems to be relatively high and has health implications since the majority used medicine that is available at home. Medicines already available at home mainly represent left over drugs from earlier episodes of illnesses. A study conducted in Yemen revealed that most respondents that self treated had no knowledge concerning the possible health risks of their anti-malarial drugs nor did they have the knowledge of appropriate use of these drugs (Abdo-Rabbo, 2003.) This highlights the potential dangers of self-medication such as over-dosage, drug resistance and use of expired drugs, which could be toxic or of low efficacy.

Biomedical care

Household members that had experienced a health problem in the month preceding the survey were asked whether they had sought care from a health care provider for this problem. Fifty six percent (614/1097) of persons that had a health problem sought care from a biomedical health care provider. As can be seen in table 10, adults (18+ years) who had primary education as highest level of education were less likely to seek care from a health care provider than those with secondary and tertiary education (52% versus 64%). This difference is statistically significant (odds ratio [OR] = 0.602, 95% confidence interval [CI] = 0.38-0.954, p=0.03). Lawson D (2004) had also reported a similar relationship between education and utilisation of health services in Uganda.

Table 10: Respondents that sought care from a health provider by their education level

Highest level of Education attained	Sought care from a health care provider		Total
	Yes	No	
Primary	158 (52%)	145 (48%)	303
Secondary and Tertiary	67 (64%)	37 (36%)	104
Total	225 (55%)	182 (45%)	407

Persons with primary level education as their highest education level attained are less likely to seek care from a health care provider.

Type of Biomedical provider visited

Respondents were asked the name and type of health provider that they visited for the health problem that they experienced in the preceding month. As shown in table 11, PFP and Public healthcare providers were the most commonly visited health care providers, with 44.5 % (273/614) visiting PFP and 41.1% (254/614) visiting public providers. Only 13.2% (81/614) visited providers in Private Not for Profit (PNFP) facilities. Among biomedical workers, the informal health care providers' role appears to be minimal, receiving just 1% (6/614) of the respondents.

Table 11: Type of health care provider visited

Healthcare provider visited	Frequency	Percentage
PFP	273	44.5
Public	254	41.4
PNFP	81	13.2
Informal*	6	1.0
Total	614	100

**This excluded the traditional healers*

Effect of socio-economic status on choice of provider

Peasants were more likely to visit providers in public health facilities than private facilities (these included PFP, PNFP, Informal).

Table 12: Type of health care provider visited by respondent's occupation

Highest level of Education attained	Type of Health Care Provider Visited		Total
	Public	Private	
Peasant	100 (52%)	93 (48%)	193
Other (trader)	24 (38%)	42 (62%)	64
Total	124	135	257

Peasants were more likely to visit public providers

As can be seen in table 12, of the 193 sick peasants that sought for care 100 (52%) sought care from a public provider while among traders only 38% went to public facilities. This difference is statistically significant (odds ratio 1.88, 95%CI=1.02 – 3.49, and p value=0.03). Only persons aged 10 and above were included in this analysis. Public health care facilities in Uganda offer free treatment. This may explain why peasants were more likely to visit a public provider other than private providers who charge for services that they offer. However, these findings are contrary to Hutchinson's (1999) results that showed that the poor

and non-poor alike preferred curative care from PNFPs and private clinics to the less expensive government care.

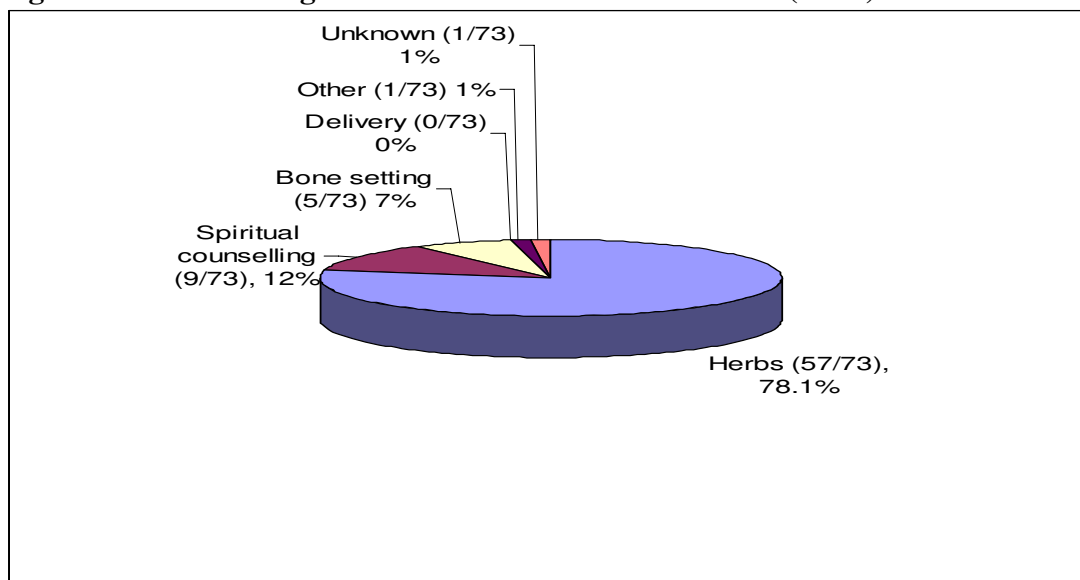
The role of traditional healers

All the respondents were asked whether they had at any one time visited a traditional healer for the health problem that they had experienced in the month preceding the survey. Approximately 7.0% (73/1097) reported having visited a traditional healer. Among those who sought for care this fraction is 10.6%. This proportion is relatively low and contrary to the health facility mapping results, which showed that 67.4% of all the mapped facilities were owned by traditional healers, implying that they are the most locally available health resource. This finding presents a paradox that has also been reported in the 2005 World Bank report. One possible explanation for this low share is the likelihood that responses to this question are an under estimation of the actual level of utilization of traditional healers owing to the stigma attached to traditional healing and its association with witchcraft. Traditional healers that participated in the focus group discussions informed us that a large number of their clients consult at night, under the cover of darkness to avoid being seen. They also reported that most of their clients come from far away, a majority of patients preferring to visit healers outside their area of residence to further conceal their identity. This feeling was also echoed by many of the community leaders that participated in focus group discussions.

Type of Health Care Services Sought From the Traditional Healers

Respondents were asked what type of service they had received from the traditional healer. As shown in figure 1, the most commonly mentioned treatment was herbal medicine, being reported by 78.1% (57/73) of the respondents that had visited a traditional healer. Other services received were spiritual counselling 12.3% (9/73) and bone setting 6.8 % (5/73).

Figure 1: Services sought for from the traditional healers (n=73)



Herbal treatment was the commonest service sought from traditional healers

It is not surprising that herbal medicine was the most frequently utilised traditional health care service since herbal medicine is a popular and widely accepted mode of treatment in Uganda unlike spiritual counselling, which is often stigmatised. In light of this, there is a high likelihood that respondents withheld information on spiritual counselling. A rapid appraisal by Sara Nalugwa on indigenous approaches to HIV/AIDS scourge in Uganda revealed that

there's a widespread belief that traditional herbs are more effective in management of AIDS related opportunistic infections, being able to treat ailments that had resisted pharmaceutical drugs. Better still herbal medicine is cheaper and herbalists are willing to offer it on credit making it accessible to many people (www.ossrea.net/ssrr/no30/ssrr30.htm). The use of herbal medicines by AIDS patients may have popularised this mode of treatment.

No deliveries were reported to have been attended to by traditional healers. Among the traditional healers, delivery services are a reserve for traditional birth attendants (TBAs). TBAs are generally not considered by the community as traditional healers but more of community health workers since a majority have received some training from the formal health sector. This may explain why none of the respondents reported having received delivery services from a traditional healer. Also delivery is not considered a disease or health problem by many people, so the way the question was asked may have caused this lack of response. Further analysis was done on all persons that had responded to the question that inquired whether one had visited a traditional healer or not. This involved a comparison of the type of health problems experienced with whether one visited a traditional healer or not. Only the top 9 health problems reported in this study were included in this analysis and results are shown in table 13.

Table 13: Type of health problem experienced by whether one visited a TH

Health problem	Visited a Traditional Healer		Total
	Yes No. (%)	No No. (%)	
Fever	22 (5.6%)	368 (94.4%)	390
Cough	6 (7.7%)	72 (92.3%)	78
Body ache	3 (7.9%)	35 (92.1%)	38
Headache	3 (8.6%)	32 (91.4%)	35
Reproductive health problem	2 (25.0%)	6 (75.0%)	8
Diarrhoea/vomiting	1 (3.3%)	29 (96.7%)	30
Dental problem	1 (9.1%)	10 (90.9%)	11
Flu	0 (0%)	29 (100.0%)	29
Eye problem	0 (0%)	15 (100.0%)	15

The traditional healers were not popular for treating common conditions such as fever or cough. Less than 10% of the respondents with fever, cough, body ache, headache, diarrhoea or vomiting, and dental problems reported having visited a traditional healer. It is worth noting that none of the respondents that had experienced an eye problem or flu consulted a traditional healer. However, 25% (2/8) of the respondents that reported having experienced a reproductive health problem visited a traditional healer. From this analysis, reproductive health problems appear to be the most popular for traditional healers.

Information from the focus group discussions with community leaders and traditional healers revealed that more females than males visit traditional healers. It was further revealed that females mainly consult traditional healers on matters related to infertility/barrenness and family relationships, while males seek for wealth. It was therefore, very unlikely to capture this gender difference from the quantitative data that we collected, since the survey questions were limited to health problems. The gender bias reported in the FGDs is consistent with information from the Participatory Rapid Appraisal study on indigenous approaches to the HIV/AIDS scourge in Uganda (www.ossrea.net/ssrr/no30/ssrr30.htm).

To facilitate comparison of the level of utilisation of the public and private health care sectors, all respondents that mentioned having visited a traditional healer, PFP, PNFP and informal providers were collapsed into one group, which is the private health care sector. Out of the 687 respondents that had sought care for an illness in the last 30 days prior to the survey, 63.0% (433/687) went to a provider in the private sector while the public sector received 37.0% (254/687). On the basis of this finding we concluded that in rural Uganda communities, the private sector handles 63% of the morbidity burden compared to the public sector which handles 37%. This ratio is in line with the MOH estimates.

Health Care Seeking Behaviour among Persons that had Fever

Since malaria is a leading cause of morbidity and mortality in Uganda, further analysis was done on the health seeking behaviour for persons that had suffered from fever (used as proxy for malaria). As shown in table 14, the health seeking behaviour in this subgroup was generally similar to that seen in the general health care seeking behaviour for any illness experienced (table 8). A majority of respondents (43.5%, 313/720) self treated fever as compared to other treatment options available in the community. Drugs already available at home were used to self treat fever by 26.4% (190/720) of persons that had experienced fever while 19.4% (140/720) self-treated using home-based medicine. This finding may be explained by the fact that antimalarial drugs are readily available on the Ugandan market even in drug shops and general merchandise shops and are often stocked at home for prompt treatment of fever. Also some of the drugs at home are left overs from previous treatment.

Table 14: Type of Health Care Received by HH members that had fever

Type of care	Frequency (n=720)	Percentage
Self Treated	313	43.5
Visited a Biomedical health provider	224	31.1
Visited a Traditional Healer	22	3.1
Did Nothing	161	22.4

Fever was largely self-treated

Reasons for choosing a particular health care provider

Respondents that had experienced a health problem were asked why they chose to visit a particular provider. The major reasons given for choosing a Public provider were: perceived good technical skills of personnel 44.5% (113/254) and convenient location 40.5% (103/254). The main reasons for visiting PFP were convenient location 58.2% (159/273) and good technical skills of personnel 26.0% (71/254). The important reasons for choosing PNFP were convenient location 55.6% (45/81) and good technical skills of personnel 40.7% (33/81). The main reason given for visiting the informal (biomedical) sector was convenient location, which was given by 83.3% of the respondents. The main reasons stated for visiting a TH were technical skills 36%, convenient location 17.8% and relatively low cost 19.2%. Reasons given for visiting a particular provider are summarised in table 15, which compares the various reasons given for visiting a particular health provider.

The key finding is that convenience of location was the main reason why persons with a health problem chose to visit PNFP, PFP and informal providers, while technical skills of the personnel was the main reason given for visiting a provider in a public health facility or a traditional healer. This finding shows that a convenient location and good technical skills of health workers play a big role in determining the type of facility where patients seek treatment i.e. whether private or public.

Table 15: Reasons why respondents visited a provider by type of provider

Reason	Public		PNFP		PFP		Informal		Traditional healer	
	NR	%	NR	%	NR	%	NR	%	NR	%
Convenient location	103	41.0	45	56.3	159	59.1	5	83.3	13	17.6
Technical skills of personnel	113	45.0	33	41.3	71	26.4	0	0	27	36.5
Courtesy of personnel	4	1.6	0	0.0	29	10.8	0.0	0.0	7	9.5
Relatively low cost	29	11.6	8	10.0	30	11.2	1	16.7	14	18.9
Recommended by friend/family	8	3.2	3	3.8	8	3.0	0.0	0.0	11	14.9
Referred	5	2.0	3	3.8	4	1.5	0	0	4	5.4
Other	9	3.6	3	0.5	2	0.3	0	0	0	0
Total	251	100	80	100	269	100	6	100	74	100

The most important reason for each provider category is highlighted. For public providers and THs it is technical skills, while for all other PSP groups it is convenient location.

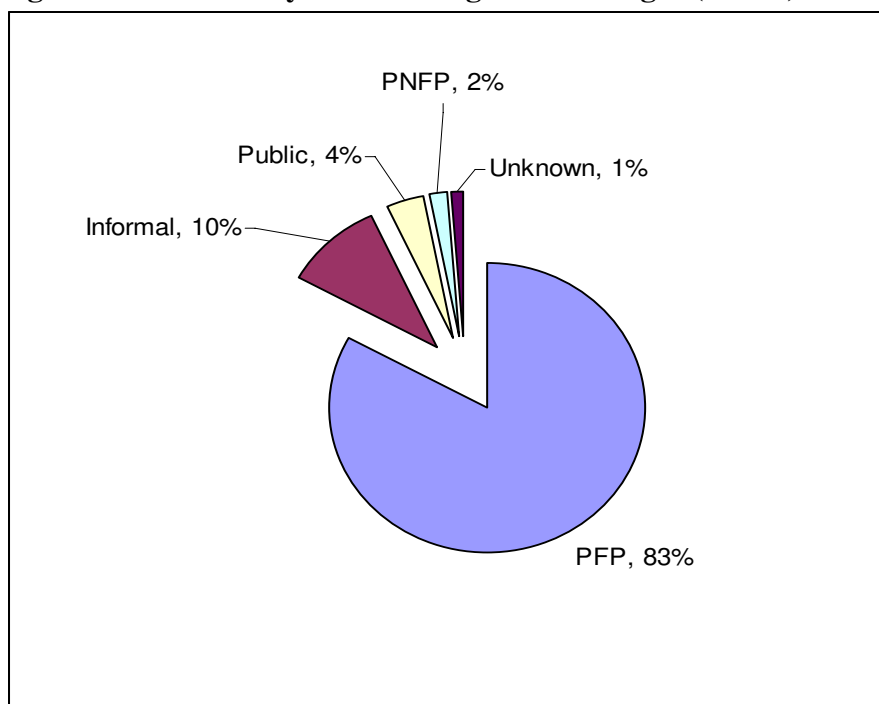
Geographical access is a key element in utilisation of health services. Distance has been mentioned as a constraining factor for seeking health care in Uganda (World Bank, 2005). Since private health providers (which include PNFP, private for profit as well as informal sector) are the most frequently occurring providers, they are most easily accessible, explaining why most people that visited private providers mentioned convenient location as a reason for choosing them. Ssewanyana et al (2004) found that the probability of seeking care from any formal provider decreases with increase in distance to that provider. This is not surprising since distance is highly related to travel costs and hence contributes to total cost of treatment even when health care services are free as is the case today in Uganda's public health care facilities.

Low cost of treatment did not rank high among the reasons given for visiting a provider in a public facility. It came third (11.6%, 29/251) to technical skills of personnel (45%, 113/251) and convenient location (41%, 103/251). This finding suggests that the government's policy of offering free medical services may not necessarily be the most important factor to attract patients to public health facilities.

Purchase of Drugs and Medical Goods

Respondents were asked whether they had bought drugs at any one time to manage the illness that they had experienced in the month preceding the survey. Fifty four percent (592/1097) of them reported having bought drugs. Of the 592 respondents that reported having purchased drugs, 83% (491/592) bought drugs from private for profit (PFP) facilities, followed by 10% (59/592) from informal providers, 4% (24/592) from public facilities and 2% (12/592) PNFP. For 1% (6/592) of the respondents, the source of the drugs was not known. It is a common practice for a patient to send someone else to buy the drugs and not know the exact source of the drugs. During the conduct of this study, we found a that there was plenty in common between private for profit (PFP) clinics and drug shops since both offered clinical care and sold drugs. Therefore the 83% (491/592) represents both private clinics and drug shops. Many drug shops actually operate like private clinics especially in the smaller trading centres.

Figure 2: Facility Where Drugs Were Bought (n=592)



Reasons given for buying drugs from a particular provider

Respondents who reported having bought drugs were asked the reasons why they chose to purchase from a particular provider. Table 16 shows the reasons why persons choose to buy drugs from a particular type of provider. Convenience of location was reported by 71.6% of the respondents as the reason why they bought drugs from a particular provider, making it the major factor that influences choice of drug source. Other reasons were minor. These results explain why the majority of respondents bought drugs from PFP facilities (83%), since these are the most commonly occurring type of health care facility in the community. They made up 66% of the biomedical facilities in the facility mapping exercise.

