

HOUSEHOLD COPING STRATEGIES IN RESPONSE TO THE INTRODUCTION OF USER CHARGES FOR SOCIAL SERVICE:

A CASE STUDY ON HEALTH IN UGANDA

IDS WORKING PAPER 86

Henry Lucas and Augustus Nuwagaba

SUMMARY

This study examines approaches to health care seeking and financing by households living in communities in two poor rural districts of Uganda. It seeks to explore differences in the choice of provider and methods of funding care between the two districts, and the economic circumstances and social attitudes which influence these differences. It considers the impact on households budgets of health care charges, both at public facilities (licit and illicit) and by private sector providers. Qualitative fieldwork was used to determine attitudes to the introduction of user charges, the extent to which they have influenced health care seeking behaviour and whether attempts by households to find sustainable coping strategies, either individually or through community organisations, have been successful in ensuring adequate health care for all their members.

The research raised issues as to the appropriate definition of utilisation of services in circumstances where profession staff are often substituted by 'assistants' and drugs are frequently prescribed in public facilities but then have to be purchased from private suppliers. It stresses the relative autonomy of facility staff and constraints on effective supervision. Under these circumstances there is room for considerable confusion between sanctioned user-charges and illicit demands by providers. Many households face difficulties with what they see as a multiplicity of demands for *cash* payments, of which education and health charges are a major component. Community organisations do not appear to make a major direct contribution to meeting such charges. However, community based savings and credit societies, where they exist, appear to play a central role in overcoming seasonal fluctuations in cash availability. Making these more accessible to poor households or developing effective and sustainable systems for providing services on credit might alleviate current problems.

1 INTRODUCTION

1.1 Background

In the late eighties there was considerable pressure on governments in many parts of the world, particularly those forced by deteriorating economic circumstances to undertake major economic restructuring, to introduce user charges for services such as health and education which in some cases had traditionally been seen as 'free'. (Creese, 1991). Such charges, it was argued, would not only increase efficiency in line with standard neo-classical economic theory (Akin, 1986), but could also promote equity by reducing the tendency for services funded by taxation to be 'captured' by wealthier, often urban, populations (Griffin, 1992).

The widespread acceptance of health sector user charges was a reflection of the increasing difficulties most governments were facing in sustaining adequate expenditure levels (Kanji, 1989). The combination of economic crisis, increasing population and high disease incidence, including the AIDS pandemic, forced most sub-Saharan African governments to seek new options for raising resources, with the 1987 World Bank policy paper on health financing (World Bank, 1987) providing the main focus. Among a range of other policies, this advocated: charging fees to the non-poor at public health facilities, decentralising as many health activities as possible, and developing risk sharing mechanisms to protect the population from catastrophic health expenses

There is now a collection of research findings on the impact of cost-recovery schemes on health service utilisation and revenue generation (Gilson, 1995). However, they provide radically divergent results. Heller (1982) and Akin (1986) found that price increases had minimal effect on the decision to seek health care in Malaysia and the Philippines. Meyer (1985) found similar results in Mali. On the other hand, Waddington and Emjimayen (1990) demonstrate that utilisation of health care in Ghana was severely affected by a substantial increase of health care prices in 1985. Similarly, Mbugwa (1993) in a Kenyan study found that utilisation of all government health facilities fell sharply after the announcement of user charges, while attendance at dispensaries which continued to provide free services rose. This study also found that the poor were more sensitive to price than the rich, as did research in Cote d'Ivoire and Peru (Gertler and Van der Gaag, 1990) and in Swaziland (Yoder, 1989). However, Akin (1995) finds no differences in price responsiveness in a Nigerian study.

The great majority of studies have focused narrowly on the introduction of user fees and the short-run implication for utilisation and revenue generation. Limited work has been undertaken on the effect of user charges on general household expenditure patterns and coping strategies (Russell, 1996), and the few findings available are contradictory. Studies in Ghana (Waddington, 1990) and Tanzania (Abel-Smith, 1992) indicate a considerable impact on household resources, while a general review of the Bamako Initiative in Africa (McPake, 1992) finds little evidence.

There is an urgent need to clarify these issues. Households in countries which have adopted health sector cost-recovery policies are simultaneously having to deal with the impact of a range of other financial burdens arising as a consequence of economic crisis. Even if utilisation of health services is maintained, it is essential to know if this is being achieved by reductions in other aspects of well-being, for example by asset sale, or reduced expenditure on food or education, or by individual sacrifices made by some members of the household, for example by mothers on behalf of their children. If this is the case, there are liable to be serious implications for

the longer-run health and welfare of such households. The aim must be to develop policies which allow and facilitate the adoption of appropriate, sustainable coping strategies at the household level.

1.2 Cost recovery in Uganda

Though payment for health services has a long history in Uganda (Uganda, 1996), public sector health services have traditionally been provided free of charge. However, in consequence of long years of political and economic crisis, funding of health services have seriously declined (Smithson, 1993), real wages of health sector personnel have reached very low levels and illicit charges have become endemic (Assiimwe, 1997b). In 1990 the Ministry of Health attempted to introduce a formal system of user charges, but there was widespread opposition and the proposal was defeated. Three general objections were raised: that it would represent double charging, as the population were already funding the services through taxation; that cash fees would introduce a major barrier to the poor; and that the quality of services was so low that the population were not willing to pay (Okunzi, 1995).

The rejection of a national system of user charges did not, however, prevent district authorities from raising revenues in this way, and many chose to do so. In 1992, the World Bank made new loans for support of the health sector conditional on the introduction of a national system of user-charges. However, the situation is still confused (Mwesigye, 1995) with a variety of local models in operation and limited central monitoring, though detailed guidelines have now been issued to all districts (Uganda, 1996c). In particular, the nature and effectiveness of exemption practices are largely unknown.

Initial indications based on utilisation rates suggest that these schemes have lead many households to seek alternative sources of care. Given that the cost of good private health services put them also beyond the reach of the poorer sections of the population, there is a risk that there will be an increasing dependence on poor quality care providers or self medication. Given the findings of Mbugwa (1995) in Kenya, there must be some concern that this could lead to a reduced impact for government preventive health programmes, even though these are still provided free of charge.

1.3 The research project

The current research is a result of a proposal to the Department for International Development (DFID) by the second author to undertake an study of the health care situation and household coping strategies in his home district of Kabale in South-West Uganda. This was motivated in part by the widely held belief that the people of this district maintained 'traditional Ugandan values' concerning the importance of community organisation and action. The research issue was thus whether such attitudes and practices would have positive implications in terms of assisting individuals and households to cope with the various demands imposed by sickness within the context of recently introduced user charges at public facilities.

The Institute of Development Studies, which had a long standing collaborative arrangement with Makerere University, was approached by the DFID, who regarded the proposal as interesting, to see if there were

possibilities for a joint project. The first author agreed to collaborate on the development of a formal project proposal to ESCOR.

As a result of these discussions, it was agreed that a comparative study be undertaken, including a second district in which there was general agreement that community based organisations were much less well developed. It was eventually decided to select Iganga, in the South-East of Uganda. The project was to be based around three activities: a qualitative study in selected villages in each district, a review of public health facilities in selected parishes to consider supply-side effects, and a longitudinal sample survey of households in those parishes. Following the joint development of survey instruments and procedures, training workshops were organised in Uganda by the two authors in early 1997 and fieldwork was then undertaken by the second author, in collaboration with colleagues from Makerere University, over the months of February to May. Analysis and initial write-up took place over the period June-August 1997 in both Uganda and the UK, following which the second author held workshops in the two districts to report back to district officers and discuss findings. He is currently arranging a final workshop with officials of the Ministry of Health in Kampala.

This study examines approaches to health care seeking and financing by households living in communities in two poor rural districts. It seeks to explore differences in the choice of provider and methods of funding care between the two districts and the economic circumstances and social attitudes which may influence these differences. It also attempts to examine the impact of health care charges, both at public facilities (licit and illicit) and by private sector providers on household budgets. By means of qualitative fieldwork it considers attitudes to the introduction of user charges at public facilities, the extent to which user charges have influenced health care seeking behaviour and whether attempts by households to find sustainable coping strategies, either individually or through community organisations, have been successful in ensuring adequate health care for all their members.

2 METHODOLOGY

The study adopted a range of research methods in order to gather data on health facilities and providers, household health care seeking behaviour and coping strategies. An initial review was made of secondary sources, focusing on existing data on cost-recovery schemes operating at district level, including the scale of charges in public sector facilities and available evidence on changes in utilisation rates. The 1991 Household and Expenditure Survey from the Ministry of Finance and Economic Planning was utilised to review basic district level information on incomes and expenditure.

2.1 Sample selection and initial activities

Two rural districts were selected for field work: Kabale and Iganga. It should be stated clearly at the outset that it is not intended that these districts should be seen as representative of other regions of Uganda. Kabale was initially chosen for the reasons described above. Iganga was selected on the basis of the assumed limited role of community based organisations, given the initial requirements that both districts should be largely rural and heavily reliant on public primary health care services, have a substantial proportion of poor households (Bigsten

1995) and be accessible, both in a physical sense (parts of Northern Uganda were considered unsafe by fieldworkers) and in terms of obtaining the agreement of local authorities, which now have a considerable degree of autonomy.

At district level, an initial review was undertaken of available data on health status and services, with particular attention to both supply-side limitations and service utilisation. This study focuses on the demand for and utilisation of public health services. Clearly, if the facilities intended to provide those services were either closed or so run down as to be ineffective (i.e. if there were major supply-side constraints), this would considerably complicate the interpretation of any findings. At this initial stage, selection of study communities was based on assurance by local officials that such supply-side constraints were absent. This situation was later verified by visits to the relevant facilities.

Interviews were also undertaken with district officials to gather information on local cost-recovery schemes, focusing on cost structure, exception practices and revenue. A multi-stage sampling technique was then employed to select counties, sub-counties, and parishes for the study, subject to the constraint that there was at least one effectively functioning public facility in each selected parish, based on advice from district officials. This procedure resulted in the selection of eight parishes as indicated in table 2.1.

Table 2.1 Selected communities in the study

District	County	Sub-County	Parish	Villages
Kabale	Rubanda	Bubare	Kagarama	Habutiki*, Kyarujumba
		Hamurwa	Igomanda	Hamuko, Habukubo Rwebukyenka
	Rukiga	Bukinda	Nyakasiru	Hamuganda*
		Kamwezi	Kigara	Kabirizi
Iganga	Busiki	Namutumba	Nakyere	Bulyabwita*
		Nsinze	Buwongo	Buwongo
	Bunya	Baitambogwe	Lugolole	Wayina
		Imanyiro	Manuge	Kyebando*, Luwanula

* Villages selected for rapid appraisal exercises.

