

Challenges and Barriers to the Health Service Delivery System in Uganda

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Abstract:*This paper summarizes the barriers of the health service delivery system in Uganda including but not limited to policy matters, medical staff, transport, distance and referral mechanism, drugs and medical facilities, costs and financing of services, corruption and bribery, culture and attitudes.;the manuscript summarizes with futurerecommendationsto government of Uganda in terms of improving thereferral mechanism, encourage community financing health schemes, adopt collaborative practices, conceptualize and implementation of the Alma-Ata-Declaration of 1978, recognize the importance of informal providers of healthcare to the poor, sensitization of health workers on infection control and post exposure prophylaxis, government should develop strategies to enhance public hospital management and awareness of threats related with expiry medicines.*

I. Introduction and background

Improving the health of the nationals of any given country is an international priority and a Millennium Development Goal. To this effect since late 1980s Uganda has instituted numerous health sector reforms and policies aiming at improving the functioning and performance of the health sector and, ultimately, the health status of the population. Despite these reforms and policies, including an overall decentralization of government, health services and health status remain largely unchanged in Uganda. In fact the health care and health status indicators for Uganda have remained poor. For example data from the Uganda Demographic Health Survey of 2000–2001 suggest further declining health status and health service delivery compared to the situation five years earlier. A case in point, the Maternal Mortality Ratio (MMR) was estimated in 2006 at 435 maternal deaths per 100 000 live births (Uganda Bureau of Statistics and Macro International Inc. 2007), showing little progress towards the government's own goal of reducing maternal mortality from 500 to 300 between 2001 and 2008. Considering these developments, an overview is necessary to analyze the current status as well as past trends regarding health service delivery in Uganda with an object to identify the various challenges and barriers in the system and possibly come up with recommendations in this paper.

Health services in Uganda are provided by the Ministry of Health (MoH), Ministry of Local Government (MoLG), Private and non-government organizations (NGOs) particularly religious groups. MoH is responsible for planning and developing health policies and for providing health care in all government hospitals while the MoLG is in charge of health care delivery at the district level and below. The NGOs provide services both in hospitals and in smaller medical units. The current health system is organized under four levels of health care: primary, secondary, tertiary and quaternary. The primary level care (comprising of health centres and other lower units; the secondary level comprises a network of district and rural hospitals; the tertiary level includes all General Referral Hospitals based at regional capital; and the two national hospitals (Mulago and Butabika) comprise the quaternary and highest level of care. Usually each of original 39 districts in the country has at least one hospital and several other smaller health units (Health Centre IVs & IIIs). With this arrangement, it was estimated that some 27% of the population are within 5 km of the nearest health unit, while 57% are within 10km (Uganda Government, 1992)

Therefore, the sources of health care in Uganda include Government and Non-Governmental Organization (NGO) health facilities, community medicine distributors (CMDs), traditional healers, drug shops and private clinics. With an aim to increase access to health care for people, the government removed user fees in all government health units (Burnham et al. 2004; Nabyonga et al. 2005) and started the Home Based Management of Fever (HBMF) in 2002 using CMDs to distribute antimalarials for free in the villages (Government of Uganda, 2002).

II. Study problem

The health care and health status indicators for Uganda have remained poor, and the existence several barriers and challenges to the use of health service delivery, including distance, transportation, bribery, informal costs or low perceived quality etc. Barriers against use of services include internal factors such as the popularity

of the facility (which may reflect perceived quality of care or costs incurred by users), as well as external barriers such as distance and transportation problems. As a result of differences in these barriers, certain facilities may be utilized dramatically more than others, even within a reasonably small geographic area such as a district (where socio-cultural norms of facility use may be fairly homogenous). So while the typical barriers are known, there is little information available to national and local level planners or district health officials on how to identify which barriers to service use are pronounced in an area, or crucially limiting the use at a specific facility. In this way, using routinely available local data from various studies, hospital records and census information, it was possible to draw preliminary conclusions about which barriers are more or less important in particular health facilities and service delivery.

