



**HAL**  
open science

## Decentralization and the challenges of primary health care delivery in Uganda. The case of Tororo District

Dauda Waiswa Batega

► **To cite this version:**

Dauda Waiswa Batega. Decentralization and the challenges of primary health care delivery in Uganda. The case of Tororo District. Sociology. 1999. dumas-01277912

**HAL Id: dumas-01277912**

**<https://dumas.ccsd.cnrs.fr/dumas-01277912>**

Submitted on 23 Feb 2016

**HAL** is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

Decentralization and the Challenges of  
Primary Health Care Delivery in Uganda  
The Case of Tororo District

1999

**DECENTRALIZATION AND THE CHALLENGES  
OF PRIMARY HEALTH CARE DELIVERY IN  
UGANDA. THE CASE OF TORORO DISTRICT.**

IFRA



No. d'insert

IFRA003007

**BY**

Date 25/01/01

UG/WAIT362.11

**Dauda Batega Waiswa**

**HD/97/377**

**Supervisor: Dr. C.B. Rwabukwali**

**A dissertation submitted for the partial fulfillment  
for the award of a Masters Degree in Sociology  
of Makerere University.  
December 1999.**

IFRA  
AWARD  
WINNER

## **DEDICATION**

This work is dedicated to my mother, Mariam Batega, for her unequalled love, support and encouragement. She has been both a mother and a father to me

## DECLARATION

I Waiswa Dauda Batega, hereby declare that to the best of my knowledge, this dissertation has not been presented in any University for any award. This work is entirely and originally mine – unless where acknowledged.

Signed .....

Date .....

Supervisor.....

Signature.....

Date.....

## ACKNOWLEDGMENT

A number of people have been instrumental in my efforts to accomplish this dissertation. I am greatly indebted to Dr. Charles Rwabukwali, Associate Professor in the department of sociology, Faculty of Social Sciences (MUK), who stimulated my academic my interest in health delivery systems in developing countries. As my research supervisor, he provided valuable criticisms, and wise counsel right from proposal development to writing this dissertation.

I also express special gratitude to Dr. Edward Kirumira, the Head of Department of Sociology, for his invaluable guidance and theoretical grounding in issues of social services reform. I am also grateful for the financial support extended to me by the department of Sociology, and to Makerere University for the tuition waiver.

I express my thanks to Dr. Andrew Mickleburgh, the Coordinator of M.A Sociology program, for his persistent but parental encouragement and support. I have had un wavering support from my colleagues Mr. Arojjo O Steven and Mr. State Andrew. We shared a lot in common throughout our studies. My colleagues in Room 5 Mr. Wasike Mangeni, Mrs. Doris Muhwezi, and Mr. Fred Bateganya, are thanked for their constant encouragement.

My family and mother endured my absence during data collection with utmost patience and encouragement. May The Almighty God bless them. Lastly, I thank my respondents in Tororo district, for their time and wisdom. I hope I have correctly represented their views.

## ABSTRACT

This study is informed by the comprehensive primary health care school of thought, to examine and understand the roles, opportunities and challenges of institutionalized community participation in PHC delivery at the local levels. Specifically, the study aimed at assessing the perceived roles and functions of LC I secretaries for health, health committees (HCs) and health unit management committees (HUMCs) by community members. Also the study aimed at establishing the factors that facilitate or militate against effective performance of HCs and HUMCs in the delivery of PHC services. The study also aimed at assessing the perceived impact of the integration of HCs and HUMCs into the health delivery system by community members. Lastly, the study sought to explore and identify necessary interventions to enhance the performance of HCs and HUMCs in the delivery of PHC services at local levels.

The area of study was Tororo district. Field data was collected from two randomly selected sub-counties (Kisoko and Kwapa) and one purposively selected division in Tororo municipality. The focus of this study was at village level where a survey was carried out with 89 respondents to assess community members perceptions about the roles of LC I secretaries for health, HCs and HUMCs in PHC delivery. Key informant interviews were held with senior civil servants and political leaders at the district and sub-county levels to assess the opportunities, challenges and alternatives to PHC delivery at the local levels. Also at the district and sub-county headquarters, health related plans, annual budget and expenditure estimates and records of meetings were reviewed to assess orientations of district and sub-county plans to PHC.

The study established that most of the community members were aware of LC I secretaries for health, HCs and HUMCs, (and their associated roles). However a number of misconceptions were noted among the community members. It was also established that HCs and HUMCs were engaged in roles that reflected PHC orientations. However, the social-economic life chances the community members have been exposed to, affects

their participation in PHC design and delivery. A number of challenges militate against effective participation of HCs and HUMCs in PHC delivery, such as; lack of adequate funds, uncordial relationship between different levels of governance, nature of donor funding and lack of collaboration and capacity building among others. The study also established positive outcome as a result of the participation of HCs and HUMCs in PHC design and delivery. Some of the lessons from this study can be applied to a number of situations in Uganda and beyond.



## TABLE OF CONTENTS

Dedication	i
Declaration	ii
Acknowledgment	iii
Abstract	iv
Table of contents	vi
List of Tables	xi
List of Figures	xii
List of Acronyms	xiii

### CHAPTER 1: INTRODUCTION

1.0	Background to the study	1
1.1	Statement of the problem	5
1.2	Objectives of the study	5
1.3	Research questions	6
1.4	Significance of the study	7
1.5	Scope and area of study	7
1.6.1	Theoretical orientation	8
1.6.2	Conceptual framework	10

### CHAPTER 2: LITERATURE REVIEW

2.1	Introduction	13
2.2	The nature of community participation	13
2.3	The history of community participation in Uganda	15
2.4	History of decentralisation in Uganda	17
2.1	Challenges of decentralisation and health delivery	18
2.2	Perceived roles and functions of local leaders	19

2.3	Conclusion	20
-----	------------	----

### **CHAPTER THREE: METHODOLOGY**

3.1	Overall research design	21
3.2	Sampling procedure	21
3.3	Data collection methods and instruments	23
3.4	Data analysis	24
3.5	Ethical considerations	25
3.6	Limitations of the study	25
3.7	Problems encountered during the study	25
3.8	Conclusions	25

### **CHAPTER FOUR: THE HEALTH SECTOR AND HEALTH SITUATION OF TORORO**

4.1	Introduction	27
4.2	The health sector and PHC elements in Tororo district	27
4.3	The health sector and PHC financing	29
4.4	The health situation in Tororo district	31
4.5.1	Health related plans /policies of Kwapa sub-county	32
4.5.2	Health related plans/policies of Eastern division	33
4.5.3	Health related plans/policies of Kisoko sub-county	34
4.6	Health related plans policies of the district	34
4.7	Conclusion.	36

### **CHAPTER FIVE: THE SOCIO-ECONOMIC BACKGROUND OF SURVEY RESPONDENTS.**

5.1	Introduction	37
5.2	The sex of the survey respondents	37
5.3	The Age distribution of the survey respondents	38

5.2	The educational level of respondents	39
5.3	The occupational background of survey respondents	41
5.4	Conclusions	43

**CHAPTER SIX: COMMUNITY MEMBERS PERCEPTIONS  
ABOUT THE ROLES AND FUNCTIONS OF LC I  
SECRETARIES FOR HEALTH, HCs and HUMCs.**

6.1	Introduction	44
6.2	Respondents awareness about the roles and functions of LC I Secretaries for health	44
6.3	Residents awareness about the roles and functions of HCs	48
6.4	Residents awareness about the roles and functions of HUMCs	53
6.5	Residents awareness of the policies made by HCs and HUMCs	57
6.6	Conclusions	59

**CHAPTER SEVEN: PERCIEVED IMPACT OF HCs AND HUMCs IN  
PHC DELIVERY IN TORORO DISTRICT.**

7.1	Introduction	61
7.2	Respondents perceptions towards changes in the health delivery system	61
7.3	Respondents perceptions towards equity of access to health services	64
7.4	Percieved socio-economic changes	65
7.5	Conclusions	67

## **CHAPTER EIGHT: OPPORTUNITIES AND CHALLENGES TO THE DELIVERY OF PHC SERVICE.**

8.1	Introduction	68
8.2	Opportunities for PHC delivery at the local level	68
8.3	Challenges to PHC delivery	73
8.4	Conclusions	78

## **CHAPTER NINE: DISCUSSIONS**

9.1	Introduction	80
9.2	Socio-economic opportunities and implications for community participation	80
9.3	Health related plans of HCs and HUMCs, and PHC Orientations	82
9.4	Health infrastructure and implications for community participation	83
9.5	Opportunities for PHC delivery	84
9.6	Challenges to PHC delivery	85
9.7	Percieved impact of HCs and HUMCs in the delivery of PHC services	87
9.8	Theoretical implications of study findings	88
9.9	Conclusions	90

## **CHAPTER TEN: SUMMARY AND RECOMMENDATIONS**

10.1	Introduction	91
10.2	Summary of the study findings	91
10.2.1	Health sector and health situation in Tororo district	91
10.2.2	Socio-economic background of survey respondents	92
10.2.3	Respondents awareness about LC I secretaries for health, HCs and HUMCs	92
10.2.4	Opportunities and Challenges for PHC delivery	92

10.2.5 Perceived impact of HUMCs and HCs in PHC delivery	93
10.3 Policy recommendations to enhance PHC delivery	94
10.4 Recommendations for further research	95
10.5 Conclusions	95

<b>REFERENCES</b>	96
-------------------	----

## **APPENDICES**

Appendix 'A' The survey questionnaire

Appendix 'B' Topic guide for focus group discussions

Appendix 'C' Interview guide for key informants

Appendix 'D' Introductory letter to the sub-counties

## LIST OF TABLES

Table I	Types of respondents selected and methods used	23
Table II	The sex of the survey respondents by sub-county	38
Table III	The age groups of survey respondents	38
Table IV	The educational level of survey respondents by sex	39
Table V	The educational level of respondents by sub-county	40
Table VI	The occupational background of respondents by sex	41
Table VII	Respondents awareness about LC I secretary for health by sub-county	45
Table VIII	Residents awareness about LC I secretary for health by education	46
Table IX	Residents responses about the roles of LC I secretary for health	47
Table X	Respondents level of awareness about HCs by sub-county	49
Table XI	Respondents level of awareness about HCs by educational level	50
Table XII	Residents responses about the roles of HCs	50
Table XIII	Respondents level of awareness about HUMCs by sub-County	53
Table XIV	Respondents level of awareness about HUMCs by age	54
Table XV	Residents responses about the roles of HUMCs	55
Table XVI	Respondents level of awareness about policies of HCs and HUMC by age	58
Table XVII	Respondents reasons for perceived improvement in health services delivery	62
Table XVIII	Percieved Social-economic changes by community Members	66

## LIST OF FIGURES

Figure 1	Conceptual framework	11
----------	----------------------	----

## LIST OF ACRONYMS AND ABBREVIATIONS

CAO	-	Chief Administrative Officer
CP	-	Community Participation
DANIDA	-	Danish International Development Agency
DDP	-	District Development Plan
DMO	-	District Medical Office
GoU	-	Government of Uganda
HC	-	Health Committees
HUMC	-	Health Unit Management Committees
LC	-	Local Council
MFEP	-	Ministry of Finance and Economic Planning
MoH	-	Ministry of Health
MOH.Typ	-	Ministry of Health Three Year Plan
MOH.Fyp	-	Ministry of Health Five Year Plan
MoLG	-	Ministry of Local Government
NGOs	-	Non- Government Organisations.
PHC	-	Primary Health Care (may be used interchangeably with Comprehensive primary Health Care-CPHC).
SPHC	-	Selective Primary Health Care
WHO	-	World Health Organization



# CHAPTER ONE

## 1.0 BACKGROUND TO THE PROBLEM

Uganda once enjoyed a well-developed health delivery system in the 1960s, with effective curative and preventive services (Adome *et.al*, 1996:7). However, Uganda, like many sub-Saharan countries, experienced social, political, and economic crisis in the 1970s, and early 80s (see, World Bank 1993; Edmonds, 1995:95-110; Obbo, 1995:205-223; Brett, 1991:297-310). The health sector, like other sectors, was severely affected, partly through declining budgetary allocations in real terms, implying that available funds from various sources have fallen far short of the minimum requirement necessary to maintain an adequate health delivery system. Total health spending in Uganda is estimated to be only \$ 5.65 per capita, consisting of government expenditure of \$ 2.82 per capita including external aid, and an estimated private expenditure of \$ 2.83. This compares poorly with the minimum \$ 12 required to provide essential cost effective health services in low-income countries. This is recognised by The Ministry of Health (MoH 1993:4). In the past two decades, health facilities became dilapidated, and services dwindled drastically. For example, between 1971 and 1979, the total number of doctors in Uganda dropped from 978 to 575, dentists from 42 to 24, pharmacists from 116 to 15 (see Schyer and Dunlop 1985:34-35; Whyte 1991:132; Adome *et al*, 1996:10)<sup>1</sup>

To-date, health conditions in Uganda are not satisfactory. For example, the infant mortality rate averages 120:1000, twice the level of similar low income countries, the child mortality rate is 180:1000, while the maternal mortality rate averages 500:100,000 (MoH 1993:6). The high infant and child mortality rates reflect poor social-economic conditions and inadequate preventive and promotive health services. Many of the causes of poor health (see the Uganda demographic and health survey, 1995) particularly communicable diseases, which continue to burden the communities, are largely associated with poor access to maternal and child care

---

<sup>1</sup> For a detailed description of the breakdown of health services in Uganda see; Dodge D P and Wiebe, P.D (Eds), 1985, Crisis in Uganda. The breakdown of health services in Uganda.

services, and, lack of knowledge regarding health promotive and preventive behavior among others. Such diseases can be prevented through Primary Health Care (PHC), even with limited resources available to the country (MoH National health policy, 1998:2 ; MoH. White paper, 1993:9).

Access to good quality health care is still a wish by most Ugandans (despite an average annual 5% growth in GDP), with only 49% of the population within five kilometers of a health service. Wide disparities exist in access to health services, ranging from 8.9% in some parts of northern Uganda, to over 90% in Kampala City, while 60% of Ugandan mothers do not benefit from trained assistance during the time of delivery. Inadequate and poor management of health services has resulted into poor quality care, provided by an equally poorly motivated health personnel (MoH. National health policy, 1998:3).

Government (between 1986-1996) undertook steps to rehabilitate and restore the health delivery system in the country. These steps included; the rehabilitation of war damaged health units and replacement of equipment (to restore functional capacity of health units), staff development and redeployment in up-country health units, introduction of cost sharing schemes in health units, the adoption of an expanded immunization program and a donor funded essential drugs program, consolidation of the existing health facilities to extend coverage, and encouraging institutionalized community participation in the delivery of basic health services at the local level, among others. During this period, (and shortly after), the adoption of the Primary health care (PHC)<sup>2</sup> strategy remained largely peripheral, attracting only 4% of MoH 1992/93, 1993/94, and 3% in 1995/96 annual budgets, with most funds going to curative services (MoH. Annual budget estimates).

Despite the corrective measures taken, imbalances in the health delivery and access are still apparent. Donor support and health recovery programs have mainly brought more health resources and infrastructure to the relatively small urban populations, than to the rural majority

---

<sup>2</sup> The PHC strategy entails the development of community intergrated, adequate and effective health promotive, disease preventive, basic curative and rehabilitative health services through institutionalised community participation (see WHO, 1988).

(MoH 1993:19). Over 50% of the hospitals are situated in urban areas and most health centers are located near trading centers, hence the majority of the population (90%) who live in rural areas have little access to health facilities, with a few sub-counties without a health facility (MoH. White paper, 1993:13). As already noted, the bulk of government health expenditure is devoted to curative treatment of mostly preventable problems, leaving preventive measures substantially under-funded (World Bank 1993). Other organizational anomalies (until 1997) in the health delivery systems included; the parallel and uncoordinated health service delivery between the Ministry of Health (MoH) and Ministry of Local Government (MoLG), especially at the district level. It has also been recognized that the MoH will not secure significant additional financial allocations from central government within this decade, given the latter's priorities like defence, debt servicing, universal primary education (MoH TYP, 1993:16/17).

Thus, given this experience, the health delivery system was due for reform, a reform that is in tandem with other national political developments like the decentralization policy, and the 1995 National Constitution. The MoH national plans (1993/94-94-95/96, 1997/98-2000/1), and the national health policy (1998), have all emphasized the need for health reform as their major objective. That is, the reorientation of health services towards PHC, so as to promote the application of cost-effective interventions based upon health promotion and disease prevention. The health services reform also aims at increasing the coverage of health services to rural areas, promote equity of access and social justice, redress the over emphasis on curative health services and hospitals, and promote community participation in health services delivery at the local level (MoH, 1997:14-15).

The 1995 National Constitution Article 176(2b), and the Local Government Act. 1997, provides for legislation that entrenches decentralization (the transfer of authority and responsibility from the central government to the local government) as the legitimate form of local government in Uganda. It also institutionalizes community participation (through local councils and committees) and the transfer of responsibility of social services delivery to local governments at the district and sub-county levels. Therefore, the re-orientation of health services to PHC has to be analyzed within the context of the decentralization of health service. The decentralization of health services is aimed at bringing services and decision making nearer to the communities,

promote resource mobilization and prioritization in allocation, and strengthen the management of health services right from the local government levels. The corollary of these assumptions is that, the decentralization of health services will improve upon democratic accountability of health services, prevent abuse of health resources, and redress organizational anomalies in the health delivery systems of the MoH and MoLG, by devolving functions, powers, and resources from the MoH and MoLG to local government authorities. Thus, creating management unification in health delivery at local level. It is important to note that, the overriding principle in all these policy reform objectives is that of community participation<sup>3</sup> in the health delivery system at the local levels.

The re-orientation of health services to PHC, and the decentralization of health services to the district and sub-county levels has implied new roles, functions, and challenges for local government authorities. It has also implied the formation of local structures (election of local councils and functional sectoral committees) at different local government levels (LC III - LC V) to accommodate these new roles and functions besides the roles of health technical personnel. Hence district health committees, sub-county health committees, health unit management committees, LC I secretaries for health (at village level) have been established, among others (see Local government act, 1997).

Local councils and health committees<sup>4</sup> at district and sub-county levels can be looked at as vehicles for mobilizing communities in matters of their own health and the key to successful implementation of PHC services (MoH. Five year Plan/FyP, 1997:25). This is a similar opinion of the World Bank, which argues that, community participation increases the transparency and sustainability of such health initiatives at the local level (World Bank, 1993:51). The structures that have been established for community participation in PHC design and delivery (LC I secretaries for health, health committees, and health unit management committees), are relatively new institutions. Their integration in the health delivery system and their expected contributions

---

<sup>3</sup> community participation in the context of this study refers to institutionalised participation of community members in the design, planning, monitoring and evaluation of PHC services at the local level.

<sup>4</sup> According to the local government Act 1997, local councils are elected at the village, parish/ward, sub-county/division, county/municipality, and district/city levels. From the sub-county and district local councils, functional sectoral committees can be formed, such as health committees. The committee members do not exceed 9, of which at least one member should be a woman.

towards PHC services at the district, sub-county and village levels is still a matter of contention. Therefore, it has been the intention of this study to collect data that documents the extent to which these new institutions (LC I secretary for health, health committees and health unit management committees) are meeting their expectations, and other related incidental factors.

### **1.1 Statement of the Problem**

It has been argued by government and academicians that the decentralization of, and the re-orientation of health services to PHC, through institutionalized community participation (in this case through health committees and health unit management committees) can lead to the identification and prioritization of local health related needs and solutions, as opposed to health directed needs from above/center (MoH, 1998; Muyinda, 1988: 57; Muzaale & Birungi 1997:22). In addition, health committees and health unit management committees are thought to increase public accountability and efficiency of health delivery systems, mobilize community members and local resources towards promotive and preventive efforts, and initiate community PHC related policies. The problem is that the decentralization of health services and re-orientation to PHC poses new challenges and roles for local governments in general and health committees in particular, which are also relatively new. The extent to which their integration into health delivery system has yielded the above expectations is the domain of this study. There was need for a systematic inquiry, particularly focused on the roles, functions, and challenges of these committees, in the design, organization and delivery of PHC services at the district and sub-county levels.

### **1.2 Objectives of the study**

This study sought to assess the roles, functions, challenges and the perceived impact of LC I secretaries for health, HCs and HUMCs<sup>5</sup>, in the design, organisation and delivery of PHC

---

<sup>5</sup> HCs are sectoral select committee appointed from the local council members at the LC III and LC V levels by the chairpersons of the respective councils, to oversee and plan for health services delivery together with the health personnel in their areas of jurisdiction. HUMCs are appointed by the HCs on recommendation of the local council I II, to oversee and supervise the provision of health services at the health unit in their respective areas

services at the district, sub-county, and village levels, and explore necessary interventions and concerted actions to enhance the performance of such committees. Specifically, the study sought:

- a) To assess the perceived roles and functions of LC I secretaries for health, health committees and health unit management committees, by community members.
- b) To review policies and decisions taken by HCs and HUMCs, and how such decisions reflect PHC orientations;
- c) To establish factors that facilitate and/or militate against, the effective performance of HCs and HUMCs in the delivery of PHC services,
- d) To assess the perceived impact of the integration of HCs and HUMCs into the health delivery system, by community members.
- e) To explore the necessary interventions and concerted actions to enhance the performance of HCs and HUMCs in the delivery of PHC services at the district and sub-county levels.

### **1.3 Research questions**

The study was guided by the following research questions:

- What organizational changes have taken place since the integration of HCs and HUMCs into the health delivery system at the district and sub-county levels, and with what implications?
- What are the perceived roles and functions of HCs and HUMCs by community members?
- Do the decisions and policies of HCs and HUMCs reflect PHC orientations?
- What are the capacities of the districts and sub-counties in the implementations of the PHC policies and decisions taken by HCs and HUMCs (indicators of capacity between decisions and implementations)?
- What is the kind of collaboration between HCs and HUMCs, and other stakeholders in the delivery of PHC at the district and sub-counties, and with what implications?
- What is the perceived impact of the roles and functions of HCs and HUMCs, by community members?
- What are the factors that facilitate and/or militate against the effective functioning of HCs and HUMCs in the delivery of PHC services?