In each, one village was then selected at random and visited by the research team. In three cases, because of the limited number of households in the sampled village, and the close proximity of similar small villages, it was decided to derive a household sampling frame based on two (and in one case three) village lists. The final sample of villages is also shown in table 2.1.

To ensure that the condition of availability of services was indeed met in all the sampled villages, a survey was undertaken of each of those public health care facilities previously identified by district officials as being the primary source of care for the relevant population. Information was gathered on the general condition of the

facility, medical personnel, and availability of drugs, materials and equipment. Facility data on utilisation and treatments was reviewed. Interviews were also conducted with the heads of each facility to discuss local health issues, the implementation of cost-recovery and their perceptions of its impact on services. Facility accounts relating to cost-recovery payments and use of resulting income were examined and discussed.

2.3 The household survey

The aim of the household survey was to study the health care seeking and financing behaviour of a representative group of households in each selected county. A longitudinal approach was adopted, primarily to avoid the recognised risk of unreliability associated with a single recall-based questionnaire survey (Tipping, 1994). This involved the collection of baseline data on each household and monthly data on sickness, health care seeking behaviour and expenditure over the following three months.

Households for the study were selected with the assistance of the local Resistance Council officials who are required to maintain an up-to-date list of all residents. Fifty households were selected in each parish, using a list-sampling procedure. As indicated above, in five cases the sample was taken from a single large village and in three from more than one village. This process resulted in a total sample size of two hundred households in each district.

During the initial visits to the study villages, discussions were held at local schools to recruit teachers to conduct the fieldwork for the survey. While it was recognised that the use of enumerators based in the surveyed communities could pose problems, for example in terms of the possibly greater unwillingness of some households to disclose sensitive information to such individuals, on balance it was decided that their local knowledge, acceptability in the community and availability to conduct interviews at times convenient to household members outweighed potential disadvantages.

Following interviews with potential candidates, one teacher was appointed in each parish to collect the required baseline and monthly data on the fifty sampled households. This resulted in a team of four enumerators in each district. Each team was supervised by a graduate student from Makerere University, who lived in the district over the survey period. A one-week training workshop was held in the capital town of each district to instruct the fieldwork teams and make final revisions to the survey questionnaires and related fieldwork instruction manuals. Towards the end of this week, a pilot exercise was undertaken in a nearby village.

To allow the enumerators to operate on a part time basis, while performing their normal teaching duties, it was agreed during the workshops that each would collect data over a two week period in each month of the survey, following a sequence determined by the supervisor. This sequence would be designed to ensure that approximately one month elapsed between visits to any given household. By recording the dates of interview, allowance could be made for minor variations in time period at the analysis phase. The supervisor visited enumerators during the two weeks following each collection period to check completed questionnaires, advise on problems arising and undertake quality control follow-up visits to a small number of surveyed households. The questionnaires were then taken to Makerere University for data entry and computer analysis.

The household questionnaires collected data as follows:

Baseline data

- Age, sex and household structure.
- Level of education and occupation of head of household.
- Asset ownership.
- Knowledge of public health facility and attitude to utilisation.

Monthly data

- Cash expenditure on food, clothing, education and other items
- Cash income received by source
- Sickness of household members since previous visit

Sickness data

- Sickness occurrences to members over previous month.
- Nature of illness and limitation on activity.
- Type of health care sought.
- Travel cost, drug cost and other treatment cost.
- Method of financing costs

3 THE FIELD STUDY AREAS

3.1 Kabale

Kabale District is located in the extreme Southwest of Uganda, sharing its Southern border with the Republic of Rwanda. Though lying just South of the equator, its altitude of 1200-2300 metres above sea level results in a temperate climate with an average annual temperature of 17°C and rainfall of 1,000-1,500 mm per annum. It covers an area of some 1,700 sq kms, and in 1991 had a population of around 420,000 giving a population density of 247. There are some 40,000 hectares of bamboo and afro-alpine forest. Subsistence agriculture is by far the dominant activity, being the main source of livelihood for 84% of households according to the 1991 census. The land is intensely cultivated, mainly for the food crops of potatoes, sorghum, beans and pigeon peas. There are also large populations of cattle, goats and sheep, and fishing on Lake Bunyonyi, which occupies a large area in the Southwest of the district. According to estimates made by Appleton (1995), some 17% of households in Kabale district fell in the bottom quartile on a measure of household expenditure based on the 1992 Household Budget Survey.

The district is divided into four counties, Ndurwa, Rubanda, Rukiga and Kabale Municipality. The district administration is located in Kabale Town, which is home for the great majority of the 7% of the population who live in urban areas, and the location of the one district hospital. In addition to this hospital, health facilities current consist of a dispensary, 7 health centres and 25 sub-dispensaries. There is also one NGO health centre and 7 sub-dispensaries.

3.2 Iganga

Iganga district is in the Southeast of Uganda, around 120 km from Kampala and with a long Southern border on Lake Victoria. It lies around 1,100 metres above sea level, with temperatures usually over 21°C, and rainfall between 1,200 and 2,200 mm per annum. There are 24,000 hectares of forest, including dense tropical rain forest. The total area is 4,800 sq. kms and the 1991 census population was around 950,000, giving a population density of 198. Agriculture is divided between a wide variety of food crops, including finger millet, maize, sorghum, rice, bananas and potatoes, and the cash crops of coffee, cotton and rice. Cattle and goats are also farmed, and fishing is an important activity for those living alongside Lake Victoria. On the basis of the analysis described above, 29% of households in Iganga were in the bottom household expenditure quartile based on the 1992 budget survey.

The district is divided into six counties: Bugweri, Bukooli, Bunya, Busiki, Kiggulu and Luuka. The administrative centre is located in Iganga Town, which with the other main towns of Bugiri, Busembatia, Busesa and Magamaga account for some 5% of the population. There are two hospitals, in Iganga and Bugiri, and 10 health centres.

3.3 Comparative demographic and health indicators

Table 3.1 shows selected comparable indicators on the two districts taken from the 1991 census. As can be seen, the two districts account for just under ten percent of the total population of Uganda and exhibit very similar characteristics in terms of population distribution, literacy rates and proportion of female-headed households.

Table 3.1 Basic demographic data for study areas (1991 census)

	Kabale	Iganga	Uganda
Population	417,218	945,783	16,671,700
0-4	20.3	20.1	18.9
5-14	29.6	27.1	28.3
15-64	46.4	49.2	49.2
65+	3.6	3.6	3.6
Growth rate	2.2	3.5	2.7
Male literacy rate (10+)	62	56	65
Female literacy rate (10+)	42	38	45
Female headed households	33	23	26

Table 3.2 provides estimates of key health status indicators, taken from local records for each district and a range of other sources for Uganda as a whole.

Again, the district and national indicators are similar, except for that relating to AIDs. Morbidity data relating to local public health facilities also show similar patterns, with around 30% relating to fever/malaria, 10-20% to respiratory diseases and around 5% to each of diarrhoea and wounds. Worm infestation, skin diseases and eye infections were also regarded as serious problems in both districts. (For additional health status data on Iganga see Biritwum, 1995).

Table 3.2 Health status indicators for study areas

	Kabale	Iganga	Uganda
CDR	16	na	*19
IMR	114	125	***122
U5MR	191	209	***203
MMR	506	na	**500
AIDS/million pop	***913	***538	***2314

*United Nations, 1994, **WHO Regional Office, 1996

*** Uganda National Council for Children, 1994

In table 3.4, recent estimates for ratios of patients to qualified health workers (based on Ministry of Health data) are presented. Data for the two districts is very similar, with perhaps indications of a slightly worse situation in Iganga. Comparison with Uganda as a whole simply emphasises the lack of personnel in rural areas.

Table 3.4 Patients per qualified health worker

	Kabale	Iganga	*Uganda
Pop/Physician	68,800	67,429	27,140
Pop/Nurse Midwife	18,764	26,222	12,478

* Uganda National Council for Children, 1994

4 FINDINGS FROM COMMUNITY LEVEL STUDIES

4.1 Introduction

As indicated above, qualitative fieldwork activities were undertaken in four villages, one in each of the selected counties. In this section an initial description of health issues and sources of care in each village is followed by a general discussion of issues raised, drawing on material from individual communities where relevant.

4.2 Background on the study villages

Habutiki village lies in the Kagarama parish of Rubanda county in Kabale. Health care in the village depended mainly on Kagarama sub-dispensary, which was located within the village and run by a nurse. In addition, there were at least three recognised traditional healers, and around ten TBAs (two of whom described as mid-wives), who were said to charge 3,000-5,000shs for a delivery. Rugarama Health Centre was some 14km and Kabale Hospital 15km from the village. Community groups listed malaria, dysentery, cough, flu, body pains, skin rashes, worms, AIDs, ebinyaro (syphilis), eye problems, skin diseases and malnutrition as the main health concerns. In general, there was a reasonable understanding of the cause of most of these conditions, though the cause of ringworm was not known and coughs were attributed to dust or drinking dirty water.

The sub-dispensary was generally seen as the first source of treatment for those who became sick, though some might try local herbs first or visit a traditional healer. It was seen as poorly equipped but providing access to a range of basic drugs. In addition, many were not convinced of the ability of the nurse to correctly diagnose other than common conditions. Many said that they would prefer to see a doctor at Kabale Hospital. However, the sub-dispensary was much cheaper and therefore used for most conditions. Travel to the hospital was also

said to be very difficult, with hilly terrain and no regular transport. In extreme cases patients were said to be sometimes taken there by stretcher.

The second village in Kabale, *Hamuganda* lay in the Nyakasiru parish of Rukiga county. Public sector health services for the village were provided by Bukinda Health Centre, which was some 4km from the village. The closest providers were two drug shops, one less than $\frac{1}{2}$ km away, but at least 3 private clinics were also within walking distance. Kabale Hospital was around 30km from the village. Within the village itself there were said to be 3 TBAs and at least 5 traditional healers. The diseases listed by a community group as the most common included malaria, cough, dysentery, skin rash (obuhere), ulcers, tuberculosis, meningitis, ear infections, and pneumonia. They were also concerned about 'oburo', which was described as 'a new and strange disease that attacks glands within the body'. Many diseases, including cough and pneumonia, were said to be associated with dusty conditions in the dry season.

Self medication was common for a variety of conditions, including dysentery and worms. Treatment might involve traditional herbs or allopathic medicines purchased from the drug shop. Traditional healers were said to be useful for some specific diseases including obuhere and oburo. The latter was associated with witchcraft, not responsive to western drugs and was said to have caused a number of deaths among young children. Transport to Kabale Hospital was very difficult, given the distance and the hilly terrain. This plus the perceived high cost of treatment was said to make hospital care very much a last resort.

