

# STUDY OF THE DEMAND FOR HEALTH FINANCING SERVICES AMONG FINCA UGANDA CLIENTS



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All photos were taken by Ana Klincic.

## List of Abbreviations

| Abbreviation | Explanation                              |
|--------------|--|
| ACT          | Artemisinin Combination Therapy          |
| ARV          | Antiretroviral                           |
| FCAT         | FINCA's Client Assessment Tool           |
| FGD          | Focus Group Discussion                   |
| HC           | Health Centre                            |
| IDP          | Internally Displaced Person              |
| ITN          | Insecticide Treated Net                  |
| MoHU         | Ministry of Health Uganda                |
| ORS          | Oral Rehydration Salts                   |
| PRA          | Participatory Rapid Appraisal Tools      |
| OVC          | Orphans and Vulnerable children          |
| SIDA         | Swedish International Development Agency |
| STDs         | Sexually Transmitted Diseases            |
| TB           | Tuberculosis                             |
| UDHS         | Ugandan Demographic and Health Survey    |
| USD          | United States Dollar                     |
| Ush          | Ugandan Schilling                        |
| WB           | World Bank                               |
| WHO          | World Health Organization                |
| WHR          | World Health Report                      |

## **Executive Summary**

This study explores the unmet demand for health services by FINCA Uganda clients. Research was conducted in Lira, Mbarara, and Jinja, three locations where FINCA Uganda currently operates, using qualitative research methods such as focus group discussions (FGDs), participatory rapid appraisal (PRAs) tools and in-depth interviews with FINCA Uganda clients and health care providers.

Malaria, HIV/AIDS and tuberculosis were identified as key health risks faced by FINCA Uganda clients. Sickneses such as these pose a tremendous economic burden because they levy both direct and indirect costs. The high costs of treatment drain financial resources while the loss of productivity impedes a household's future income generating ability. According to study participants, malaria and HIV/AIDS cause the greatest associated financial pressures. A leading cause of infant, child and adult morbidity and mortality in Uganda, malaria is endemic in all parts of the country and remains present throughout the year. The long-term financial impacts of routine HIV/AIDS treatments are staggering. On top of this, the loss of productivity and risk of opportunistic infection increase both the direct and indirect costs of the disease.

Most respondents do not have specific health coping mechanisms but rather, employ a combination of strategies *ex post* based on the financial need and their financial capacity. In the event of sickness, a household will commonly seek financial support from family and friends, reallocate household income and/or sell livestock and small household assets. Diverting business loans and using business income and business stock are other methods used by FINCA Uganda clients to pay for medical expenses. Informal savings schemes are common insurance methods in all three geographic areas. Savings is used where and when accessible but the amount of medical expenses usually exceeds the amount saved. Although respondents do borrow for medical emergencies, it is the least preferred option because it is perceived as the most costly.

Despite the number of coping mechanisms in place, these mechanisms are often costly for the clients and do not adequately cover overall medical costs. Clients, however, seem content with the systems in place. The biggest advantage of current practices is the speed with which cash can be secured for medical expenses, regardless of how ineffective or costly these strategies may be.

Issues of availability, accessibility, affordability, and acceptability create barriers to obtaining health care. The most significant factor for those seeking health care is having the cash to afford health care services, as health care costs can be prohibitive. Interviews with health care providers and clients revealed that clients' lack of knowledge about diseases, symptoms, and treatments is another key obstacle to seeking health care. Unavailability of doctors and lack of drugs were also cited as barriers. The barriers to obtaining health care increase when we consider other indirect costs associated with care, for example transportation costs. In the rural area of Lira, lack of transportation and far distances inhibit accessibility to health facilities.

FINCA clients' awareness of and current use of health insurance is limited. A few clients mentioned having a health insurance policy with MicroCare Uganda. Other respondents employ

informal self-insurance strategies such as diversification of income sources. Overall, the researchers perceived a general lack of understanding of insurance products. Although respondents did not see the added benefit of insurance, this study concludes that health insurance is a product needed by FINCA Uganda clients.