- What are the necessary interventions to enhance the performance of HCs and HUMCs at the district and sub-county levels?

#### **1.4 Significance of the study**

The significance of this study is threefold; firstly, it is an exploratory study that highlights organisational issues in the recently decentralised and re-oriented health delivery system. Secondly, the research provides information to policy makers and other stake holders, towards enhancing the effectiveness of district and sub-county health delivery systems. Thirdly, the study findings add on to the existing literature on organisational issues in decentralised health services and PHC delivery in particular.

#### **1.5 Scope and Area of the study**

The occasion for this study has been LC I secretaries for health at the village levels, health committees at the district and sub county levels and health unit management committees at the sub-county health units, and members of the community. This study investigated the roles, functions, challenges and perceived impact of LCI secretaries for health, health committees, and health unit management committees in the design, organization, and delivery of PHC services at the district and sub-county levels in Tororo district.

The study area, Tororo district lies in the eastern region of the county. It borders with the districts of Pallisa in the north, Mbale in the northern-East, Bugiri in the west, Busia in the extreme South and the republic of Kenya in the East. The district covers approximately 2,634 sq.kms., lying at an approximate altitude between 1,097 and 1,219 meters above sea level, with a moderate rainfall. Tororo district has a population of 555,574, of which 282,354 are females, 273,220 are males, with 11.4% of the people living in urban areas and 88.6% in rural areas. The district has 3 counties, one municipality, with a total of 46 sub-counties and two divisions in the municipality, (1991 population and Housing census, 1998 National and District Resource Endowment survey). Main languages spoken are; Japadhola, Lusamia-Lugwe, Ateso, Lugwere, and Lunyole. The major economic activity is peasant agriculture. Food crops grown include;

finger millet, rice, maize, cassava, sweet potatoes, beans and sorghum. The major cash crop is cotton. The researcher is familiar with the District Health directorate, and the district was one the first to benefit from decentralization program, thus making it ideal as a point of reference for the study.

## **1.6 THEORETICAL AND CONCEPTUAL FRAMEWORK**

### **1.6.1 Theoretical Orientation of PHC**

There are two schools of thought regarding PHC. That is, Comprehensive Primary Health Care, (CPHC) and Selective Primary Health Care (SPHC). The latter school of thought was made popular by Walsh and Warren (1980), and with support from (Boland and Young, 1982) among others. The SPHC school of thought argues that, CPHC as defined by the 1978 Alma Ata Conference was too idealistic and had to be narrowed down to allow planning for manageable and cost effective programs for particularly disease control. SPHC sees health as the absence of disease (of most prevalent ones), and suggests that health improvements are the reductions achieved in those diseases, which are most harmful and are most feasible to control, the control program under those professionally trained to deal with disease. By definition and practice, SPHC focuses on mobilizing health services to attack the most prevalent disease problems. It centers the solutions on medical interventions and cost effectiveness about those interventions. It does not recognize or solicit the help of non-professionals. Community involvement is only significant in terms of getting larger populations to accept the medical interventions designed by health professionals (Mahler, 1981).

Comprehensive primary health care (CPHC) on the other hand, has broadened the meaning of health from that of absences of disease and has focused on a positive state of well being (Rifkin and Walt; 1986: 560-565; WHO, 1988). CPHC removes health planning and delivery of health services from the sole responsibility of medical professionals, and highlights the significance of the political, economic and social contexts, among others. Equity and community participation are the pillars on which CPHC rests. Therefore, the management of health needs to include not only the management of health services, but also, the management of agriculture, schooling,



decision making, and nutrition e.t.c (this is the assumption of inter-sectoral collaboration). The conclusion is that health is not only a disease problem, but also, a development challenge calling for institutionalized community participation, multi-sectoral approach including health services adaptable to specific local conditions. It sees health as a result of meaningful motivations of attitudes of critical actors and of communities with the support from the center (responsibility and authority decentralized), and medical professional involvement as a resource for the local people's choices. This study is informed by the CPHC school of thought, because it emphasizes meaningful transfer of authority and responsibility from the central authorities to local communities (districts and sub-counties), it emphasizes equity, inter sectoral collaboration and institutionalized community participation in health care, design and delivery. These are key themes of this study.

Since the 1978 Alma Ata PHC conference, community participation has been proclaimed as the key to success in the implementation of PHC and promotion of effective health development. There are however, considerable differences as to the practical meaning of community participation. Some see it as a means to improve their service delivery system (managerial technique), the results of participation more important than the act of participation (WHO: 1988:50). An alternative view (and in the context of this study) is to see participation as an end in itself. As a process in which confidence, co-operation, and participation of people is built up and constitutionally guaranteed and anchored in political structures which uphold and protect the participation process (see, Hollinsteiner, 1982: 38). Therefore, PHC calls for a series of mechanisms in which community participation becomes an end and dynamic political process, as well as in changes (re orientation's) in the health delivery system. In the context of this study the argument provides, that decentralization (the transfer of authority and responsibilities of service delivery to the district and sub-county levels) through local councils and sectoral committees has implied new challenges for the equally newly established local structures towards the delivery of re-oriented health services (PHC). The extent to which community participation (as a result of decentralization) has become integrated into health delivery system at the district and sub-county and has met the expected outcomes is the thesis of the study.

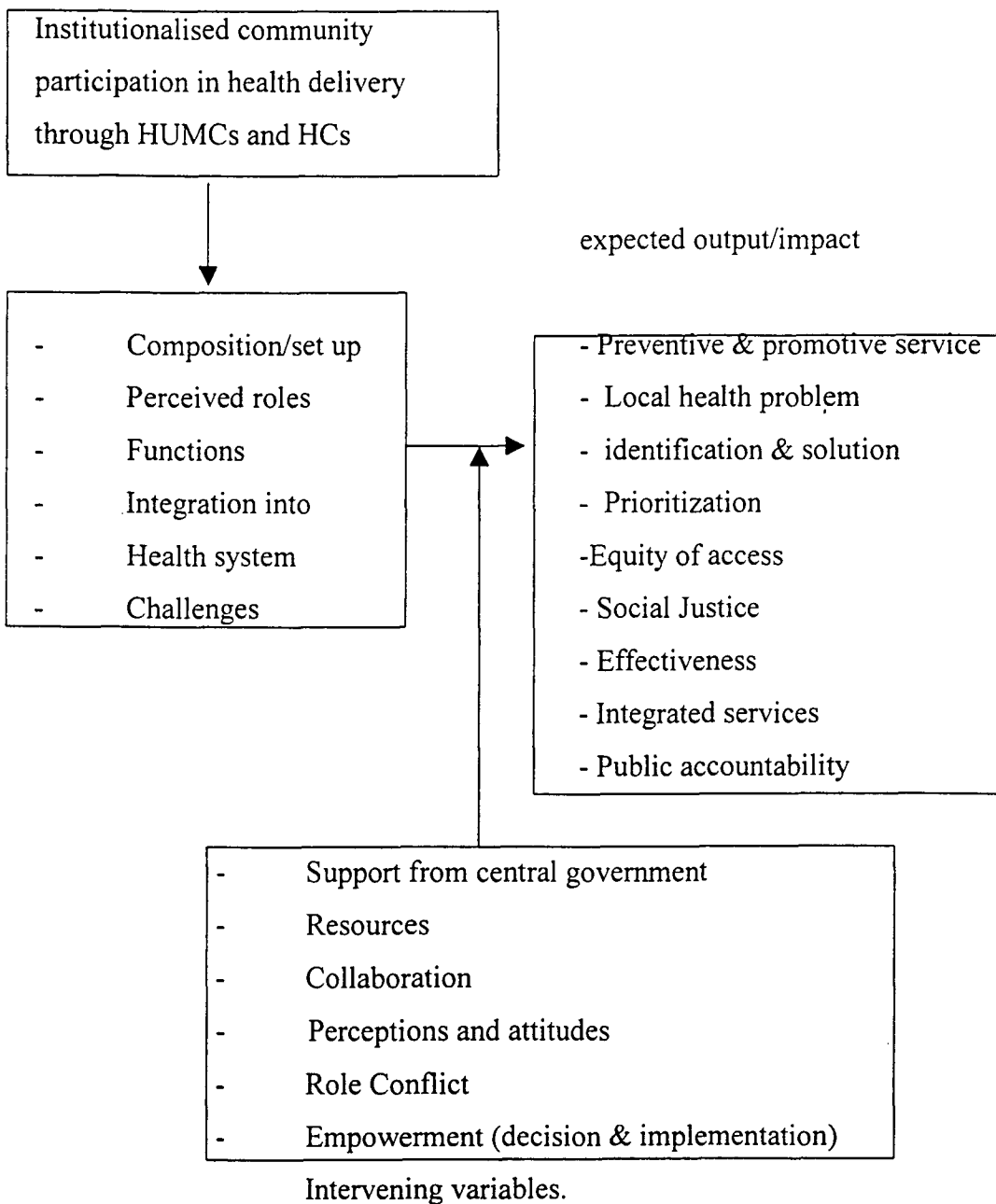
## **1.6.2 Conceptual Framework**

This study has been conceived around the assumptions that, decentralization has implied institutionalized community participation in all the affairs of local government. The implication being the establishment of constitutionally recognized structures for community participation such as local councils and health committees. The study had to be looked at in a decentralised administrative framework.

**Fig. 1 The conceptual framework**

This figure shows the sequence and flow of assumptions about the study. It is indicated that the expected out put of institutionalised community participation in health delivery at the local level, will be affected by a number of intervening variables.

Background/study themes



For this study, the main theme is the participation of communities through local councils and sectoral committees in decentralized and re-oriented health delivery systems. This has implied new roles, functions and challenges, to the equally newly established HCs and HUMCs, which

## **CHAPTER TWO**

### **.0 LITERATURE REVIEW**

domiciled in areas they represent, understand local language, and local cultural beliefs and able to command the respect of the community, and make moral and financial sacrifices. From the findings of this study, these criteria appear to be met in the Uganda context. However, the kind of voluntarism expected on the side of the communities is over-assumed and as demonstrated in chapter seven of this study, this voluntarism turns out to be a challenge/constraint in the long run. As can be seen, the Nigerian experience described by Ransom-Kuti *et al* (1991) does not make desegregated representative criteria of the different interest groups, like women, youths, religious leaders, and technocrats. The study by Ransom-Kuti *et al* does not recognise the implications of such representative criteria from the equity principle of PHC.

Most authors on PHC (Ransom-Kuti *et al*, 1991; WHO, 1988; Hollinsteiner, 1982) seem to agree that community participation is a process in which confidence, co-operation and the participation of people is built around constitutionally guaranteed political structures, which uphold and protect the participation process (participation as an end perspective). The nature of community participation in PHC strategy calls for re-orientations in district social service planning and delivery system like, the recognition of local level derived priority plans and their integration into the overall district plans. This system appears to be reflected in the district development planing (in the findings of this study), but the integration of the sub-county PHC priorities among others, is not significantly reflected in the priority implementation of activities of the district (see chapter 4).

Despite the above kind of theorizing, a number of studies fail to recognize the fact that, whereas decentralization to local governments may be genuine, in other situations, it may be a component of system redress, a handmaiden reinforcement of a flawed state institution. For example, the central government 'shedding off' its responsibilities to the people under the guise of decentralization. The district can also shed off responsibilities of service delivery under the same negative principle of giving autonomy to the sub-county, even when it is clear that such sub-counties may not have the necessary material and resource base to deliver such services. A review of decentralization and accountability in Uganda by Kullenberg and Porter (1998:11) points to incidents of reluctance and inadequacies by central government in its commitments to the decentralization process. For example, central government fiscal transfers to local

governments fall short of the minimum requirements, unconditional grants are arbitrarily cut and funds withdrawn from certain services, and abrupt changes made in modalities of fiscal transfers to local governments. (This is one of the challenges faced by local authorities in implementing their PHC plans at district level). Most likely, therefore, the nature of community participation is as important as the nature of relationship between central government and local governments, as regards their commitments to the decentralization process.

The role of donors in community participation may facilitate decentralised service delivery, but at times it may complicate matters. Many donors prefer sectoral and vertical financing and are reluctant to integrate their resources into local government planning and budgeting processes. To ensure quick delivery of the projects they finance, many donors (in partnership with central governments) continue to create parallel adhoc implementation structures, and negotiate projects with the line ministries without regard to the impact of fiscally strapped local governments (Kullenberg and Porter 1998). This undermines effective decentralization. This study also investigated the nature of community participation (HCs and HUMCs) in donor and NGO health driven programs at the district and sub-county levels. Segall M., (1983:24) concludes:

To ensure that mechanisms and structures to re-orient health care delivery system to PHC, a lot of political will is required, especially to enable resistance to inevitable opposition to beneficiaries of the present system including health professionals. Ultimately PHC doesn't only involve re-direction of resources within the health sector, but shifting the bases of power in favor of the majority and loosening the grip of professionals and technocrats particularly in the setting of priorities.

What Segall does not mention are the indicators of this shift of power. But certainly, one of the indicators is the capacity for HC/HUMC to make decisions and be able to have them implemented, monitored and reviewed (complete cycle of community participation). This was one of the research issues of the study.

### **2.3 History of community participation in Uganda**

A fair description of the history of community participation in Uganda is provided by Muzaale and Birungi, in their study of the evaluation and application of the concepts of community participation, community management, and enabling governance in Uganda (Muzaale and

Birungi, 1997). They argue that, the earliest forms of community participation existed long before the country came under colonial rule, for example, local burial assistance associations and labor sharing groups. However, modern forms of community participation in this country can be traced to the emergence of the community development movement promoted by Britain in its colonial territories after World War II, from the late 1940s to 1950s (Muzaale and Birungi, 1997:15). The distinguishing characteristics of this community participation, was lack of community involvement in the overall planning of the various development programs. Local representation in the initiation of the schemes was characteristically minimal. In some districts, technical government functionaries dominated the process without consulting local communities. Consequently, in most districts community development programs failed to serve as stimuli to sustained community participation.

Community participation during the post independence era of 1960s was not much different from that of 1950s. Central government functionaries always planned the community development activities. The approach to community mobilization was essentially directive, generally being enforced by chiefs and sanctions regularly used. In retrospect, these approaches did more to erode, than promote sustainable community participation. Most programs (e.g. latrine building) almost collapsed totally following the disorganization of central authority in 1970s (Muzaale and Birungi, 1997:16). Amin's reign (1971 - 1979) did not fair any better. His policy was epitomized by the famous but compulsive "Keep Uganda Clean" slogan, which violated all known principles of generating sustainable and voluntary community participation (it was compulsory conscription and participation for all adult members). This too, greatly undermined the spirit of voluntarism and involvement in community affairs.

In 1986, the NRM government introduced the Resistance councils system (now the local council system) as a form of popular community participation in all affairs of local communities. Progressively there has been a shift from highly centralized governance, which characterized previous regimes to one based on popular participation, and institutionalization of various kinds of bottom-up structures, and a decentralised system of local governance (see Muzaale and Birungi, 1997; Nsibambi, 1993). This has implications for the process of community



participation as an end. It is this perspective which is thematic to this study, in relation to PHC delivery at the district and sub-county levels.

### 2.4 History of decentralization in Uganda

President Museveni launched the current decentralization program, on the 2<sup>nd</sup> of October, 1992. However, decentralization is not entirely a new phenomenon in Uganda. Between 1962 - 67, political power was decentralised under the 1962 quasi - federal constitution, where there existed kingdoms of Buganda, Bunyoro, Toro. Ankole and the territory of Busoga, along side other areas which received unitary status with central government namely Acholi, Lango, Bukedi, Kigezi, Teso, West Nile, Karamoja, Madi and Sebei. This arrangement was short lived and in 1967 a republican constitution replaced the 1962 constitution which had devolved significant powers to the local authorities and granted them sufficient revenues to deliver social services (Nсібамбі 1991, 1993; Kamugisha 1995).

From 1967, after the passing of 1967 local administration Act, all former kingdoms were divided into districts, and their autonomy reduced to only providing services to the people following directives and plans from central government. The local administrative offices became appointive from central government, without direct accountability to the local communities they served. Kamugisha (1995:36) notes that: “with loss of legitimacy and authority by local leadership, enforcement of by-laws became ineffective and community development projects came to a near stand still, leading to a decay of socio-economic infrastructure, the health sector inclusive”. Therefore between 1967 - 1986, Uganda had a highly centralized system of governance. (Kullenberg and Porter, 1998., Kamugisha, 1995).

The more recent process of decentralization in Uganda has been carried out in phases. The first began in 1993/94 financial year, with 13 districts of Arua, Mukono, Jinja, Kabale, Gulu, Lira, Tororo, Mpigi, Masaka, Rakai, Kabarole, Mbarara and Mbale. Other districts followed; in the 2<sup>nd</sup> and 3<sup>rd</sup> phases (see MoLG Annual progress report on decentralisation in Uganda 1997). Decentralization in Uganda has involved the creation of autonomous local government systems (at the districts and sub-county levels and as bodies corporate) with responsibilities for planning,

researching, prioritising and implementing development plans. The responsibility for social services delivery (health services inclusive) has been transferred to local governments with limited participation of local administrative units. Local councils exist from village/zone (LC I) level up to the district level (LC V). At each local government level, specialized functional committees are established (see the local government Act 1997)<sup>6</sup>. As can be seen, the available literature on decentralization in Uganda appears too general in nature, especially with regard to the challenges of social services delivery at the districts and sub-county levels. Moreover, the available literature is parochial in scope and mostly published by government. Studies by Nsibambi (1991, 1993) and Kamugisha (1995) also look at the general challenges of the decentralization processes. This study has focused on the challenges faced by the newly created institutions/structures like the LC I secretaries for health, HCs and HUMCs, in the design and delivery of PHC at the district and sub-county levels, as a point of reference.

## **2.5 Challenges of Decentralization and Health Delivery.**

Maclure (1991) notes that planning for decentralization in any given system is a complex task, than the actual implementation and maintenance of administrative decentralization. For example, in his study of decentralization in Burkina Faso, Maclure noted that participatory management of primary schooling is bound to be extraordinarily difficult for rural communities, which may be too frequently impoverished and politically marginalised<sup>7</sup>. This is a similar opinion by Weillers (1990) whose general observation is that in return for a greater role in the making educational decisions, the community is expected to express a strong sense of commitment towards generating additional resources for decentralised services. But in certain instances this may not be possible.

Kullenberg and Porter, in a recent evaluation of decentralization and accountability in Uganda (1998:17), argue that world-wide it is notoriously difficult to devise incentives and sanctions to

---

<sup>6</sup> The local government Act 1997 gives effect to the provisions of decentralisation in the 1995 constitution. The Act provides for political and administrative set up of local governments, the election of local councils, the devolution of functions, powers and responsibilities of some services delivery, and the democratic participation in, and control of decision making by the people.

<sup>7</sup> For example, the fiscal relationship between the district and sub-counties in Tororo district is inappropriate. The sub-counties appear marginalised in resource mobilisation economically and politically.

ensure accountability in public sector investment programs. In many developing countries, the challenges of decentralization are great. For example, decentralization as a policy of local governance is still evolving. Institutions and legal frameworks to promote accountability are not strong. New procedures and regulations are unfamiliar or unclear, while legal provisions are sometimes contradictory<sup>8</sup> and most local governments face human resource constraints. There is also a general lack of political restraint to keep expenditure within approved budget limits; corruption and collusion disrupt revenue collection, contracting and accountability of local politicians. Kamugisha (1995) points out the general poor resource terms. Nsibambi (1993) shares a similar opinion. However, the impact of such challenges is not detailed out by different studies reviewed, especially the impact on PHC service delivery at the local levels. The challenges described by these studies are also not desegregated by level of local governments (at the LC III and LC V levels). This study has tried to address such limitations through its findings.

## **2.6 Perceived roles and functions of local leaders and committees.**

According to the MoH 1997 policy guidelines for decentralised health services, the HCs and HUMCs, are supposed to perform the following functions. Identifying local health problems, prioritising the problems and developing strategies to solve them, mobilizing resources, initiating and debating by-laws concerning health for approval by local councils, and discussing health plans and budgets. However, according to a study of health services delivery in Tororo district by Kostanjsek (1997:34-36), these functions are far from being realized. Whereas some sub-county HCs had for the first time, drafted work plans and budgets in 1997, some members of the sub-county HCs and HUMCs perceive themselves most of the time as some kind of health extension workers. Meanwhile, their awareness and performance in political roles is less developed. For example the decision making is largely informal and lobbying for health resources at sub-county level is low. However, Kostanjsek in her study does not show the impact of such perceptions on the health delivery systems at the various levels of local government.

---

<sup>8</sup> There are contradicting provisions between the Local Government t Act 1997 and the Land Act 1998 as far as the collection of ground rates are concerned. The Local Government Act gives powers of collecting all local revenues to the sub-counties, while the Land Act 1998 gives the powers to collect ground rates to only the district. This has led to conflicts between the sub-county and the district in revenue collection thus, affecting PHC delivery.

## **2.4 Conclusion**

This chapter has presented a review of related readings to the study. These reviews have been done around the sub-themes of the study. The history of community participation in Uganda through the pre-colonial to the postcolonial period is described. The history of decentralization in Uganda and the nature of community participation are also described. The challenges of decentralizing authority and responsibility of social service delivery to local governments is also examined in detail. Lastly, the perceptions of local leaders about their roles in health delivery is also reviewed. The limitations of the various studies reviewed are presented alongside the reviews, and some research issues to address such limitations have been pointed out. The next chapter describes the methodology adopted by the study.