III. Significance of the study

The cause of poor health care and health status has been a challenge for most governments of developing countries because it is critical to the functioning and performance of the health sector and, ultimately, the health status of the population. The main objective of the study was to assess health service deliveries in Uganda resource use, costs, and financing of health facilities. This paper, therefore, investigates the issues and dynamics of health sector management. It analyzes a number of studies, each reflecting the type and level of health service delivery in Uganda and other developing countries. The paper would provide informational support as contribution to academic efforts to clarify the various challenges and barriers to health service delivery in order to develop policy recommendations to minimize or eliminate those barriers in the Ugandan health system.

IV. Review of Related Literature on challenges and barriers to health service delivery.

Areas of significant interest for this study were for example; health policy matters, medical staffs, drugs and medical facilities, costs and financing of health services, corruption and bribery in the health system, absence of referral mechanism, people's culture and attitude, and accessibility to health facilities. A number of barriers to the use of professional health services have been identified, however, both internationally and in Uganda alike. These include: distance to facilities (or transportation problems), costs involved, perceived low quality of services, or socio-cultural norms against the use of services (WHO 1998; Amooti-Kaguna and Nuwaha 2000; Bantebya Kymuhendo 2003).

V. Policy matters

During the early period of Independence, policy development was no major issue in the Ugandan MoH but two events finally changed this situation: the Alma-Ata conference on Primary Health Care (PHC) in 1978, and the decentralization of the Ugandan government during the 1990s. The Alma-Ata conference, which was arranged by WHO and UNICEF in 1978 developed the concept of PHC (World Health Organisation, 1978). This concept was a shift of paradigms in various aspects. PHC was a political concept: the issue was to involve politicians and lay leaders in order to ensure that the needs of the people were met, rather than the interests of the medical profession and was aimed at involving the local community in decision-making in health matters. Unfortunately, the conference as such was mainly attended by ministers of health and senior officials and instead of the intended political purposes; however, the concept of PHC triggered several vertical technical programs focusing on one or a few diseases: immunization programs, diarrhoeal control programs, programs for controlling malaria and many more. These were biomedically oriented technical programs with their blueprints made by international agencies outside the country (Smith et al., 1988). This showed that such a major policy was passed without much consideration for the local context, and this may partly explain the challenges faced during the implementation.

The second major event that changed the foundation of governance through policies was the overall decentralization of the Ugandan government in the 1990s. This reform included all line ministries such as MoH. Now only hospitals providing referral and medical training remain the responsibility of the MoH. Following decentralization, the main role of a ministry is to develop policies and guidelines within its respective sector, monitor activities, and provide logistical support where necessary. In the case of the MOH, the shift of roles has been described as a change from a 'Ministry for Hospital Services' to a 'Ministry for Health Policy Development' (World Bank, 1994). The ministry increasingly becomes disengaged, or disembedded, from the local context. This means that it is rather a part of a system that operates in the respective country as well as in a global 'center' rather than a part of an indigenous process. The paradox is that while MoH attempts to improve the links with the global expert community.

The overall policy goal for the current Health Policy (1999–2009) is to accelerate the attainment of a good standard of health by all Ugandans in order to promote healthy and productive life. The policy is drawn within the framework of the 1995 Constitution of the Republic of Uganda and the 1997 Local Government Act. The policy also directly and heavily reflects Alma-Ata Declaration of Health for all (HFA),

the National Health Sector Reform Programme, the Poverty Eradication Action Plan and the Health Sector Poverty Action Plan (Jeppsson et al., 2005). For purposes of policy development and implementation during the planning period of 2000–2005, the Government adopted a focused definition of poverty which emphasizes basic needs and provision of services. Certain donors, or different constellations of donors, promote each one of the principles guiding the policy, based on a legitimacy derived from another political, social and cultural context than the one of Uganda. The point is not that these principles are in conflict with the Ugandan society, but rather that they are developed outside this context, and delivered to Uganda as various packages of solutions to general global problems. The value and usefulness of these ready-made packages are normally trusted by the expert system that constitutes the recipient ministry, but they may not always be so easy to incorporate in the local context hence a challenge to health service delivery.