Table 16: Reasons given for having bought drugs from a particular health care provider

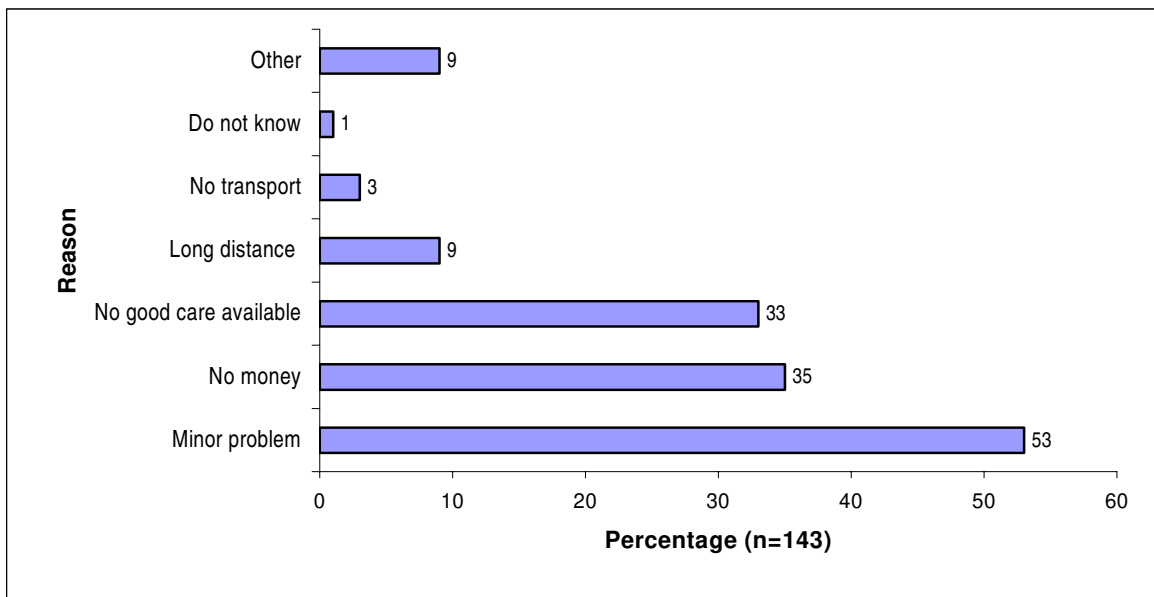
Reason for choice of facility	Type of Provider				Total	
	Public	PNFP	PFP	Informal	No.	(%)
Convenient location	16	5	356	44	421	(71.6)
Technical skills of provider	0	2	8	1	11	(1.9)
Relatively low cost	5	3	47	0	55	(9.4)
Referred	1	0	43	9	53	(9.0)
Courtesy of personnel	0	1	7	0	8	(1.4)
Recommended by a friend/family	1	0	19	0	20	(3.4)
Other	0	0	17	3	20	(3.4)
Total	23	11	497	57	588	(100)

Convenient location is the most significant reason for choice of source of drugs

Persons who did nothing about the Health Problems

Approximately 12% (130/1097) of respondents that had a health problem did nothing to alleviate that problem. These respondents were asked why they did not seek for treatment when ill and the reasons are shown in figure 3.

Figure 3: Reasons why household members did nothing about health problem



The main reason for doing nothing was because the condition was perceived as minor

The perception that the problem was minor was the main reason given for doing nothing about the health problem, given by 53% (76/143) of the respondents. This is consistent with findings from earlier studies (Ssewanyana et al, 2004). Other reasons such as lack of money were less frequently given.

As mentioned in previous sections, most patients have got to pay for the health care services that they utilise. Even when services are meant to be free, the patients have to meet their transport costs. Also, during periods of drug stock outs in public and PNFP facilities, the patients have to buy the drugs. The stock out rate for essential drugs in Uganda public facilities is relatively high at 30% and at 16% in PNFP facilities (World Bank, 2005). In such instances patients have got to buy from private providers and therefore lack of money is still a big barrier to seeking health care. Lack of transport appears to be a minor barrier to access to health facilities as compared to the other reasons mentioned. To some extent, the transport sector in Uganda has tremendously improved during the past decade. Better road networks now exist, even in remote areas, and the public transport system has wide coverage. The issue now is availability of money to meet transport costs other than lack of transport.

What illness is handled by which providers?

We analysed the illnesses against choice of provider to see if some providers were commonly preferred for some illnesses. To achieve this objective, we compared the reported type of illness experienced by household members in the preceding month with the type of provider that was visited. Results are presented in table 17.

Fever: Most persons that reported fever visited a PFP provider (51.8%, 117/226). This was followed closely by the Public sector which received 39.8% (90/226) of the fevers.

Table 17: Type of health problem experienced by type of health provider visited

Health Problem	Public		PNFP		PFP		Informal		Total
	No.	%	No.	%	No.	%	No.	%	
Fever	90	39.8	18	8.0	117	51.8	1	0.4	226
Cough	20	42.6	6	12.8	20	42.6	1	2.1	47
Headache	9	50	1	5.6	8	44.4	0	0.0	18
Body ache	6	42.9	1	7.1	7	50.0	0	0.0	14
Diarrhoea/ vomiting	16	94.1	0	0	1	5.9	0	0.0	17
Flu	10	47.6	2	9.5	9	42.9	0	0.0	21
Sexual/ Reproductive	3	42.9	1	14.3	3	42.9	0	0.0	7
Dental Problem	3	37.5	0	0	5	62.5	0	0.0	8
Eye problem	5	71.4	0	0	2	28.6	0	0.0	7
Others	63	52.9	12	10.1	44	37.0	0	0.0	119

Fever is mainly handled by the PFP sector while cough is equally shared between the public and PFP sectors. Diarrhoea is a public sector preserve.

Cough: Treatment for cough was mainly sought from the Public providers (42.6%, 20/47) and the PFP providers (42.6%, 20/47). PNFP providers received 12.8% (6/47) of the cough patients while 2.1% (1/47) visited informal providers.

Headache: The majority of persons that had experienced a headache visited Public providers (50%, 9/18) and PFP providers (44.4%, 8/18). Only 1 person (5.6%) visited PNFP facility and none visited an informal provider.

Body ache: Fifty percent (7/14) of respondents who reported body aches sought for care from PFP providers, 42.9% (6/14) from Public, and 7.1% (1/14) PNFP. None visited an informal provider.

Diarrhoea and or vomiting: The public providers treated 94.1% (16/17) of household members that had suffered from diarrhoea or vomiting in the month preceding this survey. Only 1 person (5.9%) visited a PFP provider. None of the respondents reported seeking for care from PNFP

Flu: Most of the persons that had experienced the common cold (flu) visited Public (47.6%, 10/21) and PFP (42.9%, 9/21) and 9.5% (2/21) visited PNFP providers. It is surprising that none of them mentioned having visited an informal provider.

Sexual/Reproductive health problems: An equal number of respondents reported having Public (3/7, 42.9%) and PFP (3/7, 42.9%) providers. Only 14.3% (1/7) visited PNFP facility. None visited an informal provider.

Dental problem: Five out of 8 (62.5%) respondents with a dental problem reported having visited a PFP facility while 3/8 (37.5%) visited a public provider. None visited PNFP or informal provider.

Eye problem: Five of 7 (71.4%) respondents with eye problems visited a provider in a public facility while 2/7 (28.6%) visited PFP providers. None went to the PNFP or informal provider.

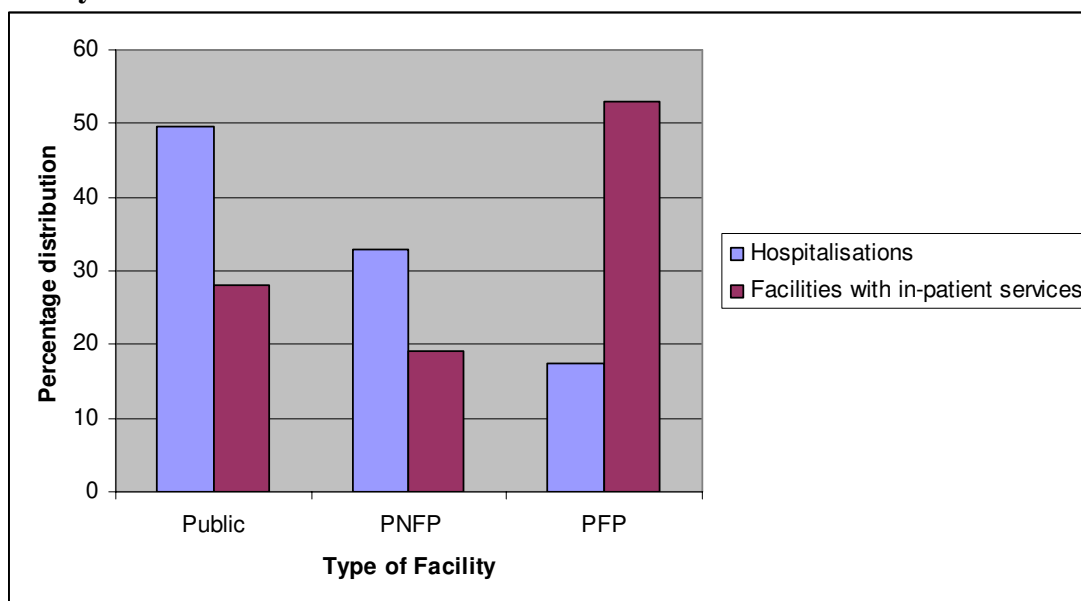
Considering that fever is the leading cause of morbidity in this setting, and these results show that half of the patients with fever visited PFP providers, then the private for profit providers are playing a key role in health care delivery. It is also interesting to note that more than half of patients with dental problems visited a PFP provider. On the other hand, the public health care sector handled almost all the reported cases of diarrhoea and vomiting. It also handled the majority of eye problems. The PNFP sector appears to handle far less cases of all reported illnesses than the PFP and public sector. The informal sector handled only a few cases of fever and cough; and these were the most commonly reported illnesses in this study. This finding points to the fact that this sector is demand driven.

Illness That Resulted In Hospitalisation

Prevalence of hospitalisation In the Last One Year: All household members were asked if they had been admitted in a health facility during the one year preceding this survey. In this study, hospitalisation was defined as a stay at a hospital or a health facility over a night. Only 5.5% (143/2580) of the respondents had been hospitalised in the last year. Mpigi District reported the highest number of hospitalisations (45.5%, 65/143), followed by Masaka (31.5%, 45/143) and Iganga (23.1%, 33/143). The average number of hospitalisations per respondent was 1.4 hospitalisations with a range of 1 to 10. The average duration of hospitalisation during the most recent admission was 7.8 days (range of 1 to 70 days). The leading cause of hospitalisation was illness (83%; 121/143), followed distantly by pregnancy related conditions (13%; 19/143). Accidents accounted for 1% (2/143). One person (0.7%) did not know the exact cause of hospitalisation.

Facility where admitted for most recent hospitalisation: Close to fifty percent (71/143) of the reported hospitalisations took place in public health care facilities. This was followed by PNFP facilities (32.9%; 47/143) and PFP (17.5%; 25/143). We compared these results with those from the facility mapping exercise and present the results in figure 5. This analysis only considered hospitals, health centres at level three and four as well as private clinics operated by doctors and midwives that were mapped, since these are the only facilities that are licensed to offer hospitalisation services. As shown in figure 5, PFP facilities had the least number of hospitalisations (17.5%), despite the fact that the majority (53.0%) of the mapped facilities that were capable of admitting patients were PFP facilities (doctors or midwives private clinics). Majority of the hospitalisations were in Public facilities (50%) though public facilities accounted for only 28% of the facilities mapped. The explanation is that public facilities are usually larger than PFP facilities.

Figure 4: Comparison of reported hospitalisations and facilities mapped by type of facility



Admission procedure

Seventy percent (100/143) of the admissions were referrals from another health facility, 25% (36/143) came in direct from home while 4.2 % (6/143) were referrals from the facilities outpatient department.

Reasons for choice of facility where admitted

These are summarised in table 18. Technical skills of personnel (20%, 28/143), convenient location (18%, 25/143) and referrals (12%, 17/143) were the most commonly given reasons for having chosen a particular facility for hospitalisation.

Table 18: Reasons for choosing a particular health facility for hospitalisation

Characteristic	Frequency (n=143)	Percentage
Technical skills of personnel	28	20
Convenient location	25	18
Referred	17	12
Low cost	5	4
Recommended	2	1
Courtesy of personnel	1	0.7
Other	3	2.1
Unknown	62	43

“Technical skills of personnel” was the commonest reason among those where the reason was given.

Preventive and other health services

This portion of the report discusses the level of utilization of preventive clinical services such as immunization, antenatal care, delivery care, family planning services, as well as curative services for dental and eye diseases.

Reproductive Health: Reproductive health is an important program in Uganda's health sector strategic plan due to the high maternal and infant mortality rates in the country. This survey set out to assess the health seeking behaviour of people in Uganda related to reproductive health care. Under reproductive health, we looked at the level of utilisation and choice of family planning, prenatal care, delivery and postnatal care, as well as factors that influenced the respondents' choice of provider. This analysis focused on women of reproductive age (15-49 years) to describe reproductive health seeking behaviour. There were 513 women of reproductive age. Majority were currently married (55.9%) and 90% had attained at least primary education.

Family planning services: Women were asked whether they had used any family planning (FP) services in the 1 month preceding this survey and what FP method they had used.

Out of the 513 women aged 15-49 years, only 7 (1.37%) had used family planning. The most commonly used method of contraception was injectables (3/7), followed by condoms (2/7) and the pill (2/7). Only one person used the rhythm method. Table 19 shows the service providers for FP.

Table 19: Place where family planning services were accessed

Type of Provider	Frequency (n=7)	Percentage
Public	2	29
PFP	2	29
PNFP	1	14
Informal	1	14
Not known	1	14

There was a very low rate of family planning use reported

The proportion of women of reproductive age who utilized family planning services in the preceding month was very low. This is not surprising, as the estimated national contraceptive prevalence rate is only 23% for all methods and 18% per cent for modern methods (Uganda Bureau of Statistics and ORC Macro, 2001).

We were unable to do further analysis due to the limited number of Family planning users. Nonetheless, these study results have shown that both public and private health sectors offer family planning services. This is very encouraging as involvement of these 2 sectors improves on access to a much needed service considering that Uganda has a total fertility rate of 6.9, one of the highest in Sub-Saharan Africa.

Prenatal care: The major objective of prenatal care is to identify and treat problems arising during pregnancy. Prenatal care services offered in Uganda include provision of prophylactic antimalarial drugs, immunisation against tetanus, screening for syphilis and other sexually transmitted diseases including HIV, screening for pregnancy complications and their management, and advice on delivery.

Only 2% (11/513) of all the women of reproductive age reported having received prenatal care during the month preceding the survey. Mpigi district had the highest number of ANC users (7/11), followed by Iganga (3/11) and one person from Masaka District. Prenatal care services received included check up (2/11), and drugs (3/11). Six people did not mention what services they had received. Those who utilised antenatal care visited public providers (3/11) and PFP providers (2/11).

Delivery services: Only 3 deliveries were reported in this study. They occurred among married women, who were peasants and had attained primary education. 2/3 Iganga and 1/3 Mpigi. Two out of three deliveries took place in health facilities (1/3 public, 1/3 PFP) and the other was a home delivery. All deliveries were successful. Again due to the limited number of deliveries reported in this study, we were unable to do detailed analysis related to utilisation of delivery services and factors which influence choice of delivery place. However, the 2000/1 Uganda demographic health survey revealed that only 37% of all births occurred at health facilities (Uganda Bureau of Statistics and ORC Macro, 2001). This means that the majority of deliveries still take place in the community and yet delivery place and type of assistance received during delivery influence the delivery outcome. Considering that Uganda has a high maternal mortality ratio of 505/100,000 live births, there is a need to improve the proportion of assisted deliveries if Uganda is to achieve the 5th millennium development goal i.e. to improve maternal health.

Postnatal care: Postnatal care is important for both mothers and the baby's' health especially in the first 6 weeks after delivery. The Uganda minimum health care package recommends that all mothers should receive PNC within the first 6 weeks (puerperal period) due to complications that could arise during this period. Only 1 mother received PNC in the month preceding the survey. She was 24 years old, currently married peasant from Iganga District. She visited a public provider. This finding is not surprising; since the 2001 UDHS data showed that only 1% of the women receive postnatal care.

Dental services and Eye services: Oral health and eye care are some of the services targeted by the Ministry of Health program on essential clinical care under the minimum health care package for Uganda. It was therefore important for us to determine the number of persons that received dental or eye care services in the month preceding the survey, type of treatment received and factors that influenced choice of a provider.

Dental services: All household members were asked whether they had visited any person or facility to receive dental services in the month preceding the survey. Only 3% (74/2580) of the respondents visited a dental provider. Among those that visited a dental facility or provider, 68.9% (51/74) had tooth extractions while 20% (15/74) were given medicine to manage the dental problem. The rest received dental check ups (2/74) and herbal medicine (2/74). Four out of seventy four did not state what dental care service they had received. Public (41.9%) and PFP (36.5%) facilities were the most frequently used facilities for dental health care. Most people mentioned visiting a particular provider because of the technical skills of the personnel in that facility (60.8%, 45/74) as well as convenient location of the facility (35.1%, 26/74).

Table 20: Characteristics of Dental Services Received

Characteristic	Frequency	Percentage
Dental provider (n=74)		
Public	31	41.9
PFP	27	36.5
PNFP	11	14.9
Informal	2	2.7
Traditional healer	2	2.7
Complementary	1	1.4
Reason for choosing dental care provider (n=74)		
Technical skills of personnel	45	60.8
Convenient location	26	35.1
Recommended by friend/family	2	2.7
Referred	1	1.4
Relatively low cost	1	1.4
Courtesy of personnel	1	1.4
Other	1	1.4

Eye care services: Only 1.2% (32//2580) of the household members mentioned having received eye care services. Majority of the respondents had eye checkups (53%) while 34% were given medicine, only 2 people got spectacles. Public facilities were the most commonly consulted for eye care services (53%). This was followed by PFP 19% and PNFP facilities 9%. Only one person visited a traditional healer while none went to an informal provider. Technical skills of personnel were the major reason why people selected a particular eye care provider, being mentioned by 50% of the respondents. Other reasons given included: convenient location (28%), relatively low cost (6%), and recommended by a friend (3%). Referral was not one of the reasons given for having selected a particular provider.

Table 21: Characteristics of Eye Care Services Received

Characteristic	Frequency	Percentage
Eye care provider (n=32)		
Public	17	53
PFP	6	19
PNFP	3	9
Informal	0	0
Traditional healer	1	3
Complementary	0	0
Not stated	5	16
Reason for visiting eye care provider (n=32)		
Technical skills of personnel	16	50
Convenient location	9	28
Relatively low cost	2	6
Recommended by friend/family	1	3
Referred	0	0
Courtesy of personnel	0	0
Not stated	4	12

The public sector leads in providing eye care

Conclusions on health seeking behaviours

The level of morbidity recorded in this study is high and is predominantly due to malaria and cough. This highlights the fact that communicable diseases are the leading cause of ill health in our communities. Traditional healers are the most commonly occurring providers in Uganda. However, a majority of the sick persons seek for health care from biomedical providers with less than 10% visiting traditional healers. Therefore, geographic accessibility of health facilities does not necessarily imply that they will be the most commonly utilised facilities.

The most commonly consulted biomedical providers were those in private clinics and drug shops (PFP), highlighting the significant role played by the private sector in health care provision in Uganda today. This same sector appears to treat the majority of fevers, which are the leading cause of morbidity and mortality in Uganda. However, PFPs handle very few diarrhoea cases, these cases being almost exclusively managed by the Public sector. Overall, a convenient location was the main reason why persons chose to visit a particular provider, especially for providers in the private sector. On the other hand people visited public facilities when they perceived that an illness required management by personnel with good technical skills.

Cost of treatment was not a major consideration when choosing a provider. Instead it appears to influence whether one seeks for treatment or not. The perception that an illness is minor was a major prohibiting factor to seeking treatment. Self-medication is quite common in the country, which calls for health education on the dangers of irrational self medication such as drug resistance and overdose. Hospitalisation tends to be reserved for public and PNFP facilities. Preventive services such as family planning and curative services (dental and eye) and are underutilised.

There is need to improve preventive care through closer collaboration with the private sector and regulation of this sector, especially the PFP providers. About 12% persons that experienced a health problem did nothing to manage the problem. This is quite a substantial number that needs to be reached by health education messages to improve on their health care seeking behaviour.