Bulyabwita village was in the Nayere parish of Busiki county in Iganga. The nearest government facility was Namutumba District Maternity Unit (DMU), which was some 4km from the village. There were two drug shops/private clinics in the village, two TBAs and at least five traditional healers. Two alternative government facilities at Bulange and Kigalama were within 8kms.

The most important health problems identified by a community group were malaria, 'convulsions', diarrhoea, measles, scabies and headaches. There was also considerable concern about epilepsy (there was said to be a case in the village) and madness, which were regarded as due to witchcraft or evil spirits. Though one household was identified as having a member with slim and there were several cases of TB in the community, AIDS was not identified as a central concern.

For most common diseases, including malaria, diarrhoea and measles, it was said that treatment would initially be sought at the drug shop. It would only be if this proved unsuccessful that people would go to the government facility. Private clinics were favoured on a number of grounds. Most importantly, they could usually provide the drugs they prescribed, which was often not the case at the DMU. Many patient complained that having paid to see a health worker at this facility, they would be sent to purchase drugs elsewhere. Travel time and a long wait at the facility were also cited as deterrents. The DMU was favoured by pregnant women, if they could afford the charges for delivery. TBAs were used because of their low cost, but were regarded as very much a second best alternative. Traditional healers were seen as having an important role in conditions such as convulsions and madness, for which no treatments were available elsewhere, and for other problems if allopathic remedies failed.

Kybando village was in the Mayuge parish of Bunya county. The nearest government facility was Mayuge Health Centre, 6km from the village. There were two drug shops/private clinics in the village and at least two

traditional healers. There was an Islamic dispensary nearby at Ahluilbait and an NGO Health Centre/Hospital at Buluba, a distance of some 12km. Two DMUs were around 10-15km from the village.

The main health problems in the village were said to be: diarrhoea, measles, malaria, cerebral malaria/convulsions (claimed to affect many children), yellow fever, AIDS/slim, headaches and eye problems (tracoma, conjunctivitis). The community were knowledgeable as the cause of most of these conditions, referring to an earlier period when convulsions were wrongly believed to be caused by spirits. AIDS was said to be caused by promiscuity, with some suggesting that it “came from the whites to finish off Africans”.

Herbs and traditional healers were an important component of health care in the village. Some households said they would seek advice on the choice of treatment and healer from a community elder and believed in their effectiveness, though for others herbs were simply a last resort for those who could afford no other treatment. The drug shops/private clinics in the village would usually be the first allopathic providers approached, followed by Mayuge health centre and, if they could not deal with the problem, Iganga Hospital. The drug shops were seen as very effective in terms of treatment for malaria, cough and measles. However, if it was immediately recognised that the health condition was complicated or serious, for example poisoning or a hernia, people would choose a government facility. Women preferred public facilities for ante-natal care.

4.3 Wealth ranking

Focus groups in each of the villages were asked to discuss how they would categorise households in terms of their wealth holding. It emerged that the most acceptable framework for this discussion was to distinguish between people who were: “doing well”, “so-so” and “poor”. In terms of distinguishing indicators, there was a considerable measure of agreement across all four communities. Table 4.1 lists indicators by village.

Table 4.1 Wealth indicators identified in study villages

Indicator	Habutiki	Hamuganda	Bulyabwita	Kybando
Land ownership	X	X	X	X
Land available for cash cropping			X	X
Cattle ownership	X	X	X	X
Other livestock: goats, chickens	X	X	X	
Painted house – corrugated iron roof	X		X	X
Ability to pay school fees	X	X		
Employment of labour		X		
Bicycle	X	X	X	
Radio		X	X	
Married	X			
Small family		X		

Land ownership was uniformly considered the most important criterion for assessing if households were “doing well”. Strict rules on the inheritance of land in Kabale have resulted in a situation where many families are cultivating very small plots of land, often scattered over a wide area, and considerable concern was expressed as to the prospects for coming generations if this pattern continued. In Iganga, great importance was attached to owning sufficient land such that cash crops, particularly coffee, could be cultivated without sacrificing the food

crops required for family consumption. Livestock ownership, focusing on cattle, was again generally agreed to be the second most important criterion, with dairy cattle rated particularly highly in Kabale in terms of providing both nutrition and income in addition to being a highly valued asset.

Assessment of dwelling quality was again widely regarded as a key indicator, particularly for identification of the “poor”. As discussed below, around one third of dwellings covered in the survey did not have the corrugated iron roof regarded as an essential feature of a good quality house. The ability to pay school fees was rated highly in Kabale. Those “doing well” should be able to meet the cost for all their children to go to school, while in most households this would require considerable efforts and some might not attend. Children of the “poor” would usually have little or no schooling. In terms of household assets, bicycles and radios were by far the most commonly regarded as indicative of “doing well”.

Finally, two related aspects of family compositions were raised in discussions in Kabale. Firstly, that there were men in the village who were too “poor” to get married. This seemed to relate not only to the costs of maintaining a wife and family but also to the initial costs of a marriage ceremony. Secondly, it was observed that many “poor” households were large in size, with many children, while those “doing well” often had relatively small families. This issue was again related directly to the cost of school fees.

It was noticeable that while villagers in Kabale readily classified households into comparable size groups on the above indicators, suggesting that around 25% were “poor”, 50% “so-so” and 25% “doing well” in Kabutiki for example, the communities in Iganga tended to identify only a very small group as “doing-well”, with a much larger proportion reported to be in the middle group. This “doing-well” group was also much more an elite group, described as having at least an acre under coffee cultivation and with trading or other business or employment activities which supplemented their income from agriculture. The impression was gained of a greater awareness of unequal distribution of wealth in Iganga and possibly higher aspirations to join those who were “doing-well”.

4.4 Seasonality

Clearly, any community reliant on agriculture experiences high levels of seasonal variation in income flows. In all four villages there were two additional cycles which appeared central to household well-being: cash income resulting from the harvest and sale of specific cash crops, such as tobacco in Habituki (Kabale) or coffee in Kybando (Iganga), and routine cash expenditures, for example on school fees. The seasonal calendars in tables 4.2 and 4.3, which were again developed by community members following a focus group discussion, indicate rather different seasonal patterns of these latter cycles in Kabale and Iganga. In the former, the survey (running from late January to late April) followed a period of very low cash incomes and coincided with one of low incomes and high cash expenditures, including school fees and taxes. In the latter, produce sales at the end of 1996 and start of 1997 generated high or moderate incomes until March, which helped offset a similar cash expenditure pattern.

Seasonality similarly plays a major part in determining the extent of the burden of health care costs, given that public facilities required payment in cash and would rarely provide treatment on credit. In Kybando, for

example, it was said to be fortuitous that the peak periods for disease coincided with a peak period for the sale of cash crops.

Table 4.2 Seasonal activities, income, expenditure and health: Habutiki village, Kabale

Month	Activities	Cash income	Expenditure	Health Problems
Jan	Harvesting tobacco Ploughing	LOW Tobacco sales Potato sales	HIGH Tax, School Fees, Food	Diarrhoea Skin
Feb	Planting, Weeding	LOW Tobacco sales Potato sales	HIGH Tax, School Fees, Food	Diarrhoea Skin problems
Mar	Planting, Weeding	VERY LOW Stored produce sales	HIGH Seeds, Food, Labour hire	Diarrhoea Fever Worms
Apr	Weeding, Hired labour	VERY LOW No produce Some labour income	HIGH Seeds, Food, Labour hire	Fever Worms
May	Ploughing, Planting, Hired labour	VERY LOW No produce Some labour income	HIGH Food, School fees	Diarrhoea Fever Worms
Jun	Planting, Weeding, Hired labour	VERY LOW No produce Some labour income	HIGH Food, Labour	Fever Red Eye Skin problems
Jul	Harvesting	HIGH Produce sales Trading	LOW Household needs	Fever Red Eye Skin problems
Aug	Harvesting, Brewing, Festivals	PEAK Produce sales Alcohol sales	LOW Household needs	Diarrhoea Red Eye
Sep	Clearing, Planting	HIGH Stored produce Seeds	MODERATE School fees Seeds	Diarrhoea Red Eye
Oct	Planting, Weeding	VERY LOW No produce	HIGH School fees Food, Labour hire	
Nov	Planting, Weeding	VERY LOW No produce	HIGH Food, Labour hire	
Dec	Planting, Hired labour	VERY LOW No produce Some labour income	VERY HIGH Festivals, Food Labour hire	Diarrhoea

Table 4.3 Seasonal activities, income, expenditure and health: Kybando village, Iganga

Month	Activities	Cash income	Expenditure	Health Problems
Jan	Clearing, Preparing gardens	MODERATE Produce sales	HIGH Tax, School Fees, Labour	Red eye
Feb	Sowing millet	MODERATE Produce sales	HIGH Tax, School Fees, Food	Red eye
Mar	Weeding, Planting	VERY LOW No produce	HIGH Seeds, Food, Labour.	Skin problems
Apr	Weeding, Planting	VERY LOW No produce	MODERATE Food	Skin problems
May	Harvesting beans	MODERATE Produce sales	HIGH Food, School fees	Diarrhoea Malaria
Jun	Main harvesting	HIGH Produce sales	MODERATE Household needs	Diarrhoea Malaria
Jul	Ploughing, Hired labour	HIGH Produce sales Some labour income	MODERATE Household needs, Labour hire	Diarrhoea Malaria
Aug	Ploughing, Planting	HIGH Coffee sales	LOW Household needs	
Sep	Weeding	HIGH Coffee sales	MODERATE School fees Seeds	
Oct	Weeding	VERY LOW No produce	HIGH Food, Labour hire	
Nov	Harvesting	VERY HIGH Produce sales	HIGH Food, Labour hire School fees	Diarrhoea Malaria
Dec	Harvesting	HIGH Produce sales	HIGH Festivals, Food	Diarrhoea Malaria

4.5 Health seeking behaviour and attitudes to cost-recovery

The attitude in the study villages to payment at public facilities was complex. It has frequently been observed that payment for both public and private health services has in practice long been the norm in Uganda (Uganda, 1996b) and that cost-recovery is to some extent providing a legal framework for (and hopefully better control over) such payments. However, while payment to private health providers was seen by the study communities as a perfectly reasonable market transaction, one of the most common complaints in discussions on public sector charges in both districts was that people objected to 'paying twice' for such services, both directly and through taxation.

There was also concern that the boundary between licit and illicit payments was now blurred. Both communities in Kabale claimed that when patients visited a clinic, they might meet demands for money from various staff members, all of whom would refer to the cost-recovery system as the basis for such demands.