Another health policy worth mentioning in this paper is Performance-based contracting (PBC) promoted in both high and low income health systems as a means of delivering improved performance from providers both institutions and individual health workers, and hence better outcomes from health service provision (Loevinsohn & Harding, 2005). PBC is a tool that links monetary or material rewards to measurable actions or achievements in relation to predetermined performance targets. In their study, Ssenooba et al. (2012) concluded that health centres were given insufficient opportunity to select service targets strategically and this, combined with a dormant period that created individual and institutional memory loss about the pilot resulted in a lack of purposeful actions to achieve the pilot targets. Lack of success in relation to the malaria treatment target was specifically explained by parallel interventions that reduced malaria incidence and recourse to the health centres for treatment.

Analyzed also was the policy of hospital autonomy for Uganda, however, the policy response has largely been very weak. In Private not-for-profit (PNFP) and Public hospital comparison study, showed that both have problems with personnel management but drug supply management appears better in PNFP hospitals. PNFP hospitals' performance is plausibly related to three areas of managerial autonomy; better management of drug supply facilitated by their freedom to purchase drugs from the open market; greater success with personnel management is plausibly related to their greater autonomy over staffing; and higher levels of cost recovery are enabled by their freedom to set fees. Larbi (1998) argues that the reason for implementation failure in Ghana was that stakeholders, critical for the implementation of management decentralization were excluded from the policy design process.

VI. Medical staffs

There are multiple reasons for disorganization of practice, one of the areas of major concern is the belief that a large proportion of the health budget not only continues to go to the hospitals which are mostly located in towns leave peripheral units and HCs depleted of health resources but also are completely inadequate. Together with poor motivation of staff due to low salaries, led to a feeling that the general standard of care and services particularly in government owned units had fallen drastically and there is a general feeling among health care providers and consumers that NGO and private health facilities are offering better quality services than government owned units. (Okello et al., 1998).

They further noted that generally the proportion of skilled personnel to unskilled personnel decreases as the level of complexity of the health unit falls. The lower units were predominantly staffed by unskilled ward maids/dressers that formed 40% of the work force who are usually school dropouts that got trained on the job and are reported to run most of the lower unit levels because trained nurses were not available. There is a large body of informal sector practitioners, who are the major providers of health care to the poor, especially in rural areas, but lack knowledge which is essential for designing a need-based pro-poor health system.

It is also observed that there is lack the capacity both in terms of technical & institutional human resource areas in the Uganda health system, which created an informal class of health practitioners with less professional background including knowledge and practices on common illnesses and conditions. The traditional healers, traditional birth attendants (TBAs), and unqualified allopathic providers (village doctors and drug sellers,) emerged as major providers in the health care scenario of Uganda. These have less years of schooling in the profession but their main routes of entry into the profession were apprenticeship and inheritance (traditional healers, TBAs, drug sellers), and short training (village doctors) of few weeks to a few months from semi-formal, unregulated private institutions.

Given the shortage of qualified health workforce in Uganda and the inequity of their distribution, people prefer to seek health care from non-qualified providers in the informal sector, especially the poor and the disadvantaged (Okello et al., 1998). On the demand side, various barriers also impede the use of qualified providers such as lack of access to information on available services, lack of health awareness (unfelt need), lack of opportunity due to exclusion from social and health institutions, cultural factors prohibiting females from seeking care outside home from male providers, and inability to pay (Ensor and Cooper 2004).

For example in their study Parkhurst and Ssengooba (2009) observed that only 39% of women delivered with a skilled attendant, slightly below the African average of 42% (Uganda Ministry of Finance and Economic Planning and Macro International Inc. 1996; Safe Motherhood 2001; Uganda Bureau of Statistics 2001). Staff numbers were also found to be fairly similar across facilities, with between one and three midwives in each facility. These levels indicate great variation in numbers of deliveries per midwife in the facilities, ranging from 12 to as many as 213 per midwife per year. Even if clinical officers also regularly undertake deliveries (which was not authorized in Uganda at the time of the research), the more popular facilities would clearly have difficulty in providing full-time delivery services over the course of a year given their high demand.