3.4 Access to Health Services

The concept of “access” usually refers to the presence or absence of physical or economic barriers that people might face in utilising health services. Physical barriers are usually related to the general supply and availability of health services and distance from health facilities, while economic barriers relate to the cost of seeking and obtaining health care (Knowles, 1997). This section looks at the implications for access to health services in view of the health care seeking behaviours and the costs incurred in accessing and utilizing health services. It combines all these with the findings of the facilities mapping exercise.

Self-medication as a proxy for poor access to health services

Table 9 shows that 41.2% of household members, who reported a health problem, self-treated. In most Ugandan households, you will find leftover medicines from treatment of fevers and other common ailments. It is therefore not surprising that a large number of

household members self treated. On the other hand, this high rate of self-medication could indicate problems of access to health services. If services were easily accessible physically and economically, there would probably not be so much self treatment. Among those who self treated the condition and were 10 years or older at the time of the survey, 60% (267/447) reported to have missed work or school due to the illness. Missing work or school can be used as a proxy for severe illness. Considering that 60% were sick enough as not to work or attend school but opted to self medicate instead of visiting a healthcare provider shows that access to health services is less than satisfactory.

Access to Health Service Providers for Outpatient Services

Table 11 shows that of the 614 household members that visited a type of health provider 44.5% (273/614) visited the PFPs, followed by the public facilities with 41.4% (254/614). This might indicate that among all health care providers, the private for profit group are the most accessible providers making them the preferred choice for first contact care.

Convenient location

When respondents were asked the reasons for choice of provider, the most commonly mentioned reason was “convenient location” given by 51.8% (323/623) followed by the technical skills of the provider given by 35.5% (221/623). For all providers except the public and traditional healers, the main reason for choice of that provider was convenient location implying easy access. Distance is a proxy for the time price of health care; greater distance generally means more travel time and more time away from productive labour. All individuals are less likely to use a service the further they are from that health facility, but the effects are no greater for the poor than the non poor, and in fact it has been reported that the poor are actually more likely than the non poor to use services if they live further away (Hutchinson, 1999).

Perceived quality of services

Several factors appear to influence the anticipated satisfaction patients receive from health services. These include the availability of drugs, the qualifications and attitudes of the staff, the sophistication of the equipment and the perceived success of previous contacts with the service. Some studies suggest that perceived quality of service is more important than fees when consumers are choosing a health service. Patients may avoid conveniently located providers who have poor services in order to obtain treatment they prefer elsewhere (Hutchinson, 1999). The presence of a doctor at a health facility and greater numbers of support staff appear to have a positive impact on whether poor people decide to use the nearest health facility. Increasing the availability of doctors increases the likelihood that both the poor and non poor will use modern curative services by approximately 10 percent. In short, the quality of services is at least as important as distance and price in determining use of curative care for both the poor and non poor alike (Lavy, 1994; Akin, 1995; Hutchinson, 1999).

Direct cost of treatment

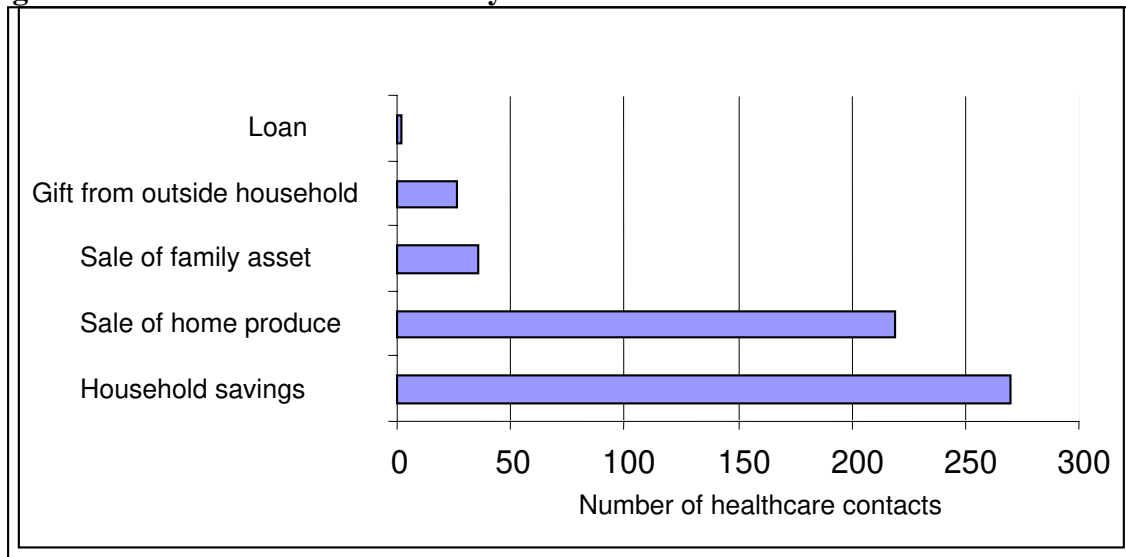
Respondents were asked how much they paid for the service received from the healthcare providers. The proportion of clients who were charged for the service at the different providers was: public 50% (127/254), PNFP 84% (68/81), PFP 86.5% (236/273), and Informal 16.7% (1/6). We further analysed amounts paid for care among only those that paid. The mean amount at any of the providers was USHS 5355 (range 100-150,000) among those who paid. The average amount paid for service to the different health care providers was: Public 5381, PNFP 7647, PFP 4626. The average amount is lowest for the PFP sector,

implying that they are the cheapest providers. In a low resource setting, this makes them the most accessible providers.

Sources of Funds

Respondents were asked where they got the funds from to pay for the healthcare bill. Figure 6 shows that the major sources of funds were household savings (44%) and sale of home produce (36%). Majority of the rural population in Uganda depend on the sale of produce from the family farm.

Figure 5: Source of Funds used to Pay Health Care Provider



Household savings in rural Uganda are so small and mainly from the sale of produce after the 2 major harvests in a year. There are no insurance schemes, except for a few middle and upper class citizens in the major towns. For most households after a harvest, produce is sold for cash, and the rest retained for consumption by the household, and as seed for the next planting season. Therefore, for households that sold home produce to meet the medical bill, it is likely that many were forced to sell the family food reserves or even seeds reserved for the next planting season. These data show that financing is a major burden and barrier to accessing health care in Uganda. It was found that 36/614 episodes compelled households to sell their valuable assets to meet the medical bill. For these households, health care is not easily accessible and ill health clearly sends them further into poverty.

Purchase of Drugs and Medical Goods

For some of the health problems reported, households purchased drugs or medical goods. Some of the purchases were initiated by the clients (walk-ins), while others followed a consultation with a health provider. In 54% (592/1097) of the health problems reported, drugs or medical goods were purchased. The main source of drugs was the PFP providers as seen in figure 2. These are largely Over-the-Counter drug shops, and small clinics largely manned by lower level health professionals. The main reason for the choice of the facility where drugs or other medical goods were bought was convenient location as seen in Table 15. The choice of facilities therefore shows the types that are accessible to the study communities. Of all the purchases 80.5% (497/588) were done from the PFP facilities and on this basis these are the most easily accessible for drug purchase. The traditional healers are very numerous but do not stock any of the popular drugs. The PFPs and Informal providers are within easy reach of households and one can get drugs quickly and in any quantities

without difficulty. On the other hand, with the Public and PNFP facilities, obtaining drugs must be with a prescription of a physician. For these reasons, the PFPs and Informal providers are very attractive and accessible to the general public.

Amount paid for drugs/medical goods

This could be a barrier to accessing health care. Respondents were asked how much had been paid for the drugs or medical goods. The mean amount paid was USHS 1613 (range 50-40,000). The lowest mean amount was paid at the informal providers (USHS 397), while the highest was paid at the public facilities (USHS 2067). On average the PNFPs charged USHS 2064, while the PFP charged USHS 1709. It is surprising that the public providers charged more. This might be due to more severe illness or conditions filtering to the public and PNFP facilities as opposed to the PFP and informal sector. The main source of funds to pay for drugs bought was cash revenue or regular income (47.5%) as seen in Table 22.

Table 22: Source of funds used to pay for drugs/medical goods

Source of Funds	Frequency (n= 592)	Percentage
Cash revenue	281	47.5
Household savings	277	46.8
Sale of family asset	40	6.8
Gift from outside household	37	6.25
Loan	2	0.3
Social program targeting the poor	1	0.2

Drugs and medical goods were bought using cash revenue or household savings

Traditional Healers

From table 9, 6.7% (73/1097) of household members who reported experiencing a health problem visited a traditional healer. The responses to this question could be an under estimation of the utilization of traditional healers due to the stigma attached to utilization of traditional healer services. Our qualitative data indicate that a large number of the visits to the THs occur at night, and outside the community where the client resides to avoid being seen by members of their community. It is therefore difficult to make a quantitative assessment of the level of access to traditional healers apart from the results of the census mapping that shows them to be the most numerous providers.

3.5 Range and Quality of Services Delivered By Different Health Service Providers

This section presents results on the range and quality of services provided by the various health providers that were studied. We assessed both technical quality and “perceived” quality as judged by clients. Technical quality was assessed on the basis of the qualifications of the providers and the diagnostic equipments available to them. Clinical competence was further assessed using clinical case scenarios that evaluated a provider’s ability to identify the most likely diagnosis for a provided scenario. The scenarios depicted conditions of public health importance. The preferred treatment and advice to the patient were also assessed. The perceived quality of services, as assessed by the clients, was obtained from focus group discussions in the community.

Characteristics of sampled health facilities

The facilities that were studied are shown in table 23 below.

Table 23: Type and Ownership of sampled Facilities

Sector	Ownership Category	Health Facility Type	Frequency	Percentage
Formal	Public	Health Centres / Hospital	22	26.8
	PNFPs	Health Centres / Hospital	10	12.2
	PFPs	Clinics	17	20.7
		Maternity Homes	5	6.1
		Drug Shops	28	34.2
Total			82	100.0
Informal	PFPs	Herbalists	14	14.4
		Spiritualists	9	9.3
		Bone Setters	7	7.2
		TBAs	8	8.3
		General Merchandise shops	59	60.8
Total			97	100

After purposive sampling, we obtained 22 public facilities, 10 PNFP facilities and a total of 50 PFP facilities that included clinics, maternity homes and drug shops. A total of 38 traditional healers and 59 general merchandise shops categorised as informal health providers were also included.

Other general characteristics of the various providers were also assessed including; gender of the providers interviewed, highest level of education attained, type of formal education obtained for those in the formal health sector.

Gender of the Health Providers

The female to male ratio (F: M) was 3:1 overall. However among formal providers the ratio was 5:1 (F:M) and 1.4:1 among traditional healers. This finding reflects that of a study by Orach (2001) in Nebbi District, which established that most PFP facility owners and medically responsible persons were of the nursing cadre, most of whom (in Uganda) are women.

Highest formal education attained

The highest level of education attained by the formal health workers (both PFP and Public sectors) are comparable but vary significantly with the traditional healers as seen in the table 24.

Table 24: Level of education attained

Highest Level of education	Formal providers		Traditional healers	
	Frequency	%	Frequency	%
Primary or None	1	1.2	30	78.9
Secondary	46	56.1	6	15.8
Tertiary	35	42.6	2	5.3
Total	82	100	38	100

Only 16% of the traditional healers had secondary education or higher compared to formal providers (in both public and private sector) who had secondary (56%) and tertiary education (43%).

Position of the interviewed health provider (operationally managing the facility)

Public facilities are owned by government while PNFP facilities are often owned by faith – based organizations (managed by the religious medical bureaus). Of the respondents in the 50 clinics and drug shops (PFPs) 42% (21/50) interviewed were found to be owners of the health facilities while 58% (29) were employees who were medically responsible / in-charge of the operations of the facilities. Meanwhile, for the traditional healers, 92.1% (35/38) owned the facilities and were also medically responsible and only 3 out of the 38 Traditional healers interviewed were not owners of the business. Traditional healers tend to be one-person ventures as this knowledge tends to be passed on to individuals.

Table 25: Position of interviewed person in the facility

Facility Type	Owner		Medically Responsible		Total
	frequency	%	frequency	%	
Public	0	0	22	100	22
PNFP	0	0	10	100	10
PFP	21	42	29	58	50
Traditional Healers*	35*	92.1	38*	7.9	38

* All traditional Healers are medically responsible for their practices and their businesses tend to be one-person ventures. In a few cases, they may have an assistant(s).

Most PFP and 1 TH facilities were found to be operationally managed by medically trained persons, although the facilities are financed by the owners who may not be health professionals. This calls for good supervision of the facilities by local health authorities so as to ensure quality of health service delivery to communities is not compromised. Regular supervision would also strengthen the interface between the local health authorities and the private sector.

Experience in the public sector

The study revealed that 1 out of 10 health providers in PNFP units and 20 out of 50 formal private health providers had previously worked in the public sector health facility before settling to work in the PFP sector; this seems to be important, because it is this experience of working in public sector health facilities that might have provided the basis of medical

knowledge for their current practice, especially those with a background of little or no medical training.

Range of services provided by facilities of different private health service providers

The identified range of services provided by the private sector covers an array of preventive services, home visiting, counselling, curative services, and referral services.

Home visits:

Characteristically the health services delivered by traditional healers have got well established home visiting, with 68.4% (26/38) of them carrying out home visiting routinely. The public sector and PNFP do not conduct home visiting any longer, but they carry out “outreach” services. These may be primary health care services to an out post or supervisory visits to lower level health facilities to oversee the quality of care provided.

Preventive, Curative and Referral Services:

Table 26 below shows the range of preventive, screening and counselling services offered by the different providers. Although screening services are usually offered by high-level formal health facilities like HC IVs and Hospitals, basic preventive services (like immunisation and ANC) are expected to be available in most health facilities regardless of level and ownership.

Table 26: Preventive services offered by Private Sector Health Providers

Preventive Service	Public facilities (n=22) No. (%)	PNFP facilities (n=10) No. (%)	PFP facilities (n=22) No. (%)
Basic Preventive Services			
Immunization (EPI)	5 (22.7%)	5 (50%)	6 (27.3%)
Antenatal Care (ANC)	9 (40.9%)	6 (60%)	8 (36.4%)
Post Natal /Well baby Clinic	7 (31.8%)	4 (40%)	6 (27.3%)
Family Planning	6 (27.3%)	5 (50%)	6 (27.3%)
Screening Services			
Blood Slide for Malaria parasites	4 (18.2%)	1 (10%)	2 (9.1%)
TB Sputum (ZN Stain)	2 (9.1%)	0 (0%)	2 (9.1%)
Counselling Services			
HIV/AIDS/VCT	5 (22.7%)	2 (20%)	1 (4.5%)

* *excluding drugs shops*

PNFP facilities exceed both public and private health providers in delivering a range of the basic preventive and screening services. Fifty percent of the PNFP facilities conduct immunization services compared to only 22.7% public facilities and 27.3% of the private clinics. Public facilities do better in screening services such as blood smear examination for malaria parasites (18.2%) compared to only 10% of PNFPs and 9.1% of private clinics. Overall, availability of screening services is very low across the different sectors. Counselling services are also poorly available at only about 20% for both public and PNFP facilities compared to only 4.5% in private clinics. Since studies in Uganda (IMCI Multi-country study- Uganda, 2000; MOH, 2004) have confirmed that up to 83% of the community seek first level health care (especially curative) from private sector health facilities, it is critical for

health authorities to work out mechanisms for involving the private sector in delivery of basic preventive services as well.

Management of top five causes of morbidity

Table 27 assesses participation of the various health providers in prevention, diagnosis, treatment and referral of the cases of the top five causes of morbidity and mortality.

Table 27: Prevention, Diagnosis & Treatment of Top Five Causes of Morbidity

Diseases	Number of formal Health Facilities involved in :									
	Prevention		Diagnosis		Treatment		No. of facilities referring specific cases to			
	FF*	Other*	FF	Other	FF	Other	Private Facilities		Public Facilities	
	FF*	Other*	FF	Other	FF	Other	FF	Other	FF	Other
Malaria	9	17	16	17	20	21	6	5	19	18
Diarrhoea	10	18	13	18	19	23	6	5	17	18
RTI/ARI	4	11	10	13	15	15	6	7	11	14
Anemia	3	13	8	12	10	13	3	4	16	14
HIV/AIDS	6	9	8	4	9	6	4	2	14	14

* FF – formal facilities including Public, PNFP and private clinics (n= 54)

* Other – includes drug shops and traditional healers (n= 66)

A disproportionately small number of health facilities are involved in prevention activities of the main causes of morbidity. Only up to 21.6% of facilities are involved in malaria prevention, yet malaria is the leading cause of ill-health and death in Uganda. It is however positive to note that for all major causes of illnesses, there is evidence of referral of patients from the private clinics to the public or PNFP facilities for further management. Less than 23.6% of traditional healers are involved in management of malaria, diarrhea and RTIs which constitute the top 5 diseases in Uganda.

Factors influencing quality of services provided

Formal Education of interviewed persons:

Forty nine percent (18/37) of the THs had no formal education but one had tertiary education; this was found to be a dental surgeon now practicing traditional medicine in Mpigi District. Forty two percent of the formal providers had tertiary education. Only 1 out of 81 had primary education only.

Table 28: Formal Education of interviewed persons

Facility Ownership	Health	Highest Level of Formal Education				Total
		No Formal Education	Primary	Secondary	Tertiary	
Formal providers		0	1	46	34	81
TH		18	12	6	1	37
Total		18	13	52	35	118

* Non response by 1 formal provider & 1 traditional healer

Generally there is a poor level of formal education among the traditional healers. This poses a serious challenge to the quality of health services they deliver to communities they serve. This greatly limits their access to training and CME for sustainable improvement of the quality of their services.

Medical Qualifications of interviewed health providers: Trained health workers were predominantly found in Public, PNFP and PFP facilities. Only 1 dental surgeon practices as a traditional healer. Most of the owners or medically operational responsible persons were found to be of the nursing cadre, constituting about 47.6% of all the respondents. The persons who were interviewed included 1 doctor, 4 clinical officers, 1 dispenser, 39 nurses/midwives, 29 nursing assistants. Nursing assistants constituted 35.4% of the health workers interviewed. The Uganda Ministry of Health being cognizant of the role nursing assistants play in the health system, has put in place a training programme that enables nursing aides to be trained and covert to nursing assistants. In this training they are exposed to some level of medical training that allows them to manage simple health problems like treatment of fevers.

Most PFP health providers were found to be lower level and mid-level health professionals with basic medical training after secondary level formal education. The beginning point of most PFP health providers for health service provision is getting medical experience by initially working in public health facilities. Service delivery quality control should therefore be built into the curriculum of training institutions so as to instil crucial customer management skills as well as knowledge of health service regulations in the graduating health professionals. Some of these skills are bound to be acquired by all public sector health workers who may end up retaining these skills even when they opt to do private practice.

Equipment in Health Facilities:

PNFP facilities are the best equipped of all other health provider facilities under study. Public facilities closely followed by PFP facilities were the worst equipped with basic clinical equipment as detailed in the table 29 below.

