

Intra-Household Social Determinants of Maternal Health and the Preventive Function of Primary Health Care in Rural Uganda: Opportunities and Challenges

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Abstract:

The paper provides insights into how lower-level health facilities can integrate intra-household factors into their Primary Health care Strategy through interviews with Mbarara District health officials, health workers at Bwizibwera health centre IV and community leaders on the Health Centre Management Committee. It also uses documentary evidence from the 2010 Mbarara District Health Reports and the 2009 Bwizibwera Health Centre Reports. The findings suggest that there are challenges with implementing a comprehensive primary health care package, including inadequacies in monitoring and evaluation of health centre activities with regard to the roles of different parties and community needs, insufficient resources and weak relationships with the community leadership that hamper community participation.

This paper proceeds as follows: First, it examines the background history of assenting to global PHC declarations and the adoption of PHC as an official health policy in Uganda. Secondly, it analyses the Ugandan health sub-district primary health care structures, based on the case of Kashari County, Mbarara District. Thirdly, the paper analyses the gaps in operationalising a functional

primary health care structure to provide a basis for discussing integration of intra-household determinants of maternal health care.

Key words: intra-household social determinants, maternal health, primary health care, rural Uganda

Background: Primary Health Care and Decentralisation of Uganda's Health Care System

Following the signing of the 1978 Alma Ata Declaration on PHC, in 1987 the Government of Uganda adopted PHC as an official health policy for making essential health care accessible to households (Okello, Lubanga et al. 1998). The core principles of PHC initiatives emphasise service provision based at lower levels of health care and within the community, through decentralisation of decision-making, universal access to healthcare, empowerment and the promotion of women and children's health (McPake, Hanson et al. 1993). In 1987, the Government of Uganda's Health Review Commission recommended the health centre (HC) as the lowest level of health care (Okello, Lubanga et al. 1998). The influence of the PHC approach on community participation in planning and providing health services has been viewed as one of the big forces behind the 1990's decentralisation of the public sector in both Africa and Latin America (Akin, Hutchinson et al. 2005).

Within the health sector, the process of decentralisation generally involved transferring responsibility for service delivery from central governments to districts and local provinces (Hutchinson et al. 2006). In the case of Uganda, as in many other African countries, decentralisation was undertaken in addition to a variety of other reforms, including introduction (and subsequent abandonment) of user fees, experimentation with the autonomy of local governments, district hospitals and prepayment schemes (Jeppsson 2001). At that time, Uganda

was going through reforms and the 1997 Local Government Act's establishment of local governments (currently referred to as local councils) provided the structure for the subdivisions' primary health care centres (Hutchinson et al. 2006).

As a result, the establishment of PHC centres in Uganda followed the local government structure, a system of five tier governance linked through complex political and administrative arrangements. Starting from the lowest governance levels, the first tier involves creating contact between the community and health workers through the VHTs located at the village level. This is followed by the second tier, which is health centre level II (parish level), an equivalent of an outpatient dispensary. A health centre II provides the first level of interaction between the formal health sector and communities. It also provides for community outreach services and linkages with VHTs. The third tier is health centre level III (sub-County level), and is structured to provide basic preventive, promotive and curative care. They are also required to provide supervision of the community and health centres at level II that fall under their jurisdiction. The fourth tier is health centre level IV (county or sub-district level), which is designed to offer inpatient and outpatient health services, including obstetric emergency care. A health centre IV facility is mandated with planning, organisation, budgeting and management at this and lower level health centres, including private-not-for-profit (PNFP) and private for profit (PFP) health facilities under their jurisdiction. However, only 28% of the 145 of these facilities in Uganda are fully operational (Uganda 2009). Finally, the fifth tier consists of the district hospitals that, under normal circumstances, link all the other health centres (Uganda 2010).

VHTs and health management committees form the support structures for community participation in decision-making and planning for health services provision (Uganda 2009). The other strategy for community participation is through extension of the Ministry of Health engagement to

PNFP hospitals and health centres (Bossert and Beauvais 2002; Uganda 2010). As such, involving communities in defining health priorities has been taken on as a principle that helps in mitigating the formidable challenges of effective delivery of PHC programs at lower level health facilities within districts (Kapiriri et al. 2003).