Key research findings:

1. Illness occurs frequently
2. The cost of medical treatment is high
3. Most respondents rely on savings and the sale of assets to deal with health emergencies
4. Lump sums of money are needed and are needed quickly
5. Sickness expenses are not planned for
6. The knowledge about sickness prevention is low

## 1. Introduction

Microfinance institutions (MFIs) can no longer overlook the health care needs of their clients. Therefore, an increasing effort to develop health financial services has been seen among MFIs. Health financing for clients is one of the most challenging financial products because health financing products should both improve clients' health outcomes and be profitable for the institution. Sickness changes the behavior of the clients not only when it comes to loan repayment, but also in relation to demand for products and services. Financial implications of client illness, which ultimately impact the MFI, usually include: diverting the loans towards medical expenses, inability to repay the loan due to sickness, decreasing business income and assets, etc. FINCA Uganda has recognized the importance of health care financing and has as a result implemented various health care services for its clients, mostly through partnerships. For example, FINCA Uganda provides loans for health insurance in collaboration with Microcare; it also provides loans for mosquito nets.

*"When clients fall sick, they cannot work as much, their business is disrupted, they don't pay the loan, they can't afford anything." FINCA Credit Officer*

Uganda is a land-locked country located in East Africa, which mainly depends on peasant farming. More than 85% of the country's population is rural based (Health Profile Uganda SIDA, 1999). It has a population of about 24 million people with a high annual population growth rate of over 3% (Ministry of Health Uganda MoHU, 2007). Life expectancy in Uganda is one of the lowest in the world: 49 years in 2002 (World Health Report WHR, 2006). Prior to the political upheavals and civil strife that beset the country between the mid-1960s and mid-1980s, Uganda had some of the best health indicators in the region. This period of decline led to the collapse of most sectors including health and the economy. This led to a reversal of the health indices, which are now among the worst in the region (Makerere University Institute of Public Health, 2006). According to the burden of disease studies, the top ten diseases dominating morbidity and mortality are: malaria, HIV/AIDS, tuberculosis, acute respiratory tract infections, diarrhea diseases, malnutrition, anemia, intestinal infections, trauma/accidents, and skin infections (SIDA, 1999). In 1993, Uganda reported the highest rates of AIDS cases per capita in Africa and the world (2,314/1,000,000). In 2001, 2.4 million Ugandans were HIV positive while about 0.9 million had the full blown disease. There is a strong political commitment to controlling this disease (World Health Organization, WHO 2001). Government allocation to the health sector increased from 2.5% in 1987/88 to about 10% of the national budget in 2005. Uganda's economy has been growing at about 6% per annum for the past 10 years, but it still remains one of the poorest countries in the world with a GNP per capita of around \$USD 300 (World Bank, 2005).

Uganda is divided into over 70 administrative districts. Each of these is divided into counties, which are themselves divided into sub-counties, and then into parishes, and finally villages, which are the smallest administrative units. A district has an average population of 400,000 people, a county about 100,000, a sub-county 30,000 (20,000 – 50,000), a parish 5,000 and most villages have about 500 – 1,000 people.

FINCA has been operating in Uganda since 1992. It was the first program in Africa and is now their largest program in the world with over 44,000 clients. In July 2004, FINCA had an active portfolio of \$USD 5.5 million, client savings of \$USD 2.2 million, and total YTD lending of \$USD 20 million. Based on the 2004 FINCA Client Assessment Tool (FCAT), 58% of FINCA's Ugandan clients<sup>1</sup> lived in peri-urban areas, 31% lived in rural areas and 17% in urban areas. Average household size was 5.9 and 61% of respondents had two income earners per family. Average age of clients was 33 years. 90% of respondents lived below \$2 a day. The survey showed that clients spent only 3% of their income on health expenses compared to 41% that was spent on food consumption.

In July 2007, FINCA had 45,000 clients, where 95% are organized in groups. Loans range from \$USD 30<sup>2</sup> to \$USD 3,000 and loans are mostly used for working capital.

The purpose of this report is to describe the demand for health protection services by FINCA Uganda clients. The information gained through this research will support FINCA's efforts in developing and launching relevant financial and non-financial health promoting products.