The high risk of occupational exposure and transmission to health workers in hospitals attending to such patients is also affecting staffing levels in some health facilities worsening the already bad shortage of health workers. For example, the risk of HIV transmission from a patient to a health worker has been shown to be between 0.3% and 0.09% following percutaneous and mucocutaneous exposure respectively. A study carried out at Mulago National Referral Hospital in Kampala, Uganda, to assess the occurrence and risk factors of needle stick injuries among nurses and midwives showed that the rate of needle stick injuries was 4.2 per person per year and the most important risk factors for needle stick injuries were lack of training on such injuries, long working hours, working habits, recapping the needle, suturing wounds and experience. Most respondents were exposed due to long working hours, lack of training and standard HIV guidelines, lack of protective gadgets, and little experience in patient management (Odongkara et al., 2012).

VII. Transport, distance and referral mechanism

However, there are many possible barriers to the use of services beyond their perceived popularity. Distance and transportation problems in particular may affect utilization rates, and so it is important to look beyond simple use rates to help guide policy on where improvements are needed. Looking at this indicator in combination with the number of deliveries can help illustrate the importance of distance or transportation barriers with regard to others which could be classified as 'internal' barriers to the facility influencing its popularity (such as perceived low quality, or informal costs charged in a facility). In general it appears that many people travel outside their local area to reach the more popular services, which would indicate transportation is not necessarily as important as the perception of the facility. However, it is unknown how far the average travel distance was, as this data were not available. Access to treatments is poor, and many people die from infections for which treatments or prophylaxis should be available readily (Shabbar et al., 2004).

Willingness to travel appears to be linked with the popularity of the service, but this finding in itself still leaves unclear how much of facility utilization can be attributed to ease/difficulty of transportation from surrounding areas, as opposed to internal factors affecting the popularity of the facilities. Bypassing has been described elsewhere (Akin and Hutchinson 1999), and can present a picture of the relative importance of transportation versus popularity, showing when individuals are willing and able to overcome distance issues to reach more desirable services.

Rapid economic growth and widening economic inequalities have been associated with increased injuries, both unintentional and intentional, such as road traffic injuries and interpersonal violence, in low- and middle-income countries (LMICs), necessitating establishment of emergency trauma care systems (Mock et al. 2004). Injury is a growing public health concern worldwide. Since severe injuries require urgent treatment, involving smooth, timely patient referral between facilities, strengthening of the referral system would reduce injury mortality but this has been discovered not the case in this study. Smooth referral consists of identification of severe cases, organization of transportation, communication between facilities and prompt care at the receiving facility. Although most of the previous studies used patients' individual data to analyse factors associated with behavior and barriers to service use, many of the factors influencing the referral are facility-specific: e.g. referral guidelines, communication (practices and systems), and transportation (availability and cost). Unavailability of transportation is a widespread barrier to emergency referral (Kobusingye et al. 2005). A study in Uganda reported that relatives have to obtain money by selling assets or borrowing before starting patient transfer (Peterson et al. 2004). Financing such costs, along with treatment and indirect costs, can push poor people into the poverty trap (Mock et al. 2003; Hardeman et al. 2004). Lack of communication can also deter referral (Kalter et al. 2003) and reduce the quality of trauma care, and the supply of referral and feedback letters is inconsistent or even rare in developing countries like Uganda.

The existing information on referral included the presence of referral guidelines for injured patients, distance of referral, commonly used transportation and its cost, communication with receiving facilities, and fast-tracking at receiving facilities. However, formal referral systems were not functioning well in some areas (insufficient communication and underutilization of ambulances), and informal systems were frequently involved (patient transfer by taxi or referral by community volunteers, and treatment by traditional healers) but were not fully integrated into the referral network (traditional healers seldom referred patients to public

facilities). The referral distance was long for most of the surveyed facilities and transportation costs were high when transferring from remote areas, even by ambulance (Nakahara et al., 2010). A few studies investigating the prompt transfer of injured patients revealed a deficiency in the ambulance system or communication devices but did not examine the referral mechanism as a whole (Nakahara et al. 2007). The referral system fails to function and service users largely ignore it and go directly to that level of the system which offers the best combination of quality and access (geographical and financial) from their perspective (Okello et al., 1994)