Interestingly, however, there were indications from these same communities that the introduction of cost-recovery payments had to some extent reduced demands for illicit payments rather than adding an additional burden on patients.

There was little support for the idea that public sector health workers needed to augment inadequate government salaries. Almost all respondents saw illicit payments as subsidiary income to an individual who already had a better standard of living than themselves. Some clearly believed that certain public sector health workers were making large amounts of money from illicit sources (for the plausibility of this assumption see Assimwe, 1997b).

Overall attitudes toward both licit and illicit payments for public health services reflected a mixture of resignation and irritation, the balance often depending on the perceived quality of services: where this was acceptable, all such payments tended to be seen as an unpleasant but unavoidable fact of life. In discussion of the timelines developed in each community, perceptions of quality, particularly in Iganga, were often linked to the run down of services during the political turbulence of the 1970s and early 1980s. As discussed in Macrae (1996), many public health units in Uganda were essentially non-functional by the late 1980s. Community respondents perceived public facilities as still suffering from the effects of that collapse, with run-down and badly maintained buildings and a lack of basic equipment.

There were also many complaints that patients were very often not seen by fully qualified staff members but by 'assistants', whose status, training and ability sometimes gave rise to considerable suspicion. However, by far the most common concern with respect to quality of service, voiced by respondents in all study communities, related to the non-availability of drugs. Many cited instances where, having paid to see a health worker and been prescribed treatment, they were then told that required drugs were out of stock and would have to be purchased elsewhere. A number asserted that this reflected an illegal sale of public sector drugs by health workers, either directly to patients or to private providers. Access to drugs appeared to be a major factor in seeking private sector care, though it was also frequently suggested that private health workers were both more sympathetic, particularly in terms of allowing credit, and possibly more skilled.

In Hamuganda (Kabale), most people said that they would seek treatment at one of the private clinic if possible. Only those who had very little money would go to the government health centre. The private clinics seemed to be preferred not only because of their more friendly attitude to patients, but also because, though more expensive, they were seen in some ways as more honest than staff at the health centre: 'they provide drugs that are equivalent to the money paid'. Respondents frequently complained that they had need to pay the standard fee of 200shs to several health centre staff members before receiving attention, and then often found that the prescribed drugs were not available. Corruption and illicit practices by staff at government facilities was widely alleged. When asked to suggest improvements at such facilities, one respondent proposed a 'system of spies to report corruption and under dosage'.

A similar preference for the private sector was expressed in Kybando (Iganga). Here private clinics were judged superior on the basis of cost, proximity and convenience. The public health centre was regarded as very expensive, particularly given the perceived low quality of service. The standard treatment for malaria, for example, reportedly cost 2000-2500shs, when treatment in the private sector could be obtained for only 1,000shs. It was said that there were long waiting periods to see a junior health worker, who was often rude to

patients. Many people would be given only part of the drugs prescribed, having to purchase the rest from a drug shop. As in Hamuganda, the payment system was regarded as irregular and unsupervised, with patients routinely facing demands from the gate-man, records office and dispensing office. It was generally agreed that there had been no improvement in quality of care with the introduction of cost-sharing. Some respondents reported recent improvements in terms of refurbishment and replacement of equipment, which they attributed to the new source of funding, but regarded these as of limited importance.

It was clear from all the community exercises that the introduction of cost-recovery in health services was not usually considered in isolation, but was seen as part of an increasing burden of demands for cash payments. The other two main components of this burden were identified as taxation, though discussion as to exactly how and to what extent taxation impinged on the communities was not very illuminating, and the costs of education. This latter was almost universally seen by those with children of school age as posing the greatest problems. Many argued that they simply could not meet what they saw as the ever increasing demands for both health care costs and a variety of school fees and related educational outlays for their children.

In Kabale, focus group respondents typically estimated that between 25 and 50% of their total cash expenditure was spent on school fees and health care services. While routine charges at the dispensary were seen as generally affordable, with 200shs being quoted as the standard cost of a course of treatment, larger or regular health care payments were seen as a major problem. Serious or prolonged illness was identified as a major contributor to poverty. Many in the community were said to be very poor, to the extent that they suffered periodic periods of food shortage and their children often had little education because there was no money for school fees.

Similarly in Kybando (Iganga), disease was seen as a major threat to household livelihoods. It was said that many people had been driven into poverty by illness, having to sell productive assets including land and livestock. Households could also be forced into debt to meet health care costs, having to take loans which could only be secured by mortgaging their land.

In Bulyabwita (Iganga) the cost of health care was said to rank ahead of cash expenditures on school fees, food and essential household commodities. It was suggested that 20% of people with serious health problems could not afford treatment at either public or private sector providers. Many respondents complained that the quality of care at public facilities depended on the amount of money offered for treatment. "The health worker asks if you came with your 'brother', which means with money". 'Paying twice' for public services, through taxation and user charges, was widely resented. It was argued that health workers who are receiving government salaries should not ask fees in addition: "we do not know what the money from user charges does". The antagonism to fee paying was closely associated with poor services. "People are willing to pay if the tax is moved by local government and the quality of services is improved".

There was no support in either district for any form of broad based community support for those who could not afford health care. The usual response was that most people were very poor and simply could not afford to assist others outside of their immediate family. The community's responsibility was seen as limited to helping to transport a sick person to the health facility. In Kabale it was argued that households were already having to routinely borrow money or sell productive assets during lean periods of the year simply in order to survive, and had to retain whatever cash savings they earned to repay loans or repurchase assets. They were very

aware of the possibility that serious illness could well strike their own families but saw this, not as a reason for involvement in risk-sharing schemes, but rather as an additional reason for maintaining household savings.

It was suggested that most people could meet health care costs even for an illness that required expensive or prolonged treatment if they were willing to sell or mortgage land or livestock. Other members of the community might be willing to lend money, but this was seen as very much an individual decision and they would have to be very convinced that they would be repaid. It was argued that people were more willing to lend money to finance productive activities, where there was a reasonable prospect of repayment, than to finance illness which simultaneously increased a household's requirement for cash and reduced their earning capacity.

Questions as to what could be done for those with serious or chronic sickness whose households could not afford treatment, typically elicited the response that other family members would have to assist. Sometimes it was suggested that members of the extended family or friends in other communities, or those who had found employment in urban areas should be approached. On the other hand, some had doubts as to whether the traditional family support systems which had worked in the past would be able to provide help in future, given the high level of sickness in the communities and the limited opportunities for well-paid employment in the towns. It was recognised that some people simply would not be successful in raising money. In Hamuganda (Kabale) a focus group came to the conclusion that such people should 'just wait for God's mercy'.

In Bulyabita (Iganga), illness was again seen as a family concern, except in cases where there was no capable adult in a sick person's household. In such a case the community might provide some practical assistance to the children. In general people were said to be simply too poor to provide help to those in need of health care. On the other hand, if the sick person were to die, the community would have an obligation through the Burial Association to contribute food, firewood and labour to help with the funeral. Interestingly, this organisation also took a very active role in the promotion of improved household sanitation and hygiene to reduce disease risk, for example by assisting with latrine construction.

A number of possibilities for borrowing money to pay for health care were suggested. Private health care workers might be willing to provide credit. Traditional healers would usually agree to accept various forms of payment in kind. In Kybando (Iganga), drug shops were seen as helpful to people with little money because, unlike government facilities, they were usually prepared to offer treatment on credit. Repayment of this credit was said to be enforced by local officials, who had close links to those who ran the drug shops.

The next recourse would be to borrow from relatives or friends either within the community or outside. In both districts there were also individuals and community organisations that could be approached for loans. However, obtaining such a loan was said to always require security, either in the form of land or assets. In Habutiki (Kabale), for example, it was said that those who had problems with larger health costs could borrow money for three months from the community credit organisation. However, interest of 10% per month would be charged and the loan would have to be secured with land. Failure to repay could result in confiscation until the money was forthcoming.

Focus groups of women, particularly in Iganga, stressed that they were in a particularly difficult position with regard to payment for health care. In many households it was said that women were required to take sole responsibility not only for their own health but for that of their children. However, it was frequently the men in the household who had available cash, particularly where this was derived from cash crop sales, and were

therefore the effective decision makers in terms of seeking health care. There was also an expectation that women would care for those who became sick, increasing their work load and reducing the time available to earn income.

5 THE HEALTH FACILITY SURVEY

Sample villages were selected on the basis that they were served by at least one functioning and effective public health facility, such that access was not restricted by basic supply side constraints. This was not by any means an unlikely possibility. The system of rural health care facilities in Uganda was almost completely disrupted during two decades of political and social upheaval. Though a very active rehabilitation programme is in progress, many facilities are still very run down, poorly equipped and staffed by personnel who are often poorly motivated due to a combination of low salaries and very limited supervision (Okello, 1998).

In theory, there should be a rural network of PHC facilities: dispensaries, staffed by a medical assistant and a nurse; dispensary-maternity units (DMUs) with maternity beds and additional staff with midwifery skills; and health centres, with 24 beds, staffed by a medical officer and 4-6 nurses. In practice, many lower level facilities are run by 'ward maids', (often referred to as nursing assistants or nursing aides), with only on-the-job training, because qualified nurses are not available.

As described above, the initial selection procedure was based on the advice of district health officers. During the study the facilities identified by them as primarily responsible for serving each study community were assessed using a methodology derived from that developed by the African Medical and Research Foundation (AMREF) (Kielmann, 1991, Kipp, 1991 and 1994). Tables 5.1 and 5.2 summarise the outcome of those assessments which broadly confirmed the initial discussions at district level. Functioning public facilities with trained personnel, equipment and drugs were available to all the study populations, though overall conditions were at best adequate and at worst highly undesirable.