## **Organization of the report**

The report is organized as follows: Chapter 2 outlines the purpose of the market research, followed by the conceptual framework for health seeking behavior (Chapter 3). Chapter 4 outlines the research methodology and sampling strategy. Chapter 5 describes the household economy in selected areas followed by a discussion on risks faced by households and risk coping mechanisms (Chapter 6). The report then describes the health risks faced by FINCA clients and health seeking behavior (Chapters 7 and 8). Chapter 9 looks into barriers to obtaining health care. Chapter 10 ends with a summary of findings of the market research.

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<sup>1</sup> Sample size 252. Source Summary FINCA Uganda FCAT 2004, courtesy from FINCA International, Washington, DC

<sup>2</sup> Exchange rate \$USD 1 = Ush 1600 is used throughout the paper

## **2. Purpose of the Market Research**

The purpose of the market research was to assess the most common and the most costly problems for FINCA Uganda clients and their families and to describe the predominant coping strategies currently employed by FINCA clients to deal with medical problems and medical costs. This information will then be used to inform a process of financial and non-financial product prototype development that corresponds to the identified needs of FINCA clients and their families in Uganda. Ultimately, the information gathered in this research will help FINCA to develop health financing interventions that will improve the health outcomes of FINCA clients and mitigate the financial impact of health care costs on the clients and their households.

The key research questions were:

- What key health risks do FINCA clients face?
- What are the impacts of these key health risks?
- How do FINCA clients cope with these health problems when they occur?
- What do they do to prevent them ahead of time?
- What key gaps exist for FINCA's target group related to health protection?
- What priority needs does this target group have in terms of health protection services?
- What is the awareness of and current use of health insurance among FINCA clients?
- What are the attitudes towards insurance?
- Who manages health within the family? Who makes healthcare and health seeking decisions in the household?
- What products could help to meet clients' health protection needs?

### 3. Conceptual Framework for Health Seeking Behavior

A conceptual framework helps to understand the complexity of health seeking behavior. This report draws on a conceptual framework developed by Kroeger and discussed in *Health Seeking Behavior and The Health System Response* (Muela et al., 2003). In this framework, health seeking behavior is defined as the way an individual responds to her health problems and needs. Health seeking behavior is influenced by knowledge, practices, and attitudes towards health care. In health research, knowledge is usually assessed in order to see to what degree the knowledge of the community corresponds to biomedical knowledge. However, in this particular research we have not assessed the clients' knowledge of medical issues. Attitudes refer to beliefs (that is, feelings and values related to health seeking behavior) while client practices are the measures used for input into the development of the health care options. This research has focused only on the practices of health seeking behavior. Kroeger's model of health seeking behavior was considered appropriate for the research because it combines both financial and social aspects of health seeking behavior [See Figure 1].

**Figure 1: Determinants of Health Seeking Behavior**

|  |  |   |
|--|--|---|
| <b>1. Socio-demographic Factors</b><br>Age, gender, family size, education, and occupation | <b>2. Environmental Factors</b><br>Access to clean water, proper waste disposal  | <b>3. Financial Accessibility Factors</b><br>Amount of money available for health care, level of income |
| <b>4. Economic Factors</b><br>Poverty level, food availability                             | <b>5. Health Decision Making Factors</b><br>Decision maker in the family when it comes to health                                 | <b>6. Physical Accessibility Factors</b><br>Transportation, physical distance, time                     |
| <b>7. Personality Factors</b><br>Self esteem, perception of health needs                   | <b>8. Health Services Factors</b><br>Attitude of health workers, satisfaction with treatment, received treatment, and medication | <b>9. Socio-cultural Norms</b><br>Perception of sickness, sickness acceptability, etc.                  |

*Adopted from Kroeger, 1998.*

In this research, we have examined health seeking behavior by employing these nine factors to evaluate the behaviors of FINCA clients when they are sick.

## 4. Research Design

### 4.1. Research methods and sampling strategy

The market research employed qualitative research methods to gather information on the health seeking behavior of FINCA's clients. The following research methods were used:

- *Focus Group Discussions* (FGD) with clients using Discussion Guides and Participatory Rapid Appraisal Tools (PRA),
- *In-depth interviews* with health care providers,
- *Direct Observation* of health facilities.

All the research tools were developed by Microfinance Opportunities and can be obtained upon request.