Table 29: Availability of key equipment in various provider health facilities

Equipment Seen	Type of facility				Total n=120	% of all facilities
	Public n=22	PNFP n=10	PFP n=50	Traditional Healers n =38		
	No. (%)	No. (%)	No. (%)	No. (%)		
Examination Bed	6 (27.3)	5 (50.0)	21 (42.0)	13 (34.2)	45	37.5
Sterilizer	4 (18.2)	5 (50.0)	15 (30.0)	0 (0.0)	34	28.3
Thermometer	5 (22.7)	6 (60.0)	25 (50.0)	0 (0.0)	46	38.3
Stethoscope	6 (27.3)	5 (50.0)	15 (30.0)	0 (0.0)	37	30.8
Hand washing amenities*	11 (50.0)	9 (90.0)	17 (34.0)	3 (7.9)	40	33.3

*Hand washing basin plus running water and soap

Only 7.9% (3/38) of the TH facilities have hand-washing amenities. The PFP and Public health facilities are a little better at 34% (17/50) and 50% (11/22) respectively.

Availability of functional basic equipment in health facilities at all service delivery levels is a precursor to good disease detection / diagnosis which in turn improves the overall quality of health care given to patients and clients. This specifically applies to formal / allopathic health services but not to traditional healer facilities. The plight of the formal PFP health facilities, the worst equipped of the allopathic facilities, needs addressing through extensive stakeholder consultations and possible governmental intervention such as the support offered to private not for profit facilities (often faith based facilities).

Continuing Medical Education (CME):

Health Service Providers accessing CME constituted 78% (64 out of 82) of the total number of the respondents. The rest had no access to CME. Only 28.9% of the TH had access to CME (through THETA). CME should be universally accessible to all health practitioners since it is very important to practising health workers as it refreshes their professional knowledge and updates their skills on new medical practices. This in turn improves quality of health services delivered to the community.

Affiliation to Professional Bodies:

An average of only 35% (29/82) of the interviewed health workers in public and private health provider facilities belonged to professional associations. Membership to professional bodies was 60% in public facilities, 55% in PNFP, 31% in PFP facilities and 26.3% (10/38) among traditional healers.

Affiliation of private sector health providers to professional bodies was generally weak. TH had constraints with the affiliation process, especially financial extortion by professional associations. This tends to compel many of THs to opt out of affiliation to professional associations. Nevertheless, streamlining health providers into professional bodies improves quality of health services delivered by the providers. Professional associations have etiquettes of operation, and conform to sector specific government regulations. They also enhance peer review mechanisms and collective professional bargaining. These control quality of performance by all types of providers to deliver the minimum health care package to the community nationwide. Affiliation to professional bodies should be enhanced through the policy for PPPH.

Nature of employment: Full time or Part time:

Most (75 out of 82) of the formal health providers interviewed were full time employees. Only 8.5% were part time. Working full time confers personnel commitment to service, stability in the work place, and reduces turnover rate in health facilities. This enhances continuity of service provision, quality and availability. It may also contribute to fostering a strong client / patient relationship - which may in turn influence clients' perceived quality of services delivered. On the other hand, most part time private sector workers were THs with only 65.8% (25/38) offering full time service compared to the 91.5% among the formal health providers who are full time. This may be because THs often vary their health practice with agricultural practice - a predominant occupation in rural areas where many of the TH facilities are located.

Number of days of service provision per week:

Seventy four percent (89 out of 120) facilities provided services on daily basis (seven days a week). Twenty one percent remained open for six days (from Monday to Saturday) to provide services.

Table 30: Distribution of health facilities by number of days of service provision per week (of seven days)

Health Provider Facilities	Days of opening per week for service provision			Total
	Up to 5	6	7	
Public	1	8	13	22
PNFP	1	1	8	10
PFP	3	11	36	50
TH	1	5	32	38
Total	6	25	89	120

Ninety five percent (114/120) of all providers are open six or seven days a week. Only 5% (6 out of 120) of the facilities provided services for only five or less days in a week. Opening of facilities for service provision at least six days a week is a strong incentive for access of services by the community.

Duration of service provision per day:

The duration PFP and TH facilities offer health services is well distributed throughout the 24 hours of each day, as seen in table 31 below. Traditional healers tend to be available 24 hours as opposed to drug shops that close at the end of the day. PNFP facilities too tend to be open most of the day and 50% operate beyond 10pm. Many PFP and TH offer services well beyond 12 hours, comparing favourably with Public sector facilities of which only 27% operate beyond 10pm.

Table 31: Provider opening hours per day

Facility type	Up to 5pm	Up to 10pm	Beyond 10 pm	Total
	No. (%)	No. (%)	No. (%)	
Public	9 (40.9%)	7 (31.8%)	6 (27.3%)	22
PNFP	1 (10%)	4 (40%)	5 (50%)	10
Formal PFPs	10 (5%)	24 (48%)	16 (32%)	50
Traditional Healers	2 (5.3%)	19 (50%)	17 (44.7%)	38
Total	22 (18.8%)	54 (45%)	44 (36.7%)	120

Most PFP facilities provide services for longer hours than public health facilities. This gives clients / patients flexibility for accessing health services while maximizing the efficiency of their time management. This may be yet another factor influencing clients' / patients' choice of health facilities for desired health services. This, coupled with short distance to private health facilities, could also be one reason why most patients in Uganda first go to private health facilities for health services in preference for the free public sector facilities (IMCI Multi-country study- Uganda, 2000; ALPS, 2005).

Supervision of health facilities by the Local Health Authority: Provider-specific details of supervision of health facilities by local authorities are as presented in table 32. Private for profit facilities were not supervised as well as public or PNFP facilities. Although 54% (27 out of 50) PFP facilities were supervised either monthly or quarterly, 36% (18 out of 50) were either never supervised at all or supervised only once a year. This contrasts with

supervision of public sector health facilities, where 50% (10 out of 20) were supervised monthly, 35% (7 out of 20) quarterly and only 5% (1 out of 20) never supervised at all.

Table 32: Supervision of health facilities by the Local Health Authority

Facility	Supervision by Local Health Authority						Total
	Never	Monthly	Quarterly	Six Monthly	Annually (once/year)	Others	
Public	1	10	7	1	1	0	20
PNFP	0	7	3	0	0	0	10
Formal PFP	5	7	20	5	10	3	50
Traditional Healers	22	4	4	2	3	2	37*
Total	28	28	34	8	14	5	117

**Non response by 3 traditional healers*

Overall, public sector health facilities and PNFP facilities were better supervised than PFP and TH facilities by local health authorities. Yet in the event of sickness, about 83% (IMCI Multi-country study, 2000) of households were found to seek their first health care services from formal PFP and TH facilities - which are poorly supervised. Most of the PFP facilities were, on average, supervised by the local health authorities at either monthly or quarterly interval. Regular supervision often leads to improvement of availability and quality of health services delivered by health service providers, regardless of ownership.

Poor supervision of private facilities by local authorities poses key management concerns; all of which undermine availability and quality of health services delivered to the community, and as well as weakening the district health system. There is a communication gap between the local authorities and private sector health providers. Population health outcomes may therefore continue to either stagnate or deteriorate unless remedial actions are instituted in the health system. The MoH is addressing this concern in the health policy in form of strengthening public private partnership for health (PPPH) through more active engagement with other private health care providers during HSSP II of the current health policy (MOH HSSP II, 2005). It is envisaged that the engagement of the private health care providers will significantly contribute to achievement of the millennium development goals (MDGs), (MoFPED, 2003).

Health Management Information system (HMIS) of private health providers:

An attempt was made to elicit the type and quality of health records being kept by PSP, if any. Availability of HMIS or health activity record keeping provides a source of evidence for decision-making by facility and other health managers (e.g. DHMT, MOH, etc). This is an indicator of good health management practice which can positively influence quality of service delivery. An average of only 43% (21 out of 49) formal PFP health facilities kept basic health records: Age, Sex, Address, Diagnosis and Treatment given. The formal PFP facilities where records were not being kept were mainly drug shops. Legally these are supposed to function as over the counter (OTC) sellers of simple medicines, but it is widely known that they operate as fully fledged clinics.

Record keeping is worse in TH health facilities where only 27% (10 out of 37) of health facilities kept basic health records. This contrasts sharply with PNFP and Public sector health facilities where records, (HMIS and other health activity data), were kept by all (100%) of the facilities studied. It was not established by this study whether the records kept

were being utilized or shared with local health authorities and other health managers for decision-making.

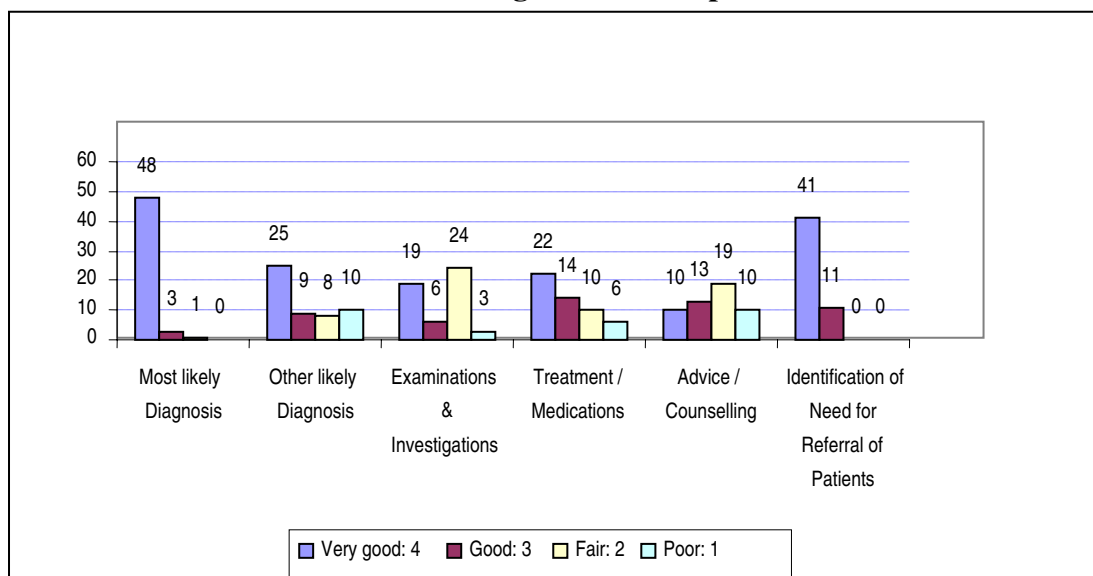
Keeping good health management information facilitates tracking of facility-specific as well as universal health service quality trends in district health systems. In addition, availability of HMIS or good health record keeping provides not only evidence bases for decision-making by facility and other health managers but also enables monitoring of population health trends. These are crucial milestones in any health system for positively influencing quality of health services delivered to communities. Therefore, there is need to reverse the remarkably poor record keeping practice in formal PFP and Traditional healers facilities.

Quality of clinical care in formal private health facilities

The technical quality of services provided by formal or allopathic health facilities was derived from clinical interviews based on case-scenarios in 52 health facilities. Providers were presented common clinical case scenarios on fever, acute respiratory illnesses and diarrhoea among children and diabetes mellitus in adults. Health provider interpretation of the case history, diagnostic skills and choice of investigation, and treatment approaches were assessed against the national treatment guidelines. It was observed that the general trend is the existence of good level of technical quality of care in formal/allopathic practice by clinicians in Public, PNFP and PFP health facilities combined. Performance is particularly good in clinical diagnosis, treatment and identification of need for referral of patients - this may be a reflection of good basic clinical training most clinicians get from training schools.

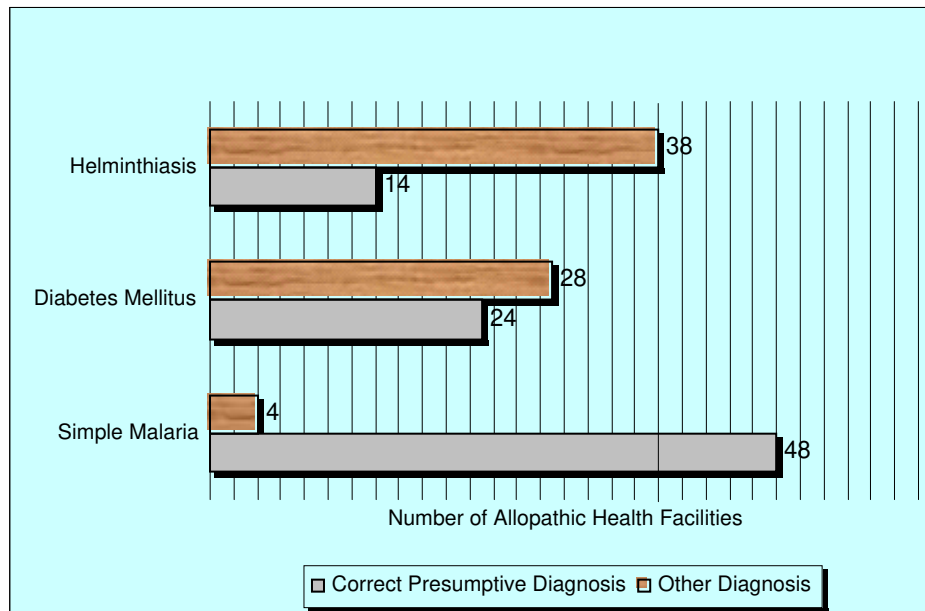
Given that fever/ malaria is the commonest reason for seeking health care, health workers were assessed on the ability to make correct diagnosis given a case scenario. Majority of the health providers were able to make a correct diagnosis of fever (48/ 52) and correctly identify cases that would require referral (52/52) based on the case scenario as shown in figure 6 below. However, being able to decide and conduct appropriate investigations and provide relevant advice/ counselling were the areas in which the providers performed poorly (25/ 52 and 23/ 52 respectively).

Figure 6: Quality of Allopathic Clinical Management in Public, PNFP & PFP Health Facilities: Management of Simple Malaria



The accuracy of clinical diagnosis and treatment for some of the commonly occurring diseases by providers from different types of health facilities was also assessed. Out of the 52 allopathic health facility clinicians interviewed, accuracy of disease specific diagnoses and treatment varied as follows: Simple Malaria 48; (93.3%) got it correct, Diabetes Mellitus 24; (46.2%) got it correct, and helminthiasis 14 (26.9%) got it correct.

Figure 7: Accuracy of Allopathic Clinical Diagnosis and Treatment by health facilities



Regarding TB treatment, clinicians in most health facilities had good knowledge of TB management. Most health facilities used clinical and laboratory methods for diagnosing TB and they knew when to refer TB patients for further management in higher level facilities. The inference on quality of clinical management is that the technical quality of formal clinical care in private health facilities is generally good except for the weak laboratory diagnostic functions and counselling services- especially in PFP facilities.

The identified weaknesses in clinical diagnosis and treatment could be a manifestation of lack of continuous medical education (CME). To maintain the generally good technical quality of health services delivered by private health facilities, professionals in those facilities need to improve or replenish their knowledge through access to medical education resources and further medical training, especially in-service training.

Range and Quality of services offered by General Merchandise Shops: A total of 59 general merchandise shops that acknowledged selling medicines or condoms were included in the survey. Iganga District contributed 13, Masaka 23 and Mpigi 23 shops. When asked whether fever is one of the reasons people seek for medicines from their shops 68% (40/59) agreed. The fever remedies they offered included paracetamol (panadol) 29%, chloroquine 25%, or indeed any other medicine that the customer asks for. It was found that 49% (29/59) of the shopkeepers provide some advice about dosage. After checking their answers for paracetamol dosages for children and adults, it was found that only 64% (38/59) of them actually knew the correct dosages. Sixty three percent of the respondents (37/59) reported that they usually provide some advice to people with fever. While 51% (30/59) of the shops in the sample were selling condoms only 20% (12/59) of them ever gave advice to clients on

how to use condoms correctly. The type of advice provided varied and the answers provided included how: to wear the condoms, to check expiry dates or intact seal and consistent use of condoms. It was interesting to note that in cases when the shopkeepers did not have the medicines that the customers wanted to buy; most of them referred them elsewhere. This was said by 95% of shopkeepers. The referral units included health facilities 51%, drug shops 38%, other general shops 11% and other places.

Generally, the practice of selling medicines from general merchandise shops is quite common. These shops are conveniently located in the communities but the range of services they offer is very narrow.

Conclusions

Private health providers, in various forms, remain the closest facilities to communities, giving communities easy and flexible access for health services from these facilities.

Resource availability and quality are a big challenge to health service delivery. Quality of human resources for health in private health facilities is being compromised by several factors such as poor access to medical education resources (CME), limited access to further medical training and weak affiliation to professional bodies.

PNFP facilities were the best equipped while Public and PFP facilities were the worst equipped of the allopathic facilities.

In all PFP facilities, lack of functional Health Information Management System or sound health record system was found to be undermining evidence based management: the worst hit being TH practitioners. This in turn compromises comprehensive health planning and quality of health services delivered to communities.

Most private health facilities provide services for longer hours than public health facilities, giving patients flexibility in accessing health services while maximizing the efficiency of their time management. Coupled with short distance to private health facilities and courtesy to clients, this influences clients' choice of health facilities for desired health services.

Effective regulation of private health service delivery is constrained by: lack of regular supervision by local health authorities especially among the PFP and TH facilities, weak affiliation to professional bodies - occurs in the health facilities of all the categories of private health service providers; as well as lack of Universal Health Service Quality Control Standards set and enforced by health policy stewards- MOH and DDHS, respectively.

The technical quality of formal clinical care in private health facilities is generally good except for the weak laboratory diagnostic functions and counselling services, especially in PFP facilities. These may be a manifestation of specific skill deficits in counselling and laboratory diagnosis, and lack of CME.

Recommendations and Suggestions for future interventions

I. Policy Measures

1. Promote affiliation of all categories of health providers to professional associations so as to improve regulation and quality of health services they deliver to communities

2. Clearly classify PFP health provider facilities by level of service delivery so as to ease the supervision and enforcement of laws.
3. The Public Private Partnership for Health should address partnership concerns for a wider range of partners not only PNFPs.
4. Appropriate essential record keeping packages should be developed for low level PFPs including THs, so as to obtain a *Comprehensive HMIS* for the entire health sector, overseen by the MOH.
5. The MOH should, as a policy measure, compile and avail Essential Equipment List for various PFP health service providers after extensive stakeholder consultations.

II. Service Quality of PFPs

1. PHC services delivered by private health providers to communities should be strengthened in line with the National Minimum Health Care Package
2. Supervision of private health facilities by local health authorities should be strengthened; this should be preceded by multi-stakeholder sensitization workshops
3. Clinical support services like laboratory investigations should be strengthened in the formal/allopathic facilities mandated by their service delivery level, while counselling skills should be promoted in all health providers at all levels
4. Support schemes that promote PFP facility infrastructure development should be developed

III. Human Resource Quality of PFPs

1. Establish functional adult literacy mainly for THs and some Drug shop owners, in collaboration with local health authorities and CSOs / NGOs like THETA
2. CME should be scaled up among formal PFPs and THs while strengthening that of Public and PNFPs

3.6 Linkages between the Public and Private Health Sectors

We assessed the nature of linkages between public and private providers. The term “linkage” is used as an embracing term covering collaboration, competition and referral. Good collaboration could mean sharing equipment and facilities. Referral was considered to be the most important linkage because it is an indicator of the quality of care. A facility survey tool was used to elicit information from selected respondents at various health facilities for all categories (Public, PNFP, PFP and Traditional healers). The study covered a total of 120 health provider facilities. The health providers covered included 22 Public health facilities, 10 Private not-for-profit (PNFP), 50 Private for profit (PFP) and 38 Traditional healers. The traditional healers comprised of four different categories namely the herbalists, the spiritualists, the bone-setters and the traditional birth attendants (TBAs).