Table 5.1 Overview of surveyed facilities in Kabale

	Kagarama	Igomanda	Nyakasiru	Kigara
Type	Dispensary	Dispensary	Health Centre	Health Centre
Physical condition	Maintenance required	Good condition	Reasonable	Maintenance required
Cleanliness	Reasonably good	Good	Unsatisfactory	Reasonable
Services	Curative, MCH, EPI, FP	Curative, MCH, EPI, FP	Curative, MCH, EPI, FP	Inpatient, Curative, MCH, EPI, FP
Qualified staff	Nurse	Two nurses	Two nurses	Medical officer, two nurses
Standard visit fee	200shs	200shs	200shs	200shs inpatient 500shs
Patients per day per qualified health worker	31.2	14.4	13.8	14.3
Annual visits per capita	0.29	0.29	0.27	0.28

Table 5.2 Overview of surveyed facilities in Iganga

	Nakyere	Buwongo	Lugolole	Mayuge
Type	DMU	Health Centre	DMU	Health Centre
Physical condition	Reasonable	Reasonable	Reasonable	Reasonable
Cleanliness	Unsatisfactory	Satisfactory	Satisfactory	Satisfactory
Services	Inpatient, Curative MCH, EPI, FP	Inpatient, Curative MCH, EPI, FP	Curative MCH, EPI, FP	Inpatient, Curative MCH, EPI, FP
Qualified staff	Medical assistant Two midwives	Four nurses	Nurse	Nurse
Standard visit fee	500shs	500shs inpatient 1000shs	1,000shs	500shs
Patients per day per qualified health worker	17	16	10	13
Annual visits per capita	.3	0.3	0.1	.3

6 FINDINGS FROM THE HOUSEHOLD SURVEY

6.1 Demography

The 200 surveyed households in each district provided data on 1,519 individuals in Iganga and 1179 in Kabale (Table 6.1). Female respondents slightly predominated in both districts, accounting for 52.3% of the total in Iganga and 53.7% in Kabale. The age distributions were similar, though the proportion in the age range 15-34 was somewhat lower in Iganga, particularly for males. This may reflect higher levels of out-migration for this group, given the proximity to Kampala.

Table 6.1 Age/sex composition of sample households

District	Age group	Male	Female	Total
Iganga	0-4	16.1%	16.1%	16.1%
	5-14	36.3%	35.8%	36.0%
	15-24	18.9%	17.1%	18.0%
	25-34	7.4%	9.7%	8.6%
	35-44	7.0%	8.2%	7.6%
	45-54	5.1%	6.2%	5.7%
	55-64	4.7%	3.0%	3.8%
	65+	4.4%	3.9%	4.1%
	Total	725	794	1519
Kabale	0-4	14.3%	17.2%	15.9%
	5-14	34.1%	36.0%	35.1%
	15-24	21.6%	17.9%	19.6%
	25-34	9.2%	11.2%	10.3%
	35-44	7.0%	7.7%	7.4%
	45-54	7.3%	4.4%	5.8%
	55-64	3.3%	3.5%	3.4%
	65+	3.3%	2.1%	2.6%
	Total	546	633	1179

Some 19% of households in Kabale had a female head, as compared with 11% in Iganga. The large majority of female-headed households were reported as due to widowhood, around 67% in both districts.

6.2 Wealth distribution

Two basic approaches were adopted in an attempt to examine the distribution of wealth between and within districts. The first involved a direct estimation of the value of the principle items of wealth ownership indicated by the qualitative fieldwork: land and animal stock. Each household was asked to estimate the total area of land owned and the number of various types of livestock animals. They were also asked to value their holdings of each. Using the value estimates, a median unit value was calculated and applied to the quantity data, on the assumption that this was probably the more reliable. On this basis, table 6.2 indicates very similar average wealth holdings in the two districts.

Table 6.2 Mean estimated land and stock values (,000shs)

District	Mean estimated land value	Mean estimated stock value
Iganga	1,761	106
Kabale	2,053	101
All	1,906	103

The distribution of land (in hectares) and animal stocks (by estimated value) within districts are shown in tables 6.3 and 6.4. These indicate a somewhat greater inequality of wealth holding in Iganga, with the bottom 30% of households each owning less than 1 hectare, compared to 2 hectares in Kabale, while the top 30% have holdings greater than 4.65 hectares compared to 5 hectares in Kabale. A similar pattern holds for stock. In this case the 70th percentile for Iganga is considerably higher than that for Kabale, while the 40th percentile is lower.

Table 6.3 Landholding distribution (hectares)

Percentiles	Iganga	Kabale
30%	1.00	2.00
40%	2.00	2.50
50%	2.25	3.00
60%	3.00	4.00
70%	4.65	5.00

Table 6.4 Distribution of stock by value ('000shs)

Percentiles	Iganga	Kabale
30%	0	0
40%	4	6
50%	15	20
60%	30	40
70%	120	92

For analytical purposes the above indicators were used to classify sample households into those above and below the district median on each. For convenience the below-median groups will be referred to as land-poor and stock-poor respectively.

The second (indirect) approach to wealth holding, again derived from the qualitative fieldwork, was via the construction materials used in dwelling construction, which were directly observed by the enumerators. Roofing material, usually regarded as the most useful such indicator, showed remarkable similarity between districts (table 6.5), with around one third of households in each using thatch as opposed to purchased corrugated iron sheet. The other two indicators for walls and floors suggest that the use of more expensive material (brick and cement) was somewhat more common in Iganga, with around 30% of houses using burnt or unburnt brick for wall construction as compared to just 5% in Kabale.

Table 6.5 Distribution of households by dwelling construction materials

	Roof		Walls		Floor	
District	Thatch	Iron Sheet	Mud/ Poles	Brick	Earth	Cement
Iganga	33	67	70	30	84	16
Kabale	30	70	95	5	94	6

As might be expected, there was a reasonable degree of convergence between the wealth indicators. Table 6.6 shows the percentage of households classified as 'poor' according to the row indicator who also fall into this category on the basis of the column indicator. For example, 68.8% of those in Iganga with thatched roofs are also in the land-poor category while 69.6% are in the stock-poor category. However, given that the degree of over-lap is limited, all three indicators were retained.

Table 6.6 Extent of convergence of wealth indicators (%)

District		Land-Poor	Stock-Poor
Iganga	Thatch	68.8	69.6
	Land-Poor		63.6
Kabale	Thatch	69.6	71.2
	Land-Poor		66.3

6.3 Household incomes and expenditures

One issue frequently raised by community members in the qualitative studies was that demands for cash payments has risen consistently in recent years, for example in the form of education fees, health care costs and tax payments. Even though overall agricultural production might be adequate, households could still find great difficulty in generating sufficient cash resources at certain times of year. It was the possibility of sickness at a time of cash scarcity that raised most cause for concern.

At the time of each monthly enumeration, therefore, households were asked to estimate cash income derived from a variety of sources since the previous visit. In table 6.7 these activities are grouped into three broad categories: output from productive activities, wage income and income from trading. Overall, total cash incomes over the three month period appear very similar between the two districts. However, while incomes

from each source were relatively stable in Kabale, Output income in Iganga was very high in the first month, probably reflecting sales of cash crops as indicated above, but then fell substantially in months two and three.

Table 6.7 Average monthly household income by source

	Month	Output	Wages	Trade	Total
Iganga	1	63,709	17,749	20,748	102,005
	2	13,792	24,103	25,490	63,439
	3	16,763	26,405	17,752	60,618
	All	31,446	22,746	21,336	75,379
Kabale	1	23,629	32,291	11,530	67,518
	2	24,463	19,220	17,095	60,778
	3	25,693	32,018	20,160	77,921
	All	24,595	27,843	16,261	68,739

On average, monthly incomes varied in line with each of the household wealth indicators. This was not an obvious correlation, since the wealth indicators involved either quantity measures or imputed valuations of quantity measures, while the income estimates related strictly to cash flows. However, in general the survey indicated that the wealthier households had cash incomes roughly twice those of the poorer. Note that, though roof materials appears to indicate the greatest differential, this is probably simply a reflection of the smaller numbers of households with this characteristic (around 30% of households have thatched roofs while the other two indicators are based on the 50% of households above and below median values).

Table 6.8 Average monthly income by household wealth indicators

District	Land-Poor		Stock-Poor		Thatch Roof	
	Yes	No	Yes	No	Yes	No
Iganga	54,102	96,839	53,426	98,420	41,291	92,241
Kabale	53,481	81,890	51,413	87,634	41,177	78,488

To gain some impression of household cash expenditures, without resorting to lengthy and detailed inquiries, the survey collected information on reported outlays each month for three selected items which had been identified by the study communities as key cash expenditure areas: food, clothing and education (table 6.9). The first month of the survey coincided with payment of school fees and this clearly has a major impact on expenditures, reflecting the concern with education costs described above. For those with at least one child in school, education expenditures accounted, on average, for around one quarter of monthly income in both districts. It was also indicated that the higher expenditure on clothing in this month was also partly a reflection of the start of a new school term.

The relatively high monthly income in Iganga in the month when school fees were paid may account for the considerable difference in school attendance between the two districts. In Kabale 28% of 6-10 year-olds surveyed (the target group in Uganda for Universal Primary Education by the year 2000) were not attending school, whereas in the Iganga communities the proportion was reported at less than 5%. As the expenditure

data refer to overall household expenditures, they might seem to indicate that in many household in Kabale only some children of school age were attending.

Table 6.9 Average monthly expenditure on food, clothing and education

	Month	Food	Clothing	Education ¹
Iganga	1	15,965	7,525	23,422
	2	15,483	3,099	5,234
	3	15,048	1,085	3,296
	All	15,499	3,908	10,663
Kabale	1	10,490	7,343	14,223
	2	11,873	2,758	1,559
	3	15,301	1,657	880
	All	12,554	3,919	5,554

1. Only for those households with expenditure on education

Education expenditure was by far the most important factor distinguishing the expenditure patterns of wealthier and poorer households in both districts. While the wealthier had somewhat higher expenditures on food and clothing (though only marginally so in Iganga), their expenditures on education (comparing only households with some educational expenditure) were between three and four times those of the poorer.

Table 6.10 Average monthly expenditure by wealth indicator

District	Action	Land-Poor		Stock-Poor		Thatch Roof	
		Yes	No	Yes	No	Yes	No
Iganga	Food	13,189	17,583	13,376	17,706	13,143	16,667
	Clothing	3,943	3,952	3,865	3,993	3,105	4,290
	Education ¹	5,226	19,714	6,969	18,586	5,240	15,928
Kabale	Food	10,309	14,882	10,450	14,850	11,388	12,946
	Clothing	3,195	4,756	3,118	4,794	3,088	4,286
	Education ¹	5,383	9,374	2,955	11,963	2,817	8,936

1. Only for those households with expenditure on education

6.3 Community groups

Our initial aim in the selection of districts for study was partly determined by the expected level of household involvement in various types of relevant community organisations: those potentially ready to provide cash assistance in times of hardship, which could include periods when household expenditure was increased or income diminished by sickness. Preliminary discussions had strongly suggested that while such organisations were particularly well established in Kabale, they were very weak in Iganga. Table 6.11 would appear to strongly support this initial assessment. In Kabale, almost all households reported active membership (attending meetings, contributing to funds, engaging in joint activities) of such organisations, compared to just over one quarter of households in Iganga. (Note that households may belong to more than one type of organisation).

Though the number of such community groups in both districts was very large, it was possible to combine the great majority into three categories in terms of their main purpose: production/income, involving an income generating activity such as crop processing; savings/credit, where money was paid into a fund from which loans were available; and burial. The latter, though primarily intended to meet the costs associated with a customary

burial ceremony (which was regarded as extremely important in both districts), were also said to sometimes provide loans for other purposes, including meeting the costs of illness. Savings and credit organisations were the most commonly reported in both districts, though whereas some 65% of households in Kabale were members of such groups, the corresponding figure for Iganga was just over 11%.