The following PRA tools were used:

- Seasonality of Diseases: This tool explores the seasonal patterns of diseases. FGD participants prepare a seasonality chart of diseases using annual calendar.
- Seasonality of Income/Expenditure/Savings and Credit: This tool explores seasonal patterns of income, expenditure, savings and credit. FGD participants prepare a seasonality chart to show variations in income, expenditure, savings and credit by month.
- Life-Cycle Profile to Analyze Health Care Needs over Time: In this tool, the participants draw a life line chart with life phases to show when different illnesses occur.
- Health Care Seeking Behavior Map: In this tool clients discuss where they seek medical care and why.
- Health Care Services Matrix: In this tool clients discuss which health service providers are used by different socio – economic sectors.
- Relative Preference Ranking: In this tool clients discuss what attributes e.g. proximity, cost etc. are of a relative importance when making the decision about where to seek health care.
- Health Care Financing: In this tool clients discuss different financial mechanisms used to finance medical expenditure
- Risks and Risk Coping Mechanisms: In this tool clients discuss what risks they are facing in their daily life and what financial and non-financial mechanisms they use to cope with risks.

Figure 2 below shows the number of respondents per each tool used.

**Figure 2: Number of Respondents per Tool**

| Participatory Rapid Appraisal Tool used | Number of Respondents (N) |
|---|---------------------------|
| Seasonality of Diseases                 | 12                        |

| Participatory Rapid Appraisal Tool used                   | Number of Respondents (N)   |
|---|---|
| Seasonality of Income/<br>Expenditure/Savings/Credit      | 20  |
| Life-Cycle Profile to Analyze Health Care Needs Over Time | 9   |
| Health Care Seeking Behavior Map                          | 18  |
| Health Care Services Matrix                               | 20  |
| Relative Preference Ranking                               | (20)* This number is excluded in total no. of respondents because Ranking tool was used together with Health Care Services Matrix |
| Risks and Risk Coping Mechanisms                          | 12  |
| Health Care Financing                                     | 34  |
| <b>Total</b>  | <b>125</b>  |

The study was conducted in Lira, Mbarara, and Jinja, three locations where FINCA Uganda currently operates. Lira is located in a rural area of Northern Uganda. The majority of activities in the area involve farming and fishing. The majority of people in Lira are subsistence farmers or petty traders.

Jinja is located in the eastern part of Uganda. It is densely populated with over 500,000 people. People in Jinja are mostly petty traders and the majority of women work in the market selling food.

Mbarara is located in Southwest Uganda and is the second largest city after Kampala. Mbarara is economically vibrant.

The sampling strategy was purposive: that is, clients were selected with the research purpose in mind. FGD were conducted in each area. In total 20 FGD were conducted with 125 participants. Segmentation included occupational status, gender groups, age, and rural/urban clients. In total 125 respondents participated in the Focus Group Discussions: 59 respondents in Lira, 44 in Jinja and 22 in Mbarara. The number of respondents was lower in Mbarara due to the difficulties experienced by FINCA's Mbarara branch in organizing the FGD.

There were 25 in-depth interviews conducted with health care providers using the health care service provider discussion guide prepared by Microfinance Opportunities. An extensive document and literature review on the health situation in Uganda, health seeking behavior, and health financing was also conducted.

In order to ensure confidentiality for respondents, names have been omitted throughout the report. The consent to take pictures of the respondents and facilities was obtained for each photo included in the report.

Field research was conducted from July 2 – July 22, 2007.

## **5. Household Economy in Selected Areas**

In this chapter of the report, a brief description of the respondents' socio-economic profile is provided.

### **5.1. Participants' socio-demographic profile**

The average household size among the respondents in this survey was 4.4 people which correspond to the Ugandan average of 4.8 persons<sup>3</sup>. The household size was the largest in Jinja (7.32) and lowest in Mbarara (4.55). The average number of people who earn income in each household was 1.76 people (Lira 1.56, Jinja 2.09 and Mbarara 1.64 respectively). The research shows that the average dependency ratio<sup>4</sup> is 2.52 which means that two family members depend on one income earner. The dependency ratio is the highest in Lira at 3.72 household members per income earner, which can be an indication of either lower economic status in that area and/or larger family size.