Referral

Referral was considered to be a process of advising a patient to go to another health provider for purposes of further management. Ideally the process of referring patients should be done in writing to avoid ambiguity. The Health Management Information system (HMIS) in Uganda has a provision for referral forms that should be used by all clinicians who want to refer patients/clients from one practitioner to another. The referral note is used for Outpatient, Inpatient, Family Planning, antenatal care, and maternity patients and clients. The health facility of first contact fills one part of the referral note and the referral site is expected to fill another part to complete the referral process (MoH 2005).

Receiving referred patients regularly

In order to establish the type and level of collaboration, health providers were asked whether their health facilities received referred patients regularly. Out of 120 health facilities, 72 (60%) indicated that they received referred patients regularly and 48 (40%) indicated that they did not receive referred patients regularly (Table 33).

Table 33: Receiving patients regularly referred by other health care providers

	Frequency	Percent
Receive referred patients regularly	72	60
Do not receive referred patients regularly	48	40
Total	120	100

Availability of Pre-printed referral letters

Referral letters for diagnostic services

Respondents in each of the health facilities were asked whether they had pre-printed referral letters for both diagnostic services not available in their facilities and special treatment facility. Responses indicated that pre-printed referral letters for diagnostic services were only available in 23/120 (20%) of the health facilities visited. This means that in 97/120 (80%) of the health facilities, pre-printed referral letters for diagnostic purposes were not available. When further analysis was done to categorize health facilities by availability of pre-printed referral letters for diagnostic services it was found that 10/22 (45%) of the Public facilities, 8/10 (80%) of the PNFP and 5/50 (10%) of the PFP had pre-printed referral letters. All the 38/38 (100%) traditional practitioners did not have pre-printed referral letters for diagnostic services (table 34).

Table 34: Availability of Pre-printed referral letter for diagnostic services by health provider category

Health Provider	Availability of Pre-printed referral letter for diagnostic services (n=120)	
	Yes	No
	No. (%)	No. (%)
Public (n=22)	10 (45.4%)	12 (54.5%)
PNFP (n=10)	8 (80.0%)	2 (20.0%)
Traditional healer (n=38)	0 (0.0%)	38 (100.0%)
PFP (n=50)	5 (10.0%)	45 (90.0%)
Total	23 (20%)	97 (80%)

Referral letters for specialist treatment

Of the 120 health facilities that were interviewed, 72 (60%) had pre-printed referral letters for specialist/special treatment.

Further analysis was done to categorize health facilities by availability of pre-printed referral letters for specialist or special treatment. Results of this analysis are summarised in table 35. Among the Public health facilities only 7/22 (32%) had pre-printed referral letters for specialist or special treatment. When this was compared to PNFP the percentage was more or less the same. It stood at 3/10 (30%), while in both PFP health facilities and traditional practitioners, there was no pre-printed referral letter for specialist treatment.

Table 35: Availability of Referral letters for specialist treatment by health provider category (n=120)

Health Provider category	Availability of Pre-printed referral letter for specialist/special treatment			
	Yes		No	
	No.	%	No.	%
Public (n=22)	7	31.8	15	68.2
PNFP (n=10)	3	30.0	7	70.0
Traditional healer (n=38)	0	0.0	38	100.0
PFP (n=50)	3	6.0	47	94.0
<i>Complementary (n=3)</i>	0	0.0	3	100.0
<i>Doctor's private clinic (n=5)</i>	1	20.0	4	80.0
<i>Clinical officer's private clinic(n=4)</i>	0	0.0	4	100.0
<i>Midwife's clinic/Maternity home (n=5)</i>	1	20.0	4	80.0
<i>Nurses Private clinic (n=1)</i>	0	0.0	1	100.0
<i>Nursing Assistant/Nursing Aides' clinic (n=3)</i>	0	0.0	3	100.0
<i>Drug shop (n=27)</i>	1	3.7	26	96.3
<i>Both Drug shop and clinic(n=2)</i>	0	0.0	2	100.0
Total	13	10.8	107	89.2

Type of health facilities referring patients/clients

Further analysis was done to find out the behaviour of health providers in referring patients/clients to other providers as a way of collaboration. Findings indicated that one provider may refer patients to various providers for purposes of further management.

Public Health Providers

Of the 22 Public health providers, 18 (81.8%) referred patients to fellow Public health facilities, 1/22 (4.5%) referred patients to PFP health facilities and only 3/22 did not refer patients (table 36). None of the Public health providers was found to be referring patients/clients to PNFP health providers according to the data available.

Table 36: Health care Providers/institutions where patients are referred

Facility	Health Provider where facilities refer								Total referring No. (%)
	Public		PNFP		PFP		Traditional Healer		
	No.	%	No.	%	No.	%	No.	%	
Public (n=22)	18	81.8	0	0.0	1	4.5	0	0	19(86.3)
PNFP (n=10)	7	70.0	2	20.0	1	10.0	0	0	10 (100.0)
PFP (n=50)	26	52.0	6	12.0	8	16.0	0	0	40 (80.0)
Traditional Healer (n=38)	16	42.0	3	7.9	4	10.5	2	5.3	25 (69.4)

PNFP Health Providers

Out of 10 PNFP health providers 7 (70%) referred patients to public health providers, 2/10 (20%) referred patients to their fellow PNFP and only 1/10 (10%) referred patients to PFP health providers (table 35).

PFP Health Providers

The PFP health providers totalled 50 in number including Doctors' clinics, Clinical officers' clinics, Midwives' clinics/Maternity centre, Nursing Assistants' clinics, drug shops and complementary medicine. Out of these only 40 (80%) answered this question. Results indicated that 26/50 (52%) referred patients to public health providers, 6/50 (12%) referred patients to PNFP health providers while 8/50 (16%) referred patients to their fellow PFP health providers. Most patients were being referred to public health providers. This could probably be linked to the fact that in rural areas, many health providers are public due to increased number of HC level III at every sub-county and HC Level IV at every county which are predominantly public facilities.

Traditional Healers

Out of 38 THs, only 25 (69.4%) answered this question. Results indicate that 16/38 (42%) referred patients to public health providers, while 3/38 (7.9%) referred patients to PNFP and 4/38 (10.5%) referred patients to PFP. Only 2/38 (5.3%) indicated that they referred patients to their fellow traditional healers (table 36).

Sharing of x-ray and laboratory services

One of the indicators for collaboration in this study was the extent to which Health Practitioners accepted to share facilities that are not widely available such as x-ray and some laboratory services. The responses were summarized as indicated in table 37. Out of 120 health providers only 22 (18.4%) reported that their facilities shared such services. A substantial percentage of respondents 85 (70.8%) reported that they did not share x-ray and laboratory facilities while 13 (10.8%) did not respond to this question. This implies that there is collaboration among health facilities to the degree represented by 18.5% who share x-ray and laboratory facilities.

Further analysis was done to establish the category of providers that were sharing x-ray and laboratory facilities as indicated in table 38. Among public health facilities 41% (9/22) reported that they shared services, while 7/10 (70%) of PNFP and 6/44 (14%) of PFP shared. All the traditional healers indicated that they did not share x-ray and laboratory facilities.

Table 37: Sharing of X-ray and Laboratory services among health facilities

	Frequency	Percent
Share services	22	18.4
Don't share services	85	70.8
Did not answer the question	13	10.8
Total	120	100.0

Table 38: Number of Providers who share x-ray and laboratory facilities by type

Health Provider	Providers sharing laboratory and x-ray facilities		Total
	Yes	No	
Public (n=22)	9	13	22
PNFP (n=10)	7	3	10
PFP (n=50)	6	38	44
Traditional Healer (n=38)	0	31	31
Total	22	85	107

Sharing of health Staff

Health providers were asked as to whether they shared staff. Responses were recorded as indicated in table 39. Staff in this case included all categories of trained health workers, Doctors, Nurses, Nursing Assistants and other persons employed to provide a health service. Out of 120 health providers only 106 (88.3%) answered this question. Out of these only 9/109 (8.3%) reported that they share staff but the majority 97/106 (91.5%) reported that they did not share staff. This means that most of the health providers did not necessarily share staff. It was also noticed that out of the 9 who reported that they shared staff 1/9 (11.1%) were public providers, 6/9 (66.7%) were PNFP providers and 2/9 (22.2%) were PFP health providers. No body among the traditional healers reported sharing of staff.

Table 39 Sharing of Staff by Provider category

Health Provider	Sharing of staff		Total
	Yes	No	
Public (n=22)	1	20	21
PNFP (n=10)	6	4	10
PFP (n=50)	2	41	43
Traditional Healer (n=38)	0	32	32
Total	9	97	106

Exchanging, bartering or borrowing materials

Health providers were asked as to whether they exchanged or bartered materials. Findings indicated that out of 120 health providers only 112 (93.3%) answered this question. Responses of all those that answered the question were recorded in table 40.

Table 40: Providers who exchanged bartered or borrowed materials as part of collaboration

Health Provider	Exchange/Barter materials				Totals
	Yes		No		
	No.	%	No.	%	
Public (n=22)	7	21.2	15	19.0	22
PNFP (n=10)	4	12.1	6	7.6	10
PFP (n=50)	16	48.5	30	38.0	46
Traditional Healer (n=38)	6	18.2	28	35.4	34
Total	33	100.0	79	100.0	112

Materials bartered in this case included syringes and needles, cotton wool and other sundries. Out of the total 112/120 who answered this question 33/112 (29.5%) reported that they exchanged or bartered materials with other health providers. Among these, 7/33 (21.2%) were Public Providers, 4/33 (12.1%) were PNFP and 16/33 (48.5%) were PFP providers while 6/33 (18.2%) were Traditional Healers. Most of the health providers 79/112 (70.5%) reported that they did not exchange or barter materials.

Further analysis was done to establish the type of health providers that our respondents were bartering of materials with. Out of the 33 health providers who answered in affirmative to this question 27 (81.8%) indicated the type of facilities they were bartering with. Results out of this analysis are summarized in table 41. It was found that public facilities dealt mainly with other public facilities, PFP mainly with PFP, but PNFP was exchanging with both public and PFP facilities. Traditional healers dealt mainly with other traditional healers.

Table 41: Health providers type by category of provider that they barter materials with

Health Provider	Collaborating facility					Total
	Public	PNFP	PFP	TH*	Not stated	
Public (n=22)	5	0	0	0	2	7
PNFP (n=10)	2	0	3	0	0	5
PFP (n=50)	0	3	9	0	4	16
Traditional Healer (n=38)	0	0	0	5	1	6
Total	7	3	12	5	7	34

*TH= Traditional Healer

Provision of credit facilities

Health providers were asked as to whether they provided credit facilities as part of collaboration with other facilities or practitioners in health service provision. Findings of this analysis were recorded in table 42. Out of the total 120 health providers, only 106 (88.3%) answered this question. Only 18.2% (4/22) Public facilities, 30% (3/10) PNFP, and 10% (5/50) of the PFP facilities mentioned that they offer credit facilities to other practitioners. None of the traditional healers extended credit facilities to other practitioners.

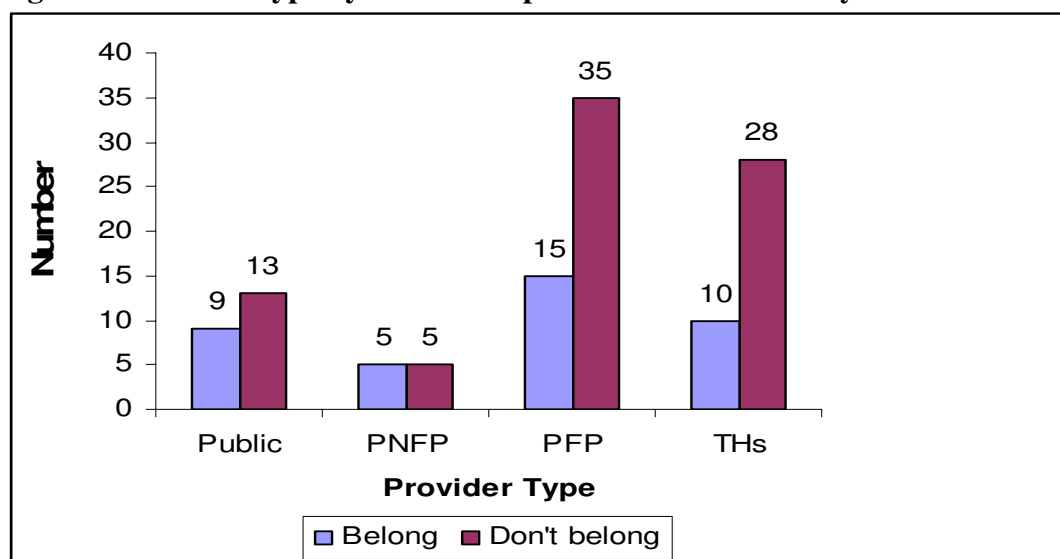
Table 42: Providers who provided credit facilities as part of collaboration with other facilities

Health Provider	Provision of credit			Total
	Yes	No	Not stated	
Public (n=22)	4	17	1	22
PNFP (n=10)	3	7	0	10
PFP (n=50)	5	40	5	50
Traditional Healer (n=38)	0	30	8	38
Total	12	94	14	120

Professional Associations

Membership to professional associations or societies is one way of realizing interactive cohesiveness and a channel through which linkages may be increased among health providers. This study used this channel to measure the extent to which collaboration may take place through Professional mix. Respondents were asked if they belonged to professional association/societies (Fig 8). It was established that out of 22 Public providers 9 (40.9%) belonged to a professional association, 50.0% (5/10) PNFP, 30.0% (15/50) PFP and 26.3% (10/38) THs were members of professional associations.

Figure 8: Provider type by membership to Professional Society



Although this study did not specify which professional associations' individuals belonged to, it was apparent that all types of providers had some linkage with professional associations with varying levels of participation. This implies that there is collaboration at the professional level with varying degree of involvement.

Competition among the health care providers

In general, health facilities do not operate in isolation but, rather in a complex health care provision market. This study was interested in capturing the presence of competition and services were competition was felt as a proxy for the degree of competition faced by different categories of providers. Health providers were asked to list major competitors in the services that they provided. Out of 120 health providers only 48 (40%) felt competition. Out of these, 13 were Public Health facilities, 3 were PNFP, 16 belonged to PFP and 11 were traditional health. Table 43 shows who the different providers perceived their competitors to be.

Table 43: Type of providers where competition was felt

Health Provider	Category of perceived competitor				Total
	Public	PNFP	PFP	TH	
Public (n=13)	4	2	5	2	13
PNFP (n=3)	0	0	2	1	3
PFP (n=16)	3	3	8	2	16
Traditional Healer (n=11)	2	1	8	5	16

Further analysis indicated that the majority of providers felt they were competing with other health providers. Among the public health providers, 5/13 felt they were competing with PFP, 4/13 felt they were competing with their fellow public facilities, 2/13 felt they were competing with PNFP and 2/13 (9%) felt they were competing with traditional health practitioners.

PNFP Health Providers

When the PNFP health providers were asked the same question, 2 reported that they were competing with the PFP and 1 felt that they were competing with traditional healers.

PFP Health Providers

Among the PFP health providers, 8/50 (16%) felt they were competing with their fellow PFP, 3/50 (6%) felt they were competing with public health facilities and 3/50 (6%) felt they were competing with PNFP.

Traditional Health Providers

Among the traditional Health providers 8/38 (21.1%) felt that they competed with PFP, 5/38 (13.2%) felt they were competing with their fellow traditional healers and 2/38 (5.3%) felt that they were competing with the public health providers (table 42).

Services where competition was felt

Table 44: Services where competition was felt

Services	Type of Provider								Total n=120	
	Public n=22		PNFP n=10		PFP n=50		TH* n=38			
	No	%	No	%	No	%	No	%	No	%
Accident services	0	0.0	0	0.0	2	4.0	2	5.3	4	3.3
All services	2	9.1	0	0.0	0	0.0	0	0.0	2	1.7
Blood Screening	2	9.1	1	10.0	0	0.0	0	0.0	3	2.5
Curative Services	1	4.5	1	10.0	3	6.0	3	7.9	8	6.7
F/P and Immunization	0	0.0	1	10.0	0	0.0	0	0.0	1	0.8
Malaria treatment	1	4.5	2	20.0	1	2.0	1	2.6	5	4.2
Maternity services	2	9.1	3	30.0	4	8.0	4	10.5	13	10.8
Mental Health	0	0.0	0	0.0	1	2.0	1	2.6	2	1.7
Plaster casts	0	0.0	0	0.0	1	2.0	1	2.6	2	1.7
Quick services	2	9.1	0	0.0	0	0.0	0	0.0	2	1.7
Selling drugs	0	0.0	1	10.0	0	0.0	4	10.5	5	4.2
TH* services	1	4.5	0	0.0	0	0.0	0	0.0	1	1.7
X-ray services	0	0.0	0	0.0	0	0.0	1	2.6	1	1.7

*TH= Traditional Healer

Health providers were asked to identify the services where competition was felt. As the first answer, responses were captured as shown in table 44.

Public Health Providers

Out of the 22 Public health providers 2/22 (9.1%) felt that competition was in all services; while 2/22 (9.1%) felt competition was in blood screening transfusion, 2/22 (9.1%) felt competition was in maternity services and 2/22 (9.1%) felt that competition was in quick services. Quick services in this case referred to the time taken from the point when the patient arrives to when he leaves the health provider.

PNFP Health Providers

Among the PNFP health providers, competition was most felt in maternity services with 3/10 (30%), followed by malaria treatment 2/10 (20%) and the third being blood screening and transfusion, curative services and selling drugs with 1/10 (10%) responses each.

PFP Health Providers

Among the PFP health providers, competition was most in maternity services with 4/50 (8%) followed by curative services with 3/50 (6%) responses and accident services with 2/50 (4%) responses.

Traditional Health Providers

Among the traditional health providers, the highest competition was felt in maternity services and selling drugs with 4/38 (10.5%) responses each; followed by curative services with 3/38 (7.9%) and accident services with 2/38 (5.3%) responses as indicated in table 44.

Conclusions on linkages

- Referral is a common practice and some 60% of facilities participate in the referral process either as recipients or as referring facilities. Most of this, however, is done informally in an undocumented manner.
- Sharing services is a less common practice with only some 20% of facilities reporting sharing services such as x-rays or laboratory work. It mainly occurs within sectors.
- Sharing of personnel is quite rare. Only 8% of facilities reported doing it to some degree and it occurs mainly within sectors.
- Perceived competition is fairly common and occurs between and within sectors. Some 40% of facilities reported this perception.

3.7 Qualitative Report Covering Health Seeking Behaviours, Perceived Range and Quality of Services Available In the Community

Introduction

The findings presented here are from the focus group discussions (FGD) that were conducted in the districts of Masaka, Mpigi and Iganga. They comprised of various community leaders, mostly local council (LC) chairpersons and opinion leaders, and some traditional healers. These were drawn from the various parishes that participated in the study. Focus group discussions were always held in each study parish after completion of the household survey, health facility survey and facility mapping exercise. In all, a total of 15 FGDs were held.