## **CHAPTER THREE**

### **3.0 METHODOLOGY**

#### **3.1 Overall research design.**

The study employed both quantitative and qualitative research methods. The quantitative methods were used to establish the perceived roles, functions and impact (and associated factors) of the of HCs and HUMCs by community members. Qualitative methods were used to assess the experiences of, and challenges faced by HCs and HUMCs. Secondary sources of data were accessed at the district and other institutions to supplement on primary sources of data.

#### **3.2 Sampling Procedures**

Tororo District has three counties and one municipality. A multi-stage random sampling procedure was employed. Two counties were randomly selected and the municipality purposively selected. From each selected county and municipality, one sub-county/sub-division was randomly selected. One zone/village was finally randomly selected from each parish/ward, from which the ultimate sample of respondents was drawn. The two sub-counties selected were Kwapa sub-county (from Tororo county) and Kisoko sub-county (from west Budama county). The division selected was the eastern division (in Tororo municipaity). The ultimate villages selected were; Nyangole (from kwapa sub-county), Kisoko 'A'and 'B' (from Kisoko sub-county), and Kasoli (from eastern division of the municipality). It is from these villages that the survey respondents were ultimately sampled and interviewed.

A sampling frame consisting of household heads and their spouses was constructed with the assistance of a field guide and L C I chairperson. A sample of 15 households were then randomly sampled from each zone/village, from which the household head and spouse (where applicable) were selected and interviewed after consent. In households were there were no spouses, one other adult member present would be interviewed after consenting. However, some of the

randomly selected households were female headed (with no male adult members), thus other female adults present were selected and interviewed, giving the total female respondents sampled to be 46 and that of males to be 43. Therefore, a total number of 89 survey respondents were sampled and interviewed using a semi-structured questionnaire.

### **Key informants.**

A total of 11 key informants were purposely selected and interviewed. These comprised the following: Three local councils secretaries for health in each selected zone/village, three local council chairpersons at each selected sub-county, three sub-county chiefs at each selected sub-county, Assistant CAO in charge of health services, and DMO. These key informants were selected because they were considered to be potentially and actually knowledgeable, and critical actors in the design and delivery of health services at the district and sub-county levels. With these key informants, it was ensured that knowledge and experience about PHC services are adequately sampled.

Four focus groups were recruited purposively because they constituted the focus of the study (HCs and HUMCs). These comprised of the following. Two sub-county HCs and two HUMCs members focus group discussions. The HC of Kisoko sub-county is non functional because all sub-county councillors have shunned the responsibilities of chairing the HC, while the Eastern division of the municipality of Tororo does not have a health unit, hence the HUMC is non-existent. Therefore a total of four FGDs were conducted. Each FGD comprised of at least seven participants. The type of respondents sampled and methods used are shown in table I below.

**Table I. Types of respondents selected and methods used.**

Structured interviews	In-depth interviews	Focus Group Interviews
46 females and 43 males	-3) LC I sec. For health. - 3)LC III chairpersons, - 3) sub-county chiefs - 1 DMO - 1 Ass. CAO in charge of health services	- 2 sub-county HC Focus group discussions - 2 sub-county HUMC Focus group Discussions (From Kisoko Health center and Kwapa Health unit).
Total: 89 survey Respondents	11 key informants	4 focus group discussions

### 3.3 Data Collection Methods and Instruments

Four methods of data collection were employed; Survey interviews, key informant interviews, focus group discussions and secondary data review. For quantitative data, structured interviews were held with the survey respondents using a semi-structured questionnaire (see appendix 'A' for a copy of the questionnaire). The selected survey respondents were contacted in their residences and their consent sought. The objectives of the study were explained to the respondents and an appointment fixed for the actual interviews. Where possible, the researcher and research assistant carried out the interviews. The survey respondents were asked for their perceptions about the roles, functions and impact of HCs, LC I secretaries for health, and HUMCs. Each interview lasted for an average of 30 minutes. The survey interviews were concluded by the end of April 1999.

For qualitative data, in-depth interviews were conducted with purposively sampled key informants, using an interview guide (see appendix 'B' for a copy of the interview guide). Prior appointments were made with the key informants after seeking their consent. The assistant CAO in charge of health services introduced the researcher to the key informants at the district level. The sub-county chiefs introduced the researcher to the key informants at the sub-counties level.

Meanwhile the LC I chairpersons introduced the researcher to the key informants at the village. Each key interview lasted an average of one hour. Also, focus group discussions were carried out at the sub-county and the health units (for HCs and HUMCs members respectively) using a topic guide (see appendix 'C' for a copy of the topic guide). Each FGD lasted for average of 1 hour. All FGDs and key interviews were concluded by the end of May 1999. The interview and topic guides were designed according to sub-themes of the study. Lastly, secondary sources of data were accessed and reviewed. At the district and sub-county headquarters, development plans, annual reports, budget and expenditure estimates, minutes of HCs and HUMCs were reviewed among others. At the MoLG headquarters library, annual fiscal transfers to districts and decentralisation appraisal reports were reviewed.

### **3.4 Data Analysis**

#### **3.4.1 Quantitative Data Analysis**

Each interview schedule was edited before leaving each respondent. The researcher and research assistant checked for uniformity, accuracy, completeness and consistency. The survey data was coded and tabulated using the statistical package for social sciences (SPSS program). Frequency tables, cross-tabulations, bar and pie charts have been used to describe the findings. Chi-square tests were done (at 5% level of significance) to determine correlation between key variables of the study.

#### **3.4.2 Qualitative Data Analysis**

In-depth interviews and focus group discussion were transcribed and analysed continuously during and after fieldwork. The analysis was done around sub-themes of the study. Where possible code categories were identified, written in the margins of the transcripts and added together, from which general trends and significant differences between transcripts were drawn and conclusions derived.



### **3.4.3 Quality Control**

To check and increase the quality of information collected, pre-testing of research instruments, supervising and working with research assistants, editing of questionnaires before leaving the respondents and daily evaluation of field progress were undertaken.

### **3.5 Ethical Considerations**

During data collection and analysis, the rights of individuals and institutions were respected. The researcher first sought the informed consent of all respondents, who were assured of the confidentiality of their responses. All the necessary protocol was followed; the researcher got an introductory letter from the University authorities, which was presented to the Chief Administrative Officer (CAO) and other district leaders. The CAO introduced the researcher to the selected sub-counties (sub-county Chiefs and LC III Chairpersons) who in turn introduced the researcher to the Chairpersons of the selected zones/villages (LC I). With the help of LC I Chairpersons, sampling frames of each zone were constructed and appointments made with sampled household respondents.

### **3.6 Limitations of the study**

Since the study is about one case study (Tororo District), it may be quite difficult to generalise the findings to the challenges of PHC delivery in decentralised administrations across the whole country. The study did not really measure the impact of the integration of HCs and HUMCs into the district and sub-county health delivery systems but only assessed the respondents perceived outcome of the roles of HCs and HUMCs in PHC delivery.

### **3.7 Problems encountered during the study**

A number of problems were encountered during the study. Firstly, communication barrier as the district is multi-ethnic. Where possible swahili language was used since it is common in the

district, and research assistant recruited was fluent in most of the local languages. Secondly transport problems between the sampled sub-counties, as these were far apart. Boda-boda motorcycles become handy in such circumstances. Funding for this study was unclear and largely funded from my meager salary.

### **3.8 Conclusions**

This chapter addressed the key methodological issues of the study. This chapter described in detail the research design adopted by the study, the sampling procedures used, the sub-counties selected, the types of respondents sampled and rationale. The data collection methods and instruments, the data analysis and data quality control techniques applied. Lastly, the protocol followed, ethical considerations, the study limitations and problems encountered during the study are also described. The next chapter describes the health sector and health situation in Tororo district.

## **CHAPTER FOUR**

### **4.0 THE HEALTH SECTOR AND HEALTH SITUATION OF TORORO DISTRICT.**

#### **4.1 Introduction**

This chapter describes the organization of the health sector and health situation Tororo district. It also describes in detail, the health infrastructure, the health sector financial commitments to PHC and the predominant diseases in the district. A review of the sub-county and district health related plans formulated by HCs, HUMCs, and the DMO are also presented in this chapter.

#### **4.2 The health sector in Tororo District.**

Tororo district has 43 health units, with 28 health units aided by government, while 15 health units are run either privately or by Non-Governmental organization (NGOs). There is at least a public health unit in each sub-county/municipality division- apart from the eastern division in Tororo municipality (Tororo District Development Plan, 1994-97). The social- political crisis that the country experienced between 1971-86 equally affected the district. Although there is a marked improvement in the health sector, the health infrastructure in the district is still characterized by uneven distribution. For example, Tororo municipality with a population of 26,783 (4.8%) out of the total district population, has two hospitals (out of the three in the district) and an average 50% of all the medical staff in the district. The remaining rural population (95.2%) shares one hospital, 50% of the medical staff, and some poorly equipped health units-save for a few private/NGOs ones (Tororo District Development Plan, 1994-1997). Such a situation has implications for the nature of planning for health service delivery and the re-orientation of health delivery system to PHC at the district level. For example, the expenditure of some PHC conditional grants from central government is according to what has been called "Health sub-district". The defining criteria of these "health sub-districts" are hospitals located in the respective areas. There is Busolwe health sub-district in Bunyole County (because of

Busolwe hospital) and some of the PHC funds are managed from Busolwe hospital. There is also the municipality health sub-district (because of Tororo- hospital) and some of the PHC funds are managed from the hospital (see Tororo District health plan, 1997/98). Whereas it was difficult for the researcher to establish the extent of re-orientation of health services delivery to PHC within the hospital sector, it is quite clear (from FGD findings), that the nature of collaboration between HCs and hospital management at the county and sub-county levels is blurred.

The district has 11 on service doctors. The population to doctor ratio stands at 1: 56,199, while, the population to nurse ratio is 1: 4,199. Out of the total number of doctors, 90% are based in urban areas. The district is over staffed with 78 nursing aides (16% excess) and 28 health assistants (12% excess). Meanwhile the district is under staffed with critical staff such as; 18 enrolled nurses out of the approved 32 (43.7% less), 21 enrolled mid wives out of the approved 56 (62% less), and 20 medical assistants out of the approved 36 (48% less). It is important to note that the rural areas are adversely affected than urban areas. This is because about 50% of all medical staff in the district are found in urban health units (see Tororo district Development Plan, 1994-1997). Therefore, the distribution of health providers does not adequately meet rural health needs. For the last 27 years there has been no major expansion/addition of health facilities, despite an annual 2.8% population increase in the district (see The 1991 population and housing census, Tororo district Annual health report, 1996).

Most of the essential PHC elements (as defined by the Alma-Ata conference)<sup>9</sup> have been long in establishment at the sub-county and district levels. In all sub-counties/division in the study area, there was a health inspector, an agricultural assistant, veterinary assistant (vermin control officer in municipality), community development assistant and a sub-county chief (assistant town clerk in the division). The communities are represented by elected sub-county councils and appointed sectoral committees. Notably lacking PHC essential sectors at the sub-county level are the education and water department. However, the community development department can handle the role of community education. While the role of water and sanitation department is co-ordinated by the sub-county health inspector, in conjunction with the rural water and sanitation

---

<sup>9</sup> The essential elements outlined in the Alma-Ata declaration are; promotion of nutrition, provision of adequate safe water, basic education, immunisation against major infectious diseases, safe motherhood, control of local endemic diseases, preventive and promotive health education and appropriate treatment for common ailments.

(RUWASA) project. Such PHC elements, when properly co-ordinated and integrated can constitute the building blocks of an effective PHC delivery system. The sub-county chiefs and the Assistant Town clerk, as the heads of civil service at the sub-county and the municipality's divisions respectively, can act as the pivot for co-ordination and collaboration in PHC delivery. This is in recognition of the fact that, a great deal of PHC success relies on significant contribution outside the conventional health sectors.

In most sub-counties of the district, there is a health unit apart from the eastern-division Tororo municipality (see Tororo district development plan, 1994-1997). The health facilities are horizontally spread out in most sub-counties. This is near 'location' equity. It also implies that in each sub-county that there is a health facility for first contact and subsequent health care in sub-county. This is an essential element for any PHC delivery system in number of ways. Firstly, it is essential for the control of most common infections in the community. Secondly, it is a platform for the implementation of decisions taken by community representative institutions such as HUMCs and HCs. Thirdly, the integration of some of the locally identified PHC priorities with the knowledge of health technicians can be partly felt at the health unit. Also the essential drugs component of the PHC strategy can be executed at the health unit.

### **4.3 The health sector and PHC financing**

Budgeted district expenditure on health services for previous years has been low, except for the 1998/99 financial year. For example, in the 1997/98 financial year, budgeted expenditure for health services was shillings 778,955,246 (an average 15%) of the total district budget of shillings 5,164,206,268. For the 1998/99 financial year, budgeted health expenditure was shillings 3,150,622,110 (33%) of the total district budget of shillings 9,534,000,415. The actual expenditure on health services in previous years has been extremely low, averaging 3% of the annual total district expenditure. For example, in the 1996/97 financial year, actual expenditure on health services was shillings 202,529,657 (4.6 %) out of the total district expenditure of shillings 4,309,031,253. Also in the 1997/98 financial year, actual expenditure on health services was shillings 142,608,009 (2.1%), out of the total district expenditure of shillings 6,753,117,119. Most of the district health funds come from donors. For example, in the 1998/99 financial year

donors were expected to contribute total shillings 2,583,510,130 (82%), and central government contributing an average shillings 567,111,979 (18%), with almost nothing from the district's locally raised revenues (see Tororo district recurrent and capital estimates, 1998/99 and Tororo district health plan 1998/99). At the sub-county level, budgeted finances for health services is extremely low and actual expenditure in some sub-counties has been 0% in previous years on health services. For example, the actual expenditure of Buhehe sub-county in the 1994/95 financial year was 0% (see Tororo district development plan 1994-97).

The district development plan (DDP., 1994-1997:30) notes that; *"the provision of hospital based services ignores health protection measures like control of environmental influences which may not be covered by medicine. It is recognized that improvements in the health status of a population do not depend on investments in the health sector per se, but also on improvement and development of interrelated sectors such as water, sanitation, food production, nutrition, education, among others"*.

Despite this official recognition, most of the resources allocated for health services are directed towards curative and hospital based care. A review of the financial commitment of the district authorities towards PHC in the previous three years, shows a big gap between the intentions of the district (plans) and the actual willingness to implement such intentions. The district expenditures on PHC over the previous years have been largely peripheral. The review of annual district health expenditures shows that in 1996/97 financial year, PHC expenditure was shillings 14,720,700 (7.2%) of the total annual health expenditure of shillings 202,529,657, and (0.34%) of the total district expenditure of shillings 4,309,031,253, with almost nothing coming from the locally raised revenue. The 1997/98 district annual budget estimates shows that PHC was to consume shillings 93,125,000 (11.2%) of the total district health budget. However, actual PHC expenditure for the 1997/98 financial year was shillings 10,890,300 (7.6%) of the district health expenditure of shillings 142,608,009, and (0.29%) of the total district expenditure of shillings 3,703,143,521 (see Tororo district recurrent and capital estimates, 1998/99). This trend of events shows that the re-orientations of the district health system to PHC, has not been matched with significant changes in financial commitment to PHC at the local levels. Nonetheless, there has been a commitment by central government to increase PHC conditional grants to the districts by

over 500% beginning with the 1998/99 financial year. The provision and budget for PHC in Tororo district in the 1998/99 financial year was shillings 1,884,270,000 (60%) out of the total health budget of shillings 3,150,622,110, and (20%) of the total district budget. The provisional budget projections for PHC services in 1999/2000 financial year for Tororo district stands at 60% of the total health budget (see Tororo district recurrent and capital estimates 1998/99).

#### **4.4 The health situation in Tororo district**

According to the district annual health reports (1995), the top ten diseases recorded in all registered health units are; malaria (28%), acute respiratory infections (21.9%), diarrhea (9.2%), intestinal worms (9.2%), trauma (5.9%), eye infections (5.1%), skin diseases (4.6%), anemia (4.2%), malnutrition (1.9%) and ear diseases (1.8%). According to the annual health report (1995:31), malnutrition is more serious among children due to lack of food and balanced diet. It is important to emphasize the fact that most of these diseases can be prevented through simple disease preventive and health promotive interventions, even with the limited resources available at the district.

#### **4.5 Health plans and policies of sub-counties and the district**

A review of health plans and policies formulated by HCs and HUMCs was undertaken at the sub-county level. Also, a review of the district health plans in general and PHC plans in particular, was undertaken at the the DMO. This was done to determine the nature of policies and plans that had been made and the extent to which such policies and plans reflected PHC orientations. It should be noted that the HUMCs cannot pass health policies, they can only initiate policy recommendations, which are then forwarded, to the HCs at for consideration and adoption by LC III council. Therefore at most, HUMCs have only tentative plans for their respective health units. All sub-counties in the study area had, at least, some kind of a health plan. These health plans are partly reflected in the sub-counties annual incomes and capital estimates and records of meetings of HCs and HUMCs.

#### 4.5.1 Health plans and policies of Kwapa sub-county.

From Kwapa sub-county the following intentions are cited in the sub-county 1998/99 annual budget estimates and records of the HC. Firstly, the completion of the maternity wing of health unit. Secondly, protecting of water sources not covered by rural water and sanitation project (RUWASA). Thirdly, facilitating community health volunteers (through bicycle allowances) to carry out public health campaigns and routine household sanitation check ups (see Kwapa sub-county annual recurrent and capital estimates, 1998/99). The HC of Kwapa sub-county had formulated ad hoc health related by-laws regarding household sanitation, hygiene and, immunisation. In addition, a policy framework relating to health unit user fees had been discussed and, recommendations sent to LC III council and DMO for consideration (source: key informant interview)

According to the sub-county key informants, there is a wide discrepancy between the PHC plans and actual implementation, partly, as a result of lack of funds. However, the orientations of such health related plans, and policies towards the PHC strategy, is quite evident. The plan to mobilise resources towards the completing of maternity wing of the health unit is intended to strengthen the mother and child health care services, which are a vital component of PHC delivery. The plan for the protection of wells and springs is intended to guarantee safe drinking water for community members, and prevent waterborne infections in the longrun. Meanwhile, the by-laws relating to proper household sanitation and immunisation are disease preventive in nature. Largely missing from the health plans of Kwapa sub-county are essential components like nutritional campaigns (although mentioned in the district health plan 1998/1999).

The annual 1998/99 tentative plans of the HUMC for Kwapa sub-county health unit include the following; repair and extension of health unit (maternity wing), user fee savings for emergency expenditure (when essential drugs run out) and motivational allowances for health workers (see Kwapa sub-county health unit budget estimates, 1998/99). These health plans reflect the initiative to consolidate basic health services within the community. These health plans are also largely reflective of the local health problems identification and initiatives to solve them through community participation. From the point of view of the mandate of HUMCs, the PHC element of



consolidating the basic health services has been initiated albeit quite ambitions, given the resources at the sub-county disposal. Therefore, the institutionalization of community participation in health care design and delivery can lead to meaningful identification and prioritisation of local health problems and, solutions to overcome such problems.

#### **4.5.2 Health policies and plans of Eastern-Division Tororo Municipality**

It is important to recall that the municipality's eastern division does not have a HUMC. This is because the division has no health unit. The health related plans and policies reviewed relate to the HC of the division. The following intentions are cited in the divisional budget estimates for 1998/99 and, the divisional work plane for 1998/99. Firstly, the plan to construct public health toilets/conveniences in congested slum areas for example Kasoli. Secondly, the plan to construct first AID clinics in all LC II zones (Parishes). Thirdly, the extension of water stand pipes to peri-urban areas not served by National Water and Sewerage Co-operation (NWSC). Fourthly, the plan to conduct monthly community tours with health officials. Lastly, financial assistance to schools for sanitation improvement (see Eastern division recurrent and capital estimates 1998/99- Tororo Municipality, and Eastern Division work plan 1998/99). According to key informants, the division had also passed by-laws regarding sanitation and immunisation. For example, every household should have toilet facilities, utensils stand and soak pits.

The above mentioned health plans are generally indicative of disease preventive and health promotive considerations. They also reflect the capacity of HCs to identify local health related priority needs. These health-related plans however, appear ambitious (given the nature of the fiscal relationship between the municipality and the division, and the financial resources available to the division). For example, in the 1998/99 financial year, shillings 5,060,236 (5%) was budgeted for PHC services, out of the total divisional budget estimates of shillings 100,988,750 (see Eastern Division recurrent and capital estimates, 1998/99-Tororo municipality). This study could not establish whether these divisional plans had been reflected and integrated into the municipality annual health plans. The study could not establish the extent to which the division had made financial commitment towards PHC in previous years, since the division had for the first time produced a working budget in 1998/99. The fiscal relationship

between the division and central municipality does not favourably guarantee that the division can achieve its PHC targets (see chapter eight for a detailed explanation). Notably missing on the divisional health plans is the nutritional element and, the mother and childcare elements.

### **4.5.3 Health plans and policies of Kisoko sub-county**

The following health intentions are cited in the Kisoko sub-county budget estimates and work plan for the 1998/99 financial year. The construction of maternity wing using funds from sub-county revenues. Secondly, the expansion of latrines at Kisoko health unit. Thirdly, monthly health outreach centers for each parish. Fourthly, water sources (boreholes) maintenance. Lastly, the facilitation of community health workers and volunteers through bicycle and lunch allowances (see Kisoko sub-county recurrent and capital estimates, 1998/99). All these aspirations have been budgeted for in the 1998/99 financial year. Also, according to the key informants at the sub-county, ad-hoc by-laws regarding immunization and sanitation are in place. Some of the health plans such as community outreaches, maintenance of boreholes and, by-laws regarding immunization are largely disease preventive and health promotive in nature. The degree of financial commitment towards PHC is also low mainly due to the low revenue resource base of the sub-county, among other reasons. For example, in the 1997/98 financial year, shillings 1,816,000 (3.2%) was budgeted for PHC services out of the total sub-county budget of shillings 55,054,800, but only shillings 689,400 was spent. Also, in the 1998/99 financial year, shillings 2,298,500 (3.7%) was budgeted for PHC services out of the total sub-county budget estimates of shillings 61,172,000. By the end of May 1999, only shillings 850,445 (0.37%) had been spent on PHC services (see Kisoko sub-county recurrent and capital estimates, 1998/99). When measured against the local resources, these health-related plans appear ambitious. Therefore, like in the other sub-counties, there is a wide discrepancy between the aspirations and the actual implementations.