VIII. Drugs & medical facilities

Most studies have stated that one of the most important aspects for facility users in Africa is the stock of drugs available (Jitta et al. 2003). Therefore, in addition to service use statistics, facilities were surveyed for their availability of key drugs and supplies, as well as staff numbers, to see if there were obvious differences between facilities that might explain their desirability to potential users. Since significant funds are invested in pharmaceuticals, they tend to be in the focus of the health care system, and the fact that a major proportion of the resources for health care are invested in a commodity like drugs makes such an item extremely highly valued. Instead of regarding pharmaceutical therapy as one among many components of the health care system, drugs instead become central. Drugs become powerful, and they distort the interest from preventive interventions, promotive health care services and other therapeutic interventions. Furthermore drug-therapy becomes a symbol of biomedical care: a commodity to be consumed. Consequently, several studies have suggested a considerable leakage of drugs from public health facilities [24]. According to one study by McPake et al. (1998) the mean leakage at health facility level is estimated at 78%. Also several scandals have rocked two of the institutions in the pharmaceutical system of Uganda, the National Medical Stores (NMS) and the National Drug Authority (NDA). At the time of writing, no Managing Director has been appointed to NMS; the head and two other senior officials of NDA has been interdicted (New Vision, 1999).

While hospitals may be over-staffed, there is too little investment in maintenance of equipment and facilities (Health Planning Department, 1998), a challenge facing health service delivery in Uganda. The problem of the expiry of medicines in the supply chain is a serious threat to the already constrained access to medicines in developing countries. Some of the findings indicate that medicines prone to expiry include those used for vertical programmes, donated medicines and those with a slow turnover. In developing countries, where budgets for medicines are often tight, the supply cycle needs to be well-managed to prevent all types of wastage, including pilferage, misuse and expiry. This wastage reduces the quantity of medicines available to patients and therefore the quality of health care they receive. The expiry of medicines highlights a problem with the supply chain, which includes medicine selection, quantification, procurement, storage, distribution and use. In Uganda, volumes of valuable medicines have expired at the National Medical Stores, in district and hospital stores, (Mwesigye, 2006) and the problem has also been reported in Botswana, India and the United Republic of Tanzania. Surprisingly, all these top-expiring medicines are either essential (with a high turnover because they are used by the majority of the population) or vital (without them, the patient would die).

On further analyzing this challenge on contributing factors in the supply chain, the main ones found included neglect of stock monitoring, lack of knowledge of basic expiry prevention tools, non-participation of clinicians in medicine quantification in hospitals, profit- and incentive-biased quantification, third party procurement by vertical programmes and overstocking. Poor coordination appears to be responsible for some expiry incidents. For example, expiry due to treatment policy change and duplicate procurement can be prevented by sound coordination between key stakeholders. Even though a medicine procurement and supply management task force was set up by Uganda's Ministry of Health to plan the phasing out of chloroquine and sulfadoxine/pyrimethamine, the expiry of large stocks of the latter suggests a serious lapse in coordination. Countries undertaking similar ventures should involve their national medicine regulatory agencies at all stages of the transition process to guide local production and to curtail entry of phased-out

IX. Costs and financing of services

Finally, another factor that can affect use of a particular facility is costs charged. In Uganda, maternal health care is meant to be free. As such, expenses accrued tend to be classified as 'informal' costs—payments made unofficially, or expenditure on drugs or supplies intended to be free (McPake et al. 1999; UNFPA 2004a). Barriers against use of services include internal factors such as the popularity of the facility (which may reflect perceived quality of care or costs incurred by users), as well as external barriers such as distance and transportation problems. As a result of differences in these barriers, certain facilities may be utilized dramatically more than others, even within a reasonably small geographic area such as a district (where sociocultural norms of facility use may be fairly homogenous).