As opposed to implementing the comprehensive requirements of a PHC system¹, in reality there remains considerable domination of medical approaches and selective approaches to PHC (Bhutta et al. 2008). Operational health care plans and budgets are focussed on the availability of medicine at PHC centres as a key determinant of the quality of health services (Nazerali et al. 2006). This undermines the other components of comprehensive PHC (prevention, promotion, rehabilitation and community participation) (Rohde et al. 2008), and some studies have indicated that this is a result of failed consideration of community-based health care programmes in the delivery of health services (Bhutta et al. 2008).

Subsequently, a number of factors are associated with the limited uptake of comprehensive PHC. Firstly, Rohde et al. (2008) assert that during the past 30 years since the 1978 Alma Ata declaration many countries have instead implemented selective PHC focused on child survival interventions (growth monitoring, oral rehydration, breastfeeding, immunisation, community health workers and case management of pneumonia supervised by district hospitals), and found that skilled birth attendance remained low even when they improved child health. However, countries such as Rwanda and Bangladesh that systematically implemented comprehensive PHC

¹ Comprehensive health systems take into account all phases of life from infancy to old age and integrate all aspects of being, including physical, psychological, mental, social, environmental, political and so on Yamamoto, M. (1986). "The place of primary health care in a comprehensive health system." *Social Science & Medicine* 22(11): 1229-1234.

(immunisation, family planning, nutrition promotion, recruitment of health and application of national drug lists), were found to reduce child mortality as well as improve use of family planning (Bhutta et al. 2008).

Secondly, failures in implementing comprehensive PHC have been associated with countries' colonial history. In the case of Uganda, Okuonzi and Mactrae (1995) assert that the country has historically been dependent on health policies influenced by colonial administration, donors and NGOs/missionaries, whose bias has been towards selective PHC. Uganda has a history of having a health care system dominated by medical approaches, which often undermine the national capacity to implement comprehensive PHC. While Uganda's Minimum Health Care Package (MHCP) core interventions could be seen as an attempt to deal with the comprehensive approach, there are significant biases towards selective PHC, and towards attracting human resources to fill gaps in health care providers (Kapiriri and Norheim 2004). In addition, there has been a persistent bias in research towards increasing cost-effective health care through improving health care financing, human resources, supervision, management and collaboration.

Thirdly, the capacity to pursue a comprehensive PHC approach has been diverted by the shifting attention of donors towards the challenges posed by HIV/AIDS and related vertical programmes on malaria and tuberculosis (Travis et al. 2004). Evidence shows that HIV/AIDS aid levels in sub-Saharan Africa exceed the entire sum of national budgets (Shiffman 2008). As a result, while Uganda is credited for its comprehensive approach to treatment and management of HIV/AIDS (Agaba 2009), the comprehensive primary health care practices used in HIV/AIDS programmes have not practices have not been transmitted to other health sectors. On the other hand, the health plans reflect a strategy to implement comprehensive programmes that combine major health

challenges such as mobilisation of resources with a focus on the major burden of disease determinants like treating malaria, elimination of user fees in public health centres, dispensing HIV/AIDS antiretroviral drugs, treating respiratory and sexually transmitted infections and maternal and child health (Uganda 2010).

In practice, Uganda's limited health care resources are mainly prioritised in financing tertiary health care facilities like district hospital and health centres (Jeppsson et al. 2003; Kapiriri et al. 2003). This focus of funding ignores the massive burden of preventable diseases that result from diminished productivity and increased poverty (Okidi and McKay 2003). This contradiction shows the health care system's underestimation of other factors that cause poor health and the inaccessibility of health care to individuals and communities (Okunzi and Macrae 1995).