### **4.6 Health plans and policies at district level**

A significant number of health related activities are cited in the annual health work plan 1998/99 of Tororo district. These activities cannot all be reproduced in this review. This study has

accordingly restricted itself to a review of the district PHC plans. The following PHC activities are cited in the district health workplan 1998/99, as priority initiatives. The control of malaria, the school health program (sensitization of headteachers and screening school children for common diseases), the nutrition program, integrated information and education campaign, safe motherhood, immunization, water and sanitation, management of special health problems, rehabilitation and consolidation of health units, financial support to health sub-districts, and support supervision to sub-county health units (see Tororo district annual health plan, 1998/99).

All the basic PHC elements are cited in the district health plan 1998/99. However, a number of PHC activities have not been earmarked for funding in the health plan. The PHC activities not earmarked for funding are; nutrition (especially the training of community based growth monitors and the orientation of sub-county health workers on nutrition), the screening of school children for common diseases and the sensitization of local councilors on safe motherhood. This is mostly due to lack of adequate financial resources to target all PHC elements

The segregated and disjointed funding of some PHC elements (and the neglect of others) has implications for the nature of PHC services delivery within the district. It does not foster the integrated and holistic approach expected of the PHC strategy, especially when some essential elements like nutrition have been left out. The significance of the element of nutrition in disease prevention and health promotion cannot be over emphasized. From interviews with DMO and, a review of the district health plans, the health department was supposed to establish demonstration gardens, encourage nutritional related competitions among schools and, train health volunteers in nutrition campaigns. This has not been entirely the case. Only breastfeeding is emphasized at health units. The district health team and local leaders seem to underplay the relationship between nutrition and disease infection. A mistake appears to be the failure to appreciate the important role of malnutrition in the etiology of disease infection. Yet it is well recognized (see Ebrahim, 1988) that a large proportion of morbidity and mortality arises from the fact that a malnourished individual cannot master an adequate immune response to fight infection, recovery is prolonged and may not be optimal. Hence, the under emphasis of the nutritional element in PHC workplan is likely to undermine the outcome of PHC plans cited in the annual district health workplan. The annual district health workplan does not elaborate inter-

sectoral collaboration with other departments. It is important to emphasize the fact that a great deal of PHC strategy requires actions and support outside the traditional health sector. This appears not to have been emphasized by district and sub-counties authorities.

#### **4.7 Conclusion**

This chapter has described the health sector and health situation in Tororo district. The health infrastructure of the district is characterised by uneven distribution, largely in favour of urban areas. Despite the official recognition of PHC strategy in district development plan, the financial commitment towards PHC in the previous years has been largely peripheral – save 1998/99 financial year. Most funds for health services come from donors and central government, with almost nothing from the district treasury. There is also a wide discrepancy between the stated health plans and their actual implementations, mainly because of lack of funds, among other reasons. The top diseases that burden the communities can be largely prevented. The process of planning for health services delivery among sub-counties is relatively new and not so well developed. The fiscal relationship between the district headquarters and the sub-counties does not easily facilitate PHC services delivery to local communities. Mean while, inter-sectoral collaboration necessary for PHC services delivery has not been significantly emphasised in both the sub-county and district health plans. The health related plans and policies of sub-counties and the districts reflect some PHC orientations. The next chapter describes the socio-economic background characteristics of the survey respondents.

## **CHAPTER FIVE**

### **5.0 THE SOCIO-ECONOMIC BACKGROUND OF SURVEY RESPONDENTS**

#### **5.1 Introduction**

This chapter describes the frequency distribution of the sex of the survey respondents, the age distribution of the survey respondents, the educational level of the survey respondents, the occupational background of the survey respondents, and the interpretations of the analysis of these background variables.

#### **5.2 The sex of the survey respondents.**

A total of 89 survey respondents were interviewed using a semi-structured questionnaire. A deliberate attempt was made during sampling to have an equal number of males and female respondents from each selected sub-county in the study area. Therefore, from each household sampled, at most one adult male and one adult female were selected and interviewed. Out of the total number of 89 survey respondents, 43 respondents were males (48.3%) and 46 respondents were females (51.7%). As demonstrated in the next chapter, the sex of the survey respondents did not significantly determine the perceptions of the respondents about the roles, policies, and impact of HCs and HUMCs. The frequency distribution of the sex of survey respondents by sub-county is reflected in the Table II below.

**Table II. The sex of the survey respondents by sub-county**

Sex	Sub-county			
	Kisoko	Kwapa	Eastern Division of Municipality	Total
	Freq. %	Freq. %	Freq. %	F %
<b>MALES</b>	16 (53.3)	13 (44.8)	14 (46.7)	43 (48.3)
<b>FEMALES</b>	14 (46.7)	16 (55.2)	16 (53.3)	46 (51.7)
<b>TOTAL</b>	30 (100)	29 (100)	30 (100)	89 (100)

*\* Percentages reflected in all the tables are column percentages*

### 5.3 Age distribution of the survey respondents

The analysis of the age distribution of the survey respondents was done around five age-group categories. This was done to ensure that all major age groups of adult community members are reflected in the analysis. The age of the survey respondents did not significantly determine their perceptions about the roles and functions of HCs and HUMCs in PHC delivery at the local level. The age group distribution of the respondents is reflected in Table III below.

**Table III. The age –group frequencies of survey respondents.**

Age group	Frequency	Percentage
15-24	26	29.2
25-34	26	29.2
35-44	16	18.0
45-54	16	18.0
+55	5	5.6
<b>TOTAL</b>	<b>89</b>	<b>100 .0</b>

#### 5.4 Educational level of respondents

The analysis of educational level of respondents was done at five levels; with 16.9% of the respondents having had no formal educational at all, while 33.7% of the respondents had attended primary school education. Also, 39.3% of the respondents had ever attended secondary school and 8.9% of the respondents had ever attended tertiary/vocational or university education. There was an exception of one respondent who attended catechism instruction at the Church. The educational level frequency distribution shows a pattern of education system where access to education is unequal, and where the chances of education achievement narrow down the higher one goes on the educational ladder. This situation may have implications for the nature of community participation in PHC design and delivery. The relationship between level of education and gender are shown in the Table IV below.

**Table IV. The educational level of the survey respondents by gender.**

Sex	Educational level											
	No. Education		P1-P4		P5-P7		Secondary		Tertiary/University		Total	
	F	%	F	%	F	%	F	%	F	%	f	%
<b>Males</b>	3	(20)	4	(44.4)	11	(52.4)	19	(54.3)	5	(62.5)	42	(44.7)
<b>Females</b>	12	(80)	5	(55.6)	10	(47.6)	16	(45.7)	3	(37.5)	46	(52.3)
<b>Total</b>	15	(100)	9	(100)	21	(100)	35	(100)	8	(100)	88	(100)

$$X^2 = 0.2768 (p > 0.05)$$

As reflected in Table IV above, There was no observed statistically significant relationship between sex and educational attainment [ $x^2 = 0.2768 (p > 0.05)$ ]. The sampled respondents appear to have had no major differences in their levels of educational attainment.

There were observed unequal educational opportunities in the different sub-counties of the study area. The relationship between the sub-counties' location and educational opportunities was statistically significant [ $\chi^2 = 0.05000$  ( $p < 0.05$ )]. Therefore, rural areas, as expected, tend to have less opportunities of access to education than urban areas. For example, out of the total number of 15 respondents who never attained formal education, 8 of the respondents (53.3%) were from Kisoko sub-county which is typically rural, while only 2 respondents (13.3%) were from the municipal council (Eastern division) The remaining 5 respondents (33.3%) were from Kwapa sub-county. Also chances for higher education are tilted in favor of urban areas than in rural areas. For example, out of the 35 respondents who attained secondary education, only 6 respondents (17.1%) are from Kisoko sub-county, which is typically rural, compared to 14 respondents (48.3%) from Tororo municipality-Eastern Division. This is demonstrated in Table V below.

**Table V The educational level of respondents by sub-county**

Sub-county	Educational level											
	No educ		P1-P4		P5-P7		Secondary		Tertiary		Total	
	F	%	F	%	F	%	F	%	F	%	F	%
Kisoko	8	53.3	6	66.7	9	42.9	6	17.1	1	12.5	30	<b>34.0</b>
Kwapa	5	33.3	-	0	5	23.8	15	42.9	4	50	29	<b>33.0</b>
Eastern Div.	2	13.3	3	33.3	7	33.3	14	40	3	37.5	29	<b>33.0</b>
<b>Totals</b>	<b>15</b>	<b>100</b>	<b>9</b>	<b>100</b>	<b>21</b>	<b>100</b>	<b>35</b>	<b>100</b>	<b>8</b>	<b>100</b>	<b>88</b>	<b>100</b>

$$\chi^2 = 0.05000 ( p < 0.05 )$$

This pattern of life chances has implications for the occupational opportunities of residents. It also has implication for the nature of community participation and resource mobilization for PHC services delivery especially for rural areas. For example all the sub-county councilors including the appointing authorities from Kisoko sub-county (which is typically rural) don't consider themselves competent to chair the HC. Consequently, the HC is not functional.



*“we don’t have a chairperson for the HC because we don’t have any councilor with a health background” (male key informant- Kisoko sub-county).*

## 5.5 Occupational background of survey respondents

The occupational background of respondents was broken into at six groups (see Table VI below). The majority of respondents were peasant farmers, while 5 of the respondents (5.6%) performed other duties such as housekeeping, local defence surveillance. However, gender segregation is also evident in the occupational background of the survey respondents as demonstrated in the Table VI below. There was an observed significant relationship between the sex of respondents and their occupational opportunities [ $\chi^2 = 0.00278$  ( $p < 0.05$ )]. Women in developing countries tend to be socialized to and perform domestically oriented duties (see Norman 1988).

**Table VI. The occupational background of respondents by gender**

Occupational category														
	Peasant		Trader		Professional		Artisan		Casual Laborer		Others		Total	
Sex	F	%	f	%	f	%	f	%	f	%	f	%	F	%
Males	14	(29.8)	7	(58.3)	10	(62.5)	5	100	4	100	3	60	43	48.3
Females	33	(70.2)	5	(41.7)	6	(37.5)	0		0		2	40	46	57.7
Total	47	(100)	12	(100)	16	(100%)	5	(100)	4	(100)	5	100	89	100

$$\chi^2 = 0.00278 \text{ ( } p < 0.05 \text{)}$$

AS shown in Table VI above, out of the 47 respondents who are peasant farmers, 33 respondents (70.2%) were females compared to only 14 respondents (29.8%) who were males. Also out of the 16 respondents who have professional occupations only 6 respondents (37.5%) are females while 10 respondents (62.5%) are males. Other occupations such as artisan and casual labor are an exclusive domain of only males. Reasons for such a trend of occupational gender segregation arise from patriarchal orientations in which females tend to be more domesticated in most spheres of life especially in developing countries while males are socialized and oriented for

extra-domestic activities. This life pattern may also have implications for the active participation of women in community development activities (see Norman, 1988).

The trend in life chances of the respondents (indicated by occupational status) appears more favorable to urban and peri-urban areas compared to typically rural areas. A further analysis of occupational status of respondents by sub-county reveals that of all 47 respondents who are peasant farmers, 20 respondents (42.6 %) are from Kisoko sub-county which is typically rural. This compares poorly to 13 respondents from Kwapa sub-county and 14 respondents from the municipality, which are peri-urban and urban respectively. Also of all the 16 respondents who are professionals only 1 respondent (3.3%) was from Kisoko sub-county, unlike the 8 respondents from Kwapa sub-county and 7 respondents from the municipality (Eastern division).

Such a trend of employment opportunities has implications for the nature of community participation and resource mobilization for PHC activities. Findings from the FGDs in Kisoko sub-county indicates that all local councilors at the LC III level have shunned the responsibility of chairing the HC because they hold a perception,(including the appointing authority), that, one needs a background training in health issues to be the chairperson of the HC. This however, is not a legal requirement of the local Government Act, 1997. Consequently the HC is non-operational in Kisoko sub-county. It was also reported from FGDs that there is a general low level of graduated tax collection in the sub-counties. This kind of situation arises partly from the kind of educational life chances and employment opportunities that such a community has been exposed to. Therefore, decentralisation opportunities and community participation as a process may be held up by the nature of life chances the community members have been exposed to. Although constitutionally established and politically anchored structures such as HCs act HUMCs may be set up to foster community participation for PHC delivery, it is no guarantee that such opportunities shall always be exploited by the community members, although willing. This arises partly from the perceptions held by the local leaders themselves at LC III level as regards ones' competency to chair the sub-county HCs, and partly from the life chances or opportunities these communities have been exposed to.

## 5.6 Conclusions

This chapter has described the background characteristics of the survey respondents. The sex of the respondents was described and it was shown that a gender representative sample was adopted for the study. The age groups of the respondents were also described. The educational levels of respondents in relation to other background variables (sub-county, sex e.t.c.) and the implications for community participation have been described in detail. The occupational categories of the respondents in relation to other background variables and the likely implications have also been described. It was shown that educational and occupational opportunities are tilted in favour of urban areas than rural areas. Such situations have negative implications for community participation and resource mobilisation for PHC delivery. The next chapter deals with community members' perceptions about the roles and functions of HCs and HUMCs.

## CHAPTER SIX

### **6.0 RESIDENTS' PERCEPTIONS ABOUT THE ROLES AND FUNCTIONS OF LC I SECRETARIES FOR HEALTH, HEALTH COMMITTEES AND HEALTH UNIT MANAGEMENT COMMITTEE.**

#### **6.1 Introduction**

This chapter describes the findings from the survey sample and FGDs regarding residents' perceptions of the roles and functions of LC I secretaries for health, HCs and HUMCs in regard to PHC delivery at the sub-county and village levels. This chapter describes the community members' level of awareness (and misconceptions there in) about LC I secretaries for health, HCs and HUMCs. The community members' perceived understanding of policies taken by HCs and HUMCs are also described in relation to PHC.

#### **6.2 Respondents' awareness of the roles and functions of LC I secretary for health at village /zonal level.**

Survey respondents were asked whether they were aware that there is LC I secretary for health for their respective villages/zones. The analysis of responses shows that, 70 respondents (78.7%) of the total 89 respondents were aware, as opposed to 19 respondents (21.3%) who were not aware of the LC I secretary for health. Out of the 70 respondents who were aware about LC I secretary for health, 34 respondents (48.6%) were males, while 36 respondents (51.4%) were females. Out of the 19 respondents who were not aware of the LC I secretary for health, 9 respondents were males and 10 respondents were females. Therefore, there was no observed significant relationship between sex and level of awareness about LC I secretaries for health [ $\chi^2 = 0.9258$  ( $P > 0.05$ )]. This could be due to the fact that this is a community embedded phenomenon that is uniformly known by community members and the civic education that heralds such

local council elections. Also, women have of recent become politically active through participation in local politics among others.

The pattern of level of awareness about LC I secretary for health does not change when the analysis is done at the level of sub-counties (especially rural versus urban areas). A comparative analysis of a typically rural sub-county (Kisoko sub-county) and a typically urban area (Eastern division-Tororo municipality) shows that respondents from both urban and rural areas were uniformly aware about LC I secretaries for health. There was no observed significant relationship between sub-county and level of awareness about LC I secretary for health [ $\chi^2 = 0.4593$  ( $p > 0.05$ )]. This situation is demonstrated in Table VII below.

**Table VII. Respondents' level of awareness about LC I secretary for health by sub-county**

Awareness Category	Sub County							
	Kisoko		Kwapa		Tororo Municipality Eastern division		TOTAL	
	f	%	f	%	f	%	f	%
<b>YES</b>	22	(73.3)	20	(69.0)	28	(93.3)	70	(78.7)
<b>NO</b>	8	(26.7)	9	(31.0)	2	(6.7)	19	(21.3)
<b>TOTAL</b>	30	(100)	29	(100)	30	(100)	89	(100)

$\chi^2 = 0.4593$  ( $p > 0.05$ )

As shown in table VII above, there is a uniform level of awareness about LC I secretaries for health, among all the sub-counties. The reasoning behind such a uniform trend may be the view that, this is a village based phenomenon that is commonly known in all places. The idea about local councils has been in Uganda for the last 13 years and it is popular especially at local levels.

The analysis of level awareness about LC I secretary for health by educational level shows, that out of the 70 respondents who were aware, 12 respondents (17.1%) had never had formal

education while 23 respondents (32.8%) had attended primary education. Also 28 respondents (40%) had attended secondary education, and 6 respondents (8.6%) had either attended tertiary or vocational training (see Table VIII). The high numbers of respondents who are aware about LC I secretary for health in the primary and secondary education categories are proportionate to the equally large number of respondents sampled in those educational categories. Therefore, there was no statistically significant relationship [ $\chi^2 = 0.4728$  ( $p > 0.05$ )] between level of education and level of awareness about LCI secretary for health at village level. This is mainly due to the fact that the concept of local councils is a community based phenomenon which all community members are supposed to participate uniformly without due regard for educational attainment. Also the local council leaders at the village level are elected directly by community members.

**Table VIII. Respondents level of awareness about LC I secretaries for health by educational level.**

Awareness Category	Educational level											
	No educ		Primary		Secondary		Tertiary		Others		TOTAL	
	f	%	f	%	F	%	f	%	f	%	F	%
YES	1	80	23	76.7	2	80	6	75	1	100	70	78.6
	2				8							
NO	3	20	7	23.3	7	20	2	25	-	0	19	21.4
TOTAL	1	100	30	100	3	100	8	10	1	100	89	100
	5				5		0					

$$\chi^2 = 0.4728(p > 0.05)$$

### 6.2.1 Roles and functions of LC I secretaries for health

The community members who were aware about LCI secretary for health were further asked to identify the roles and functions of the LC I secretary for health. Multiple responses were

allowed. Table IX 4 below shows the responses per the different categories of roles and functions of LC I secretaries for health as mentioned by respondents.

**Table IX. Residents' responses about the roles of LC I secretaries for health**

Mentioned roles	Frequency	%
Mobilisation	35	32.1
Sensitisation	35	32.1
Enforce by-laws	13	11.9
Other roles	21	19.3
Don't know	5	4.6
<b>Total</b>	<b>109</b>	<b>100</b>

**Multiple responses were allowed**

As reflected in Table IX above, out of the 70 respondents who were aware about the LC I secretary for health, the majority of respondents mentioned that, the roles of the LC I secretary for health are to mobilise community members towards health related activities, and sensitising community members about proper health behaviours like having toilets, utensil stands, rubbish pits e.t.c. Another 13 respondents mentioned that LC I secretaries for health play the role of enforcing health related by-laws, while 21 respondents mentioned other roles and functions of LC I secretaries for health such as; monitoring health situations in the villages, reporting disease outbreaks to concerned authorities, enforcing sanctions against those who don't comply with the health related by-laws among others.

From the foregoing description, it appears that the integration of LC I secretaries for health into the district health delivery system as a result of decentralisation is paying off, especially as far as PHC is concerned. The majority of survey respondents are aware about the roles of LC I secretaries for health. However, there are few misconceptions held by community members towards the roles and functions of LC I secretaries for health, for example the view, that, the latter are supposed to arrest community members without toilets in their homes, and these who don't take their children for immunisation. These misconceptions could arise partly from the fact

that LC I secretaries for health may portray themselves in such roles yet these roles should be the domain of law enforcement officers like local administration police, local defence units, LC courts and police among others. Nevertheless the general trend indicates that the LC I secretaries for health are playing an important role in community based PHC, especially in preventive and promotive health initiatives, their shortcomings notwithstanding. This conclusion is substantiated with findings from FGDs in which it was observed that LC I secretaries for health were very instrumental in the mobilisation of community members towards PHC activities at the village and parish levels.

*“ Health personnel usually work with the village local council leaders and secretaries for health in the mobilization of community members towards health initiatives like immunization, cleaning of village wells e.t.c.” (FGD participant-Kwapa sub-county).*

### **6.3 Residents’ awareness about the roles and functions of health committees (HCs)**

The survey respondents were asked if they were aware that, there are HCs at the sub-county level. The analysis of responses indicates that, the majority of the respondents were aware about HCs at the sub-county (LC III) level. Out of the 89 respondents interviewed, 77 respondents (86.5%) were aware about HCs at the sub-county (LC III) level, while 12 respondents (13.5%) were not aware at all. Further analysis showed that out of the 77 respondents who were aware about HCs at the sub-county level, 39 respondents (50.6%) were males while 38 respondents (49.4%) were females, implying that there is no significant difference [ $\chi^2 = 0.2642$  ( $p > 0.05$ )] in the level of awareness about HCs between the males and female respondents. And out of the 12 respondents who were not aware about HCs, 4 respondents were males, while 8 of the respondents were females. The analysis of responses by sub-county also shows no significant relationship between [ $\chi^2 = 0.9875$  ( $p > 0.05$ )] the level of awareness about HCs and the sub-counties as shown in Table X below.