89% of all respondents came from urban areas, while only 11% of respondents came from peri-urban areas. All the respondents from peri-urban areas reside in Lira. 57% of all respondents were women, and 43% of all respondents were men (refer to Figure 4 Socio-Economic Profile of respondents)

On average respondents were clients of FINCA for 4 years. The level of education among the respondents was rather low, 33% of respondents finished primary school and 29% of respondents finished some secondary school (i.e. took some classes in secondary school). Only 17% of respondents finished secondary school. All respondents were engaged in some type of economic activity in the previous year, and 14% of clients were engaged in some sort of paid employment.

All clients reported having an outstanding loan with FINCA in the previous year. Information on the outstanding loan amount was not available to the researchers. Ninety-seven percent of clients save with FINCA, and 34% of clients belong to an informal savings and credit group.

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<sup>3</sup> Ugandan Health and Demographic Survey, 2001

<sup>4</sup> Average household size divided by the number of people earning income.

**Figure 3: Socio-Economic profile of Respondents**

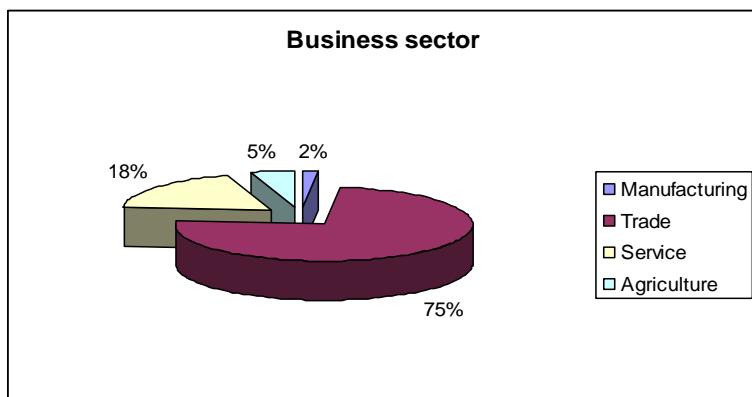
| SOCIAL PROFILE   |           |             |           |               |           |               |            |                |  |  |  |  |  |  |  |  |
|--|-----------|-------------|-----------|---------------|-----------|---------------|------------|----------------|--|--|--|--|--|--|--|--|
|  | LIRA      |             | JINJA     |               | MBARARA   |               | Total      |                |  |  |  |  |  |  |  |  |
| # of respondents   | #         | %           | #         | %             | #         | %             | #          | %              |  |  |  |  |  |  |  |  |
| <b>Geographic area</b>   |           |             |           |               |           |               |            |                |  |  |  |  |  |  |  |  |
| Urban  | 45        | 76.3%       | 44        | 100%          | 22        | 100%          | <b>111</b> | <b>88.8%</b>   |  |  |  |  |  |  |  |  |
| Peri-Urban   | 14        | 23.7%       | 0         | 0%            | 0         | 0%            | <b>14</b>  | <b>11.2%</b>   |  |  |  |  |  |  |  |  |
| <b>Category Total</b>  | <b>59</b> | <b>100%</b> | <b>44</b> | <b>100%</b>   | <b>22</b> | <b>100%</b>   | <b>125</b> | <b>100%</b>    |  |  |  |  |  |  |  |  |
| <b>Gender</b>  |           |             |           |               |           |               |            |                |  |  |  |  |  |  |  |  |
| Female   | 31        | 52.5%       | 25        | 56.8%         | 15        | 68.2%         | <b>71</b>  | <b>56.8%</b>   |  |  |  |  |  |  |  |  |
| Male   | 28        | 47.5%       | 19        | 43.2%         | 7         | 31.8%         | <b>54</b>  | <b>43.2%</b>   |  |  |  |  |  |  |  |  |
| <b>Category Total</b>  | <b>59</b> | <b>100%</b> | <b>44</b> | <b>100%</b>   | <b>22</b> | <b>100%</b>   | <b>125</b> | <b>100%</b>    |  |  |  |  |  |  |  |  |
| <b>Marital status</b>  |           |             |           |               |           |               |            |                |  |  |  |  |  |  |  |  |
| Single   | 5         | 8.5%        | 2         | 4.5%          | 5         | 22.7%         | <b>12</b>  | <b>9.6%</b>    |  |  |  |  |  |  |  |  |
| Married  | 46        | 78.0%       | 40        | 90.9%         | 14        | 63.6%         | <b>100</b> | <b>80.0%</b>   |  |  |  |  |  |  |  |  |
| Widow  | 8         | 13.6%       | 2         | 4.5%          | 3         | 13.6%         | <b>13</b>  | <b>10.4%</b>   |  |  |  |  |  |  |  |  |
| <b>Category Total</b>  | <b>59</b> | <b>100%</b> | <b>44</b> | <b>100%</b>   | <b>22</b> | <b>100%</b>   | <b>125</b> | <b>100.00%</b> |  |  |  |  |  |  |  |  |
| <b>Education level</b>   |           |             |           |               |           |               |            |                |  |  |  |  |  |  |  |  |
| None   | 2         | 3.4%        | 1         | 2.3%          | 0         | 0.0%          | <b>3</b>   | <b>2.4%</b>    |  |  |  |  |  |  |  |  |
| Some Primary   | 13        | 22.0%       | 3         | 6.8%          | 1         | 4.5%          | <b>17</b>  | <b>13.6%</b>   |  |  |  |  |  |  |  |  |