The overall objective of the study was to investigate the private health care providers' role in health care provision and assess their capacity to improve the health of the people. The focus group discussions were used to gather in-depth qualitative information to complement quantitative data.

Presentation of findings

The findings from the focus group discussions are presented under the following schemes:

- Categories of health care providers in the communities visited,
- Communities' perception on range and quality of services provided by different health care providers,
- Common health problems experienced by the community and their health seeking behaviours.

Categories of Health Providers

Participants in the focus group discussions were asked to describe the different types of health care providers that operate in their community. The following categories of health care providers were mentioned in all FGDs:

- Public health units
- Private not for profit health units (PNFP), commonly referred to as Non governmental (NGO) facilities
- Private clinics
- Drug shops
- General merchandise shops that also sell drugs
- Traditional healers who include spiritualists, herbalists, bonesetters, and traditional birth attendants (TBAs) and

The above categories can be classified into the biomedical providers, the informal providers and the traditional healers.

It is important to note that some of the parishes (Bukoyo parish in Iganga and Mabanga parish in Mpigi) did not have any general merchandise shops selling drugs. Legislations/bye laws had been passed by area leaders to that effect. This may have countered self treatment.

Range of Services offered by the different Providers

Information from all the FGDs revealed that both the biomedical and traditional practitioners as well as the informal health care providers offer a wide range of services. Some of the services cut across all the different categories of providers however, management of some conditions is restricted to particular categories of providers. Findings shall be presented by provider category.

Traditional healers

In all the FGDs it was stated that many people seek care from traditional healers. Traditional healers are said to provide both curative as well as preventive services.

Curative services

They treat a wide range of health problems including diseases which communities perceive to be incurable by allopathic treatments offered by biomedical practitioners. This perception is illustrated in the following statements.

‘Traditional healers can heal epilepsy, abnormal menstruation, barrenness and swollen legs caused by witchcraft. They handle snakebite cases and even treat diarrhea in AIDS patients enabling them to regain their bodyweight.’
(Nakiswiga Parish –Community leaders FGD, Iganga District)

‘Karim (name of a traditional healer) can cure snakebites even though the person is in coma.....’
(Nakiswiga Parish –Community leaders FGD, Iganga District)

Referral services

Some of the discussion groups mentioned that traditional healers refer patients to other providers for further management. They refer patients to the health centers or hospitals for cases that they can not manage and also refer to fellow traditional healers.

‘They give advice on referral in situations where they fail to treat the disease.’
(Makondo Parish –Community leaders FGD, Ndagwe subcounty Masaka District)

‘Sometimes we send our patients to the health centers or the big hospital for further treatment.’
(Bukoyo Parish Traditional healers FGD, Bukoyo subcounty Iganga District)

First aid services

Since traditional healers are the most frequently occurring and readily accessible health care providers in the community, they are often contacted for management of emergency cases especially convulsions, snake bites and deliveries. A local leader had this to say:

‘Some herbalists give herbal medicines to emergency cases such as convulsions as first aid treatment before these patients are taken for formal treatment at the health centers.’
(Butayunja Parish –Community leaders FGD, Kibinge subcounty Masaka District)

Specialist services

We categorised traditional healers into herbalists, spiritualists, bonesetters and traditional birth attendants, with each category offering a unique type of treatment.

Herbalists

The herbalists use herbs to treat a variety of problems which include medical conditions like HIV/AIDS related illnesses, fever, cough, skin rashes as well as some social problems such as witchcraft. Herbalists seem to be very popular and were the most frequently mentioned category of traditional healers.

“For HIV/AIDS, most people now use traditional herbal medicine because of the unavailability of biomedical drugs that treat HIV/AIDS”.
(Samaliya Parish –Community leaders FGD, Mukungwe Sub-county, Masaka District)

Spiritualists

Spiritualists are traditional healers that employ spiritual powers to diagnose and treat their clients (patients). Often times, spiritualists also use herbs in their treatment regimen. It was reported that most people tend to seek the services of a spiritualist when they have illnesses that have vague or non specific symptoms as echoed in this focus group discussion that was held with community leaders in Iganga District:

‘We cannot go to traditional healers for treatment of fever; we instead go to drug shops or clinics. However, we go to traditional healers specifically spiritualists for illnesses that we do not understand.’
(Nakiswiga Parish –Community leaders FGD, Iganga District)

It was also commonly mentioned in most of the group discussions that people tend to consult spiritualists when faced with health or social problems as indicted by the following statement:

“Some people on the other hand, mostly women, frequent traditional healers for reasons ranging from seeking fortunes in their marriages, stability of their families/ marriages and barrenness. They mainly consult spiritualists and herbalists”.
(Samaliya Parish –Community leaders FGD, Mukungwe Sub-county, Masaka District)

Bonesetters

Bonesetters are traditional healers that specialize in the management of bone conditions ranging from fractures, sprains and pain perceived to originate from the bones. These practitioners’ treatment encompasses use of herbs, physical manipulation of affected body part as well as spiritual healing. It is worthy of note that a few of the group discussions revealed that some bonesetters use splints to immobilize limbs, using a technique similar to that used by biomedical health care providers. It is evident that many people prefer to seek care from bonesetters other than biomedical practitioners. Common statements that support this impression went as follows:

“For the case of fractures e.g. broken legs, arms, people mainly go to the bonesetters because they believe that formal medical treatment takes long to make them heal. I think eight out of ten people with fractures get treatment from bonesetters”.
(Samaliya Parish –Community leaders FGD, Mukungwe Sub-county, Masaka District)

“Patients with fractures prefer to go to bonesetters for treatment. They fear that biomedical practitioners will amputate off their limbs”.
(Kavule Parish –Community leaders FGD, Kiringente subcounty, Mpigi District)

“Some bonesetters offer a better service compared to the biomedical doctors. For instance, telebonesetting is a highly specialized technique whereby a patient’s fractured limb is treated without the patients physically contact with the bonesetter. The healer uses spiritual powers to manipulate the broken bone. Good results are achieved and it is less costly as transport costs are eliminated.”
(Bukoyo Parish Traditional healers FGD, Bukoyo subcounty Iganga District)

Traditional birth attendants

Traditional birth attendants (TBAs) are traditional healers who specialize in assisting mothers at delivery. They also offer to some extent prenatal as well as postnatal care. They play a key role in attending to a proportion of the deliveries that occur in the communities, considering that about 40% of all deliveries in Uganda are registered in public or private health facilities. This role has been recognized by the formal health sector and as a result many of them have received training. TBAs are highly regarded by the community and are a ready source of assistance in cases of pregnant women who go into labour at night. The following excerpts illustrate the range of services that are offered by traditional birth attendants (TBAs):

'TBAs give herbal therapies to women who have a history of complicated deliveries such as those requiring operation. The medicine helps these women to have normal deliveries.'

(Kiryasaka Parish–Community leaders FGD, Kibinge subcounty Masaka District)

'But we also have TBAs who were trained to handle deliveries in the villages and sometimes, even the nursing aides at the health centre seek assistance from these trained TBAs.'

(Bulange Parish –Community leaders FGD, Bulange subcounty Iganga District)

'Traditional healers are easily accessed especially at night when the clinics are closed. This is especially the case with TBAs, who assist mothers to deliver.'

(Kavule Parish–Community leaders FGD, Kiringente subcounty Mpigi District)

There is a subgroup of traditional birth attendants that is specialized in delivering fetuses from dead pregnant mothers as was mentioned in the districts of Masaka and Iganga. This is an area where traditional birth attendants appear to enjoy a monopoly to a much needed service in many communities where it is a taboo to bury a dead pregnant woman with a fetus in her womb.

Reasons why people visit Traditional Healers

The focus group discussions revealed that people visit traditional healers for a variety of reasons.

The major reason given for visiting traditional healers was their accessibility. Traditional healers are located near the people and therefore can be easily accessed without incurring costs on transportation.

"People who have been treated by traditional healers find it easy to reach and access the services. This is so because most traditional healers live within the community and can be easily contacted anytime during day and night"

(Samaliya Parish –Community leaders FGD, Mukungwe Sub-county, Masaka District)

It was also mentioned in many FGDs that the traditional healers operate throughout the day as well as night, making them very accessible to the community.

Traditional healers are thought to have the expertise to treat certain illnesses that cannot be handled by biomedical health units e.g. witchcraft.

'When a disease is explained very well to the spiritualist, they are able to give perfect treatment of which the professional health workers may not be able to handle.'

(Kavule Parish –Community leaders FGD, Kiringente Subcounty Mpigi District)

It was mentioned in all districts that traditional healers are good at managing mental illness as echoed in this statement:

'We the traditional healers get patients referred to us from Iganga Hospital, especially those with mental illness.'
(Bukoyo Parish- Traditional healers FGD, Iganga District)

Other reasons mentioned by respondents for seeking care from traditional healers were the fact that some offer home-based services which reduce the treatment costs for patients by eliminating transport costs.

There was a strong perception that the cost of treatment from traditional healers is relatively cheaper than that from other health care providers. Many of the participants said that traditional healers charge a small fee especially for herbal medicine and that they also offer credit facilities as well as accepting in-kind payment.

'The cost of traditional medicine is low, with the exception of spiritualists. Usually traditional medicine is taken at patient's home, hence no recurring transport costs or admission costs. So it's cheap and suits well the low incomes of people in this area.'
(Samaliya Parish –Community leaders FGD, Mukungwe Sub-county, Masaka District)

Also traditional medicine is believed to have no side effects.

"Traditional medicine has no side effects even when taken for a long time; it does not negatively affect the patient's body unlike modern medicine."
(Samaliya Parish – Community leaders FGD, Masaka District)

Regarding traditional birth attendants specifically, they are commonly used as a source of care because of their expertise at handling pregnancies and deliveries; they also handle pregnant women politely during delivery.

Similarly, people go to spiritualists when they are sick because they are believed to have the ability to accurately diagnose the cause of many illnesses.

Shortfalls

There were however, a number of reasons that were mentioned by the respondents as to why some people do not seek health care from traditional healers.

A majority of the respondents in the FGDs believed that most traditional healers treat their patients in very unhygienic environment. Some are also said to use the same unsterilised sharp instruments on various people, which can easily lead to spread of diseases like HIV/AIDS. Similarly, many TBAs lack protective wear like gloves which puts their patients at risk of getting HIV and other infections.

"The TBAs operate with no protective wear such as gloves. They are not clean. Some are very old and do not offer good services to expecting mothers. All these can endanger the life of the mother and child or even expose them to dangerous diseases such as HIV/AIDS and tetanus"
(Butayunja Parish–Community leaders FGD, Kibinge Sub-county Masaka district)

Focus group participants also showed concern over the fact that medicines dispensed by the traditional healers are not given in standardized dosages, predisposing their patients to over dose which can have grave consequences including death.

Another fear that was commonly expressed in the group discussions was the fact that some healers hold on to patients with conditions that they cannot handle instead of referring them to the biomedical practitioners, thus putting the lives of these patients in danger. Common statements were:

“Some keep holding on to patients (do not refer them) even when they know that they cannot handle the difficult or emergency cases. For example, in some cases, some pregnant mothers bleed and collapse at the hands of TBAs”

(Butayunja Parish –Community leaders FGD, Kibinge Sub-county Masaka district)

“Some traditional healers claim to know treatment of certain illnesses yet they fail to heal them. Sometimes they do not refer patients in case of failure. This is common with TBAs”.

(Mabanga Parish- Community leaders FDG, Kirengete subcounty Mpigi District)

In addition, traditional healers lack means of transport for emergency cases that need to be referred. This is one possible explanation for TBAs not referring complicated deliveries.

“...most TBAs have no ready means of transport to transfer emergency cases to hospitals. This delays the referral process and often results in death.”

(Samaliya Parish – Community leaders FGD, Masaka District)

Traditional healers are said to lack proper storage mechanisms for their medicine which predisposes them to getting spoilt or losing their efficacy. Some lack patient-provider confidentiality. This type of view explains why people prefer to visit healers far from their community.

Some of the FGDs raised the issue of patient exploitation by the traditional healers. This was mainly related to spiritualists, who are believed to be money-minded and therefore tell lies to their patients so as to get more money as stated in this FGD:

“Some of them especially spiritualists tell lies and go on to treat what is not there in order to get money for survival”.

(Gombe Parish – Community leaders FGD, Kibibi Sub-county, Mpigi district)

“If you consult a spiritualist in your neighborhood, he may send to you witchcraft so that you consult him more often and therefore pay him more money.”

(Nakiswiga Parish – Community leaders FGD, Iganga District)

Some spiritualists practice human sacrifice while others sexually abuse their clients. Common statements made were:

“Some of the traditional healers, mainly the spiritualists, sacrifice humans to appease their spirits.”

(Mabanga Parish- Community leaders FDG, Kirengete subcounty Mpigi District)

“Some of these traditional healers especially the spiritualists sexually abuse their clients, under the pretext that they are performing cleansing rituals on female patients or treating barrenness. These rituals almost always involve sexual intercourse which predisposes patients to HIV.”

(Samaliya Parish – Community leaders FGD, Mukungwe subcounty Masaka District)

“During the cleansing ceremony locally referred to as okwambula, the traditional healer and patient both undress and then the healer bathes the patient with herbs. Often the healer ends up having sexual intercourse with his female patient.”

(Butayunja Parish - Community leaders FGD, Kibinge subcounty Masaka District)

Considering that many of the female patients that visit the spiritualists are married, sexual abuse by the healers also predisposes their partners to sexually transmitted diseases (STD) including HIV. As a result, this act of sexual abuse may be greatly contributing to the number of STD cases in the community.

Still on the issue of HIV/AIDS, one of the FGDs mentioned that traditional birth attendants lack the capacity to prevent mother to child transmission of HIV.

‘Traditional birth attendants lack the knowledge and facilities for preventing HIV/AIDS transmission. As a result they cannot prevent babies from contracting HIV from infected mothers.’

(Mabanga Parish–Community leaders FGD, Kiringete subcounty Mpigi District)

This is an area of great concern, since it counters efforts of the Ministry of Health to reduce prevalence of HIV through its Prevention of mother to child transmission of HIV (PMTCT) programs that have been introduced in most parts of the country. There is a 30% risk of mother to child transmission of HIV if appropriate PMTCT measures are implemented.

Further still, spiritualists are said to cause misunderstandings and hatred in the community because most times they interpret the cause of their clients’ ill-health to be a result of witchcraft from relatives, neighbours or co-wives.

“Spiritualists often incite enmity between patients and their friends, neighbors and relatives by linking patient’s illness to witchcraft performed by.”

(Katwadde Parish– Community leaders FGD, Mukungwe subcounty Masaka District)

Biomedical health care providers

Regarding views about the biomedical health care providers, a majority of FGDs mentioned that most people seek health care from Public Health Units and private clinics. The second most mentioned source of health care was drug shops, followed by PNFP facilities.

Public facilities

These were government facilities ranging from lower level health units to hospitals. Information from most of the FGDs indicates that providers in public facilities are the most consulted health care providers; serving as a first point of contact when available in the community.

Reasons why people seek care from public facilities

There were 2 major reasons why persons choose to visit public facilities. Firstly, most respondents felt that health workers in government facilities are highly skilled. Hence they are able to treat a wide range of illness including complicated cases.

Secondly, public facilities offer free treatment. Patients only incur costs when drugs or sundries are out of stock and patients are asked to buy these.

Shortfalls

A majority of FGDs stated that despite public facilities offering free treatment, they are faced with a problem of frequent drug stock outs.

“The government health centers do not have drugs. In most cases we are referred to buy drugs from drug shops in Bulange trading center.” (Bulange Parish –Community leaders FGD, Bulange subcounty, Iganga District)

“Drugs sold in government hospitals are more expensive than those in private clinics.” (Gombe Parish – Local community leaders FGD, Kibibi subcounty Mpigi District)

Another shortfall of public facilities that was brought up in more than half of the FGDs was the negative attitude of health workers.

“Some health workers in government facilities are very rude and harsh to patients especially those who are lower cadres (nurses).” (Gombe Parish – Local community leaders FGD, Kibibi subcounty Mpigi District)

Almost all FGDs mentioned that understaffing was another problem faced by public facilities.

“Our health centre is being run by only one nursing aide. She can not effectively treat all the patients that come in seeking for help.” (Bukoyo Parish, Community leaders’ FGD, Bukoyo subcounty Iganga District)

Drug shops

Drug shops were reported to offer health care services ranging from provision of first aid, treatment of various illnesses like malaria, cough, etc, to giving advice to clients/patients on cases that need referral.

Reasons why people seek care from drug shops

Various reasons were given as to why people seek health care from drug shops.

A majority of the FGDs mentioned that people use drug shops because they (drug shops) stock a variety of drugs and they are near to the people, therefore they can easily be accessed without incurring transport costs.

“They provide drugs within the trading centers, located within the community. So people easily get drugs without going long distances. No transport costs” (Makondo Parish–Community leaders FGD, Ndagwe Sub-county, Masaka District)

Other reasons given for seeking care from drug shops were that they are managed by medically trained personnel who give clients the right dosage, they offer services on credit services and can be accessed most of the time (both day and night). They are also said not to sell expired drugs, sell fairly cheap drugs, they handle patients politely, maintain good hygiene in their workplaces and supplement the care received from other providers.

“Drug shops are useful in giving First Aid especially when drugs are not readily available in the government facilities because drugs are readily available in the drug shops.” (Gombe Parish –Community leaders FGD, Kibibi subcounty Mpigi District)

For most common problems, there is no clear preference between drug shops and other providers.

“The diseases that we take to the health center are the same diseases that we take to drug shops. But in most cases we just go there (drug shops) to buy drugs because the health center has no drugs.” (Bulange Parish –Community leaders FGD, Bulange subcounty, Iganga District)

Shortfalls

On the other hand, the respondents also mentioned various reasons why some people do not seek health care from drug shops.

The in charges or proprietors of these shops were reported to be money-minded and therefore easily sell expired drugs and many times dispense drugs without telling their clients the right dosage.

It was also reported in a few of the FGDs that drugs are poorly stored, and that persons who are not professionally qualified run many drug shops.

“Storage of drugs is not appropriate. Some drug shops are in poorly ventilated houses with uncontrolled temperatures, which make some drugs go bad. When such drugs are consumed by patients, their health can worsen”

(Ndagwe Parish –Community leaders FGD, Ndagwe Sub-county, Masaka District)

“I know a nurse who lets her husband run the drug shop and yet he is not qualified to do so. This practice is common, with many drug shop owners employing their unqualified relatives to run the shop in their absence.”

(Samaliya Parish – Community leaders FGD, Mukungwe subcounty Masaka District)

Furthermore, since proprietors of drug shops are profit-minded, they tend to sell drugs at higher prices. Many do not go for refresher courses and hence can easily give wrong doses for new drugs.

It was alleged in some of the discussions that drug shops act as agents through which drugs are stolen from public health facilities.

“Most drug shops are allegedly used to siphon drugs from government health units”.

(Kiryasaakaa Parish –Community leaders FGD, Kibinge Sub-county, Masaka District)

“Patients are often referred to the drug shops for medicine because most of the drug shops are owned and run by health workers who work in the government facilities.”

(Gombe parish –Community leaders FGD, Kibibi subcounty Mpigi District)

Lastly, drug shops are said to sell medicine depending on clients’ financial capacity, which contravenes the medical ethics regarding prescriptions and dosage, a practice that is harmful to clients’ lives e.g. it can bring about drug resistance.