**Table X. Residents' level of awareness about HCs by sub-county.**

Awareness Category	Sub County							
	Kisoko		Kwapa		Tororo Municipality Eastern division		TOTAL	
	f	%	f	%	f	%	f	%
YES	26	(86.7)	25	(86.2)	26	(86.7)	77	(86.5)
NO	4	(13.3)	4	(13.8)	4	(13.3)	12	(13.5)
TOTAL	30	(100)	29	(100)	30	(100)	89	(100)

$$X^2 = 0.9875 (p > 0.05)$$

There was also no observed significant relationship [ $\chi^2 = 0.2439 (p > 0.05)$ ] between the age of respondents and their level of awareness about HCs. Out of the 77 respondents who are aware about HCs, 22 respondents (28%) belonged to 15-24 age group, 24 respondents (31.2%) belonged to 25-34 age group, while 14 respondents (18.2%) belonged to both of the 35-44 and 45-54 age groups. Only 3 respondents (3.9%) belonged to the 55 years and above age group. The seemingly high number of respondents in the first two categories of age groups is proportional to the large number of respondents sampled in those age categories.

The analysis of respondents' level of awareness about HCs by their level of education indicates that, respondents in this sample were uniformly aware about HCs. The respondents who had at least attended formal education were uniformly aware about HCs like those who had never attended formal education. There was no observed statistically significant relationship between the level of awareness about HCs and educational attainment [ $\chi^2 = 0.2439 (P > 0.05)$ ]. This is demonstrated in Table XI below.

**Table XI. Respondents' levels of awareness about HCs by education level.**

Awareness Category	Education level											
	No Education		Primary		Secondary		Tertiary/Vocation		Others		TOTAL	
	F	%	F	%	F	%	F	%	F	%	F	%
YES	10	(66.7)	27	(90)	31	(88.6)	8	(100)	1	(100)	77	(86.5)
NO	15	(33.3)	3	(10)	4	(11.4)	0	(0)	0	(0)	12	(13.5)
TOTAL	15	(100)	30	(100)	35	(100)	8	(100)	1	(100)	89	(100)

$$X^2 = 0.2439(P > 0.05)$$

### 6.3.1 Roles and functions of HCs

The respondents who were aware about HCs were further asked to identify roles and functions of HC members, which they were aware of. Multiple responses were allowed. Table XII below shows the number of responses per the different categories of roles and functions of HC as mentioned by respondents.

**Table XII. Respondents' responses about the roles and functions of HCs.**

Mentioned roles	Frequency	%
Community and resource mobilisation	12	11
Sensitisation	43	39.4
Planning and budgeting	7	6.4
Other functions and roles	42	38.5
Don't know	5	4.6
<b>Total</b>	<b>109</b>	<b>100</b>

**Multiple responses were allowed**

As reflected in Table XII, out of the 77 respondents who were aware about HCs, only 13 respondents mentioned that HCs are responsible for community and resource mobilisation for health services. Surprisingly, this is one of the most important roles of HC (MoLG 1997 guidelines on the role of local leaders and managers in district and sub-county health services). Meanwhile, only 7 respondents mentioned that, the HCs are supposed to carry out planning and budgeting for health services at the sub-county, yet this is also one of the important roles of HC. Further, 43 respondents out of 77 mentioned that, the HCs are supposed to carry out sensitisation of community members about health issues. However this is an over exaggeration of the roles and functions of HC, but it is likely that some of the members of HC in conjunction with health workers carry out health sensitisation activities. It is also likely that some members of the HCs regard themselves as some kind of health extension workers (see also findings of Kostanjek 1997:5). It is also reported from HC focus group discussions of Kwapa and Tororo Municipality that sometimes members of HC carry out community health tours in which they and other health workers address community members on health issues. This was mostly done during the cholera outbreaks. Also 42 respondents out of the 77 who were aware about HCs mentioned other functions of HCs such as monitoring health units, monitoring health situations, identifying health problems, providing good drinking water, recording AIDS patients. Meanwhile, only 5 of the respondents could not mention any particular roles and functions of HCs (or felt that HCs were not carrying out their duties). As can be seen, some respondents have misconceptions about the roles of HCs, for example, the view that HCs are supposed to record AIDS patients.

There is collaborated evidence from FGDs regarding community members perceptions towards the roles and functions of HCs. Members of HCs were asked during focus group discussions, what they thought were their roles and functions. This was intended to establish the knowledge and attitudes of the HC members about their official duties as spelt out in the MoLG updated guidelines on the role of local leaders and managers in the district and sub-county health services. The general trend observed from the FGDs shows that most of the HC members were aware of their roles and functions. The members of HCs mentioned the following roles and functions. That the HCs are supposed to sensitize and mobilize community members about proper health practices. That the HCs, are also supposed to plan for health service delivery at the sub-counties. That the HCs, are also supposed to appoint and oversee the HUMCs, monitor the

general trend of community health, and report disease out breaks to concerned authorities.

***“ we also plan for health services delivery and appoint and supervise the HUMC”  
(FGD participant-Eastern Division Tororo Municipality).***

None of the HCs participants in FGDs mentioned the role of resource mobilization for PHC delivery at the sub-county. This is supposed to be one of the important roles of HCs. This is collaborated with findings from the survey sample, in which few respondents mentioned such a role for HCs. None of the HC members, mentioned that HCs, were also supposed to initiate health related by-laws for approval by the local council III so as to strengthen proper household sanitation, hygiene and immunization. Nonetheless, this function is being carried out by HCs. Despite such limitations in the knowledge of HC members about their roles and function, the integration of HCs into the health delivery system at the sub-county has had a meaningful outcome for PHC delivery. The HCs, where resources do allow, have been engaged in functions such as; community mobilization and sensitization about proper health practices, planning for health services delivery at sub-county level, monitoring HUMCs and fostering collaboration with other stakeholders in PHC delivery, among others. Therefore, to a great extent the HC members appear to be aware of most of their roles and functions. A number of factors however, limit the actual implementation of the HCs plans.

From the foregoing discussions, HCs are actively engaged in roles that promote PHC delivery within sub-counties. Such roles mentioned include; mobilisation of community and resources towards health care, planning for health care services, identifying health problems and initiating actions to solve them, monitoring the delivery of health services. However, the roles of planning, resource mobilisation and the development of strategies to prevent and solve community health problems have not yet been fully exploited by HCs. Kostanjesk (1997) also reports in her study from Tororo-district that most sub-counties HCs had for the first time drafted health plans and budget beginning only in 1996/97 financial year. This indicates that the practice of planning for PHC among HCs is relatively new and calls for capacity building among HC members towards such critical roles and functions, especially as far as PHC is concerned. This also collaborated by evidence from HCs focus group discussion that annual health plans (and

plans of other sectors as well) are often produced late without concrete prioritization of health problems.

#### 6.4 Residents' awareness about the roles and functions of Health Unit

##### Management Committees (HUMCs).

Survey respondents were also asked if they were aware about HUMCs for each public health unit. The analysis of their responses by sub-county is reflected in the Table XIII below.

**Table XIII. Respondents level of awareness about HUMCs by sub-county.**

Awareness Category	Sub-county							
	Kisoko		Kwapa		Tororo Municipality		Total	
	f	%	f	%	f	%	f	%
<b>YES</b>	26	(86.7)	24	(82.8)	11	(36.7)	61	(68.5)
<b>NO</b>	4	(13.3)	5	(17.2)	19	(63.3)	28	(31.5)
<b>TOTAL</b>	30	(100)	29	(100)	30	(100)	89	(100)

$$X^2 = 0.0002(p < 0.05)$$

As illustrated in Table XIII above, out of the 30 respondents from Kisoko sub-county, 26 respondents (86.7%) were aware about HUMCs, while 4 respondents (13.3%) were not aware of HUMCs. This contrasts sharply with findings from the Municipality (eastern division) in which out of the 30 respondents from there, only 11 respondents (36.7%) were aware about HUMCs, while the majority 19 respondents (63.3%) were not aware about HUMCs. The major reasons behind such differences in levels of awareness between sub-counties, could be due to the fact that, the eastern division of the Tororo municipality does not have a public health unit, so the HUMC does not exist in this area. Therefore the respondents who are aware about HUMCs in the municipalities' eastern division could have known it through other people and from the nearby Tororo district hospital HUMC among other reasons. This observation is enforced by the

fact that there is a significant relationship between the location (sub-county) and level of awareness about HUMCs [ $\chi^2 = 0.0002(p < 0.005)$ ].

Further analysis was done to compare the age of respondents and levels of awareness of HUMCs. There was no observed significant relationship between the respondents' age and their levels of awareness about HUMCs [ $\chi^2 = 0.50007(p > 0.05)$ ], as demonstrated in Table XIV below.

**Table XIV. Respondents' levels of awareness about HUMCs by age.**

Age – group	Awareness of category		
	Yes F%	No F%	TOTAL F%
15-24	19(31.7)	7(25.0)	26(29.2)
25-34	19(31.7)	7(25.0)	26(29.2)
35-44	8(13.1)	8(28.6)	16(18.0)
45-55	11(18.0)	5(17.9)	16(18.0)
55+	4(6.6)	1(3.6)	5(18.0)
<b>TOTAL</b>	61(100)	28(100)	89(100)

$$X^2 = 0.50007(p > 0.05)$$

As far as this sample is concerned, it appears that most of the respondents who are aware of HUMCs, are between age groups of 15-24 and 25-34. However, the seemingly large number of respondents who are aware of HUMCs in these age categories is correspondingly proportional to the seemingly large number of respondents sampled from those age categories.

Further analysis shows that out of the 61 respondents who were aware about HUMCs, 19 respondents (31.2%) had attained primary education, while 26 respondents (42.6%) had attained secondary education and 6 respondents (9.8%) had attained tertiary education. The rest (17.4%) had not attained any formal education. The high number of respondents among those who had attained some education is proportional to the large number of respondents sampled in that category. Also, out the 30 respondents who had attained primary education, 19 of them (63.3%) were aware of HUMCs, and out of the 35 respondents who attained secondary education 26 respondents (74.3%) were aware of HUMCs, and out of the 8 respondents who had attained tertiary education, 6 respondents (75%) were aware of HUMCs. Lastly, out of the 15 respondents

who had not attended formal education, 10 respondents (66.7%) were aware about HUMCs. There was no observed significant relationship [ $\chi^2 = 0.8583(p > 0.05)$ ] between educational attainment and level of awareness about HUMCs.

#### 6.4.1 Roles and functions of HUMCs

The respondents, who are aware about HUMCs, were further asked to mention particular roles and functions of HUMCs. Table XV below shows the number of responses per the different categories of roles and functions of HUMCs as mentioned by the respondents. Multiple responses were allowed.

**Table XV. Residents' responses about the roles of HUMCs.**

Mentioned roles	Frequencies	%
Assessing and planning	10	11.9
Monitoring and Supervising	39	46.4
Managing user fees	4	4.7
Others	14	16.6
Don't know	7	8.3
<b>Total</b>	<b>84</b>	<b>100</b>

**Multiple responses were allowed**

As shown Table XV above, out of the 61 respondents who were aware about HUMCs, the majority of respondents mentioned that, the HUMCs were responsible for the monitoring and supervising the delivery of PHC at the health unit. It is important to emphasise that this is one of the basic assumptions of decentralisation and institutionalised community participation in PHC delivery. For example, the role of preventing abuse of health services at point of delivery by making health services providers accountable to their clients. Ten (10) respondents out of 61 respondents mentioned that HUMCs, were responsible for assessing and planning for the needs of Health Units, and only 4 out of 61 respondents mentioned that the HUMCs were responsible for the management of user fee changes collected at health unit. This is a misconception since HUMCs members are not accounting officers of health units but are policy makers and supervisors. Only 7 respondents (11.5%) could not mention any particular role or functions of HUMCs (or felt that HUMC members were not performing their roles), while 14 respondents

(22.9%) mentioned other functions of HUMCs like; informing people about the health unit, controlling the out break of diseases, giving people treatment, testing blood e.t.c. As can be seen some of the mentioned roles and functions (for example giving people treatment, testing blood) are misconceptions held by community members about the role and functions of the HUMCs. However, these misconceptions are of low magnitude whose significance does not over shadow the level of awareness about the correct roles of HUMCs.

There is collaborated evidence from FGDs regarding community members' perceptions about the roles of HUMCs. Members of HUMCs were asked during FGDs what their roles and functions were. The general trend indicates that the HUMCs members were comfortably aware of most of their defined roles and functions. Most members of the HUMCs in FGDs mentioned that their roles were; to supervise and monitor health services delivery at health units, planning for the health unit, identifying the health service problems at the health unit and initiating solutions to address such problems, monitoring the utilization of cost-sharing fees, sensitizes the community about the objectives of cost-sharing and work in close co-operation with sub-county HCs, the DMO and LC III secretary for health.

***“We have to see that the health units is running well, the staff are active and the money collected from the patients is properly utilised at the health unit as planned”***  
***(HUMC member - Kisoko sub-county).***

None of the FGD participants of HUMCs mentioned that they were also supposed to initiate polices about the health unit services (although they had actually done) and make recommendations to HCs and DMO for action. A few misconceptions are also abound among members of HUMCs. For example, some members mentioned that the HUMCs were custodians of health unit property, controllers of the use of drugs, and reporting incidences of disease outbreaks to concerned authorities. As can be seen, the control of use of drugs, the custody of health unit property is largely and exclusively the role of health service providers, especially the incharge of the health unit. He/she is the accounting officer of the health unit and is liable for punitive action for any wrong doing at the health unit.



## 6.5 Respondents' awareness of policies made by HCs and HUMCs.

Survey respondents were asked if they were aware of health-related policies that had been formulated and passed by HCs and HUMCs. This was to determine the extent to which these policies had been made known to the public through implementation and the extent to which such policies reflected PHC orientations. Out of the 89 respondents interviewed, 57 respondents (64.0%) were aware of at least one policy passed by either the HCs or HUMCs, while 32 respondents (36.0%) were not aware of any policy taken by either HCs or HUMCs.

The level of awareness about health related policies passed by HCs and HUMCs is evenly spread over the sub- counties of the area of study. For example out of 57 respondents who were aware of at least a policy taken by HCs and HUMCs, 21 respondents (36.8%) were from Kisoko sub county, while 17 respondents (29.8%) were from Kwapa sub-county, and 19 respondents (33.3%) were from Eastern division of Tororo municipality. This implies that there are no major differences in the level of awareness of health related policies taken by HCs and HUMCs between the different sub-counties in the area of the study.

There were also no observed significant relationship between the age group of respondents and their level of awareness of policies taken by HCs and HUMCs [ $\chi^2 = 0.3192(p > 0.05)$ ]. Out of the 57 respondents who are aware about the policies taken by the HCs and HUMCs, 13 respondents (22.8 %) belonged to the 15-24 age group, 19 respondents (33.3%) belonged to the 25-34 years age group, while 9 respondents (15.8%) belonged to the 35-44 years age group, and 13 respondents (22.8%) belonged to the 45-54 years age group. Only 3 respondents belonged to the 55 years age group. The smaller number of respondents who are aware about HCs and HUMC policies in the latter age categories is due to the proportionally less number of sampled respondents in those age categories. The same conclusion can be derived from the analysis of the 32 respondents who are not aware of the policies taken by HCs and HUMCs. However most of the respondents (at least over 50%) in the above different age groups were aware of the policies that had been taken by the HCs and HUMCs. This shows that the level of awareness about policies of HCs and HUMCs is averagly spread among the community members. This is demonstrated in Table XVI below.

**Table XVI. Respondents' level of awareness about policies of HCs and HUMCs by age**

Awareness Category	Age group categories in years											
	15-24		25-34		35-44		45-54		55+		TOTAL	
	F	%	F	%	f	%	f	%	f	%	F	%
YES	13	50.0	19	73.1	9	56.3	13	81.3	3	60	57	65.5
NO	13	50.0	7	26.9	7	45.7	3	18.7	2	40	32	34.5
<b>TOTAL</b>	<b>26</b>	<b>100</b>	<b>26</b>	<b>100</b>	<b>16</b>	<b>100</b>	<b>16</b>	<b>100</b>	<b>5</b>	<b>100</b>	<b>89</b>	<b>100</b>

$$X^2 = 0.3192(p > 0.05)$$

The analysis of survey respondents awareness of health related policies taken by HCs and HUMCs by sex, also shows no major differences between the males and the female respondents. Out of the 57 respondents who were aware about the policies taken by HCs and HUMCs, 29 respondents (50.9%) were males, while 28 respondents (49.1%) were females.

The analysis of respondents who are aware of health related policies taken by HCs and HUMCs by their level of education shows that out of the total 57 respondents, 48 respondents (84. 2%) had ever attended school, while only 9 respondents (15.8%) had never attended school. This is likely to imply that the level of awareness about policies taken by the HCs and HUMCs is high among these who have ever attended school compared to those who had never attended formal education. However, the seemingly high percentage of awareness among the educated is due to the proportionally high number of educated respondents in the sample. There was no observed significant relationship between level of education and level of awareness about policies of HCs and HUMCs [ $x^2 = 0.6306(p > 0.05)$ ].

The community members who were aware of the health related policies taken by HCs and HUMCs were further asked to mention at least one policy which had been made by either the HCs or HUMCs. The respondents were free to mention more than one policy. Out of the 57

respondents who were aware of the policies taken by HCs and HUMCs, 52 respondents (91.2%) mentioned that, sanitation and immunisation related by-laws had been formulated and passed by the HCs/local councils. These by-laws concern immunisation of children (punitive action against parents/guardians who don't take their children for immunisation), household sanitation (each household must have a latrine, utensils stands, bath shade and a soak pit), and health unit user fee exemptions for the terminally ill e.g., T.B Patients. This shows that HCs and HUMCs have initiated by-laws to improve community health. The by-laws regarding immunisation and household sanitation are highly preventive and health promotive in nature. This is one of the cornerstones on which PHC should be built. It also shows that the integration of HCs and HUMCs into the district and sub county health delivery systems is at least paying off in terms of disease prevention, health promotion, and equity of access to basic health services.

Out of 57 respondents who were aware of policies taken by HCs and HUMCs, 5 respondents (8.8%) mentioned the policy of community out reach and sensitisation by community health volunteers and health educators. It appears that the community members were not yet fully aware of this policy mainly because it has been little implemented. This is collaborated by findings from the FGDs of the HCs that show that lack of funds for facilitating community health volunteers and health providers to carry out community health sensitisation activities is one of the major obstacles towards implementation of this policy. Meanwhile 13 respondents (22.8%) mentioned other policies like; health facility expansion, having enough food, and protection of village water sources (wells). It is important to note the disease preventive nature of the health-related policies formulated by the HCs and HUMCs.

## **6.6 Conclusions.**

From the foregoing analysis and discussions, community member's level of awareness about LC I Secretaries for Health, HCs, and HUMCs and their associated roles and functions is relatively high. The HCs and HUMCs are also carrying out duties and passing policies that reflect PHC orientations. However, some of the major functions of the HCs and HUMCs as reflected in the updated rules and regulations governing local leaders and managers in district and sub-county health services have not yet been fully undertaken by HCs and HUMCs. A number of factors are

responsible, some beyond their control. Therefore the integration of HCs and HUMCs into the district health delivery system appears to be paying off, because the HCs and HUMCs are engaged in some roles and functions, and have passed policies that are largely disease preventative and health promotive in nature, despite attitudinal, economic and institutional challenges. The next chapter looks at the perceived impact of HCs and HUMCs in the delivery of PHC services at the local level.

## **CHAPTER SEVEN**

### **7.0 PERCEIVED IMPACT OF HCs AND HUMCs IN THE DELIVERY OF PHC SERVICES.**

#### **7.1 Introduction:**

This chapter presents findings from the survey, FGDs, and key informant interviews that relate to the perceived impact of HCs and HUMCs by community members. This chapter describes the community members perceived changes in the health delivery systems at the local level. The chapter also describes the community members' perceptions towards equity of access to health services and the socio-economic impact of HCs and HUMCs in the design and delivery of PHC services. The related findings from FGDs and key interviews are presented alongside the statistical descriptions. This chapter is in line with one of the objectives of the study, which was to establish the perceived impact of HCs and HUMCs by community members.

#### **7.2 Respondents' perceptions towards changes in the health delivery system at the sub-county level**

Survey respondents were asked whether they felt there was any improvement in the health services delivery partly as a result of the roles of HCs and HUMCs. Out of the 89 survey respondents, 61 respondents (68.5%) felt that there was an improvement in health service delivery as a result of the roles of HCs and HUMCs. Meanwhile 23 respondents (25.8%) felt that there was no improvement in health services delivery. Only 5 respondents (5.6 %) were indifferent. From a community members perspective, the integration of HCs and HUMCs into the district health delivery system has had a meaningful outcome for PHC services delivery. This is substantiated with the various reasons the community members mentioned to support their perceptions about improved PHC services.

The respondents who felt that there was an improvement in health delivery, were further asked why they thought so? The respondents were free to give more than one reason. Out of the 61 respondents (who felt that there was an improvement in health service delivery), 18 respondents (29.5%) reasoned that health services were always available at the health units. Also 7 respondents (11.5%) mentioned that health workers and local leaders often carry out home visits to advise on sanitation, immunisation and hygiene. In addition, 6 respondents (9.8%) mentioned that, health workers carry out outreach immunisation services at the parish level, instead of only parents taking their children to the health units. Also 40 respondents (65.5%) mentioned other reasons (as of basis for their perceived improvements of PHC services) such as; expansion and repair of health unit, reduced disease outbreaks, and household sanitation improvement. The observations of respondents are reflected in Table XVII below.