Table 6.11 Community group membership

District	Community group purpose	Number of Households	% of Households
Iganga	Production/income	21	10.6
	Savings/credit	22	11.1
	Burial	12	6.0
	All	54	27.1
Kabale	Production/income	49	24.5
	Savings/credit	131	65.5
	Burial	126	50.2
	All	187	93.4

There was some evidence of an association between community group membership and the household wealth indicators described above (table 6.12). This was particularly evident in Iganga, where only around one quarter of the membership of production/income and savings/credit groups was made up of land-poor or stock-poor households, who made up one half of the overall sample. The pattern was similar but much less marked in Kabale.

Table 6.12 Community group membership by wealth indicators (%)

District	Community group purpose	Land Poor Households	Stock Poor Households	Thatch Roof
Iganga	Production/income	23.8	23.7	33.3
	Savings/credit	27.3	27.0	4.8
	Burial	33.3	33.3	8.3
	All Households	50.0	50.8	32.8
Kabale	Production/income	39.6	40.8	28.6
	Savings/credit	43.8	42.0	28.2
	Burial	49.2	55.6	30.2
	All Households	50.8	52.0	29.6

6.4 Health care seeking behaviour

Table 6.13 shows the number of household members seeking care by reason over the three months of the survey. Around 20-25% of individuals reported a need for some form of health care (including self-medication) over the period, with limited variation from month to month. The overall proportion seeking care in Kabale was some 6% higher on average than in Iganga. Acute sickness accounted for around 80% of cases in Iganga and 87% in Kabale, while chronic sickness was reported in just under 10% and use of antenatal services in around 2-3% of cases in both districts. Postnatal services and immunisation was cited as the reason for seeking care in some 10% of cases in Iganga but in less than 2% in Kabale. There was no obvious explanation for the higher

level of the latter in Iganga, though it was reported that district health authorities had recently conducted a promotional campaign in the study area.

Table 6.13 Number of household members seeking health care by reason over survey period

District	Reason	Month 1	Month 2	Month 3	Total	% Cases
Iganga	Acute sickness	236	237	191	664	78.6
	Chronic sickness	36	11	34	81	9.5
	Antenatal	5	6	8	19	2.3
	Postnatal/Immunisation	43	16	22	81	9.6
	Total	320	270	255	845	100.0
	Percent of all members	20.9	17.6	16.7	18.4	
Kabale	Acute	269	219	266	754	87.5
	Chronic	34	22	13	69	8.0
	Antenatal	6	12	6	24	2.8
	Postnatal/Immunisation	3	9	3	15	1.7
	Total	312	262	288	862	100.0
	Percent of all members	26.5	22.2	24.4	24.4	

On average, the proportion of individuals reporting acute or chronic sickness per month was 16.4% in Iganga and 23.3% in Kabale. Both figures are relatively high, implying annual illness incidence rates of 2.0 and 2.8 per person or 15.2 and 16.5 per household. As usual when considering data on self-reported illness, it is not clear whether the actual or comparative number of cases genuinely indicates higher levels of ill health, particularly in Kabale, or a greater propensity to report. As the current survey, in order to focus on total health expenditure, emphasised the need to collect information on all those who indicated that they had felt in need of some form of health care, it is probable that the above will include many relatively minor health problems, the reporting of which may be subject to high variation between geographical and cultural group.

Table 6.14 considers the distribution of the population reporting sickness by sex, age and household wealth indicators. For all factors except age the proportions are similar to those for the sample as a whole, with neither sex nor household wealth appearing to influence the probability of reported sickness.

The distribution by age is somewhat surprising, particularly given the health facility attendance data reported above, in that the representation of children is less than might be expected. The proportion of those under five is equal to their population share in Kabale (table 6.1), though somewhat higher in Iganga, and in both districts the 5-14 year age group are considerably under-represented. More predictably, the proportion of those over 55 in the group reporting sickness is around twice their share in the overall sample.

Table 6.14 Proportion of those sick by sex, age-group and wealth indicators (%)

District	Females	0-4	5-14	15-54	55+	Land-Poor Household	Stock-Poor Household	Thatch Roof
Iganga	52.5	22.1	23.2	40.5	14.1	49.9	48.7	31.8
Kabale	54.7	15.3	22.1	50.9	11.7	44.7	46.5	28.2

Table 6.15 shows the actions taken by those seeking care (note that more than one course of action was often taken in a single case). By far the most prevalent was self-medication using either home remedies or purchased drugs. Use of home remedies, often as an initial measure, was reported in just over 60% of cases in Iganga and just under 70% in KAabale. The extent to which purchased allotropic drugs were used for self-medication was much more difficult to estimate as it was impossible to distinguish in the survey between instances of simple drug purchase and genuine consultation with a private provider. As discussed above, for example, it was very common for patients to obtain a prescription from a public sector provider and then be instructed to purchase the required drugs from the private sector, which might involve a recognised private provider, a local shop or a market trader.

Consultation with health providers certainly appeared to be considerably more frequent in Kabale than in Iganga. Traditional healers were used more than twice as often (13% as compared to 6%) while public and NGO health facilities were consulted in 59% of cases in Kabale and 41% of cases in Iganga. This pattern is clearly strongly influenced, as indicated above, by the availability of NGO primary care facilities in three of the four parishes of Kabale. While it might have been assumed that there would be a degree of substitution between these two sources of care, attendance at public facilities remains at a similar level to that in Iganga, where NGO facilities were rarely used.

Table 6.15 Types of action taken by those seeking care

Type of action	Iganga	%	Kabale	%
Home remedy	533	62.3	590	68.4
Village health worker	6	0.7	5	0.6
Traditional/religious healer	47	5.6	115	13.3
Drug purchase/Private provider	246	29.1	293	34.0
Mission/NGO hospital/clinic	15	1.8	207	24.0
Public health centre/post	269	31.8	260	30.2
Public hospital	64	7.6	44	5.1
Cases	845		862	

The response to illness often involves not one but a sequence of decisions. In many cases the condition will be ignored or tolerated for a period in the hope that it will be short-lived. This may be followed by the use of local remedies or other medicines available within the household, with an approach to an outside provider made only when the illness fails to respond. Again, the first provider approached may be decided mainly on the basis of low cost or convenience, with more expensive or remote providers used only if the former also prove unhelpful. Clearly, the detailed sequence of health care decisions may depend on a number of factors, particularly including the severity of the illness and the individual affected. However, it will also probably depend on the extent to which households are reluctant to spend money on seeking care.

The initial action taken in the event of sickness by study household is shown in table 6.16. The main differences between the two districts appeared to centre on the greater use of public and NGO facilities, visited by 21% of those in Kabale as compared with 14% in Iganga. This would appear to be offset by the much greater use of purchased drugs/private providers in the latter.

Table 6.16 Initial action taken by those seeking care

Type of action	Iganga (%)	Kabale (%)
Home remedy	64.6	68.7
Village health worker	0.5	0.1
Traditional/religious healer	2.6	3.2
Drug purchase/Private provider	18.1	3.4
Mission/NGO hospital/clinic	1.1	6.5
Public health centre/post	10.7	14.3
Public hospital	2.4	1.3
Not specified	0.0	2.5
All	100.0	100.0

Given the high proportion of cases in which home remedies are the preferred initial course of action in both districts, table 6.17 examines the subsequent action taken by this group. The most striking difference is clearly that, while nearly 50% of those in Iganga did not pursue any other treatment, this only applied to 17% of those in Kabale, where some 28% seek treatment from the private sector (including drug purchase), and 43% public sector or NGO consultations. In Iganga, a considerable proportion, 34%, do turn to public or NGO facilities, while 13% opt for the private sector.

Table 6.17 Subsequent action taken by those initially using home remedies

Type of action	Iganga (%)	Kabale (%)
None	49.5	17.2
Village health worker	.4	.7
Traditional/religious healer	3.4	11.5
Drug purchase/Private provider	13.0	27.7
Mission/NGO hospital/clinic	.6	22.5
Public health centre/post	30.2	19.4
Public hospital	2.9	1.0
All	100.0	100.0

Tables 6.18a and 6.18b summarise the sequence of actions taken in individual cases by grouping them into broad categories: traditional (home remedy, village health worker, traditional/religious healer), drug purchase (drug purchase/private provider) and public facility (public or NGO health centre and public hospital). They would seem to support the claim made by the qualitative study communities in Kabale that drugs were often in short supply at public facilities. Over 17% of those who went directly to such facilities, and over 19% of those who used them as a secondary course of action, subsequently used the private sector, in most cases probably to obtain required drugs.

Table 6.18a Grouped secondary action taken classified by primary action (%)

District		Secondary action				
	Primary action	None	Traditional	Drug purchase	Public facility	Cases
Iganga	Traditional	49.4	3.6	13.8	33.2	549
	Drug purchase	84.2	2.7	2.1	11.0	146
	Public facility	77.1	5.1	8.5	9.3	118
Kabale	Traditional	18.4	13.1	26.8	41.7	609
	Drug purchase	75.9	3.4	0.0	20.7	29
	Public facility	60.4	4.8	17.1	17.6	187

Table 6.18b Grouped tertiary action taken classified by secondary action (%)

District		Tertiary action				
	Secondary action	None	Traditional	Drug purchase	Public facility	Cases
Iganga	Traditional	70.0	3.3	6.7	20.0	30
	Drug purchase	83.1	2.2	1.1	13.5	89
	Public facility	86.1	1.9	6.2	5.7	209
Kabale	Traditional	77.8	2.2	11.1	8.9	90
	Drug purchase	90.8	2.0	0.5	6.6	196
	Public facility	65.6	4.4	19.4	10.5	294

There appeared little relationship between household wealth indicators and the choice of action in case of sickness. Table 6.19 relates each of the wealth indicators to the broad classifications of health seeking actions and also to hospital use. Only for this final category is there evidence of greater use by those in the higher wealth category.