“Most of them do not sell drugs according to right dosage or prescriptions made. They are also driven by money motive, so they simply sell without following proper prescription procedures”

(Ndagwe Parish –Community leaders FGD, Ndagwe Sub-county, Masaka District)

Informal health care providers

These were the general merchandise shops that also sell human medicines as well as other health care related goods such as condoms. This type of provider was not mentioned as frequently as the biomedical providers or traditional healers. It is worth noting that some parishes did not have any providers in this category, since the area Community leaders had passed bye-laws prohibiting the operation of such services as evidenced from these statements:

“We do not have any drug shops or shops that sell dugs”

(This was a collective statement from Bukoyo Parish Traditional healers' FGD in Iganga District)

"There are clinics where medicine is obtained; shops were prohibited from selling drugs."

(Mabanga Parish–Community leaders FGD, Kiringente subcounty, Mpigi District)

The findings show that general merchandise shops offer services ranging from selling drugs for common simple illnesses and first aid purposes to selling condoms.

Reasons why people seek care from general merchandise shops

One of the most commonly given reasons why people seek care from these kinds of shops was because they can get drugs on credit as was mentioned in this FGD:

"The shopkeepers in this community know us well, so people are able to get drugs even on credit."

(Kifampa Parish- Community members FGD, Kabulasoke subcounty Mpigi District)

Another frequently give reason was the good accessibility of these shops to the community members. The shops are near and on top of that, they are open most of the time so patients can access them easily.

"They are easy to access. They are within the reach of the people because they are everywhere in the community"

(Kiryasaakaa Parish –Community leaders FGD, Kibinge Sub-county, Masaka District)

They are also used by the community because they sell high quality condoms as well as packed drugs with clear instructions on them e.g. hedex, cofta. This ensures that the drugs do not get easily contaminated.

"Condoms that are sold in the general merchandise shops are of a better quality compared to those given out at the health centers."

(Bulwadda Parish–Community leaders FGD- Kabulasoke subcounty Mpigi District)

"General merchandise shops mostly sell drugs that are packed in blister packs."

(Kifampa Parish Community members FGD, Kabulasoke subcounty Mpigi District)

Shortfalls

However, on a negative side, a majority of FGDs mentioned that general merchandise shops are characterized by poor storage of drugs as mentioned in this statement from Masaka District:

"Human medicine is stored along with general merchandise products, so it easily gets mixed and contaminated with such general grocery in the shop. Such drugs are harmful for human use".

(Ndagwe Parish –Community leaders FGD, Ndagwe Sub-county, Masaka District)

It was commonly stated that some of the shop attendants in the general merchandise shops give wrong medicine and or wrong doses to clients because they are not professionally trained health workers.

"Shop keepers are not trained in the health profession. They simply sell drugs without advising patients/customers on the right dosage. This results in under-dose or overdose which harms the people's health".

(Gombe Parish –Community leaders FGD, Kibibi subcounty Mpigi District)

Some of the shop keepers are profit oriented and thus can sell expired drugs to people. Often times, these shopkeepers sell drugs according to one's financial capability other than adhering to the proper dosage. This act is often profit driven as was stated in this focus group discussion.

"Most of the shopkeepers sell drugs according to the amount of money the patient has and not dosage requirements."
(Bulange Parish –Community leaders FGD, Iganga District)

These shops are also said to be characterized by poor hygiene in both storage and handling of drugs.

"Hygiene of handling drugs is poor. Shopkeepers handle tablets with dirty hands. This affects the quality of drugs and negatively affects the clients who use the medicine".
(Makondo Parish –Community leaders FGD, Ndagwe Sub-county, Masaka District)

There are shops that illegally sell injectables without advising clients on the right dosage. This was however mentioned in only one discussion group.

Common Health Problems

In all FGDs we asked the community leaders, opinion leaders and traditional healers that participated in the group discussions what the common health problems in their communities were.

Malaria was the most commonly mentioned health problem, being cited first in all the discussion groups. Convulsions associated with malaria were reported to be a common disease among children in many of the groups. It was commonly referred to as 'convulsion fever'.

"Diarrhea and convulsions are severe amongst children and they are taken to Buyoga Mission Health Centre and sometimes private clinics because the only government health centre is far from here, about 8 kilometres."
(Butayunja Parish –Community leaders FGD, Kibinge Sub-county Masaka district)

HIV/AIDS and STDs were also reported to be common health problems, but coming second to malaria. These two illnesses were reported to affect all age groups as illustrated by the following quotes:

"Many children are now born with HIV. AIDS has also had a severe effect on adults of all sexes...."
(Kiryasaaka Parish –Community leaders FGD, Kibinge sub-county Masaka District)

"Syphilis is common in all age groups..."
(Ndagwe Parish–Community leaders FGD, Ndagwe sub-county Masaka District)

"Syphilis is rampant among adults..."
(Butayunja Parish–Community leaders FGD, Kibinge sub-county Masaka District)

"Sexually transmitted diseases are common, amongst adults, the most common is syphilis"
(Katwadde Parish–Community leaders FGD, Mukungwe sub county, Masaka District)

“There are also many syphilis cases in this area, except that people fear to go and get treatment.”

(Bulange Parish–Community leaders FGD, Bulange Subcounty Iganga District)

Other diseases frequently mentioned in the FGDs were diarrhoea, cough, eye problems, worm infestations, asthma, high blood pressure, dental problems, ulcers, measles, headache, stomach pains, mental sickness, diabetes, wounds, reproductive health related problems such as barrenness and impotence, fractures, and epilepsy.

Health seeking Behaviour of the population

To address this objective, we asked the focus group discussion participants where people mostly seek health care from in their community.

For most health problems, people generally consult public facilities first, but are often times forced to go to private clinics and drug shops to buy drugs. Common statements were:

“Most people in this area mostly go for treatment to public health units, the majority being children suffering mostly from fever, diarrhea, and vomiting and convulsion malaria.”

(Samaliya Parish Community leaders FGD, Mukungwe sub county Masaka District)

“When people are sick, they mostly consult public health facilities first for cases of malaria. Most go to drug shops and clinics after failing to get drugs from the public health units”.

(Kiryasaka Parish Community leaders FGD, Kibinge subcounty Masaka District)

This was closely followed by Private for profit clinics and traditional healers, drug shops and Private not for profit health facilities in ascending order. General merchandise shops, churches and home made medicine (mainly herbal) were the least mentioned.

Biomedical health care

Most of the focus group participants felt that there are health problems that are best treated by biomedical providers and others that best handled by traditional healers.

“Every provider has his or her own specialty. Choice of provider visited depends on what one is suffering from. For example if I have spirits disturbing me, I go to the spiritualist, while if I have malaria I go to the drug shops.”

(Nakiswiga Parish Community leaders FGD, Iganga District)

“There is a difference between disease which can be treated in the hospital and those which can be treated only by the traditional healers. If the patient is suffering from spirits he has to see a spiritualist. For cases of severe malaria, typhoid, AIDS and TB, one has to be taken to hospital.”

(Nakiswiga Parish Community leaders FGD, Iganga District)

However, it was mentioned in one of the FGDS that there are some conditions that can be treated by both the biomedical as well as the traditional health care systems. These conditions include: fractures, epilepsy, abnormal menstruation, tonsillitis, madness and tetanus.

Traditional healers

Among the traditional healers, spiritualists and herbalists were the most popular, closely followed by the bonesetters. Traditional birth attendants were the least mentioned; being

brought up in only the Iganga District groups. This is not surprising since in many communities TBAs are considered to be midwives other than traditional healers.

It is widely believed that there are some illnesses that can only be cured by traditional healers. Supporting statements include:

“..But only diseases that are clinical such as malaria can be cured from hospitals. There are those that can only be cured by traditional healers.”
(Bukoyo Parish Traditional healers FGD, Iganga District)

“Some people get treatment from the traditional healers, especially for diseases that have to do or are caused by evil spirits.”
(Makondo Parish Community leaders FGD, Ndagwe subcounty Masaka District)

“Some people on the other hand, mostly women frequent traditional healers for reasons that range from seeking for fortunes, stability of their marriages and infertility. They mainly consult spiritualists and herbalist.”
(Samaliya Parish Community leaders FGD, Mukungwe sub county Masaka District)

When asked which gender utilizes the traditional healers more, most of the focus groups mentioned females. These discussions revealed that the major reasons why women consult traditional healers are quite different from those for men. Women usually seek for stability in their marriage and children while men tend to seek for wealth. There was agreement in a majority of the discussions that a gender difference exists in reasons for seeking care from traditional healers as reflected in these statements.

“Some people mostly women frequent traditional healers for reasons ranging from stability of their families/marriages and childbearing.”
(Samaliya Parish Community leaders FGD, Mukungwe subcounty Masaka District)

“Women go to traditional healers for marriage issues, to be loved by their husbands.....”
(Bulange Parish Community leaders FGD, Bulange subcounty Iganga District)

‘Women go to spiritualists so that they can win love from their spouses’ (Nakiswiga Parish Community leaders FGD, Iganga District)

“But men also go to spiritualists (Traditional healers) especially for business blessings and protection of their homes and property.”
(Bukoyo Parish Traditional healers FGD, Bukoyo subcounty Iganga District)

The discussions revealed that medical pluralism is widely practiced with people consulting both biomedical and traditional healers. This depends on the nature of the health problem and the severity of the problem. In some situations both forms of care are used concurrently as is the case with symptomatic treatment of HIV/AIDS and epilepsy or at times they are used sequentially as in the case of mental illness where patients that fail to get cured by biomedical treatment seek care from spiritualist.

“We have 3 epileptic children in this village. These usually go to the government health centre or hospital for treatment and also use herbal medicine.”
(Butayunja Parish FGD, Ndagwe subcounty Masaka District)

Most of the clients that traditional healers treat come from distant places; rarely do they come from the same neighborhood. The traditional healers had this to say:

“They always come from far places”

“But some may come from the neighborhood...basing on the nature of the problem and the urgency of the problem.”

(Bukoyo Parish Traditional healers FGD, Bukoyo subcounty Iganga District)

Fever

Since malaria was the most commonly reported health problem, the health care seeking behaviour of malaria patients was explored. Information from the FGDs shows that generally patients with malaria consult public facilities first; however, due to the frequent drug stock outs in these facilities, patients with uncomplicated malaria prefer to seek care from drug shops or private clinics (PFP). On the other hand cases of severe malaria are almost always taken to public facilities. The following statements illustrate the health seeking behaviour of persons with malaria:

“Most people consult public health facilities first for cases of malaria. However, many of them go to drug shops and clinics after failing to get drugs from the public health units.”
(Samaliya Parish Community leaders FGD, Mukungwe sub county Masaka District)

“At times drugs are not readily available in the hospital and in clinics and yet these drug shops have such drugs.”

(Gombe Parish Community leaders FGD, Kibibi subcounty Mpigi District)

“People with severe malaria are taken to Makondo health centre for treatment or when it is simple malaria they buy medicine from the drug shops.”

(Makondo Parish Local leaders, Ndagwe subcounty Masaka District)

As earlier discussed, persons with malaria do not often consult traditional healers.

Mental sickness

The community believes that traditional healers are able to heal mental illness. In some of the FGDs, it was mentioned that spiritualists are good at diagnosing and treating mental illness. Some of the traditional healers that participated in the discussions informed us that they receive many mentally ill patients and have successfully treated their illness after biomedical treatment failed to cure them.

“We (traditional healers) get patients coming from Iganga (District) hospital especially those who are mad.”

(Bukoyo Parish, Traditional healers FGD, Iganga District)

“When I went to Muyodi’s (traditional healer) place, I found some patients that had been brought from Butabika hospital (the national referral mental hospital).”

(Bulange Parish Community leaders FGD, Iganga District)

Suggestions for the Improvement of Traditional Healers' Services

When asked to provide recommendations for improving services offered by the traditional healers, the following suggestions were made by the FGD participants:

- There is need to put more emphasis on sensitizing traditional healers on areas of hygiene, avoiding of practices that put providers and patients' lives at risk of getting infections.
- Increase sensitization of traditional healers on the need to refer complicated cases i.e. cases they can not handle
- Government should facilitate the healers so as to improve storage and preservation of the medicine
- Strengthen the associations of traditional healers so as to improve the sharing of knowledge and experiences amongst themselves
- Encourage collaboration between traditional and biomedical practitioners
- Put in place bye-laws to regulate the quality of traditional medicine
- Enforce registration of all traditional healers

Conclusions

These findings show that the various health care providers (private for profit clinics, drug shops, general merchandise shops as well as traditional healers) in the private sector are playing a big role in health service provision, by providing services that complement services offered by the public health sector.

The private health care providers are readily accessible, both physical and financial access.

However, there is potential for their services to improve if the shortcomings identified by the communities are addressed.

3.8 The Effect of Policy and Regulation on the Private Sector

This section of the results addresses the effect of policy and regulation on the private sector in Uganda. The first part deals with the outcomes of the documents review; detailing the background to Uganda's health system development, current health policies including that for the Public Private Partnership. The second part deals with key informants' knowledge as well as views on health policies related to the private sector.

Uganda's Health System Development

Prior to 1995, Uganda's health system was operating under old policies and laws dating back to 1950s and 1960s. The health system at that time was being fashioned like the National Health System of the United Kingdom. Health services would be financed and provided by the Government. The role of the private sector was not envisaged. Indeed, the formal private sector was negligible, consisting of a handful of Asian and European doctors and dentists treating Ugandan elites and foreign expatriates. When the health system began to disintegrate in the 1970s, due to the collapse of the economy, the number of formal private-practitioners began to increase. By mid 1990s, the public health system had become so moribund that much of health care was provided by formal and informal private sector. The old laws operating that time were Medical Practitioners and Dental Surgeons Act 1968 and Nurses and Midwives Act 1964. The Health Policy White Paper (1993) gave more recognition to the provision of health services by the private sector. In particular, it recognized that NGOs and the other private sector providers contributed a sizeable part of the health system, perhaps offering 50-70% of curative care. However, the quality of private sector health services was regarded as questionable by the policy. The policy emphasized the need to ensure that roles of the Government, NGOs and other private sector providers were complimentary to avoid duplication and to work together in collaboration. But no guidelines for this collaboration were available.

Current Health Sector Laws

In 1995 three new laws were enacted. These laws were revolutionary in the sense that for the first time in Uganda, specific laws were enacted to regulate and promote the private sector in health services. The laws were: Uganda Medical and Dental Practitioners' Act, 1995; Uganda Nurses and Midwives Statute, 1995; and Allied Health Professional Statute 1995. The laws allowed different categories of health professionals to operate health services within their profession and level of training and competence. The laws made four provisions for private-sector operations. These are registration, training, supervision and disciplining. Only registered persons would be allowed to operate private practice. The premises would also be licensed and subject to inspection by the relevant professional council. Health professionals allowed to provide private practice are: doctors, dental surgeons, pharmacists, nurses, midwives, and allied professionals. The allied professions allowed to engage in private practice include dispensers, clinical officers, laboratory technologists, physiotherapists, and public health dental officers. Health professionals were only permitted to commence full-time practice after a mandatory period of 3 to 10 years of good work with a clean record in the Government or NGO service. Those employed in the Government were not prohibited from owning private clinics or working privately in other people's premises. The private practitioners were obliged to submit returns on their output and epidemiological profile. These were mandatory for annual registration and subject to inspection by medical audit of standards.

Requirements and Supervision

Minimum requirements and facilities for physical premises were set for all types of private practice. The laws allow for private practitioners to dispense medicines to clients, but not to stockpile. Pharmacists were disallowed from prescribing drugs in their pharmacies. Supervision requirements were more tight on nurses, midwives and allied health professionals, but less rigorous on medical doctors and dental surgeons. The latter are supposed to be supervised by the office of the Registrar with the assistance of District Directors of Health Services. The laws have no mention or control of prices, only allowing them to demand reasonable charges. The quality standards are set and enforced by professional councils. However, due to lack of facilitation and capacity this is often not done. The Quality Assurance Department of the Ministry of Health is supposed to link with the councils to ensure the standards are kept. A provision has been included which demands that for all practicing health workers, a certain level of training per year will be necessary to enable them qualify for annual renewal of license.

Linkages and coordination

A private practitioner is allowed to seek for care for patients under his care from Government institutions when that service is only in a Government health unit. But payments for such services are made directly by the patient to the Government. When healthcare user-fees were abolished, this kind of service and collaboration became difficult to operate, although referral was not restricted. The private sector is also encouraged to contract out services through public-private partnership. A policy on Public Private Partnership in Health (PPPH) 2003 has been completed and it provides details of contractual arrangements as well as other methods of collaboration. The laws have weaknesses and gaps. For example, there is lack of control over prices and lack of provisions to ensure equitable distribution of private sector services using appropriate incentive arrangements. But the biggest setback with the laws is the lack of viable enforcement mechanism, and the lack of prescribed penalties for breaking the laws.

National Health Policy

The mission of the National Health Policy is to enable Ugandans attain a healthy and productive life. The objectives are to reduce morbidity, mortality, fertility and inequities, through the provision of a minimum health care package. One of the principles of the policy is public-private partnership (PPP). The policy on PPP recognizes three types of private sector in health: for-profit, not-for-profit, and traditional and complimentary medicine.

Policy on Public-Private Partnership in Health (PPPH)

Part of the overall Policy on Public-Private Partnership (PPPH) has been completed. It addresses only the PNFP. The remaining parts of the policy to address the private sector (for profit) and traditional and complimentary medicine are yet to be developed. The rationale for partnership with the PNFP is to improve equity, access, efficiency quality and sustainability of health services. The guiding principles for the partnership between the government and PNFP are:

- Participation and consultation in policy-making and planning.
- Integration of plans and operations
- Sharing service provision
- Being complimentary to each other
- PNFPs maintaining identity and autonomy
- Ensuring equitable distribution and allocation of resources
- Ensuring transparency and accountability to each other

The goal of the PPPH is to strengthen the national health system through private sector involvement to maximize the attainment of national health policy goals. The areas of partnership between the Government and PNFP are:

1. Policy development, monitoring and evaluation of the HSSP
2. Coordination and planning at both central and local levels
3. Financial resources mobilization and allocation
4. Human resource for health management
5. Capacity building
6. Community empowerment and involvement
7. Service delivery
8. Accreditation of PNFP and Government facilities

The institutional framework for the partnership is the country's decentralized administrative structure. PNFPs will be organized to fit the different levels of administration, starting at the centre, up to the village level. Where structurally it is not feasible to organize autonomous institutions, partners, their functions will be integrated into the overall institutional framework in such a way as to ensure continuous dialogue and coordination. Therefore, while the national institutional framework will provide the overall organization of the partnership, adaptation and innovation of institutional mechanism will be required. The partnership will be formalized through legislative and regulatory instruments. Two options of formalization of the partnership are envisaged. First, the functions, resource allocation, reports and accounting will be built into central and district level mechanisms. Second, the partners will develop, negotiate and implement contracts, which will be monitored and evaluated by different levels of the Government.