**Table XVII. Respondents reasons for perceived improvement in health services delivery.**

Reasons mentioned	Frequency	Percentage
Steady health services	18	29.5
Increased home visits by health workers	7	11.5
Expanded outreach immunisation services	6	9.8
Others (health unit repairs, reduced disease outbreaks e.t.c)	40	65.5
<b>Total</b>	<b>71</b>	<b>116.3</b>

**n=61 ( multiple responses were allowed)**

This is collaborated with findings from the FGDs and key informants in which it was reported that because of the constant supervision by HUMC members, the health providers at the health units had become more responsible to the communities they serve. The health units were now providing steady basic (though not completely adequate) health services to the community members. Also the user fee charges are partly used to address community health priorities at the health units like, the emergency purchase of essential drugs (such as anti-malarials) when the consignments from the DMO run out. These actions by the HUMC have ensured that the basic health services for the treatment of common ailments are constantly provided to the community

members. Also the secretary for health at the LC III is reported to play an indirect supervisory role over the health units and the HUMCs. This outcome is in **consonance** with one of the theoretical premises of institutionalised community participation in health services delivery at the local level. That is the argument that community participation can prevent abuse of health delivery facilities and inputs by health providers, among other outcomes.

As can be seen from the above descriptions, the integration of HCs and HUMCs into the health delivery system has had a meaningful outcome expected of PHC strategy. Most of the survey respondents felt that there was an improvement in health services delivery, partly as a result of the roles and functions of HCs and HUMCs. Only 23 respondents felt that there were no improvements in health service. This perception could be due to the following reasons. The unpopularity of cost-sharing scheme among some community members (especially the feeling that HUMCs have deliberately introduced user fees for their own gain and that without paying user fees one cannot be treated). Also the un cordial feelings towards some local leaders who are members of HCs and HUMCs (if such members are seen as non performers or considered as political opponents). Some community members may not be in a position to notice such changes in the health delivery systems (for example community members who rarely visit public health centres), and those who were forced to build toilets or close their homes due to lack of latrines.

The indicators of improvements of health services delivery among community members appear emphatically to be; constant availability of health services at health units and repairs at the health unit. This implies that, the outcome of institutionalised community participation (through HCs and HUMCs) in health services delivery has been strongly felt at health units. This is corroborated with evidence from the sub-counties health plans. For example all the sub-counties in the study area had planned for the extension of health units, while the eastern division of Mororo municipality had planned for first AID clinics in all wards (LC II) of the division. The improved health services also suggest that, health workers have become more responsible and accountable to the communities they serve, as a result of monitoring by HUMCs and additional motivational allowances from the user fee charges.

### **7.3 Community member's perceptions towards equity of access to health services**

One of the principle premises of PHC theory is social justice. This assumption is derived from the fact that PHC calls for a number of support activities outside the traditional health sector. For example, contributions from agriculturists, community development workers and water officers among others. It is envisaged that this holistic approach together with community participation will heighten the levels of access by community members to basic social services. Community participation is also thought to heighten community sense of ownership and demand for social services. This is the notion of social justice as proposed in the PHC theory. This proposition should be also reflected in the equity of access<sup>10</sup> to health services by all community members.

Therefore, survey respondents were asked whether there were some community members who were benefiting more from the improved health services. Interestingly, out of the survey 89 survey respondents, 58 respondents (65.1%) agreed that, there were some community members who were benefiting more from the health services than others. Meanwhile 25 respondents (28%) felt that there was equity of access to health care as long as one was sick. Only 6 respondents (6.7%) were indifferent. These descriptions show that, there is at least, a feeling of unequal benefit from the improved PHC services among some community members.

The 58 survey respondents (who felt that there was inequity of benefit from PHC services) were further asked to identify categories of persons who were benefiting more from health services. 20 respondents (34.5%) mentioned those who can pay for health services (users fee charges), while 13 respondents (22.4%) mentioned women and children. Lastly, 24 respondents mentioned other people like, those who live near the health units or are friendly to health personnel and HUMC members of particular health units. The factor of user fee charges may discriminate against some members of the community from seeking medical attention. This is because some members may afford the user fees while others may not. However, the HCs and LC III councils from Kwapa and Kisoko sub-county had passed ad-hoc user fee exemptions for the terminally ill and the very

---

<sup>10</sup> Equity of access refers to the belief that all community members shall have a reasonably equal chance of seeking medical attention from the public service centers in the community.



poor in the community. That is, the terminally ill patients like T.B and AIDS victims are allowed to access free medical services at the health units. It appears though, that this provision of user fee exemptions to the terminally ill patients is not widely known by community members.

The view that women and children are benefiting more from the improved health services is not surprising. This is mainly due to the fact that women (because of their reproductive and nurturing roles) are more likely to frequently seek for health services compared to the men. Also children, because of their age and less developed natural immunity are more prone to infection than adults, consequently, children are also more likely to frequently seek medical attention than adults. The children may not seek medical attention alone. The mothers often accompany their sick children, to health units. It is not surprising therefore, that community members see that women and children, are benefiting more from the health services compared to other members of the community. More importantly, this trend of health seeking behavior points to the challenge of establishing adequate mother and child care facilities. This is because it is an essential element of PHC given the described epidemiology of disease among women and children. It is plausible to argue that, equity of access to PHC has been provided for by HCs at the various sub-counties in the study area. The community members' perceptions about equity of access relates more to issues of benefit from, rather than actual restrictions of access to health care services at the sub-county level.

#### **7.4 Perceived Social-economic changes in the lives of community members.**

Survey respondents (who felt that there was an improvement in health care delivery) were further asked to mention the social-economic changes that had occurred in the lives of community members, as a result of the improved health services. Out of the 61 respondents (who felt that there was an improvement in health services), 35 respondents (57.3%) mentioned improved community members' health, since the health workers and community leaders had mobilised the community members to improve on household sanitation, take the children for immunisation among other reasons. Also, the health centers were providing the treatment for common ailments hence community members did not have to travel long to either Busolwe or Tororo hospitals (reduced burden of disease), and reduced disease outbreaks, such as cholera and measles.

Meanwhile, 5 respondents (8.2%) reported savings on health expenditure (since the health units were now providing steady and subsidised services) there was no great need of travelling long distances to Busolwe or Tororo hospitals or even to private health centers). Also, 21 respondents (34.5%) mentioned other socio-economic changes like improved household sanitation and knowledge on health issues, personal hygiene, hence a better household health situation. These observations are demonstrated in Table XVIII below.

**Table XVIII. Perceived socio-economic changes by community members.**

Socio-economic changes	Frequencies	Percentages
Perceived improved community health	35	57.3
Savings on health expenditure	5	8.2
Other changes	21	34.5
<b>Total</b>	<b>61</b>	<b>100</b>

**n =61**

Whereas it is too early to speculate on the concrete impact of integration of HCs and HUMCs into the health delivery system, there is evidence to suggest a positive outcome. As can be seen from the above descriptions, there have been some positive social-economic changes in the lives of community members, partly as a result of the contribution of HCs and HUMCs in PHC delivery. The reduced burden of disease is reflective of the ability of health units to offer steady health services (not necessarily completely adequate) partly due to the monitoring and supervision by HUMCs. This makes health providers accountable and responsible to the communities they serve. The reduced disease outbreaks (such as cholera, measles) can be partly attributed to the mobilisation of communities (by HCs, LCI secretaries for health and other local leaders) to respond to immunization and observe proper household sanitation as advised by health personnel. These trends of social-economic outcomes are indicative of the central role of institutionalised community participation in PHC services design and delivery.

## 7.6 Conclusions

This chapter has presented study finding about the perceived impact of, and problems experienced by, HCs and HUMCs. The majority of survey respondents felt that, there was an improvement in health services delivery, partly as a result of the roles and functions of HCs and HUMCs. The improvement of health services delivery at the LC III level has been strong felt in terms of steady health services provision at health unit and the expansion of health units. However, over 50 of the respondents felt that some community members (those who can afford user fee charges, women, children etc.) were benefiting more from the improved health services. This is not to conclude that there is not equity of access to health services. This is because, some HCs and local council IIIs had passed ad-hoc user fee exemptions for people like, the terminally ill and very poor in the community. Perceived social-economic changes in the lives of community members (as a result of improved health services) include; reduced burden of common diseases like malaria, savings on health expenditure and better health to community members. The next chapter looks at the challenges and opportunities for PHC delivery at the local level.

## **CHAPTER EIGHT**

### **8.0 OPPORTUNITIES AND CHALLENGES FOR PRIMARY HEALTH CARE DELIVERY IN TORORO DISTRICT.**

#### **8.1 Introduction**

This chapter presents findings from focus group discussions and key informant interviews that relate to opportunities for and challenges to PHC design and delivery at the district and sub-county levels. This chapter describes the respondents' views about the institutional opportunities that exist for PHC delivery in Tororo district and the challenges that militate against effective PHC delivery. This is in line with one of the objectives of the study, which was to assess the factors that facilitate and militate against effective PHC delivery.

#### **8.2 Opportunities for PHC delivery.**

A number of institutional opportunities exist that can be exploited to enhance PHC delivery. These opportunities have been described at the district and sub-county levels. The FGD participants were asked which factors and institutions have been and, could be exploited to enhance effective PHC services design and delivery. Their responses and interpretations are described in the following paragraphs.

##### **8.2.1 Local council administrative framework and sectoral committees**

The FGD participants reported that, local council leaders at the village and parish levels can be instrumental in the mobilisation of community members towards preventive and promotive health activities. It is reported that, local council leaders especially the chairpersons and secretaries for health at the village levels have been very active in mobilising parents and guardians towards the immunisation of children. The LC I secretaries for health are also instrumental in educating the communities about, and the enforcement of, health related

by-laws. Focus group participants also reported that PHC related information and policies can easily be transmitted from the LC III level (the sub-county), through parish councilors to the village level (LC I). Information from FGDs indicates that, the parish councilors to the LC III council had presented the health priorities of their respective parishes to the sub-county council. These parish health priorities are then intergrated into the overall sub-county health plans. Sub-county councilors to the district council are also reported to play the same role at the LC V level. Therefore, the local government leadership can provide the necessary local policy framework for inter sectoral collaboration and supervision for PHC services delivery.

*“ Local councils leaders at the various levels are very instrumental in implementing the decisions of the sub-county councils and parish councils. Also, most councilors try as much as possible to draw the attention of sub-county councils to the problems of their respective areas”*  
*(FGD participants-Kisoko sub-county)*

These observations from FGDs and key informants are collaborated with evidence from the survey findings that indicate that, the LC.I secretaries for health are very instrumental in the mobilization of community members towards health preventive and promotive initiatives. Consequently, decision making and planning at higher levels of leadership will strongly reflect the concerns of lower local levels. There is evidence from the documents from the DMO that indicates that, some of sub-county health plans have been integrated into the overall district health plans.

### **8.2.2 User-fees collected at the health units and locally retained revenues**

The user fees charged at each health unit, is a financial opportunity that is used to partially maintain the health facilities. According to HUMCs members who participated in FGDs, the user-fees are used to purchase essential drugs like anti-malarials, especially when supplies from the MoH and DMO run out. This helps to ensure constant basic health services to patients suffering from common ailments such as malaria. The user-fees are also used to purchase

recurrent items like, paraffin (for lighting and sterilizing medical equipments), detergents, emergency repairs (which can't wait for the lengthy bureaucratic response from the district), and motivating the health unit staff. In addition to user fees collected at the health units, it was reported by the HCs members that, the sub-counties retain 60% of the locally raised revenues. Some of these funds are used for some PHC activities. Some of the retained revenues are remitted to parishes and villages and can be used for mobilisation of community members towards PHC initiatives.

*“ most of the funds collected as user fees at the health units are used for to purchase essential drugs when supplies from the DMO run out. The drugs are purchased on the recommendations of the DMO” (key informant-Kisoko sub-county).*

### **8.2.3 Central government and donor support**

Key informants at the district observed that, beginning with the 1998/99 financial year, central government had increased PHC funding by over 500%. That is from shillings 93,125000 in the 1997/98 financial year, to shillings 1,884,270.000 in the 1998/99 financial year (also see Tororo district health plan, 1997/98). If these funds are adequately and timely transferred to the local governments, and locally approved plans of PHC developed, a significant number of start up PHC activities can be supported. This observation is substantiated with evidence from the records of the district revenue and expenditure estimates. The key informants at the district level also observed that the district enjoys a substantial donor funding towards PHC activities, without which little would be achieved.

*“ without donor support we would have only empty health units or purely private public services” (male key informant-the DMO Tororo).*

### **8.3 Challenges to PHC delivery**

The FGD participants mentioned a number of challenges that affect the effective delivery of PHC services. These challenges range from economical, legal, financial and political factors.

These challenges have been described at the district, sub-county and villages levels in the subsections that follow.

### **8.3.1 Funding and resource mobilisation for PHC services**

All the FGDs participants and key informants mentioned lack of adequate funding for PHC as the biggest challenge to effective PHC delivery. Key informants and FGD participants observed that, the financial resources for PHC services available at the sub-county level are too little to have a sustainable impact on PHC services delivery. This observation is substantiated with evidence from the records of the sub-county budget estimates. The records of sub-counties expenditure estimates show a low level of financial commitment towards PHC activities and about 1% actual spending out of the budgeted amounts. For example, in Kisoko sub-county budget estimates for 1998/99 financial year, shillings 2,298,500 (3.7%) was budgeted for essentially PHC services, but only 0.37% had actually been spend on PHC services by the third quarter of the financial year. Also according to the 1997/98 budget estimates, only 3.5% of the sub-county expenditure was budgeted for PHC services, but only 1.3% was actually spent (see Kisoko-sub-county the recurrent and capital estimates, 1998/99, 1997/98).

Also, financial records from the Eastern division of Tororo-Municipality, show that out of the 100,988,750 shillings budget for the 1998/99 financial year only 5,060,236 shillings was budget for PHC and general health care services. This is only 5% of the total divisional budget. Though the records of expenditure were not readily available to the researcher, information from key interviews indicates that, the expenditure on PHC activities is far less than was originally budgeted for(see Eastern division recurrent and capital estimates, 1998/99 Tororo municipality). These PHC budget allocations and expenditures compare unfavorably with other budget items such as; general administration (58%), local council expenses (18.3%), technical services and works (18%). The budget analysis of five other sub-counties in the district (Buhehe, Butaleja, Lunyo, Mole and Paya) in the 1996/97 financial year, shows a similar trend of budget allocation for PHC services. The health sector in general, in all the above sub-counties consumes an average 4% of the total sub-counties budget. This allocation compares poorly with the averages

of other sectors like, the general-purpose vote (49%), technical services and works (27%), and, 19% for education (see DDP, 1994-1997).

***“ Our biggest problem as the HC is adequate and timely funding to implement our plans”  
(FGD participant, Eastern Division-Tororo Municipality).***

This trend of financial commitment to PHC is likely to compromise the already under funded PHC activities and consequently affect the desired outcome. The FGD participants and key informants at the sub-counties mentioned that, the discrepancy between PHC budget allocations and actual spending is mainly a result of low tax base and unanticipated revenue shortfalls. These revenue shortfalls also negatively affect the desired outcomes of the PHC strategy.

Key informants at the sub-county level were asked why there were low budget allocations to PHC services. The over whelming response was that, the health sector (health units inclusive) receives direct substantial resource support from the DMO and other agencies. Therefore, there is little demand on the part of sub-counties’ leaders to commit some of the already little resources to the health sector in the face of other pressing demands. It appears that this kind of reasoning is ensconced in minds of political leaders in all the sub-counties of the study area. Whereas this kind of reasoning may make economic sence, it has implication for the sustainability of PHC activities in the event of shortfalls of resource support from DMO. The researcher could not readily access financial records from Kwapa sub-county for reasons beyond his control.

Key informants at the district level observed that the district treasury does not make any financial commitment from the locally raised revenues-save for the little funds committed at the sub-county levels.

***“the district treasury hardly makes any contributions towards health services from the locally raised revenues apart from the period of cholera outbreak”(male key informant-Tororo DMO).***



The lack of financial commitment to PHC by the district (from the locally raised revenues) implies that, there is no potential in the district for internal replicability of PHC activities if external donor funding is withdrawn. Even when central government support is seriously altered (as it usually happens in the fiscal relationship between the center and the district), the district cannot master resources to shake off such an effect<sup>10</sup>. Consequently when donor funding is withdrawn from particular PHC activities, then such activities have to come to a standstill. The same arguments can be raised about central government support. For example, UNICEF in 1996, withdrew funding for the control of diarrhea diseases (CDD), putting the activity on hold, until when the recent cholera outbreak demanded financial recommitment to resume massive public health campaigns on sanitation.

The PHC strategy should be looked at as system (as the theoretical premises of the PHC approach suggest). When one essential activity is stopped, the PHC delivery system becomes disjointed and loses its integrated and holistic approach. It also implies that certain essential PHC activities such as public health education on sanitation will be given the necessary priority when there is only an emergency outbreak of disease. Yet the need for a disease free environment (partly through public health education) has all along been there. The concepts of disease free environment (through prevention and control) and health promotion should be critically considered as the building blocks of PHC delivery system, among other considerations.

Key informants at the district headquarters also mentioned that donor funding to the district health programs is often accompanied by stringent conditions of counterpart funding, which at times the district cannot fulfill. The key informants further reported that, as a result some PHC programs have remained incomplete since the district has failed to accomplish its part. For example the District health support program funded by DANIDA, had an element of counterpart funding for the construction of a maternity unit at Kwapa health unit. However, due to lack of counterpart funds from the district treasury as well as from the sub-county, the structure is incomplete, two years after donors fulfilled their part.

---

<sup>10</sup> This is a similar observation made by Maclure (1991), and Weillers (1990) in their studies about decentralisation and community participation. Their general observation was that in return for a greater role in decision making about social services, communities are expected also to express a strong sense of commitment towards generating additional resources for decentralised services. In a number of situations, this may not be possible.

Also, the key informants mentioned that, some donor funded PHC programs can not be sustained by the district once external funding is withdrawn. When asked as to what would happen to such programs at the end of donor sponsorship, the key informants at the district observed that, most likely such PHC programs would collapse if the central government failed to take over such responsibilities. The key informants gave examples to substantiate their observations. The eye treatment program funded by LIONS AID-NORWAY, is not fully integrated into the district and sub-county health delivery systems. Field eye surgeons are contracted by the project headquarters in Kampala, who then visit rural health units, on days scheduled by the DMO. This arrangement is a serious compromise to sustainability of such programs within the district. Also, the RESCUE (rural ambulance) program funded by UNFPA and coordinated by population secretariat, is too expensive for the selected pilot sub-counties, once donor funds for recurrent expenditures are withdrawn. Especially, the servicing and maintenance of equipments like vehicles and radio transmitters.

### **8.3.2 Fiscal relationship between the sub-counties and the district.**

All the key informants at all the sub-counties reported that, the district does not readily and adequately remit the revenues due to the sub-counties. Similar concerns were mentioned by the key informants and FGD participants from the eastern division of Tororo municipality. For the case of eastern division of Tororo municipality, the situation has necessitated the local council III leaders to seek the intervention of the local government minister before the municipality remitted some funds due to the division. The key informants and FGD participants concluded that, because of this uncordial fiscal relationship between the sub-counties/division and the district/municipality the sub-counties/division cannot effectively and timely implement their plans. This has negatively impacted on the role of the HCs and other related sectors, in the provision of PHC services. One key informant summed up the situation as,

***“Somebody in the center (municipality) has not known his/her roles.”***

***(female key informant-Eastern division Tororo municipality)***

Consequently, the division/sub-counties do not also, regularly send the mandatory 25%, and 10% of revenues to the villages and parishes respectively. The roles of parish and village councils (the LC I health secretaries for health inclusive) are equally affected. Though counter-mechanism to resolve such situations have been outlined in the Local government Act 1997(see section 86 and schdule 5), it requires a significant amount of political and financial muscle for the division/sub-counties to challenge the status quo. Because of this situation, the divisional HC members estimate that, only 1/3 of their annul plans could have been implemented by the end of the 1998/99 financial year. This kind of fiscal relationship is collaborated with evidence from the survey in which community members mentioned that one of the problems faced by HCs and HUMCs was that, local leaders at the different levels tend to quarrel amongst themselves largely over financial resources.

Key informants at the district observed that, the central government at times makes unexpected changes in the amounts of financial resources transferred to the district. This practice affects the DMO capacity (and consequently the sub-counties capacities) to effectively implement its PHC plans, according to schedule. This observation is substantiated by findings of Kullerberg and Porter (1998)<sup>11</sup>.

### **8.3.3 Limiting legal provisions.**

The HC members in the FGDs reported that they are (like other local government councils and committees) constrained by the Local government Act, 1997 schedule I, in the transactions of their business. Schedule I of the Local government Act, 1997 limits all local council governments to call and attend meetings whose allowances for members do not exceed 15% of revenues raised in the previous financial year. The HC members observed that, because of this legal requirement they can meet for an average of three times a year-except in emergency and voluntary circumstances. Whereas this is a good control measure on the part of spending of local councils, it affects the performance and contribution of HCs towards PHC planning, monitoring,

---

<sup>11</sup> Kullenberg and Porter (1998) in recent evaluation of decentralization in Uganda point to incidents of reluctance by central government in its commitment to decentralized services. For example central transfers fall short of Local requirements, unconditional grants are arbitrarily cut and funds abruptly with drawn from certain services. Abrupt changes are also made in modalities of fiscal transfers to local government.

and delivery. It was reported from FGDs that, the HCs cannot therefore regularly meet, nor regularly monitor the delivery of PHC services in the sub-county. Even the kind of voluntarism that this legal requirement may create, on part of HC members, is not sustainable in the longrun. It is not surprising therefore, that some local councils flout this requirement. This is substantiated by evidence from the analysis done by the MoLG for the 1998/99 financial year which revealed that, only 3 out of 34 districts which had submitted their accounts budgeted with in this legal requirements (see MoLG. Financial analysis of district budgets and estimates, 1998/99).