| Primary  | 21        | 35.6%       | 12        | 27.3%         | 8         | 36.4%         | <b>41</b>  | <b>32.8%</b>   |  |  |  |  |  |  |  |  |
| Some Secondary   | 13        | 22.0%       | 16        | 36.4%         | 7         | 31.8%         | <b>36</b>  | <b>28.8%</b>   |  |  |  |  |  |  |  |  |
| Secondary  | 7         | 11.9%       | 9         | 20.5%         | 5         | 22.7%         | <b>21</b>  | <b>16.8%</b>   |  |  |  |  |  |  |  |  |
| Some University  | 0         | 0.0%        | 0         | 0.0%          | 1         | 4.5%          | <b>1</b>   | <b>0.8%</b>    |  |  |  |  |  |  |  |  |
| Completed Uni.   | 0         | 0.0%        | 1         | 2.3%          | 0         | 0.0%          | <b>1</b>   | <b>0.8%</b>    |  |  |  |  |  |  |  |  |
| Completed training college   | 3         | 5.1%        | 2         | 4.5%          | 0         | 0.0%          | <b>5</b>   | <b>4.0%</b>    |  |  |  |  |  |  |  |  |
| <b>Category Total</b>  | <b>59</b> | <b>100%</b> | <b>44</b> | <b>100.0%</b> | <b>22</b> | <b>100.0%</b> | <b>125</b> | <b>100.0%</b>  |  |  |  |  |  |  |  |  |
| ECONOMIC PROFILE   |           |             |           |               |           |               |            |                |  |  |  |  |  |  |  |  |
|  | LIRA      |             | JINJA     |               | MBARARA   |               | Total      |                |  |  |  |  |  |  |  |  |
| Percentages derived from total responses <sup>5</sup> even in case of multiple answers |           |             |           |               |           |               |            |                |  |  |  |  |  |  |  |  |
| <b>Economic Activity Background in the last year</b>                                   |           |             |           |               |           |               |            |                |  |  |  |  |  |  |  |  |
| Wage employment  | 8         | 6.4%        | 10        | 8.0%          | 0         | 0.0%          | 18         | 14.4%          |  |  |  |  |  |  |  |  |
| Self employment  | 59        | 47.2%       | 44        | 35.2%         | 22        | 17.6%         | 125        | 100.0%         |  |  |  |  |  |  |  |  |
| No wage or/and self employment   | 0         | 0.0%        | 0         | 0.0%          | 0         | 0.0%          | 0          | 0.0%           |  |  |  |  |  |  |  |  |
| <b>Experience with financial institutions in the last year</b>                         |           |             |           |               |           |               |            |                |  |  |  |  |  |  |  |  |
| Savings w/ FINCA   | 56        | 44.8%       | 43        | 34.4%         | 22        | 17.6%         | <b>121</b> | <b>96.8%</b>   |  |  |  |  |  |  |  |  |
| Use of FINCA Financial Services  | 59        | 47.2%       | 44        | 35.2%         | 22        | 17.6%         | <b>125</b> | <b>100.0%</b>  |  |  |  |  |  |  |  |  |
| Participation in ROSCA   | 5         | 4.0%        | 1         | 0.8%          | 1         | 0.8%          | <b>7</b>   | <b>5.6%</b>    |  |  |  |  |  |  |  |  |
| Participation in informal groups   | 17        | 2113.6%     | 17        | 13.6%         | 8         | 6.4%          | <b>42</b>  | <b>33.6%</b>   |  |  |  |  |  |  |  |  |
| Microinsurance   | 0         | 0.0%        | 0         | 0.0%          | 0         | 0.0%          | <b>0</b>   | <b>0.0%</b>    |  |  |  |  |  |  |  |  |
| <b>Years with FINCA</b>  |           |             |           |               |           |               |            |                |  |  |  |  |  |  |  |  |
| 1 to 3 yrs   | 38        | 64.41%      | 20        | 45.45%        | 11        | 50.00%        | <b>69</b>  | <b>55.20%</b>  |  |  |  |  |  |  |  |  |
| 4 to 6 yrs   | 9         | 15.25%      | 2         | 4.55%         | 8         | 36.36%        | <b>19</b>  | <b>15.20%</b>  |  |  |  |  |  |  |  |  |
| 7 to 9 yrs   | 6         | 10.17%      | 9         | 20.45%        | 3         | 13.64%        | <b>18</b>  | <b>14.40%</b>  |  |  |  |  |  |  |  |  |
| More than 10 yrs   | 6         | 10.17%      | 13        | 29.55%        | 0         | 0.00%         | <b>19</b>  | <b>15.20%</b>  |  |  |  |  |  |  |  |  |
| <b>Category Total</b>  | <b>59</b> | <b>100%</b> | <b>44</b> | <b>100%</b>   | <b>22</b> | <b>100%</b>   | <b>125</b> | <b>100.00%</b> |  |  |  |  |  |  |  |  |