Generally, selective PHC is as a result of the failure of government to fully fund their health care budget and the dependency on donor and international funding community. In Uganda, 50% of the health sector budget is allocated to services in secondary and tertiary health institutions, and less than a third of the health care budget goes to PHC for which most of the activities have been recentralised to meet gaps in other health sector resources (Ahmad et al. 2006). The focus on HIV/AIDS programmes has also diminished the possibility of having a comprehensive package, as most HIV/AIDS programmes are donor-driven (Shiffman 2008; Agaba 2009).

Results: Understanding the Performance of Kashari Health Sub-District Primary Health Care Structures

Data on the Kashari Health Sub-district provides an overview of PHC performance in the Mbarara District. Analysing the performance of PHC structures gives a basis for examining the integration of PHC and SDH presented in the next section of

this paper. The data on the performance of PHC structures was collected from both health workers and community leaders who were also represented on the VHTs. Health workers provided information on health services offered by the health centre, common health problems and the challenges faced in service delivery and community leaders shared views on the health programmes in general. The community leaders were asked related questions but also invited to give their opinion on their role in the improvement of health service delivery. This section thus presents an analysis of the structure and management of a health sub-district. At the district level, the interview with the District Health Office was aimed at finding information about resource allocation and the overall district health sector performance. The findings are presented in two sections. The first section explores the health care delivery system from the perception of both the health workers and community leaders and the second section examines the implications of these perceptions to determine a point of integration.

The Mbarara District health structure is based on the district local government administrative units which were established during the 1990 decentralisation process. The district is composed of three health sub-divisions which make up the health sub-districts: Rwampara (Kinoni Health Centre IV), Kashari (Bwizibwera Health Centre IV) and Municipality (Mbarara Municipal Council Health Centre IV). The study data was only collected from the district officers, Bwizibwera Health Centre IV staff and the Health Centre Management Committee who included 1 district health officer, 4 health workers and 2 local council leaders. Bwizibwera Health Centre offers all health services on a daily basis and these are categorised as inpatient, outpatient, immunisation, antenatal care, deliveries. Bwizibwera Health Centre was among the first local health centres that were upgraded during the national restructuring exercise and by 2002 it had an operating theatre. It has a small capacity operating theatre planned to provide for emergencies,

especially those related to pregnancy and childbirth, acute life-threatening childhood illnesses and accidents. However, at the time of the study the theatre was not operational, a situation that was attributed to the fact that the health centre did not have a medical doctor. The health centres' establishment is planned to foster community involvement in the planning, management and delivery of health care (Uganda 2010).

Bwizibwera Health Centre, as a health sub-district, oversees six health centre IIIs – Bubare, Bikiro, Kagongi, Kakiika, Rubaya and Rubindi and eight health centre IIs. During the interviews with health workers at Bwizibwera Health Centre IV, it was found that a number of external partners are participating in health care delivery. However, three out of four partners involved in health care services delivery (MJAB, EGPAF, AFFORD, Healthy Child Uganda) are dealing with HIV/AIDS health care services, and only one of them is a child health improvement project.

The health centre implements PHC programmes with a particular focus on child immunisation, health education for women during antenatal care and family planning. They reported that they have specific days and times when these services are offered to the community. On the other hand, when asked about other programmes on community engagement, there were no records on health education or of how decisions about health education topics are determined. The study revealed that education follows the national guidelines from the Ministry of Health, which may indicate that health education is not tailored to the community that the health centre serves. The following quotation from one of the interviews with a health worker illustrates the process of health education during antenatal care: *'...when women come we first gather them for a health talk by the health worker, particularly the midwife, then do routine checks and they leave one by one...'* However, when asked about the minimum health care package, which is one of the documents with guidelines on community participation, the

health worker expressed ignorance until I explained. This is what they were then able to say: *“I don’t know about NMHCP and I am sure most health workers at this facility have not heard about it”* (Midwife at Bwizibwera 16th September 2009).

