ABSTRACT

The Dynamics of the Delivery of Antenatal Care under Decentralized Health System in Uganda

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The study investigated Dynamics of the Delivery of Antenatal Care (ANC) under Decentralized Health System in Uganda with specific focus on institutional framework, funding and human resources. The problem was ascertaining whether the raft of reforms, commitments and considerable resources towards health by the Government of Uganda (GoU) had occasioned quality ANC and overall health services. The study covered four districts of Gulu, Mbarara, Sironko and Kampala using a mixed methods model or triangulation. The quantitative data analysis was by compressing it into user-friendly formats using classifications, tabulations, frequency counts, percentages and in a few cases cross-tabulations. The qualitative data was analysed through interpretive techniques including coding, recursive abstraction, content analysis, data classification, sorting and arranging. The study was governed by the principal-agency theory which describes the logic of delegation. The population comprised of public officers from the Ministry of Local Government (MoLG) and Ministry of Health (MoH) and from the districts where the top political leadership and technical officers were involved. The sample size was 167 while data collection was through in-depth/unstructured/open-ended interviews, Focus Group Discussions (FGDs), observation, consultative meetings, testimonies and documentary analysis. On the institutional framework, the study established that the health system operated on a six-tier continuum; and delivered in an integrated manner. Functionality of HC IVs was at 24%; only 27% of deliveries took place in Health Centres (HCs); just 47% of the women had recommended four ANC visits; and 86% encountered one serious problem accessing health care. Uganda lacked categorical legislation on ANC but had International commitments; the decentralization of health was governed by Constitutional mandate and complimentary legislation. A Health a Sub-District (HSD) served 200,000 persons; there was little coordination; partnerships existed; decentralization increased accessibility to health and GoU recognized Traditional Health Practitioners. Inhibiting factors to ANC included HIV/AIDS, bureaucracy, and HC IVs failed to fulfil their cardinal objectives. On funding, HCs that handled 90% of health care got only 10% of national health budget; central government was major source of the funding; donor funds were waning and through the Poverty Action Fund (PAF) and budget-lines existed for ANC. The government support towards the health sector stagnated at nine percent; while the districts hardly made counterpart funding. The districts absorption rates of the funds was good, disjointed planning, low local revenue, corruption, belated disbursements, and abolition of user-fees were critical concerns. On the efficacy of the human resources, expectant mothers were satisfied with health workers who put in effort beyond ordinary call of duty; while one in three Health Workers served in acting capacity. The GoU increased pay for the public workers between 25% and 90%. There were huge client workloads; an inclination to traditional medicine; poverty, and poor coordination. The HC IVs operated at 55 percent capacity; staffing-ceilings were unrealistic; stress, poor customer-care and demoralization and staff in local governments were recruited locally and did things locally. There is need for legislation on ANC; meeting International commitments, additional HSDs, close monitoring of VHTs.