The contractual approach will be developed in a consultative, planned and phased manner. Both options may be implemented at the same time for different partners, so as to ensure flexibility in the partnership. Tools for formalization of the partnership are expected to be laws and regulations, Memoranda of Understanding, agreements and contracts accreditations of facilities, registers of PNFP partners by appropriate authorities, a functioning HMIS contributed to and used by both the Government and PNFP. The policy provides strategies for developing an integrated health system. It aims at harmonizing information gathering and reporting, achieving consensus in decision-making on policies, achieving coordination and accountability in service delivery and carrying out joint health planning, monitoring and evaluation.

Traditional Medical Practice

A Bill on Traditional and Complementary Medicine 2004 has been tabled before the Cabinet for approval and enactment by the Parliament. It contains policies on pertinent issues concerning traditional medicine in Uganda. Modern medicine has become established as the official health care delivery system in all countries. However, the western system of health care has not successfully replaced the indigenous healing systems despite its many successes and general acceptance throughout the world but has instead augmented it. This is because traditional healing is deeply embedded in the culture and remains an integral part of the lives of most people. The traditional medical system should therefore be developed to co-exist with modern system. The majority of the population regularly consults both types of healers.

Traditional medical care mainly bases its success on herbal medicine. WHO defines Herbal Medicine as:

“finished labelled medical products that contain as active ingredients aerial or underground parts of plants or other plant material or combination thereof, where in the crude state or as plant preparations. Plant materials include juices, gums, fatty oils, essential oils and other substances of this nature. Herbal medicines may contain excipient in addition to the active ingredients. Medicines containing plant material combined with chemically defined active substances, including chemically defined, isolated constituents of plants, are not considered to be herbal medicines”.

In some countries, herbal medicine may contain by tradition, natural organic or inorganic active ingredients which are not of plant origin. Traditional Health Practitioners (THPs) vary from one country to another but in Uganda, the three main categories the policy will address include:

- Herbalists
- Birth Attendants
- Bone Setters
- The question of whether to recognize and include spiritualists /divine healers among THP is still debatable.

The Alma Ata Declaration in 1978, provided for the accommodation of proven traditional remedies in National Drug Policies and Regulatory measures. In developed and developing countries, the resurgence of interest in herbal medicines has been due to the demand of many consumers for products of natural origin. In both developed countries, consumers and health care providers need to be availed up to date and authoritative information on the beneficial properties and possible harmful effects of all herbal medicines. The draft law on traditional medicine sets guidelines for its development, on establishing a mechanism for incorporating traditional practitioners into the PHC, and for setting up a regulatory system for them. The justification for such a law has been given as:

- The majority of the people use traditional medicine at one stage or another. WHO estimates that 80% of the population in developing countries rely, primarily on traditional medicine for their health care needs and particularly on the use of plant extracts or their derived active ingredients.
- Traditional medicine is not free from risk to the consumer. Many of the traditional remedies often of plant origin contain potent pharmacologically active agents some of which are even highly toxic. It is imperative therefore, to include traditional medicine in all attempts of addressing the issue of safety of health care.
- Traditional medicine comprises therapeutic practices based on beliefs that have been in existence, often for hundreds of years before the adoption of modern scientific medicines. These practices are still upheld today. They are usually in line with the social and cultural heritage of different communities and are not easy to do away with hence the only answer is to streamline them.
- There is a global resurgence of interest in traditional medicine especially in developing countries.
- Traditional Health Practitioners are largely available and form a potentially important resource for delivery of health care.
- Medicinal plants are largely available and form a basis for the health care system in many countries.

The objectives of the draft law on traditional medicine are:

1. To define the potential benefits natural plants and their products offer for improved health care.
2. To define harmful aspects of traditional medicine and provide deterrents for avoiding these.
3. To promote collaboration between Modern and Traditional Health Practitioners.
4. To promote and encourage research in traditional medicine.
5. To establish a regulatory mechanism for Traditional Health Practitioners.

Traditional medicine, like the modern medicine, deals with healing the sick and hence any attempts to streamline the sector must address the issue of Ethics and Code of Conduct for practitioners who practice it. The following general aspects have been considered for inclusion in the law:

- Respect for the patients and their protection from exploitation by practitioners;
- Respect for the community values and environment;
- Promotion of beneficial effects of traditional medicine, elimination of harmful ones and enhancing its safety;
- Promotion of social justice through ensuring safe, culturally acceptable and cost effective traditional medical care to individuals and communities.

The Ethics and Code of Conduct should be established after taking into account the customary beliefs, norms, taboos, values and attitudes. The following specific fundamental ethical principles should be taken into account:

- Protection of the individual
- Confidentiality and privacy
- Informed consent
- Avoidance of prejudice and no discrimination
- Respect for proprietary rights and intellectual property
- Adequate compensation for services rendered and for suits arising from malpractices.

The legal framework to regulate traditional medicine is proposed to address the following areas:

1. Definition and standardization of basic concepts of traditional medicine.
2. Recognition of Traditional Health Practitioners (THP).
3. Definition of areas of practice and malpractice.
4. Rights, privileges and responsibilities of THP.
5. Disciplinary measures and sanctions on errant practitioners.
6. Basis for recruitment and registration of THP.
7. Protection of the profession.

The policy will acknowledge the values of traditional healers and indicate how the government intends to utilize them to promote better health for communities. Government's political will to promote traditional medicine has been spelt out in the policy. The policy will address the following areas:

1. Standards of practice of traditional medicine;
2. Identification of traditional healers and their registration;

3. Education and Training in traditional medicine;
4. Determining centres of providing traditional medical care within the health care system;
5. Cultivation of medicinal plants and preservation of bio-diversity;
6. Setting rules and regulations concerning registration, advertising, manufacture, packaging, preparation, labelling, sale, supply, exportation and importation of any herbal medicines;
7. Documentation and information; and
8. Research in traditional medicine.

Knowledge and Views of Key Informants on Health Policies Related To the Private Sector

Distribution of respondents

The results presented are from interviews of a total of 60 respondents, all of them senior health professionals and administrators from districts, ministries, NGOs and professional bodies. The distribution of the respondents is shown in table 45.

Table 45: Distribution of respondents

Area of Work	Frequency	Percentage
Districts	20	33.3
Ministries & Commissions	11	18.3
NGOs	19	31.7
Total	60	100.0

Respondents and their views on the private sector

The main functions of the organizations in which respondents worked were advisory (32.2%), policy-making (28.8%), service provision (18.6%) and Regulation (13.6%). When asked about their views about the Uganda policies on the private sector, 42% thought that the overall policy of the Government on the private sector is to compliment the Government in service provision. This is much higher than those who thought the overall policy is to compliment the Government in the economy (23.1%), to provide services (22.3%) or that it is the engine to drive the economy (12.4%). On what they thought about greater private sector involvement in health sector provision, most respondents viewed it positively and 65% said that it could improve health care if certain conditions are fulfilled, while 27% said that this should be the main strategy for improving health service delivery.

We asked respondents whether current policies addressed the private sector issues adequately and 73.7% thought that the National Health Policy addressed the private health sector issues well. But 69.8% said that these policies were being implemented only partially, 14% said that they were being implemented satisfactorily, while 7.0% did not know. We investigated awareness about the public-private partnership for health (PPPH) policy and found that 69.5% of the respondents were aware of the PPPH policy, 23.7% were not aware of it, while 6.8% were not sure. Those who were aware of the policy were largely not aware at what stage it was and table 46 shows their responses.

Table 46: Respondents' views about the stage of the PPPH Policy Process

Stages of Policy	Frequency	Percentage
Being developed	14	23.3
Approved	1	1.7
Completed	9	15.0
Being implemented	16	26.7
Do not know	18	30.0
No answer	2	3.3
Total	60	100

Meaning of PPP policy

Asked what they understood by PPP in health, 34.5% said it was sharing responsibilities, 29.6% working in harmony, 21.1% sharing resources, and 13.4% sharing policy-making roles. The correct answer is probably all these combined. Regarding the relevance of the policy on PNFP, 72.9% thought the current policy on PNFP was relevant, 20.3% did not know whether it was relevant or not and 6.8% said that policy was not relevant. Of those who said the policy was relevant, 60% gave the reason of complementing public services, 20% thought it would improve access to care, 16% thought it would lead to cheaper or affordable services, and 4% gave the reason of employment as to why the policy is relevant.

Constraint to PPP Policy Implementation

Asked what the constraints to the implementation of the PPP policy were, they gave the answers in table 47. The most commonly mentioned constraint was lack of sufficient funding, being mentioned by 56.7% (34/60) of all respondents.

Table 47: Constraints to Policy Implementation

Constraints	Frequency (n=60)	Percentage*
Lack of funding	34	56.7
Inadequate sensitisation	22	36.7
Poor coordination	17	28.3
Staff problems	16	26.7
Poor policies	13	21.7
Political interference	6	10.0

**Total percentage is greater than 100 because of multiple responses*

Current laws on private practice

Asked what laws are currently regulating the private sector in health, respondents were not up to date and they came up with the answers in table 48.

Table 48: Knowledge of current laws on private health services

Laws	Frequency (n=60)	Percentage*
Public Health Act	20	33.3
Medical and Dental Surgeons Act	5	8.3
Drug Act (Pharmacy)	4	6.7
Nurses and Midwives Act	3	5.0
HIV/AIDS Act	1	1.7
Health Service Commission Act	1	1.7
Do not know	34	56.7

**Total Percentage is greater than 100 because of multiple responses*

It is surprising to note that only about 8.3% (5/60) and 5% (3/60) of the respondents were aware of the key private sector laws of Medical and Dental Surgeons Act 1995, and Nurses and Midwives Act 1995 respectively. None of them even mentioned the other key law: the Allied Health Professionals Statute 1995.

The respondents were asked to propose what laws they thought would enable the private sector to perform better. The common responses included reduction of taxes, regulation of drug sales, controlling traditional healers, recognition of patients' rights and some said that existing laws were adequate.

When asked how the performance of the private health sector could be improved, the most popular responses were more funding from government (38%, 23/60), quality control (35%, 21/60), and monitoring and evaluation (22%, 13/60).

Forecast of policy changes

When we asked the respondents to provide an opinion about possible policy changes in Uganda's future, the commonest responses were better remuneration for health workers (45%, 27/60) and private sector dominance (27%, 16/60). Regarding the future roles of international agencies, the respondents listed funding (38%, 23/60), capacity building (20%, 12/60), complimenting services (20%, 12/60) and policy support (13%, 8/60).

Criteria for allocating funds

When asked what Government criteria to allocate funds to the private health units should be, their recommendations were catchment population (40.0%) and OPD work load (42%) as the main criteria to be used. Respondents thought that the effects of Government's financing of PNFP health facilities are that this reduces private health care prices (73.3%), has no effect on health care prices (11.7%), causes fluctuating prices (10.0%), and increases prices (3.3%).

Guarantee for value and quality

Asked what guarantees were in place to ensure that the funds given to the private sector produced value for money and compliance to contractual obligations, the main answers were regular reports 44%, supervision 35% and agreements or contracts 14%.

Conclusions on Policy and Regulation

Policies have increased formal private sector participation in health service delivery, but more private sector involvement is still needed. There is now increased public awareness and the awareness of policy-makers on the importance of non-state institutions in health service delivery. There is evidence that they have facilitated increased access to health services, but there is still no concrete evidence that quality, efficiency and sustainability of health services have improved as a result of these or other health-related policies and laws. The policy on the private sector, like most other social policies in country, is facing major constraints. Policies are not fully implemented due to inadequate resources, and there is no effective mechanism to ensure full application of the policies. The recently enacted laws have particularly increased private sector participation in service provision for both PFP and PNFP providers. However, the laws have been unable to curb professional malpractice because penalties for breaking the laws are not specified in these laws. In addition, the laws are not really enforced due to under-funding of the professional organisations, which are the bodies that are entrusted with ensuring standards.

There is a perception among policy makers that government funding of private sector institutions should decrease the health care price payable by clients in those institutions. While there is an increase in the awareness of the importance of the private sector in health services, there is a dismal amount of knowledge about specific policies and laws among the policy-makers and, by extension, among the public. This reflects the lack of awareness-creation and continuous public education about these laws. It also reflects inadequate arrangements and implementation of the policies and laws. There seems to be a wide recognition that the policies and laws on the private sector are required but that in the current form they are not good enough. A part from implementation inadequacies of the current laws and policies, they need to address issues of salary for health workers, taxation of health related services and products, sale of drugs, and patients' rights, among others.

There is apparently a positive future perspective on the private sector among policy decision makers. There seems to be a growing awareness that in the future the private sector will dominate health service provision. And yet at the same time there is also a feeling that public health services will not be sustainable in the foreseeable future, and will continue to be dependent on external donors for sometime to come. Quality is still a major concern among the PSP especially in those facilities manned by less than fully qualified providers. This is an area that may benefit from specific intervention.

CHAPTER 4: CONCLUSIONS AND RECOMMENDATIONS

4.1 Conclusions

Private sector providers are the most numerous providers of health care in Uganda and provide more ambulatory care than the public sector. They are in position to significantly impact public health in Uganda.

A considerable proportion of the population prefers to self-treat, while the rest go for modern health care services. Only a minority actually seeks traditional medical care. This is partly because many traditional healers do not treat the commonest illnesses.

Most people seeking modern health care go to PFP facilities followed by public facilities.

Economically better-off people prefer private sector providers to public providers, while poorer people prefer public services that are free.

For mild illnesses, convenient location is the most influential factor for choosing a provider of health care. This is closely followed by the perceived skills of health-workers. For more serious and dramatic illnesses such as diarrhoea, public providers are preferred.

The cost of treatment per illness is surprisingly very close between public, PFP and PNFP.

Most hospitalizations are in public and PNFP facilities.

Most facilities provide preventive services, curative services and referrals, but only a minority have the basic required equipment and sanitary facilities.

Just over one third of providers are affiliated to professional bodies with more of the affiliated ones being public providers and the least affiliated being THPs.

On quality, the PNFP services are viewed as being of good quality on the parameters of predictability, supervision and records keeping. But if quality is assessed on the basis of trained personnel, PFPs and public facilities score higher than PNFP.

Clinical/technical quality of diagnosis and treatment in PFP and informal clinics (shops) seems to be quite good for common diseases such as malaria, but are not so good for complicated and less common diseases like diabetes mellitus.

Traditional healers are visited for their being easily accessible but they are blamed for practicing human sacrifice and sexual abuse of patients.

Referral between providers is quite common but is done informally. Most referrals are made to public facilities and PNFP, indicating the trust in their capacity to handle more complicated medical conditions.

The sharing of equipment, facilities, staff and materials is practiced by most modern health care providers. The sharing may be within the different groups (eg PNFs) or across the groups of providers (eg PNF and public facilities).

Competition is mainly perceived by the public providers, PFP and TH.

The emergence and expansion of private sector providers in Uganda was by default, following the collapse of the public sector health system in 1970s and 1980s, due to civil conflict and economic mismanagement.

Over the past 20 years, the increasing role of private providers has been given more recognition and new laws have been enacted to enhance their role. The laws are however not yet fully implemented, and also need to be expanded and amended so as to address the emerging challenges.

The PPPH policy articulates the issues of supervision, standards, regulation, linkages and coordination of private providers. But the policy is not fully in operation and is constrained by inadequate funding and weak institutional capacity.

The process of developing a policy on THPs has raised issues about benefits, risks, collaboration, research and regulation of THPs. Issues about protection, confidentiality, privacy, consent, abuse of rights, intellectual and propriety-rights, compensation, and lawsuits against THPs have been raised.

Most policy-makers are of the view that the overall Government policy on the private sector is that it helps complement and improve services, and to promote economic growth.

Policy makers are of the view that the National Health Policy articulates the private sector issues well, but these issues are only partially implemented due to shortage of funds, inadequate awareness, poor coordination, and poor staffing of the health sector.

Most policy-makers and health sector leaders are not aware of the new health sector laws on the private sector.

While health-sector leaders envisage a wider role for the private sector in health, they still think the public sector will continue to play a significant role.

There is a general view that both policy and laws on health services have not fully addressed the needs for patient's rights.

4.2 Recommendations

The bulk of private health facilities are small with limited infrastructure. There is need to recognize the services these providers offer and to categorize them in special groups with well-defined roles. They need to be formally supervised and embraced by the national health system.

For minor cases of illness, most people seek care from private sector providers. It would therefore be advisable to promote private sector providers as the main service providers for these conditions. This would leave mainly more serious cases to be handled by public facilities and PNFPs.

Basic health services, such as immunization, need to be expanded, taking advantage of the extensive network of PFP facilities already on the ground. This may entail financial support to PSPs, while leaving details of innovation, design and implementation to the PSPs.

Self-medication is practiced by a significant proportion of the population. This makes public education about prevention, diagnosis and treatment of common diseases important. This can be conducted through the extensive network of private-sector facilities, by involving PFPs.

All private sector providers should be encouraged to affiliate with appropriate professional bodies.

There is need to carry out a review of laws relating to the private sector and to the partnership between private and public sectors so as to expand and amend the current laws to address the prevailing challenges and issues.

Awareness about health laws in general, and on laws regarding the private sector in particular, is very low among policy-makers and the general public. There is need to increase awareness about the laws through a programme of public education and social marketing.

The concept of Public Private Partnership for Health should be broadened to cover all the PFP providers, including private clinics, drug shops and traditional healers to address all their concerns.

Quality is still a major concern among the private sector providers with regulations being poorly enforced. This is an area that will benefit from specific intervention.

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Annexes

Annex I: Number of Health Categories per Parish/District

DISTRICT	PARISH	1	11	12	13	14	2	23	24	3	31	32	33	34	35	36	37	4	5	Number of categories
IGANGA	BUKOYO				2				4						1	2			16	5
	BULANGE				1											3			9	3
	IWAWU															1				1
	NAKISWIGA					1				1			1		3	2			10	6
	NAWAMPITI					1													6	2
IGANGA Total				3	2				4	1			1		4	8			41	8
MASAKA	BUTAYUNJA										1	2				1			24	5
	KATWADDE			1		1		1								3			32	5
	KIRYASAAKA						1					2		1		1			26	5
	MAKONDO						1					2			1	7	2		66	6
	MIRAMBI					1														1
	NDAGWE	1										2	2		7	2			62	6
SAMALIYA				1		1				2	1				5			14	6	
MASAKA Total		1		1	1	2	3	1			3	9	2	1	8	19	2		224	14
MPIGI	BULWADDA					1										2		5	5	4
	GOMBE		2								1				2	3	2	1	12	7
	KAVULE				1	1		1			1					2			6	6
	KIBIBI					2		1								3		5	6	5
	KIFAMPA				1	1														2
	KIKONDO										2								6	2
MPIGI Total		2		2	5		2			4				2	10	2	11	35		

Facility Codes

- 1 Public (Government owned)**
 - 11 Hospital,
 - 12 Health centre IV,
 - 13 Health centre III,
 - 14 Health centre II
- 2 PNFP (owned by an NGO)**
 - 23 Health centre III,
 - 24 Health centre II,
- 3 PFP:**
 - 31 Doctor's clinic,
 - 32 Midwife's clinic,
 - 33 Nurses clinic,
 - 34 Clinical officers' clinic
 - 35 Nursing aides/assistants clinic
 - 36 Drug shop
 - 37 Others (specify)
- 4 Informal (e.g. general merchandise shop)**
- 5 Traditional healer**
- 6 Complementary (Chinese, etc.)**