The study also found out that most PHC activities of the health centre are centred on child immunisation, a finding that concurs with other studies which have indicated child immunisation to be one of the most performing PHC programmes. The successes in child immunisation under the primary care programmes has been associated with the successes in the control of childhood immunisable diseases (Khaleghian 2004). As a result, PHC activities could have been ignored in the shadow of the progressive immunisation programme. In Kashari, only child immunisation outreach work is reported as PHC community engagement activity where health workers visit communities and conduct health education. While other PHC activities were not talked about during the health workers’ interviews, the Bwizibwera Health Centre PHC 2009/2010 report indicated a much more comprehensive list which included family support groups and home visits, Tuberculosis (TB) community-based dots monitoring, child health days integrated in school health programs and school health education. Another finding was related to the limited allocation of funds to PHC activities; in table 19 it is indicated that 59.2% of the total budget of 2009/2010 for the Bwizibwera Health Centre IV was allocated to medical goods and supplies and only 8.1% to PHC.

Table 1: The 2009 Priority Budget Areas for Kashari Health Centre IV –Bwizibwera

Category	Budget allocation in Ugandan Shillings (UGX)
Management costs	2,59,6000
Administration costs	1,59,2000
Property costs	8,496069

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Transport and machinery	3,730,000
Supplies and services	330,000
Medical goods and services	30,331,317
PHC	4,160,000
Total	51,235,386

Source: 2009 Bwizibwera Health Centre work plan

The 2009/10 Annual District Health Centre Report indicated that malaria, child and maternal-related illness and HIV/AIDS were ranked as the top contributors to the burden of disease for Kashari County (Mbarara 2010). As quoted from the Health Centre In-charge, malaria contributes highest to the district disease burden, and HIV/AIDS is also a challenge. In this quote, the health centre in-charge summarised Kashari County’s BOD as follows: *‘malaria is a big burden and HIV/AIDS prevention remains a challenge, people are not using condoms and in cases of discordant couples, especially when it is a woman who is HIV/AIDS positive, their husbands are not always cooperative.’*

This was confirmed by the health centre report of 2009; HIV/AIDS is captured in the report. The following Table 26 is documentary evidence showing the burden of disease for Kashari Health sub-district (accessed 16th September 2009); malaria and respiratory tract infections are the most common health problems followed by HIV/AIDS and sexually transmitted infections (STIs).

Table 2: Top contributors to burden of disease in Kashari Health Centre IV –Bwizibwera

Disease	Percentage
Malaria	53.2%
Respiratory Tract Infections (RTI)	22.7%
Helminthiasis/Tapeworm	0.2%
Urinary Tract Infections (UTI)	5.1%
STI (HIV)	10.2%
Pneumonia	1.0%
Skin diseases	3.1%
Diarrhoea	0.9%
Tuberculosis	0.01%

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Trauma	0.2%
Dental conditions	1.1%

Source: Bwizibwera Health Centre IV 2009 Annual Report

The other problem encountered by the health centre was that health workers were often absent, a problem associated with understaffing. The reason was that either a worker was absent from duty or away attending to duties outside the health centre. This was evidenced by the fact that at the time of the study, the in-charge was not present at the health centre and I later met him on another day. The health centre reports and work plans were obtained from the notice board since the in-charge was said to have been away with the office keys. In addition, it was reported that out of the recruited 21 members of staff, at the time of the study 13 of them were either on study leave or annual leave and only 8 were present for duty. As such, this study can conclude that the health care system is faced with challenges related to limited supervision and understaffing. The following qualitative quotations confirm the extent of the problem of understaffing in the lower tier health facilities:

“Health workers are there but they are always away for training, meetings, and workshops.” (Health Management Committee Chairperson- 16th September 2009). *“When health workers are transferred, they are not quickly replaced.” (Health worker at Bwizibwera Health Centre – September 2009).*

“Presently, two health facilities in Bwengule and Kongoro are closed because of lack of staff. Mbarara District Health sector is only 32% staffed.” (District Health Officer 23 September 09)