Table 6.19 Actions taken by household wealth indicators

District		Land-Poor		Stock-Poor		Thatch Roof	
	Action	Yes	No	Yes	No	Yes	No
Iganga	Traditional	67.9	64.8	68.6	64.4	62.5	68.1
	Drug purchase	30.9	28.0	31.4	27.4	33.7	27.0
	Public facility	39.8	38.0	39.7	39.3	38.6	36.9
	Hospital	6.0	9.3	7.8	7.4	4.5	9.0
Kabale	Traditional	73.0	69.4	74.8	69.8	71.5	72.3
	Drug purchase	38.7	29.3	35.2	33.0	32.6	34.2
	Public facility	54.8	54.0	54.4	54.7	57.9	53.3
	Hospital	4.4	5.9	3.2	6.7	3.7	5.7

6.5 Health care expenditures

Table 6.20 sets out the median and mean monthly medical costs per patient in the two districts over the three months of the survey. Clearly, typical expenditures on health care were reported to be considerably higher in Iganga, with median expenditures roughly twice those in Kabale. Mean expenditures, on the other hand, are only slightly higher, reflecting a very highly skewed distribution in Kabale, with a limited number of very high expenditures.

The pattern of expenditures over time are similar, with the first month showing by far the highest levels. The reasons for this are unclear. Though this month did have the highest rate of reported sickness (table 6.13), which may be related to higher relative levels of more severe illness, it is doubtful that this alone would account for the differences shown. Higher income levels in Iganga during the initial survey period may also have contributed to a greater willingness to allocate money to health care costs at this time. Though on the basis of reported incomes this argument would not appear to apply in Kabale, table 6.9 above does show much higher levels of reported expenditure on clothing in the first month of the survey in both districts.

Table 6.20 Total medical fee expenditure per patient by month of sickness for those seeking care

District	Month	Median expenditure	Mean expenditure
Iganga	1	2000	4,342
	2	1850	2,967
	3	1300	2,596
	All	1800	3,376
Kabale	1	1350	4,288
	2	550	2,632
	3	600	1,948
	All	800	3,003

Average expenditures will clearly be strongly influenced by the type of health care provider, and table 6.21 indicates the variability in treatment costs between the various types of provider considered. The most obvious difference between the two districts relates to the very different reported costs of public health facilities. In Kabale, the median reported cost per visit at both public and NGO facilities is exactly equal to the official standard charge of 200shs, while in Iganga the reported 1500shs median fee is three times the equivalent 500 shs. charge. Again, the mean costs show much less variability, except in the case of public hospitals. Here again, though caution is required as sample sizes are relatively small for estimation and costs per case extremely variable, reported median and mean expenditures are approximately twice as high in Iganga.

Table 6.21 Cost of care by type of provider

		Number	Median	Mean
Iganga	Home remedy	533	600	1,040
	Village health worker	6	650	683
	Traditional/religious healer	49	1800	3,888
	Drug purchase/Private provider	252	2000	2,786
	Mission/NGO hospital/clinic	15	4000	7,020
	Public health centre/post	277	1500	2,101
	Public hospital	66	4250	10,370
Kabale	Home remedy	592	0	405
	Village health worker	5	1000	1,100
	Traditional/religious healer	123	1000	1,441
	Drug purchase/Private provider	295	2400	3,171
	Mission/NGO hospital/clinic	210	200	1,824
	Public health centre/post	287	200	1,636
	Public hospital	44	2000	5,789

The primary focus of the current research was on overall household cash expenditures on health care. The survey attempted to estimate total outlays by asking households to report on fee payments, travel costs and other costs. This final category was simply intended to determine if all respondents were including costs of drugs and other medical supplies under the fee category. As discussed above, health care seeking actions often involved two stages: consultation, diagnosis and prescription by one provider; followed by purchase of drugs or other materials from another.

Clearly, households which had no members with sickness episodes in any given month will have made no expenditures on health care costs. Calculating average expenditures on health care over all households could be said to provide unrepresentative estimates of the impact of meeting such costs. For this reason the mean and median fee and overall health expenditures in table 6.22 include data only for those households with at least one sick member.

Table 6.22 Expenditure on health care: households with at least one sick member

District	Month	Median Expenditure		Mean Expenditure	
		Fees	Total	Fees	Total
Iganga	1	3,000	3,600	7,164	10,222
	2	2,600	3,000	4,240	5,775
	3	2,000	2,750	3,521	4,949
	All	2,500	3,000	4,997	7,014
Kabale	1	2,450	2,675	7,272	10,854
	2	1,800	2,000	4,629	6,705
	3	1,100	1,200	3,442	4,605
	All	1,900	2,200	5,219	7,554

Note that the higher reported incidence of sickness in Kabale households partly offsets the higher expenditure per case in Iganga, narrowing the differences between the two districts. The monthly pattern of expenditure discussed above is also seen at the household level., though it is again less pronounced. Overall, reported expenditures on health care appear to represent a small but far from negligible proportion of aggregate household cash budgets in both districts, comparable to that to that spent on clothing and around 20-25% of the proportion allocated to food (table 6.9). However, as the gap between median and mean expenditures indicates, average measures need careful interpretation.

Clearly, the great majority of illness events recorded in the survey could be described as routine, with relatively simple and inexpensive treatments. Indeed, as indicated in the facility survey, symptoms of fever, breathing problems or diarrhoea trigger the majority of care seeking actions. Not only providers but patients themselves are very familiar with such symptoms and have clear expectations as to treatment and cost. The highly skewed nature of the distribution of health costs, however, indicate that a considerable number of households face much higher expenditures, presumably for more severe or chronic conditions.

Comparing health care expenditures across the household wealth indicators (table 6.23) would suggest that poorer households have somewhat lower outlays. As the discussion above indicates that they have similar sickness rates and very similar patterns of utilisation of providers, lower expenditures would seem to reflect lower payments for treatment.

Table 6.23 Health care fee cost by household wealth indicators

District		Land-Poor		Stock-Poor		Thatch Roof	
		Yes	No	Yes	No	Yes	No
Iganga	Mean	4450	5444	4763	5109	3446	5664
	Median	2500	2500	2400	2750	2200	2700
Kabale	Mean	5460	5144	3634	6766	3471	5941
	Median	1650	2000	1500	2400	2000	1800

6.6 Meeting health care costs

Households were asked to indicate the means by which they had obtained the money to pay for health care. As table 6.24 indicates, in the majority of cases these costs were reported to be largely funded from existing cash or from crop and produce sales. (Note that the difference between these two categories may involve a somewhat artificial distinction: between sales specifically intended to meet health costs and other, possibly routine, sales.). Over the total period of the survey, households in Kabale appeared to have least difficulty raising funds, with some 75% meeting costs from one of the above sources. Clearly this may be related to the relatively lower cost of care in this district.

In Iganga, though payment from available cash was common in the first month, overall around 40% of households adopted one or more alternative methods, the most important being working for others (16% of cases), borrowing from friends (14%) and selling assets (8%). The latter commonly related to livestock and farm tools; there were no reports during the survey of land sales to meet health care costs, though land was used to secure loans as discussed below.

Table 6.24 Method of raising money to pay for health care¹

Method of raising money	Iganga		Kabale	
	No.	%	No.	%
Money available/savings	290	34.3	493	57.2
Sale of crops or produce	211	25.0	169	19.6
Worked for others	135	16.0	86	10.0
Sold assets	67	7.9	29	3.4
Loan from relative	16	1.9	36	4.2
Loan from friend	117	13.8	30	3.5
Loan from community group	4	0.5	12	1.4
Loan from others	5	0.6	2	0.2
Cases	845	100.0	862	99.6

1. More than one method may be adopted in a single case.

Table 6.24 indicates that community groups were approached for financial assistance in only a tiny number of cases, 4 out of 845 in Iganga and 12 out of 862 in Kabale. Borrowing specifically to pay for health care was almost entirely confined to relatives and friends. This would seem to reinforce the findings from the qualitative fieldwork on community attitudes to borrowing. Community organisations with collective funds available for loan were typically regarded as mechanisms for overcoming seasonal shortages of cash. They were certainly not seen as general social funds available for those in need. Those who borrowed from such funds would be contributing members who could offer adequate security, for example in the form of land, and meet interest

charges. They would also have to follow the fairly formal procedures adopted by the organisation and perhaps make their case in competition with others.

Given these barriers to access to community group funds, it is not surprising that households do not appear to seek loans *for health care*. Loans are instead taken out either for specific production-related activities or in response to a general lack of cash resources. Health care costs may contribute to the perceived need for such loans, but only alongside other demands for cash, for example to purchase livestock or farm equipment or pay school fees. If loans in general are considered, considerable differences are found between the two districts, which strongly reinforce the initial premise as to the role of community groups in Kabale.

Over the three rounds of the survey, there were 219 instances in Kabale and 304 in Iganga where households reported borrowing money during the previous month. In almost all cases a single source provided the loan. Table 6.25 categorises these loans by the source of funds.

Table 6.25 Loans taken out by source

District	Source of Loan	Number of Loans	% of Loans	Average Loan
Iganga	Relatives	70	22.3	12,964
	Friends/neighbours	227	72.3	13,911
	Community group	17	5.4	41,965
	All	314	100.0	15,720
Kabale	Relatives	23	9.9	20,574
	Friends/neighbours	81	34.8	18,927
	Community group	117	50.2	40,751
	Bank	12	5.2	146,667
	All	233	100.0	38,969

In Kabale community organisations provide just over 50% of all loans, compared to just over 5% in Iganga. Given that loans from such sources are on average twice the size of those obtained from either relatives or friends, their contribution to total borrowing is clearly extremely important. Overall it can be argued that the study communities in Kabale appear to have developed an elaborate system of community based savings and loan organisations which are used to smooth out the considerable fluctuations in cash resources over the course of the year. This systems almost certainly assists in meeting health care costs alongside other demands for cash, though households would not usually identify such costs as the reason for taking the loan.

6.7 Non-financial assistance to households in coping with sickness

In the final part of the monthly survey, households were asked questions as to whether any individuals or groups within the community had provided other than financial help during the sickness of a household member. Possible forms of assistance listed included the provision of goods such as food or clothing, nursing care, help with household chores or child-minding and unpaid labour. Responses to this question strongly reinforced the perception that sickness was regarded in both communities as essentially an issue for households and extended family members. As shown in table 6.26, only some 3% of households in both districts reported any assistance from non-relatives, with no reported input from organised groups.

Table 6.26 Non-financial help received from outside household

	Source	number	%
Iganga	None	661	78.2
	Relative	159	19.7
	Friend/neighbour	24	3.0
	Hired	1	.1
	Total	845	100.0
Kabale	None	771	89.4
	Relative	62	7.2
	Friend/neighbour	29	3.4
	Total	862	100.0

7 CONCLUSIONS

It would appear that the concept of 'utilisation', which is usually taken as a primary consideration when assessing health services, has become a complex issue in rural areas in Uganda. Many of those who visit a public facility, often paying for services on entry, may be seen not by the expected nurse or other recognised health worker, but by an 'assistant', whose qualifications and abilities are unknown to them. They may be prescribed drugs by this assistant and then told that those drugs are unavailable in the facility and must be purchased from private sector providers. Recording such a visit simply as 'use of public facility' clearly does not provide a realistic account of the transaction and may give a highly misleading impression of the adequacy of health services.