It was noted that during the 1980s, the government health services largely collapsed due to the civil strife in the country. Health workers were not paid their salaries, and had to develop their own survival strategies, often not in line with official government strategies. Payments for staffs in government health

facilities especially doctors, medical assistants and those with nursing training was less than a half of the comparable private & NGO's pay who in addition also receive other in-kind benefits. Since the task of the ministry was to deliver the services, and since this did not happen, it lost much of its legitimacy. During the same time external sources but administered largely by unmotivated civil servants. The external sources do not generally improve the salaries, but sometimes supports the officers with per diems and other non-monetary benefits such as travels outside the country. The result is a focus on benefits rather than the objectives of the funds, which skews the system. One experience is that of investment in infrastructure. Since the plans for constructing health facilities are often carried out without sufficient involvement by the local community, there is often a limited sense of ownership of the items procured or the infrastructure built. When there is no sense of ownership or even involvement of the local community or district leaders, maintenance and sustainability becomes a problem and many of such units soon end up in a deplorable state (Jeppsson et al., 2005). The goal, to build a health care system involving the beneficiaries is left out and health becomes a biomedical product that is handed over to the beneficiaries for their consumption. They have, however, little influence over what the services will look like.

X. Corruption/bribery

Corruption and bribery is another serious challenge facing the health service delivery in Uganda. Bribes in the Ugandan public sector appear to be fees-for-service extorted from the richer patients amongst those exempted by government policy from paying the official fees. Bribes in the private sector appear to be flat-rate fees paid by patients who do not pay official fees. Uganda is a low-income country (GNI per capita of US\$1500) classified as one of the most corrupt countries in Transparency International's Corruption Perceptions Index, with an excellent source of data on bribes by individuals in the 2002 Second National Integrity Survey (Transparency International, 2004). In the study by Hunt (2010), data showed that 37% of Ugandan bribes are paid in the health sector, due to widespread use of the health system, and a comparison between bribery in the public and private health care systems was made for this study. Almost every focus group notes that medical attention at public hospitals and health units can only be obtained in exchange for payment despite the official abolition of user fees at health units. They state that patients have to bribe to attract the attention of medical staff and pay for all medical supplies, no matter how small.

Furthermore, the participants in the study highlighted that the only drug available at Ugandan health facilities is Panadol (Tylenol) but other most drugs must be purchased at pharmacies, drug shops or private practices with connections to the doctor recommending the drug, despite the fact that they should be available free in the public health units (Jitta et al., 2003). Some groups noted that the corruption and poor service in the public health sector lead people to use private clinics, despite their cost. McPake et al. (1999) estimated that 68–77% of revenues from official fees were misappropriated and that 76% of drugs at the facilities they studied disappeared before reaching patients. Given this, it seems highly unlikely that any bribe revenue is used to fund health facility activities, rather than following the embezzled money into health workers' pockets. The abolition of most user fees shortly before my study period may simply have led health workers to extract more bribes as a way of maintaining their illicit revenue. Additional results combined with anecdotal evidence suggest that the public sector health staff extort bribes particularly from the richer among the patients who officially need not pay. The results suggest that well-intentioned policies to reduce health care payments for the poor may be thwarted by health workers seeking to supplement their own incomes. In addition to undermining the goal of increased access to health care, the effect could be to contribute to a culture of bribery which helps bribery flourish in other institutions.

XI. Culture and attitudes

However, geographic barriers are not the only factors that compel carers to first use home treatment with drugs obtained from the private sector before seeking formal care. Other barriers include gender aspects of decision-making, other responsibilities at home, and local perceptions of illness and care providers. Risk factors for most diseases like for fatal pneumonia include poor socioeconomic status, incomplete immunization schemes, malnutrition, late care seeking and inadequate treatment. Counselling at Antiretroviral Therapy (ART) initiation may not be sufficient to enable women who do not desire children to adopt relevant family planning practices. On-going reproductive health education and Family Planning services (FP), with emphasis on the restoration of fertility after ART initiation, should be integrated into ART programs for men and women. Our findings highlight the need for a more comprehensive approach to ART counseling that integrates maternal and child health, family planning (FP) and HIV care services in order to address the realities and clients' changing fertility desires. This high HIV exposure may affect the attitude of health workers towards their patients and in the long run may lead to fewer health workers opting to take on clinical work

However, even when drugs are free at the community level, people do not have timely access to them (Nsungwa-Sabiiti et al. 2007). Various studies have demonstrated that caretakers' choice for seeking providers outside the home is associated with perceived aetiology (Mwenesi et al. 1995), perceived severity of diseases, perceived quality of care, cultural and traditional beliefs (Nuwaha 2002; Nsungwa-Sabiiti et al. 2004), knowledge and symptoms of the illness (Stekelenburget al. 2002), or socio-economic status (Schellenberg et al. 2003). However, the relative contributions of these factors specifically to delayed care seeking are much less understood, these explicitly explain why caretakers delay to seek care outside the home when government health facilities supposedly provide free care.