The other challenge expressed in the following quotes is that the health units and their respective communities still have weak collaboration. Despite the existence of health management committees that are comprised of community

members and health workers, communication between the health centre and the community still needs to be enhanced. Whereas local leaders expressed awareness of health centre activities and its operations, they argued that they had limited powers to influence the performance of the entire system and called for the integration of community needs. Other studies have indicated that local governments have limited autonomy and are unable to adjust services even when they perceive demand (Khaleghian 2004; Kruk et al. 2007). In the case of this study, the following quotations can be interpreted to allude to similar a argument, which indicates a disjunction between policy plans and the actual situation on the ground: *“The village chairpersons are involved, when they’re needed for community mobilisation, community leaders are given health information which they deliver through community gatherings.”* **(Bwizibwera Local Council Chairperson 16th September 2009)**. *“Health unit management meetings are irregular, they are supposed to be three per financial year but we sometimes have only one.”* **(Bwizibwera Health Management Committee Member 16th September 2009)**. *“When you go to the health centre, you may be there for two hours before anyone has bothered to know what you want. This is discouraging”.* **(Chairperson LC1 Bwizibwera –B 17/9/2009)**

Although the decentralised PHC structure is designed to promote community participation (Magnussen et al. 2004), the findings indicate that the relationship between health workers and community leadership is still weak and could affect the expected community contribution to improving service delivery and utilisation. This finding concurs with Kyaddondo and Whyte’s (2003) work on decentralisation, which concluded that health workers hold negative attitudes towards decentralisation because community engagement through health centre management committees diminished the respect that health workers enjoyed in communities. The study argues that in instances of conflict health workers have interpreted it

as political interference. This can also be inferred from the following quotations from some of the interviews: *“Health workers think that politicians, like us, interfere with their work”* **(Chairperson Health Management Committee 16th Sept 2009)**. *“The health workers are rude, they come late, they absent themselves from duty, they do not care about patients which discourages patients from coming back and it makes the health workers who cover for them not provide quality care”* **(Midwife at Bwizibwera Health Centre IV 16th September 2009)**. *“People say that health workers are rude and they do not come”* **(Health worker, Bwizibwera Health Centre IV 16th September 2009)**.

However, the above findings can also be a sign of poor communication among the two parties. While the health workers are concerned with the stress of insufficient supplies, staffing and funds, the community demands inclusion in the delivery of health services. Therefore, more effort should be put into efforts that bring about a common understanding. Until communities and health workers understand each other’s role, participation will continue to be difficult to achieve.

The other related finding is the conflicting needs and expectations of different actors in the system. The findings of this study indicate that the problem for health workers is that they are overstretched, with a large turnout of patients that their capacity cannot accommodate. On the other side, patients complain of not being attended to. The following quotations from different perspectives – of clients/community leaders and health workers – show the differences in opinions: *“We get 100 patients a day.... utilisation is 100%. Lower health units close early so the health workers are not there and all patients come here.”* **(Health worker at Bwizibwera health centre 17th Sept 2009)**. *“People have hope in the healthcare system, but when they continue to come and don’t get treatment or they are not attended to in time, they cannot find a reason to come back to the health centre* **(Chairperson, LC1 Bwizibwera –**

B 17/9/2009). *Patients are required to buy books for their records and when they do not have them, they do not come. The book is 300 UGX which not all people can manage'* **(Chairperson, Health Management Committee 16th Sept 2009).** *"..... when people are sick they all go to the hospital. There is no reason that can stop them as long as they are sick."* **(Chairperson, Health Management Committee 16th Sept 2009).**

The demands and needs of health workers and the community which they service are therefore diversely different. For meaningful service delivery the two need to be harmonised to create an understanding of each other.

The other findings indicate that, due to insufficient funds, health centres are understaffed and there are cases of lower health facilities at the third and second levels being closed. Therefore, the entire support system needs to be improved. The following quotations show both the community and the health workers' expressions of what they feel about health services at their level: *"There is a challenge of delayed release of funds and political interference. Politicians have reached a level of looking at prescriptions, which is outside of their role of resource mobilisation."* **(District Health Officer 23 September 09)** *"We are understaffed. One health worker covers different departments despite their specialty, dispensing, clerking, community outreaches, midwifery, in-charge, health education."* **(Midwife at Bwizibwera Health Centre IV 16th September 2009).**