#### **8.3.4 Lack of constant supervision and support for PHC activities**

Key informants at the district mentioned that, because of lack of adequate manpower and funding at the district headquarters, it was quite difficult for the DMO to provide the necessary supervision and support to lower health units, HCs, HUMCs and other PHC related activities at the sub-county and villages levels. The key informants reported that, for over one year, community health volunteers had not received their transport facilitation allowances. Consequently, some of the PHC outreach activities were very low. This observation is collaborated with evidence from the records at the DMO. The records show that due to lack adequate supervision, some field health workers fake up activity reports sent to DMO. For example between 1995-1996 field data indicated the following rates for immunization: BCG = 72.3%, Polio = 41%, DDT<sup>3</sup> = 39%, measles = 42%, TT ½ for pregnant mothers = 45.2%. But shortly after, in 1996 there was an outbreak of measles and consequently a survey was commissioned. Findings from the follow up survey indicated that the actual figures were below those reported by field staff. BCG was 52.9%, Polio = 32%, DDT<sup>3</sup> = 32%, measles = 26%, TT ½ for pregnant mothers = 13% (Tororo district health report, 1996). Therefore, lack of continued supervision and support may affect the morale, integrity, and performance of field health workers in PHC delivery.

#### **8.3.5 Lack of inter sectoral collaboration and capacity building**

The FGDs participants and key informants were asked whether there was any significant collaboration between the PHC related departments (such as water, community development,

agriculture, education e.t.c) at the sub-county and district levels. The general response from the FGDs and key interviews was that, the collaboration is not always but seasonal and intermittent. The key informants at the sub-counties and the district observed that there is collaboration between the health sector, water department and RUWASA program. There was also reported collaboration between agricultural department, health department and community development department, during the first half of the unified agricultural extension project, in areas of family life education (this collaboration stopped with the end of the project). There was also reported collaboration between health units, HCs, HUMCs, political leaders, and administrative heads during the recent cholera outbreaks (this collaboration is also no more). Such seasonal and disjointed collaboration points to lack of policy initiative from the central government and districts to promote inter-sectoral collaboration in the field of PHC delivery. Such a situation compromises the unified approach expected of the PHC strategy. However, the potential for developing and strengthening inter-sectoral collaboration exist both at the district and sub-county levels. The key informants recommended that the sub-county chief and the CAO as heads of civil servants can provide the coordination needed to foster inter-sectoral collaboration. It should be noted that the re-orientation of health services to PHC implies a high degree of flexibility and adaptation to local demands in such long established PHC related but largely bureaucratic departments.

The HC members and key informants at the sub-counties reported that there was also lack of meaningful collaboration between NGOs and the local leadership. A number of non-governmental organizations exist in Tororo district that deal in PHC related activities. These include; Sasakawa – Global 2000 (food and nutrition), Africa network 2000 (food security), UNDP initiative to combat AIDS (public health education and family planning). A number of NGOs receive government funding through the district health services project (DHSP) coordinated by the DMO. These include Adhola Chingi Maromo (maternal and child care education), Church of Uganda-Bukedi diocese (reproductive health and family care support). Though these NGOs had registered their presence with the respective sub-counties, the key informants at the sub-counties expressed ignorance over the actual activities being implemented by some of these NGOs. It is reported that it appears the DMO carries out regular monitoring and supervision of NGOs. The village local leadership is only used to mobilize the community

members to respond in large numbers to the NGO initiatives. This is likely to lead to community participation as a means (managerial technique) rather than community participation as an end (community empowerment).

*“ Once these NGOs report their presence to the sub-county leaders, most of them rarely come back to inform the council about the progress of their activities. Also the sub-county leaders don't compel the NGOs to report back on their activities” (FGD participant- Kwapa sub-county).*

Key informants at the sub-counties/division observed that, there is a tendency among the local leaders to sideline programs that their predecessors had already embarked and they initiate programs completely new programs. This is mainly due to political opposition reasons. Therefore the sustainability of some the health programs is affected by such political behavior, and yet there is little the technocrats at the sub-counties can do to remedy the situation.

The HCs and HUMCs members were asked during FGDs to mention one of the needs necessary to enhance their performance. Key informants were also asked the same question. The general trend across FGDs and key interviews indicates a great need for capacity building among HCs and HUMCs members, especially in administrative, planning, and budgeting skills. The HCs and HUMCs members also mentioned that, key health personnel like, the in/charge of health units and sub-county health personnel, also require training in such skills. The HCs and HUMCs members also mentioned that, they need support in terms of guidelines to follow, when executing their roles and functions.

#### **8.4 Conclusions**

This chapter presented findings about the factors that facilitate and or militate against effective PHC services delivery, at the sub-county and district levels. This chapter described the institutional opportunities that can be exploited to enhance PHC services delivery. These opportunities include; institutionalised community participation (the HCs, local leaders and HUMCs) through effective planning, supervision and monitoring of PHC services at the local

levels. The user fee charges and local revenue retained at respective levels of local units, a central government re-commitment to re-orient health national services to PHC through increased funding, and a substantial donor support at district level. The challenges to PHC delivery described include; lack of adequate financial commitment to PHC services at the sub-county level and district levels, lack of potential for internal replicability of PHC services once donor funding is withdrawn or central government support altered, the uncordial fiscal relationship between different levels of government, and at times limiting legal provisions, and lack of adequate support and supervision from the district to the sub-county HCs, HUMCs and health units staff and, lack of capacity building for the HCs, HUMCs, health technocrats and other local leaders.

# CHAPTER NINE

## 9.0 DISCUSSIONS

### 9.1 Introduction

The chapter presents the discussions of the researcher about the findings of the study. The discussions are presented according to the chapters of the findings and in relations to the objectives of the study. The researcher also discusses the implications of the findings in relation to the theoretical premises of the comprehensive primary health care school of thought and the assumptions about decentralisation (through community participation) of health services delivery to local governments.

This study sought to establish the extent to which institutionalised community participation (through HCs and HUMCs) in PHC design and delivery, was meeting its expectations. In particular the study established and assessed the roles, functions, challenges, HCs and HUMCs in the design, organization and delivery of PHC services at the local level. This study was informed by the CPHC school of thought, especially its assumptions on the central role of community participation, the transfer of authority and inter-sectoral collaboration in PHC services delivery.

### 9.2 Socio-economic opportunities and the nature of Community Participation

This study has demonstrated that institutionalised community participation (through HCs and HUMCs) in PHC delivery can have a meaningful outcome for service delivery. However despite the political empowerment of communities members have been exposed to, the study has demonstrated that educational and occupational opportunities can have implications for the nature of community participation in, and resource mobilisation for, PHC design and delivery. This situation is highly reflected in rural areas. For example in Kisoko sub-county, due to the nature of educational and occupation life chances the community members have been exposed to, the sub-county councillors, including the appointing authority feel that to chair the sub-county HC, one must have a background training in health issues, yet this is not a legal requirement.



Since all the councillors in Kisoko sub-county don't have such a health background, the HC is non-functional and LC III council generally makes the health-related decisions, where possible.

It is therefore plausible to argue that, structures such as HCs and HUMCs may be set up to foster community participation in PHC delivery, it is no guarantee that such opportunities shall always be exploited by the community members, although willing. This arises from the perceptions held by the local leaders as regards their competence for such roles, but more significantly from the social-economic life chances these communities have been exposed to. The employment opportunities of communities in rural areas also affects resources mobilization for PHC services at the local level. Lack of meaningful employment for the residents will compromise the sub-counties' tax base. This will consequently affect the sub-counties capacity to implement its PHC plans. That is why all the sub-counties visited reported local revenue short falls, especially from graduated tax. Such situations also negatively affect the roles and functions of HCs and HUMC, among others.

The study also demonstrated that most community members were aware of roles and functions of LC I secretaries for health, HCs and HUMCs. Also, the HC and HUMC members were comfortably aware of most of the roles and functions. These are the indicators of the fact that LC I secretaries for health, HCs and HUMCs have been engaged in PHC related roles which are known to the community members. It is significant to note that, the level of awareness spread across sex, education, age and the sub-counties (location). It is plausible to argue that from a community members' perspective the integration of HCs and HUMCs into the health delivery system at the sub-county level has had a meaningful outcome for PHC delivery. The LCI secretaries for health, HCs and HUMCs have be engaged in roles that are essentially health promotive and disease preventive in nature. It is also likely that this level of awareness about LC I secretaries for health, HCs and HUMCs is due to civic education which preceded local councils election in 1997, the fact that, the local council system has been in Uganda for the past 13 years, and the system is spread right from the village level to the district level among other reasons.

The study also demonstrated that critical roles such as resource mobilisation and the development of strategies to solve community health problems have not been strongly

undertaken by HCs and HUMCs. The practice of planning among HCs and HUMCs is relatively new. This situation is also exacerbated by the lack of skills by health technocrats at the sub-county level and the nature of life opportunities the HC and HUMC members have been exposed to. Therefore whereas the HC and HUMC members may be comfortably aware of most of their roles, their skills to perform such roles affects their actual participation in PHC design and delivery. Lack of adequate skills in planning, resource mobilisation and evaluation of health care services by health technocrats especially in rural health units will equally affect the desired outcome of institutionalised community participation in decentralised health (PHC) services at the local level. It is the researcher's opinion that the decentralization and re-orientation of health services (health system reform) should be significantly matched with adequate capacity building initiatives at local levels. Especially in skills that related to the roles that the decentralisation process places upon local leaders in PHC delivery.

This study demonstrated that, whereas institutions for community participation (Such as HCs and HUMCs) had been set up, it is also necessary to have corresponding participation frameworks at the local levels. Otherwise, this will negatively affect the desired outcome of community participation in PHC delivery. For example, the eastern division of Tororo municipality does not have a health unit, hence the establishment of HUMC does not make sense. Therefore, the lack of social services structures in which community members are supposed to participate will definitely affect the assumed contribution of institutions like HUMCs. It is pertinent to argue that at each level of local governance there should be corresponding health service structures for the participation of HUMCs.

### **9.3 Health related plans of HCs and HUMCs and PHC orientation.**

This study established that all HCs and HUMCs had formulated some health related plans. Most of the health related plans had PHC orientation. Also by-laws regarding household sanitation and immunisation of children has been made. This shows that, the institutionalisation of community participation (through decentralisation) in health service delivery can lead to the meaningful identification and prioritisation of local health problem and solutions. There is also evidence to the effect that sub-county health plans had been integrated in the district annual health plans.

However, some of the essential PHC elements are missing from the sub-county health plans. For example, the element of nutrition. This compromises the integrated approach expected of the PHC strategy. Also, the health related plans appear quite ambitious, given the financial and other resources at the disposal of the sub-county. Therefore, it is not surprising that there is a wide discrepancy between the plans and the actual implementation. This study established that, there is a tendency among all sub-counties to emphasize the expansion of health facilities. This thinking is based on the fact that there is a substantial number of clients at the health units. However it is also true that a large number of these patients suffer from mainly preventable ailments. To the HUMCs, the large number of patients appears to give an impression for the need for more health facilities and curative services. Therefore fewer resources are likely to be devoted to preventive and promotive health initiatives at the sub-county level.

It is the opinion of the researcher that the decentralization and re-orientation of health services should be matched with a considerable degree of guidance by central government and other stakeholders, to HCs and HUMCs about PHC planning and prioritisation. The researcher is inclined to quickly add that, the decentralization of responsibilities for PHC delivery to sub-counties should be matched with transfers of reasonable resources from the centre to the district, for onward transmission to the sub-counties. There is a high level of centralisation of resources at the DMO, with no direct financial support from the DMO to HCs and HUMCs at the sub-county level. It is necessary that the DMO supports PHC related activities initiated by local leaders though outside the health sector of the district. Without adequate transfer of resource to sub-counties, the decentralisation process may turn out to be a component of system redress and a handmaiden reinforcement of a floured state institution. For example, the centre may shed off its responsibilities for service delivery under the guise of decentralisation. The district may shed off some of its responsibilities under the guise of giving autonomy to the sub-counties.

#### **9.4 Health infrastructure and implications for community participation**

This study has established that the dencentralisation and re-orientation of health services to PHC can be negatively affected by the nature and distribution of health infrastructure at the local

level. For example the district is overstaffed with supportive staff (nursing aides) and understaffed with approved qualified medical staff (see DDP, 1994-1997). It is also most probable that, some of the qualified medical personnel such as doctors and medical assistants may not be willing to work in rural areas. The rural areas are disadvantaged in the distribution of health personnel. The PHC strategy demands that most of the health officers at health units and sub-counties, become change agents and facilitators for HCs and HUMCs in planning, budgeting and evaluation activities. In some sub-counties especially in rural areas this may not be possible, due to the nature and skills of health personnel found there. It is plausible to argue that the decentralisation of health services does not only call for institutionalised community participation, but the radical redistribution of health personal especially to marginal rural areas. Due to lack of adequate staff and resources at the DMO, the needed support and supervision to health units has also been affected.

## **9.5 Opportunities of PHC delivery**

This study established that a number of opportunities exist that can be exploited to enhance the delivery of decentralised (PHC) health services. The local councils and committee structures were mentioned as viable and practical vehicles for the mobilisation of community members towards PHC initiatives. For example, the lower level local councils can identify health problems in their areas. These identified problems can then be integrated into the health plans and priorities of higher level local councils. Also the recommendations of the higher local councils can be effectively communicated to community's members through local councils structures. What is important and challenging is the guided process of capacity building among the local councilors (HCs and HUMCs) in matters of their community health. The emphasis should be placed on promotive and disease preventive initiatives.

The study also established that user-fees and locally retained revenues at the sub-county levels are the only sources of revenue for the sub-county PHC initiatives. The funds committed to PHC activities at the sub-county level are too little to have a sustained impact on health services delivery. The user fees may be unpopular among some community members. Nonetheless, the user fee charges have been instrumental in the purchase of essential health unit inputs in the

event of short falls of supplies from the DMO and other agencies. Whereas it is plausible to argue that user-fee charges may prevent some community members from seeking health care (thereby undermine the equity principle of PHC), its use and significance towards facilitating steady health care provision at the health units outweighs this negative perception. It is also important to note that HCs and HUMCs had formulated use fee exemption policies for the terminally ill and very poor in the communities. These exemptions are reflective of the idea of equity of access to health care services.

This study also established that the district enjoys a substantial central government and donor financial and resources support for health services. For the 1998/9 financial year, the central government increased the PHC funding to the district by over 500%. This observation is in line with the PHC premise that health system reform should be matched with a significant transfer of resources from the centre to the local levels. However, it is also evident that there is a high degree of centralisation of responsibilities and resources at the DMO, with no direct financial support to the sub-counties. The donors contribute 82% of the total district health budget. It is quite evident that with out donor support, little could be achieved in PHC delivery. This situation raises important questions about the sustainability withdrawing then support to the district.

## **9.6 Challenges to PHC delivery**

This study established both from the survey respondents and key informants that the major challenges for PHC delivery at the local levels were resource mobilisation and funding. This observation is also raised by a number of academicians like Kullenberg and Porter (1998), Adome *et al* (1996). In all the sub-counties visited there was a very low financial commitment towards PHC services. This is mainly due to the low tax base, unanticipated local revenue shortfalls, and sub-county leaders attitudes that the health sector enjoys direct material support from the DMO. It has been demonstrated in this study, that the roles of HCs and HUMCs are equally affected by the uncordial fiscal relationship between the sub-counties/division and the district headquarters/municipality. This uncordial fiscal relationship derails the sub-counties and divisions' initiatives in the timely and adequate collection of financial resources to support their planned PHC activities. The local government Act 1997 section 86 and schedule five outlines

clearly the nature of fiscal relationship and modalities of sharing of locally raised revenue. For example the Local government Act, 1997, says that, in Municipalities, 50% of local revenues is retained at the centre, while the other 50% is sent to the divisions. In rural areas, 60% of the locally raised revenues is retained at the sub-counties and 40% is remitted to the district headquarters. This study established that in a number of situations, this legal requirement has been violated by the district headquarters and the municipality. This situation has always demanded the local leaders at the LC III level, to seek the intervention of the Local Government Mminister before the district and municipality released some funds to the lower councils. This uncordial fiscal relationship between different levels of governance does not only affect the resources mobilisation of sub-counties, but also, the timely and actual implementation of PHC activities. According to some key informants from the Eastern division, number of PHC activities shall not be implemented by the end of the financial 199/99, largely due to lack of funds.

Whereas no one doubts the significance of donor funding, the nature and conditions of the funding process can in the long run become a challenge for PHC delivery. This study demonstrated that there is not internal capacity for replicability of donor funded PHC projects since the district treasury does make not financial contributions to the health sector of the district. Some of the donor funded PHC initiatives require counterpart funding which the district and sub-county can hardly fulfill. Also, some donors prefer sectoral and vertical financing of their projects and are reluctant to fully integrate their resources into the local governments planning and expenditure processes. For example, the Lions Aid- Norway funded eye treatment program, which has almost a parallel implementation structure to the DMO. It strongly appears that, there is a tendency for donors and central government ministries to negotiate PHC projects without regard to the impact of fiscally strapped local governments. For example the RESCUE (Rural ambulance) program funded by UNFPA and coordinated by the population secretariat is too expensive for the pilot sub-counties to manage once donor support ends. It appears that the negotiation of donor supported PHC projects with central government does not involve consultation of the district. Yet the district is a critical stakeholder in the implementation of such PHC programs. I wish to recommend that, the districts should be actively involved in the

negotiations of such donor funded PHC programs. This is a similar opinion shared by key informants at the district headquarters.

This study also established that HCs like other sectoral committees are constrained by the local government Act 1997 schedule 1 in the transactions of their business. That HCs and other local councils are required to call and attend meetings whose allowances for member do not exceed 15% of the local revenues of the previous year. The HCs members reported that they could only meet for three official times in a year or else it is voluntary. Therefore a number of things which require the urgent attention of HCs may go unresolved or unnoticed. Even the voluntarism that this legal requirement may produce on the side of HC members is not sustainable in the long run. Whereas this legal requirement is a good control measure on the spending of local governments, it does not take into consideration the fact that the tax base of some local governments is too low. Therefore, the 15% legal requirement is bound to lead to lack of meaningful transactions for local councils and committees.

The PHC strategy calls for not only re-orientations in health services delivery, but also a strong a significant contribution of departments outside the conventional health sector. Therefore community participation must go hand in hand with inter-sectoral collaboration, even in long established bureaucratic departments. This study established that there is no official policy framework on the part of the district and sub-county authorities (HCs inclusive) to foster inter-sectoral/NGOs collaboration. There was some reported seasonal but disjointed collaboration between the essential PHC related departments. This lack of steady collaboration compromises the unified approach expected of the PHC strategy, and consequently undermines the outcomes. However, the potential for developing and strengthening inter-sectoral collaboration exist both at the district and sub-county levels. The leaders of Civil servants (the CAO and sub-county chief) can provide the coordination needed to foster inter-sectoral collaboration.

## **9.7 Perceived impact of HCs and HUMCs in the delivery of PHC services**

This study established that the majority of community members (68.5%) felt that, there was an improvement in health services delivery, partly as a result of the roles of HCs and HUMCs.

Respondents observed that because of the steady supervision/monitoring by HUMC members there was a proper utilisation of user fee charges and a steady provision of basic health services at the health units. Other reasons mentioned for perceived improvements in health services delivery were home visits by health workers, outreached immunisation services, among others. This shows that the integration of HCs and HUMCs into the sub-counties health delivery systems has had a meaningful outcome for PHC services delivery. This outcome is in consonance with one of the CPHC theoretical assumptions that institutionalised community participation can prevent the abuse of health facilities, improve upon the responsibilities of health providers towards their clients and provide public accountability of health resources (see WHO, 1988; Hollinsteiner, 1982: 40).

Only 23 respondents said that, there had not yet been any improvement in health services delivery. This perception could be due to the unpopularity of user fees, which may be attributed to the HCs and HUMCs. Also some community members may not be in position to notice such changes especially those who rarely visit health centers or attend local councils meetings. Some community members may also have uncordial feelings towards some HC and HUMC members for a number of other reasons.

## **9.8 Theoretical implications**

The study was informed by the comprehensive primary health school of thought. This school of thought makes a number of theoretical premises about community participation in PHC delivery. Firstly, it recognises community participation as an empowerment process, in which constitutionally recognised structures are established and politically anchored in the re-oriented health delivery system (see Ransom-Kuti *et al*, 1991; Segall, 1983; WHO, 1988). Such institutions like, the LCI secretaries for health, HCs and HUMCs among others. However, the empowerment proposition suggested by the CPHC School of thought and in light of these study findings indicates whereas such that local institutions may be involved in active planning and decision making about PHC, their capacities for resource mobilisation are seriously constrained. That is why there is a wide discrepancy between the plans of HCs and HUMCs, and the actual implementations. It is important that the empowerment proposition be inclusive of both political



and economic aspects (Hollnsteiner, 1982; Ebrahim, 1988, Segall, 1983).

Secondly, the CPHC School of thought premises that, all essential PHC related elements such as nutrition, water and sanitation, community education, immunisation, and mother and child care, should be integrated under the PHC strategy (see WHO, 1988; and Mahler, 1981). The CPHC theory places a high premium on inter-sectoral collaboration. The study findings indicate that, whereas all PHC related sectors exist both at the sub-county and district level, the assumed inter-sectoral collaboration is only seasonal and disjointed. Therefore the re-orientation and decentralisation of health services to local governments should be matched with necessary reforms in other PHC related ministries. These reforms should be initiated by central government in partnership with local authorities. The emphasis should be placed on administrative flexibility and adaptation on the part of PHC related sectors within the district (see Ransome-Kuti *et al.* 1991). The district leadership should be assisted to develop administrative policy guidance by central government on the procedures of the inter-sectoral collaboration. The PHC strategy should be looked not only as health agenda but a social, economic and political consideration (see Ebrahim 1988). It is also important to recognise the fact that without adequate support of the centre and, a revision of the nature of donor funding, the assumptions of inter-sectoral collaboration may remain largely idealistic.