XII. Conclusion

Health service delivery in Uganda is often characterized by weak public health systems, with deficient financial and human resources, poor organization of health services, and lack of information about the local disease burden, are an underlying cause of these constraints. Some of patients concerns or some of the reasons cited for the low level of demand for services at lower level centres and dispensaries were: lack of medically trained personnel at these levels, lack of diagnostic facilities and clinical support services, lack of transfer facilities for patients who may get complications, and total breakdown in the referral system (Okello et al., 1998). Receiving/not receiving drugs prescribed at government establishments was because some drugs were not always available or leaked out of the system. Finally, there are differences between resource levels of NFP or NGOs and government where the latter were inadequately maintained and mostly in a state of disrepair.

XIII. Recommendation

1. Streamlining referral mechanisms will require organization of each component of the referral mechanism by strengthening the existing system and mobilizing local resources, which would allow MoH to develop an efficient system at reasonable cost, though it may differ from Western models. Guidelines including these components along with training and supervision, and expansion of the system to cover other disease conditions, would strengthen the health care system as a whole in this country. Full utilization of local resources should enable us to develop an innovative system suitable for this country at reasonable cost, which may differ from Western models of emergency referral systems. For such decisions to be made properly, written guidelines are crucial.
2. Encourage community financing schemes known as Health Equity Funds introduced in some areas to support the poor, but are diverse in operational organization, and may or may not cover transport costs.
3. The health system in Uganda must adopt the collaborative practice in order to deliver comprehensive primary health care to meet the needs of a particular practice population, through full and effective application of the knowledge and skills of the health care providers. Comprehensive primary health care includes service delivery in 5 domains: health promotion, disease prevention (e.g., performing periodic health examinations), curative care (diagnosing and treating acute illness and injury), rehabilitative care (monitoring and treating chronic illness and disability) and supportive care. 1 Family physicians
4. The original concept of PHC as formulated in the Alma-Ata Declaration of 1978 is still largely valid and suggests feasible strategies in this direction but policies presented from external sources need to be reflected upon and adjusted to the local context before adopted, if adopted at all. Health care priorities need to be identified in a negotiation process between lay people in the local community and health professionals.
5. It is essential that the public sector, instead of ignoring, recognize the importance of the informal providers for the health care of the poor. Consequently, their capacity should be developed through training, supportive supervision and regulatory measures so as to accommodate them in the mainstream health system until constraints on the supply of qualified and motivated health care providers into the system can be alleviated.
6. There is therefore need for more sensitization of health workers on infection control and post exposure prophylaxis for health workers, Hospital administrations should ensure good access to HIV exposure guidelines for all to health workers. All health workers should be provided with protective gears such as aprons, gloves, goggles, gumboots and overalls during procedures or duty to mitigate the high risk of occupational exposure and transmission to health workers in hospitals attending to these patients. Because a study by (Odongkara et al., 2012) showed that respondents who had training on infection control and those who were aware of HIV infection control guidelines were less likely to be exposed compared to their counterparts.
7. Although they appear to be potential advantages from greater public hospital autonomy, the Ugandan government should ensure it has developed strategies to enhance public hospital management and to protect access to public hospitals before advancing further with hospital autonomy. Increasing hospital autonomy

offers opportunities to use market pressure and decentralization in order to improve the efficiency with which hospitals operate, by increasing public participation and promoting internal management reform.

8. Make awareness about the threat of expiry of medicines to the delivery of health services needs to be increased. Some can adapt training modules to emphasize management of medicine expiry for pharmacy students, pharmacists and other persons handling medicines. Also sound coordination is needed between public medicine wholesalers and their clients to harmonize procurement and consumption as well as with vertical programmes to prevent duplicate procurement. Additionally, national medicine regulatory authorities should enforce existing international guidelines to prevent dumping of donated medicine. Medicine selection and quantification should be matched with consumer tastes and prescribing habits. Lean supply and stock rotation should be considered.

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