It may be particularly important to examine the concept of access in relation to poorer households. Surprisingly, the survey appeared to show little variation in health care seeking behaviour between rich and poor households, except that the utilisation of hospitals by the latter group was much lower. However, the survey made no attempt to consider the quality of treatment. Reported treatment costs are lower for poorer households, which might indicate either that they are charged less for required treatment (for example richer households may be prescribed more drugs than they require) or that they receive less or poorer treatment, for example in the form of partial prescriptions.

A very large proportion of sickness relates to a very limited number of symptoms. Fever, cough and diarrhoea, along with injuries, predominate the reasons for seeking assistance. Communities have come to see these indications of sickness as a routine aspect of life and they have fixed ideas as to the seriousness of each condition and expectations as to appropriate treatments and costs. Serious illness is seen as a potential disaster, about which they can do little, but in financial terms the costs of treatment for common ailments are viewed simply as yet one more burden among many.

Though there was a residual resentment at the introduction of fees for a service which many believed they had 'already paid for in taxes', the official charges levied at facilities were generally seen as affordable, and acceptable if they were associated with improvement in quality. However, there was considerable evidence of a range of routine illicit charges which considerably inflated the cost of care. Though there is a long history of such practices in Uganda, and public sector salaries are so low that they are almost inevitable, there was concern that the introduction of cost-sharing was being used to blur the distinction between official and unofficial charges, and justify their imposition. The finding in Kabale, district, that the majority of patients at public

facilities reported paying the official cost of 200shs, was very encouraging. However, as indicated above, many of those patients subsequently had to visit private providers to obtain prescribed drugs, often at considerably greater expense.

The impression gained at facilities in both districts was that health staff have considerable autonomy. They appear to decide on charging practices, credit arrangements, and qualification for payment exemption and often take on 'trainees' or 'assistants', whose official status is unclear. Record keeping at most facilities does not allow effective monitoring of services or auditing of finances (see also Ablo, 1998 and Uganda, 1996b). This could prove a considerable problem if it is intended that at least part of the official fees should be used to improve services.

Whether licit or illicit, charges at public health facilities are usually payable in cash and credit is offered infrequently and at the discretion of facility staff. Affordability of health services is thus linked to the availability of cash resources in the household when required. It was particularly evident in Kabale district, that many households, while being reasonably self-sufficient in terms of food crops, had at least considerable seasonal problems in raising cash. They were also very aware of increasing demands on what little cash resources they did have, particularly in terms of meeting school fees and other educational expenses.

7.7 The majority of payments for health care were made from available resources or sales of agricultural produce. However, in some 25% of cases in Kabale and around 40% in Iganga, money had to be raised by working for others, selling assets or borrowing. This would appear to indicate that finding money for health care is frequently far from straightforward.

7.8 Though the initial assumption of high levels of involvement in community organisations in Kabale as compared to Iganga was strongly supported by the study, there was no evidence that those organisations played an important direct role in providing either financial or other assistance to households facing difficulties due to the sickness of members. Health care was seen very much as an individual or family responsibility. It was generally argued that communities were 'too poor' to provide assistance through collective funds.

7.9 On the other hand, community savings and loan organisations in Kabale did appear to provide a very important indirect financial role by making money available at times of cash shortage. Indeed the majority of reported loans in Kabale came from such organisations as compared to only 5% in Iganga. Such loans were typically neither sought nor offered *for health care*. Households perceived their problem in terms of a general shortage of cash to meet a variety of demands, which at times of sickness might include health care costs.

7.10 In both communities borrowing and repayment, or alternatively sale and repurchase of assets, were important aspects of the annual financial cycle. In many households a considerable proportion of the income generated through post harvest crop sales would go to repay loans or purchase stock or tools to replace those sold at times of cash shortage. The conditions attached to loans other than from family members were strict. Security, preferably in the form of land, was always required; the payback period short and effective interest

rates high. Given that health care is regarded as very much a household or extended family responsibility, promoting reforms to existing savings and credit organisations which make them more accessible to poor households may be more effective than attempting to encourage the establishment of community organisations targeted specifically at meeting health costs. Alternatively, the establishment of an effective and sustainable facility-based system, either for providing treatment on credit or spreading costs over the agricultural year, would provide considerable benefit to many households, and remove one major barrier to the use of public facilities.

REFERENCES

- Ablo, E and R. Reinikka, 1998, Do Budgets Really Matter? Evidence from Public Spending on Education and Health in Uganda, Policy Research Working Paper 1926, The World Bank.
- Akin, J. S., 1986, 'Fees for health services and the concern for equity for the poor', World Bank PHN Technical Note Series, No 86-10.
- Akin, J. S., Griffin, C. C., Guilkey, D. K. and Popkin, B., 1986, 'The demand for outpatient services in the Bicol region of the Philippines', Social Science and Medicine, 22, 321-328.
- Akin, J. S., Guilkey, D. K. and Denton, E. H., 1995, 'Quality of Services and Demand for Health Care in Nigeria: a Multinomial Probit Estimation', Social Science and Medicine, 40, 1527-1537.
- Assiimwe, Delius and John C. Lule, "The public/private mix in financing and provision of health services in Uganda (a background paper)", mimeo, Makerere Institute of Social Research, 1992.
- Assiimwe, D., F. Mwesigye, B. McPake and P. Streetland, 1997a, "Informal health markets and formal health financing policy in Uganda: final report", mimeo, Makerere Institute of Social Research, 1997.
- Assiime, D. et al., 1997b, "The private-sector activities of public-sector health workers in Uganda", in Sara Bennett and Barbara McPake (eds.), Private health providers in developing countries: serving the public interest?, Zed Books.
- Bigsten, Arne, 1995, "Boom and poverty in Uganda", Swedish International Development Corporation, Macroeconomic Studies, 1995: 65.
- Biritwum, R., 1995, "Monitoring progress towards health for all by the year 2000: Indicators from Iganga district, Uganda", East African Medical Journal, vol 72, no 5.
- Creese, A., 1991, "User charges for health care: a review of recent experience", Health Policy and Planning, vol 6, no 4, pp 304-319.
- Gertler, P. and van der Gaag, J., 1990, The Willingness to Pay for Medical Care, World Bank, Washington.
- Gilson, L., 1995, 'The Political Economy of User Fees with Targeting: Developing Equitable Health Financing Policy', Journal of International Development, 7, 369-401.
- Griffin, C., 1992, 'Welfare gains from user charges for government health services', Health Policy and Planning, 7, 177-180.
- Heller, P. S., 1982, 'A model of the demand for medical and health services in Peninsular Malaysia', Social Science and Medicine, 16, 267-284.
- Kanji, N., 1989, 'Charging for Drugs in Africa: UNICEF's Bamako Initiative', Health Policy and Planning, 4, 110-120.
- Kielmann, A. A., K. Janowski and H. Annett, 1991, Assessing District Health Needs, Services and Systems: Protocols for Rapid data Collection and Analysis, African Medical and Research Foundation (AMREF), Nairobi and MacMillan Educational, London.
- Kipp, W., A. Kielmann and E. Kwered, 1991, "Post-war Uganda: a review of health services in Kabarole district", International Journal of Health Planning and Management, vol 6 pp 221-228.
- Kipp, W., A. Kielmann, E. Kwered, G. Merk and T. Rubaale, 1994, "Monitoring of primary health care services: an example from Western Uganda", Health Policy and Planning, vol 9, no 2, pp 155-160.

- Macrae, Joanna, Anthony B. Zwi and Lucy Gilson, 1996, "A Triple Burden for Health Sector Reform: 'Post-Conflict' Rehabilitation in Uganda", Social Science and Medicine, Vol. 42, No. 7, pp. 1095-1108, 1996.
- McPake, B., Hanson, K. and Mills, A., 1992, Implementing the Bamako Initiative in Africa: A Review and five case studies, London: PHP Departmental Publication no. 8.
- Mbugwa, J. K., 1993, Impact of user charges on health care utilisation patterns in rural Kenya: the case of Kibwezi division, DPhil Thesis, University of Sussex, U.K.
- Mbugwa, J. K., Bloom, G. H. and Segall, M. W., 1995, 'Impact of user charges on vulnerable groups: the case of Kibwezi in rural Kenya', Social Science and Medicine, 41, 829-835.
- Mwesigye, R. F., 1995, "Effects of user charges on quality of curative services: a perspective of Uganda's rural health units", Research Report, Health Planning Unit, Ministry of Health, Uganda.
- Okello, D. O., R. Lubanga, D. Guwatudde and A. Sebina-Zziwa, 1998, "The Challenge to Restoring Basic Health Care in Uganda", Social Science and Medicine, Vol. 46, No. 1, pp. 13-21, 1998.
- Okuonzi, S. A. and Macrae, J., 1995, 'Whose policy is it anyway? International and national influences on health policy development in Uganda', Health Policy and Planning, 10, 122-132.
- Russell, R., 1996, "Ability to pay for health care: concepts and evidence", Health Policy and Planning, vol 11, no 3, pp. 219-237.
- Seeley, Janet A., Ellen B. Kajura and Daan W. Mulder, 1995, "Methods used to study household coping strategies in rural South West Uganda", Health Policy and Planning, 10(1), pp. 79-88.
- Smithson, P, 1993, Sustainability in the health sector part 2: financial constraints to health sector sustainability in Uganda, The Save the Children Fund.
- Taylor, Lorraine, Janet Seeley and Ellen Kajura, "Informal care for illness in rural south-west Uganda: the central role that women play", Health Transition Review 6, pp. 49-56. 1996
- Tipping, G. and Segall, M. W., 1994, 'Longitudinal illness record: use in a case study of household care decision making in rural communes of Vietnam', mimeo, IDS.
- Uganda, 1995, Ministry of Finance and Economic Planning, Report of the Uganda National Household Survey 1993-94, Volume 1.
- Uganda, 1996a, Ministry of Health, Uganda Demographic and Health Survey 1995, Ministry of Health, Entebbe.
- Uganda, 1996b, Ministry of Health, Health Planning Department, "A synopsis of cost sharing in Uganda", mimeo.
- Uganda, 1996c, Ministry of Health, "Fees for Service implementation guidelines for health units below hospital level", mimeo.
- Uganda National Council for Children, 1995, Equity and Vulnerability: A Situation Analysis of Women, Adolescents and Children in Uganda, 1994, Government of Uganda.
- World Bank, 1987, Financing the Health Sector: an Agenda for Reform, World Bank, Washington
- World Bank, 1993, Uganda Social Sectors, World Bank Country Study, The World Bank.