The above findings from the Kashari health sub-district reveal limited community participation in the implementation of the PHC strategy. It is indicated that health workers and community leaders are still grappling with understanding their roles as stakeholders and being expected to bridge the gaps between service providers and users. The health workers and health management committees expressed divergent interests – staffing and supplies vis-à-vis quality of health care and health

workers' relationships with patients. This is reflected in the differences in opinions among the leadership (health workers and the community leaders) on what should be taken as priority in health planning and delivering health services. In addition, the health centre is still resource constrained, a finding that is in keeping with recent evidence which confirms that lowest tier health centres and government hospitals in Uganda are in a sorry state, with many of them faced with a lack of staff, electricity and drug stock (UBOS 2010; Nabyonga et al. 2011).

Discussion: Integrating Intra-Household Determinants of Use of Maternal Health Care in the Lower District Primary Health Care Centres.

To integrate intra-household determinants of the use of maternal health care in Uganda's lower primary health facilities, this section discusses conditions at two levels – the health facility, from the above data on Kashari health sub-district, and the intra-household factors discussed in papers' four, five and six.

This thesis has presented and discussed women's decision-making as the core intra-household determinant of use of maternal health care among the people of the Kashari health sub-district. While the findings about women's household level decision-making concur with other studies which have investigated women's determinants of health in terms of low levels of education and income, this thesis brings to the debate the decision-making determinants embedded in household labour, land decision-making and couple relations (Nyakato 2013; Nyakato and Rwabukwali 2015). Thus, by integrating intra-household factors into the PHC structures, the thesis provides systematic evidence to support the ways in which household socioeconomic factors impact on the use of maternal health care.

The literature not only fails to provide sufficient evidence of the relevance of household level factors in the health care system but is not specific about the conflicting roles of the different stakeholders – health care service providers and users. The findings about the performance of the lower district primary health care structures discussed in the previous section of this paper, show that the health care system and its clients have different and diverse needs that must find areas of agreement and common interest. For example, when health workers are asked about the challenges that affect service delivery and utilisation they mention issues such as poor funding, stock outs, low salaries and understaffing, which demonstrate their perspective on the problems facing health care. On the other hand, the community still feels that health workers need to improve their attitudes if they are to be able to provide services that are accessible. The concern of the community is how to improve communication with health workers. Yet both the community and health care providers agree on the need for inclusive health care leadership, timely stocking of medical supplies and tailoring health care funding to the community’s health needs. The following figure contains an illustration of the common interest of the two parties – health workers and community leaders:

Figure 1: Differences in Opinion about Health Priorities among Health Workers and Community Leaders

Health facility-related challenges – health workers’ opinions	Common areas of concern	Client-related challenges – community leaders’ opinions
Delayed release of PHC funds Health workers’ absenteeism Poor pay of health workers Non-functional structures	Streamlining leadership and management of health units (coordination and control of healthcare delivery process) Monitoring and evaluation of PHC activities; finding relevancy to community needs	Health workers are not receptive Community mobilisation Irregular meetings of the Health Management Committee

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Stockouts Understaffing	Community and health workers' attitudinal change	Long waiting hours at the health facility
Health workers' multiple roles	Timely stocking of medical supplies	Distance to the nearest health facility
Insufficient staff accommodation	Community health education agenda spontaneous for as long as the community is available.	Income level of clients
	Health workers' welfare	
	HIV/AIDS programs are predominant	

Source: Author's analysis output, November 2009

While findings of this study indicates that both sides are still grappling with quite different priorities, Bryant, Richmond et al.'s (2008) report on the progress of PHC in developing countries affirms that there remain gaps in achieving an integrated health care system that follow the demands of the 1998 Alma Ata Declaration. Essentially, an integrated PHC system involves universal community-based preventive and curative services, with substantial community involvement. In the case of Bwizibwera Health Centre, the two parties are concerned with quite different things – for example, while health care workers are concerned with challenges of service delivery and the disease burden, the community requires an understanding of their role as a link between the population and health centres which can be achieved through stream-lined communication system. In this example the findings of this analysis are in agreement with other studies which have concluded that Uganda's PHC strategy is well developed and planned but lacks only systematic implementation.