Thirdly, the CPHC school of thought assumes that, institutionalised community participation can lead to prevention of abuse of health facilities (see Mahler, 1981; Weillers, 1980 and WHO, 1988). The study findings indicate that this is largely possible. However, it can also imply a lot of other things to HUMC membership for example unwarranted interference in the medical practice of health providers at health units. Fourthly, the CPHC schools of thought assumes a general harmonious working relationship on the part of local leaders in PHC design and delivery. Study findings indicate that there are certain instances of lack of co-operation on the side of local HCs and HUMCs, and other leaders. For example, the uncordial fiscal relationship between different levels of local government compromises the roles and plans of HCs and HUMCs. It was also established that some NGOs overlook the necessity for integration of their PHC related activities into the lower local government plans, simply because they have been granted permission by a high level local or central government. Hence, undermining the very essence of

community participation (see Segall, 1983). Usually, the local leaders have nothing much they can do, to cause such NGOs to collaborate as required. Sometimes the local leadership may not know or does not feel that it is important to cause such collaboration on the part of NGOs.

The lack of adequate resources to implement the PHC initiatives and plans, makes the sub-county plans appear ambitious and idealistic. In such circumstances, some academicians would argue for selective PHC, in which only a few feasible PHC interventions are initiated and implemented (see Walsh and Warren, 1980, and Boland and Young, 1982). The researcher is reluctant to accept this theoretical proposition. In situations where insitutionalised community participation has been established and responsibilities of PHC delivery decntralised, the limitations of the CPHC strategy should be taken as challenges that can be overcome either in the short term and long term. The assumptions of the CPHC school of thought should also be looked at as aspirations to be achieved. A number of experiences in health systems reform to PHC from countries like Srilanka, Guatamala, Cuba have shown that this is possible (see Hollinsteiner, 1982 and Ebrahim, 1988). I have been tempted to quickly conclude that selective PHC strategy should be looked at as beginning point for CPHC approach.

## **9.9 Conclusion**

It has been shown that, the integration of LC I secretaries for health, HCs and HUMCs has had a meaningful outcome for PHC delivery. It has been also shown that, the re-orientation and decentralisation of health services does not only mean institutionalised community participation, but also a significant transfer of resources to the local levels, capacity building to community institutions, a redistribution of health infrastructure and a strong emphasis on inter-sectoral collaboration. A number of challenges for PHC delivery and perceived impact of HCs and HUMCs have also been discussed. The next chapter presents the summary and recommendations of the study.

# CHAPTER TEN

## 10.0 SUMMARY AND RECOMMENDATIONS

### 10.1 Introduction

This chapter describes the summary of the findings and recommendation of the study. The summaries are presented according to the previous chapters of the study. The recommendations of the researcher are presented alongside those of the respondents. The recommendations are presented in light of the opportunities and challenges for institutionalised community participation in PHC delivery at the local level, as mentioned by the respondents.

### 10.2 Summary of the study findings.

#### 10.2.1 Health sector and health situation in Tororo district.

A review of health related literature was undertaken at the district and sub-county headquarters. It was established that the health infrastructure in the district is characterized by uneven distribution, largely in favor of urban areas. All sub-counties of the study area had developed at least, some kind of health plan. Most of the planned activities of the sub-counties/division reflected PHC orientations and local health priorities. However, the financial commitment towards PHC activities at the sub-county level is extremely low. That is why there is a wide discrepancy between stated plans and actual implementation.

The district treasury hardly makes any contribution to the health sector from the locally raised revenues. A larger share (82%) of health funds comes from donors and 18% from central government. This situation has serious implications for the sustainability of donor funded PHC programs once external funding is stopped. Most of the top ten diseases that burden the communities can be largely prevented through the PHC strategy. The process of planning among

the HCs and HUMC is relatively new and not so well developed. There is a strong emphasis, in the sub-county and divisional plans for the expansion of health facilities, while certain essential PHC elements like nutrition have been under emphasised.

### **10.2.2 Socio-economic background of respondents.**

A gender representative sample was adopted for this study. This study established that educational and occupational opportunities are tilted in favor of urban areas. This has had negative implications for the nature of community participation in, and resource mobilisation for PHC delivery. It was reported that there are periodic shortfalls in anticipated revenues among the study sub-counties. This is largely due to lack of steady income generating opportunities for the community members in rural areas.

### **10.2.3 Community members awareness about the roles and functions of LC I secretaries for health, HC's and HUMCs.**

This study established that community members' level of awareness about LCI secretaries for health, HCs and HUMCs is averagely high. The level of awareness is averagely spread across sex, educational, age and locational variables, except about the HUMC in the Eastern division. This is because the latter has no health unit, hence HUMC is not existent. The level of awareness about the roles of LCI secretaries for health, HCs and HUMC is generally high among community members. This study also showed that HCs and HUMCs were carrying out duties that reflected PHC orientation. The HCs and HUMCs members were conformably aware of most of the official roles. Some community members had a few misconceptions about the roles of HCs and HUMCs. However, these misconceptions were of low magnitude compared to the correct perceptions held.

### **10.2.4 Opportunities and challenges for PHC delivery.**

A number of institutional opportunities were identified by the study that have been and can be exploited to enhance PHC services delivery at local levels. These opportunities include the

following: The horizontally spread local councils leadership in all villages especially the LCI secretaries for health, can be instrumental in mobilising community members toward PHC initiatives. Meanwhile HCs and HUMCs can provide the planning, supervision and monitoring of PHC services at the sub-county level. The hierarchy of local councils structures eases the integration of health priorities from lower and higher local councils. The LC structure also allows for the flow of policy information from the top to lower levels and vice versa. Locally retained revenues and user fee charges at health units have been used to supplement PHC funding especially of sub-county level. Lastly the central government re-commitment to PHC through increased funding to the district PHC budget and a substantial donor funding have been greatly used to implement a number of PHC related activities.

The challenges to PHC delivery established by the study include the following. The lack of adequate financial commitment to PHC services at the sub-county and district level due to low tax base and revenue shortfalls. Also, lack of potential for internal replicability of donor funded PHC programmes, the uncordial fiscal relationship between different levels of government and lack of adequate support and supervision to sub-county health delivery systems by the DMO. Also, lack of capacity building initiatives for critical stakeholders in PHC delivery at the sub-county level. Lastly, lack of meaningful motivation for HCs and HUMCs members.

#### **10.2.5 Perceived impact of HCs and HUMCs in the delivery of PHC services.**

This study established that majority of respondents (68%) felt that there was an improvement in health services delivery as a result of roles and functions of HCs and HUMCs. The study established that because of constant supervision by HUMCs and other local leaders, the health providers of public health units had become more responsible to the communities they serve. The health units were now providing steady basic services especially for the treatment of common diseases, and household/community sanitation campaigns. Consequently, community members' access to health services had generally improved. There was a reported decrease in the burden of common diseases such as malaria and increased knowledge about sanitation among community members

### **10.3 Policy recommendations to enhance community participation in the delivery of PHC services**

A number of policy recommendations have been made to enhance the effectiveness of HC, HUMCs and other stakeholders in the delivery of decentralised PHC services especially at the local levels. These recommendations are described below.

Firstly, capacity building programmes to improve upon the skills of HC and HUMC members in planning and resource mobilisation should be initiated and extended to all the sub-counties. These capacity building programs should reflect the implications of decentralising PHC services, upon the local leaders. Whereas re-orienting health services to PHC has implied institutionalized community participation, there should be, as a perquisite, parallel capacity building programmes to foster the expected community participation. The HCs and HUMC, and technical health personnel at the sub-counties should be given the necessary skills in planning, supervising, implementing, resource mobilisation and evaluation of PHC initiatives.

Secondly, a policy and framework to redistribute infrastructure, especially, health manpower in favor of disadvantaged rural areas should be put in place. This policy framework can be initiated by the sub-county councilors to the district council, in collaboration with the district service commission. Also central government and the district should strongly support sub-counties/divisions which don't have a health facilities (as a priority) to at least secure one. This will enable the actualisation of community participation through HUMCs. Otherwise, the assumption of the HUMC existing without a health unit, is like putting the cart before the horse. Examples can be drawn from the recently launched primary teachers restructuring exercise by the ministry of education.

Thirdly, the decentralisation of authority and responsibility for PHC design and delivery to local governments should be marched with adequate and steady transfer of resources. It is recommended that part of the development funds and equalisation grants from central government should be directly remitted to sub-counties. In light of this observation it is

necessary that the Local government Act, 1977 be amended to reduce on the centralisation of control of resources at the district headquarters and resolve the uncordial fiscal relationship between sub-counties and the district. Simultaneously, the capacities of the sub-county leadership should be developed to plan and manage these resources effectively.

Fourthly, central government together with local authorities should come up with policy guidelines that will foster inter-sectoral collaboration in the financing of PHC related sectoral activities at the local levels. This will lead to management unification and holistic approach expected of the PHC strategy, optimal use of resources, concerted action of all stakeholders at the local levels, and the sustainability of PHC programmes even in the event of changes in the local leadership. In this regard, the guidelines on the roles of local leaders and managers in the management of health services should be streamlined to ensure the continuity of PHC programmes, even with changes in the political leadership at the local levels.

Lastly, local governments should be directly involved in the negotiations of donor funded PHC projects with central government. This will avoid the tendency by central government and donors to over assume (or otherwise) the capacities of local governments in the participation of such donor funded PHC programs. After all, this is what institutionalized community participation and empowerment is all about.

#### **10.4 Recommendations for further research.**

The researcher has identified a number of study areas that need further research. Firstly, there is need for further research about the nature of donor funding for PHC and its related implications for community participation at the local level. Secondly, an analysis of the causes and impact of the uncordial fiscal and administrative relationship between different levels of government on PHC design and delivery at local level should be undertaken. Thirdly, a survey on resource endowments for social services delivery at the different local level, and an assessment of capacity building and training needs of the critical actors in PHC design, implementation and evaluation of PHC services should also be carried out.

## REFERENCES

- Adome, O.R., *et al*, (1996) *Pills: Community Drug Use in Uganda*. Het Spinhurs Publishers: Amsterdam.
- Boland, R. and Young M., (1982). *The Strategy Cost and Progress of Primary Health Care*. The Bull pan Organization: London.
- Brett, E.A., (1991). "Rebuilding survival Strategies for the Poor. Organizational Options For Development in the 1990s". In *Changing Uganda*. Hansen H.B. and Twaddle M., (Eds.) pp: 95-110. James Curry Ltd.: London.
- Dodge, C.P. and Weibe, P.D. (Eds) 1985. *Crisis in Uganda: The breakdown of Health Services*. Pergemon Press, Oxford.
- Edmonds, K, (1995). "Crisis Management: The Lessons for Africa from Obote's Second term." In *Uganda Now: Between Decay and Development* Hansen H.B. and Twaddle M., (Eds) PP: 95-110. James Curry: London
- Ebrahim, G.J., (1988). *Social and Community Peadriatics in Developing Countries. Caring for The Rural and Urban poor* MacMillan: London.
- GoU (Government of Uganda), Local Government Act, 1997. Government Printer: Entebbe, Uganda.
- Hansen, H.B., and Twaddle,M., (Eds) 1990. *Changing Uganda*. James Curry Ltd, London.
- Hansen, H.B., and Twaddle,M., (Eds) 1995. *Uganda Now*. James Curry Ltd, London.
- Hollinsteiner, R., (1982). *The Participatory Imperative in Primary Health Care* International Council for Adult Education: Paris.
- Kamugisha, G., (1995). *The Impact of Decentralization on Socio Economic Performance of Education in Uganda: The Case study of Kabale District*. (Unpublished) Kampala
- Kostanjesk, N., (1997). *District Health Management under the Decentralized System. A study of Tororo District*, German development service (unpublished) Kampala.
- Kullenberg, L., and Porter, D., (1998). *Decentralisation and Accountability: Recent Experience in Uganda*. United Nations Capital Development fund (UNCDF): New York
- Maclure R. (1991) "Misplaced assumptions of Decentralisation and Participation in Rural communities: Primary school reform in Burkina Faso". In *Comparative Education* Vol. 30, No. 3 pp: 240-254



- Mahler, H. (1981). "The meaning of Health for all by the year 2000" Proceedings of the World Health Forum Vol. 2, No 1 World Health Organisation: Geneva.
- MFEP (Ministry of Finance and Economic Planning) 1994. The 1991 population and housing Census (National Summary). Statistics Department, MFEP, Entebbe, Uganda.
- MoH (Ministry of Health) 1992. Three Year Health Plan (TyP). MoH: Entebbe, Uganda.
- MoH (Ministry of Health) 1993. Ministry White Paper on Health Policy, 1993. MoH: Entebbe, Uganda.
- MoH (Ministry of Health) 1994. Ministry of Health Recurrent and Capital Estimates 1994/1995. MoH: Entebbe, Uganda.
- MoH (Ministry of Health) 1995. Uganda Demographic and Health Survey, 1995. MoH, Entebbe, Uganda
- MoH (Ministry of Health) 1997. Guidelines (Updated) on the Role of Local Leaders and Managers in Decentralised Health Services. MoH: Entebbe, Uganda.
- MoH (Ministry of Health) 1998. National Draft Health Policy (1997/98-2006/7) MoH: Entebbe, Uganda.
- MoLG (Ministry of Local Government) 1999. Analytical Report 1998/1999. District Recurrent And Capital Estimates. MoLG: Kampala, Uganda.
- Munene *et al.*, (1997). *Revitalisation of Primary Health Care in Uganda* Makerere Institute of Social Research. Kampala
- Muyinda, K.A., (1988). *Resource Allocation for Primary health Services in Uganda*. Farbairn House: Leeds.
- Muzaale, P., and Birungi, H., (1997). *The Evaluation of and Application of the Concepts of Community Participation, Community Management and Enabling Governance in Uganda*. Makerere Institute of Social Research: Kampala
- Norman, B., (1988). *Gender Household and Social class*. In the British Journal of Sociology VOL. XXXIX No. 1 pp.28/46
- Nsibambi, A., (1991). *Problems and Prospects of National Integration in Uganda: 1962 to 1989* (Unpublished) Makerere University: Kampala
- Obbo Christine (1995) "What went wrong in Uganda" In *Uganda Now: Between Decay and Development*. Hansen, H.B., and Twaddle, M.,(Eds) pp: 95-110. James Curry: London.
- Ransom Kuti, *et al* (1991). *Strengthening Primary Health Care at Local Government Level: The*

*Nigeria Experience*. Ministry of Health: Abuja, Nigeria.

- Rifkin, S. B., and Walt, G., (1986). "Why Health improve. Defining Issues Concerning Comprehensive Primary Health Care and Selective Primary Health Care." In *Social Science and Medicine* Vol. 23, No. 6 pp: 559-566.
- Segall M., (1983). "Planning and politics of Resource Allocation for Primary Health Care: Promotion of meaningful National Policy." In *Social Science and Medicine* Vol. 17, No 24, 1947-1960
- Schyer S. and Dunlop D., (1985). "Health Services and Development in Uganda. In Dodge, C.P., and Weibe, P.D, (Eds) *Crisis in Uganda: The Breakdown of Health Services*. Pergemon Press: Oxford.
- Tororo District Local Administration (1993). District Development Plan, 1994-97. Tororo District Administration. Tororo, Uganda.
- Tororo District Local Administration (1996). Annual Health Report 1995. The DMO, Tororo District Administration. Tororo, Uganda.
- Tororo District Local Administration (1997a). Recurrent and Capital Estimates 1998/1999 (Annexes for sub-counties). Tororo District Administration. Tororo, Uganda.
- Tororo District Local Administration (1997b). Recurrent and Capital Estimates 1998/99, Tororo District Administration. Tororo, Uganda.
- Tororo District Local Administration (1997c). Annual Health Report 1996. The DMO, Tororo District Administration. Tororo, Uganda.
- Weillers, H. N., (1991). "Comparative perspectives on educational decentralisation: an exercise in contradiction". In *Educational evaluation and policy analysis* Vol. 12 pp: 433-448
- Walsh, J. A. and Warren, K. S., (1980). Selective primary health care: An interim strategy for Disease control in the developing countries. *New England journal of medicine* Vol. 14c
- W.H.O. (1980). *The Challenges of Implementation: District Health Systems for PHC*. WHO, Geneva.
- World Bank, (1993). *World development report. Investing in health*. The World Bank. Washington D.C
- Whyte, S., (1991) "Medicine and self-help: the privatisation of health care in eastern Uganda" In *Changing Uganda*. Hansen H.B. and Twaddle M (Eds), James curry Ltd., London.

## Annex A

### Survey Instrument

Questionnaire for community members on the perceived roles, functions, and impact of LC I secretaries for health, HCs and HUMCs.

#### Introduction:

Good morning/afternoon Sir/madam. My names are Dauda Waiswa. I am a student from Makerere University- department of Sociology, carrying out a study on health delivery issues in your locality. You have been selected randomly to participate in this study. The views you express shall be taken as important and treated confidentially. You are free to participate or not to.

#### SECTION I. IDENTIFICATION

County	Village	Interview code
Sub-county	Interview date	Interviewer's names
Parish	Interview time	Respondent's names

#### SECTION II. DEMOGRAPHIC CHARACTERISTICS

1. What is your age
  - 1) 15-24
  - 2) 25-34
  - 3) 35-44
  - 4) 45-54
  - 5) 55+
  
2. Sex of the respondent?
  - 1) Male
  - 2) Female?
  
3. What is your marital status?
  - 1) Single
  - 2) Married
  - 3) Divorced
  - 4) Widowed
  - 5) Cohabiting
  - 6) Others (specify).....
  
4. What is your educational level?
  - 1) No formal education
  - 2) Primary 1-4
  - 3) Primary 5-7
  - 4) Secondary
  - 5) Tertiary institution
  - 6) University

5. What is your occupation?  
 1) Peasant      2) Trader      3) Professional  
 4) Artisan      5) Labour      6) Other (Specify).....
6. Number of children in the household .....

**SECTION III. COMMUNITY MEMBERS AWARENESS ABOUT LC I SECRETARY FOR HEALTH, HCS AND HUMCS.**

7. Are you aware that there is a secretary for health at the LCI level?  
 1) Yes  
 2) No
8. If yes, what are the functions of the secretary for health at the village?  
 .....  
 .....  
 .....
9. Are you aware that there is a HC at each sub-county level?  
 1) Yes  
 2) No
10. If yes, what are the roles and functions of the HCs?  
 .....  
 .....  
 .....
11. Are you aware that there is a health unit management committee at each public health unit?  
 1) Yes  
 2) No
12. If yes, what are the functions of the health unit management committee?  
 .....  
 .....  
 .....
13. Are you aware of any policies/decisions that have been made by HCs and HUMCs.  
 1) Yes  
 2) No

14. If yes, what are these policies/decisions?

.....  
.....  
.....

**SECTION IV PERCIEVED IMPACT OF HC and HUMCs**

15 Do you see any improvements in health services delivery as a result of the roles and functions of HCs and HUMCs?

- 1) Yes
- 2) No

16 If yes, can you mention the improvements.

.....  
.....  
.....

17. Are there any sections of community members benefiting move from the improved health. services, compared to others?

- 1) Yes
- 2) No

18 If yes who are they and why?

.....  
.....

19. What Socio-economic changes have occurred in the lives of community members as a result of improved health services.

.....  
.....  
.....

**SECTION V. FACTORS THAT AFFECT THE EFFICIENCY AND EFFECTIVENESS OF HCs and HUMCs.**

20. What are the problems faced by HCs in execution of their roles and functions.

.....  
.....  
.....  
.....

21. What are the problems faced by the HUMCs in the execution of their roles and functions?  
.....  
.....  
.....  
.....

22. Can you identify areas where HCs and HUMCs need support.  
.....  
.....  
.....  
.....  
.....  
.....  
.....

THANK YOU VERY MUCH FOR YOUR TIME AND VIEWS.

## ANNEX B

### TOPIC GUIDE FOR FOCUS GROUP DISCUSSIONS FOR Members of HCs and HUMCs

Introduce yourself and purpose of the FGD. Explain the relevance of the Focus Group Discussions.

#### BACKGROUND INFORMATION

1. **Please record;** Names of Participants  
Position held  
Representation by gender  
Duration in office  
Sub-county/Health Unit
2. What are the Qualification and background of members of HC/HUMC? (academic or experiential qualification)
3. What is the gender representation by position held?

#### PERCEIVED ROLES AND FUNCTIONS.

4. What do you perceive as your major roles and functions as members of HCs/HUMCs?
5. Do you experience any problem in combining your roles as members of HC and other local council functions.  
Yes  
No  
If yes elaborate
6. Are you aware of the concept of primary Health Care?  
If yes, what do you understand by the concept PHC?
7. What are you doing as members of HCs/HUMCs to promote PHC?

#### COLLABORATION AND INTERGRATION WITH OTHER STAKEHOLDERS.

8. What is the nature of collaboration between HCs/HUMCs and the following government departments.
  - a) District Medical Office
  - b) Agricultural Dept.
  - c) Water and Sanitation
  - d) CAO/Sub county chief's offices
  - e) Education Dept.

9. What is the nature of collaboration between HC/HUMC with the NGOs in this district/sub-county?

What has been the outcome of this collaboration/or lack of collaboration?

### **DECISION MAKING AND PHC**

10. What are the factors you take into consideration when making decisions/policies about health issues?
11. Are the decisions/policies made always implemented? Please explain in detail.
12. Has there been a substantial change in allocation of funds/resources towards PHC activities in the last 2 years at the sub-county?

### **EFFICIENCY, GOVERNMENT AND CHALLENGES**

13. As members of HC/HUMC do you seek technical advice on PHC where necessary? Explain why and how?
14. Have you benefited from any form of support in terms of training or other forms of strengthening your efficiency?
15. Do you have any reference materials in carrying out your functions? E.g guidelines for decision making.
16. Can you identify areas where you need support to enhance your efficiency?
17. What problems do you face as HC/HUMC members?
18. What problems do you face in the implementations of PHC activities?
19. How do you cope/resolve such problems?





**Annex D**  
**Introductory letters**