A related study that was conducted by Golooba-Mutebi in the central region in 2005 analysed the post-decentralisation of the health care system and found that whereas there have been achievements in rebuilding the physical infrastructure

and delivering medical supplies there are still gaps in attaining community participation and engagement. Other studies have concluded that the implementation of the PHC strategy in Uganda is challenged by insufficient funding from both the central and respective local governments (Ablo and Reinikka 2004). The tendency is to focus on the curative function of the lower tier health care facilities and less interest in providing for community engagement programmes (Mbonye et al. 2007) .

Therefore, to deal with the challenges of reorienting the health care systems towards prioritising the other arm of the PHC Strategy – community engagement and participation – requires a complete paradigm shift. This thesis presents the health care system gaps for dealing with dealing with household factors. The overall results of this thesis indicate that the household status of a woman has a lot to do with the division of household labour and ownership and access to resources. The thesis's main argument is that these are household factors which cannot be effectively dealt with in a system that largely focuses on improving the quality and availability of health care. It thus proposes an integrated system that is based on evidence about the context within which these conditions can be incorporated into service delivery and create favourable conditions for improving the use of maternal health care.

Figure 14 above contains an analysis of the differences in opinion among health workers and community leaders to show areas of common interest. According to Bhutta et al. (2008), the main factors that contribute to failure to deliver effective maternal PHC can be summarised into four factors: firstly the lack of a universally agreed minimum set of interventions that should be delivered to all women, children and newborns; secondly, the lack of attention to demand creation and community-level intervention and strategies to promote changes in care-seeking behaviour; thirdly, the shortage of well-trained staff, and reservations about task-

shifting from more highly trained community health workers to those with less training; and fourthly, failure to allocate the resources needed to ensure strategies change. This study's findings about the Kashari Health Sub-District are in agreement with Bhutta, Ali et al.'s (2008) analysis of the challenges facing uptake of comprehensive PHC strategies by poor countries such as Uganda.

Conclusions

Evidence from this and other studies continue to show that the challenge for Uganda's PHC is that it faces both insufficient resources to fulfil its existing functions and lack of resources and effort to change its service delivery systems from the conventional curative system.

Although PHC is a key policy strategy for health and health care, it is still only partially implemented, with limited or no attention to the preventive function which allows for community participation. At Kashari Health Centre IV, a lower district level health centre, work plans and health centre activities overlook the clear evidence on the practices that support primary care. Community health promotion programmes need to be based on local examples, which require prioritising a health care practice based on continuous interaction between the health workers and the community. The village health teams, health management committees and the community engagement structures are not fully utilised by the PHC centres within the lower health sub-district. However, these are local government administrative devolutions that do not deal effectively with intra-household living conditions.

While income level is an important factor for health care access and utilisation, it should not be treated in isolation from other related factors such as education, level of income and gender relations. At the household level, factors that influence decision-making, household hierarchy, overall health behaviour

and the economic role of children combined with education, gender and income are the key individual factors that determine health care demand.

Furthermore, it is difficult for health workers to implement community participation and engagement strategies without being knowledgeable about the community and its diverse social and economic characteristics. The PHC strategy provides for an integrated approach which is only limited by the curatively biased health care system. Regarding women's access to maternal health care, success will largely depend on the extent to which care at the lower health care facilities integrate community and more specifically intra-household factors.

The limited resources from both central and local governments have been used as a justification for abandoning the comprehensive PHC approach among most poor counties such as Uganda. But evidence shows that universal health care access remains relevant (Bryant, Richmond et al. 2008), and even after 30 years of failing to implement comprehensive PHC across poor countries, experts have found no alternative strategy but to call for the rebirth of the idea of promoting universal access (Bhutta et al. 2008). In the case of maternal health care, the thesis brings to light the need to put into context daily living conditions and their impact on promoting universal access. The findings indicate that the PHC structures lack strategies to integrate intra-household factors, which are linked to the social arrangements of society.

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