<sup>5</sup> Multiple choices were available hence the number of responses may have exceeded the number of respondents

## 5.2. Participants' Economic Activity

Trade is the predominant business activity among the respondents. 75% of all economic activities are in Trade (80% in Lira, 73% in Jinja and 68% in Mbarara). 18% of all respondents work in the service sector, and 5% are engaged in Agriculture and 2% in Manufacturing (refer to Figure 4 Business Sector below). The top four trading activities are: sale of agricultural produce such as beans or bananas (21% of all respondents), sale of secondhand clothes (17.9% of all respondents), sale of groceries (14% of all respondents), and sale of new clothes (10% of all respondents).

**Figure 4: Business Sector**



The most common activities in the service sector are tailoring and transportation. Forty-nine percent of all respondents are tailors, and 10% of all respondents are involved in transportation businesses such as providing taxi services with “Boda Boda” (a local name for a motor bike).

**Figure 5: Service Sub-Sector**

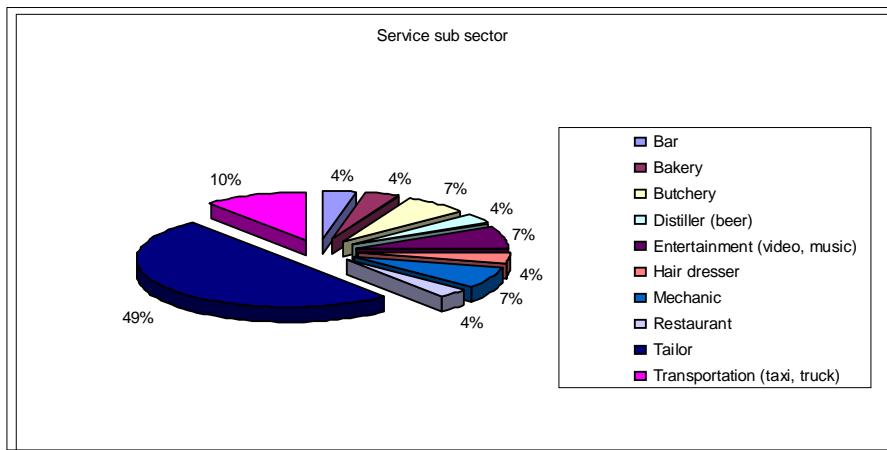
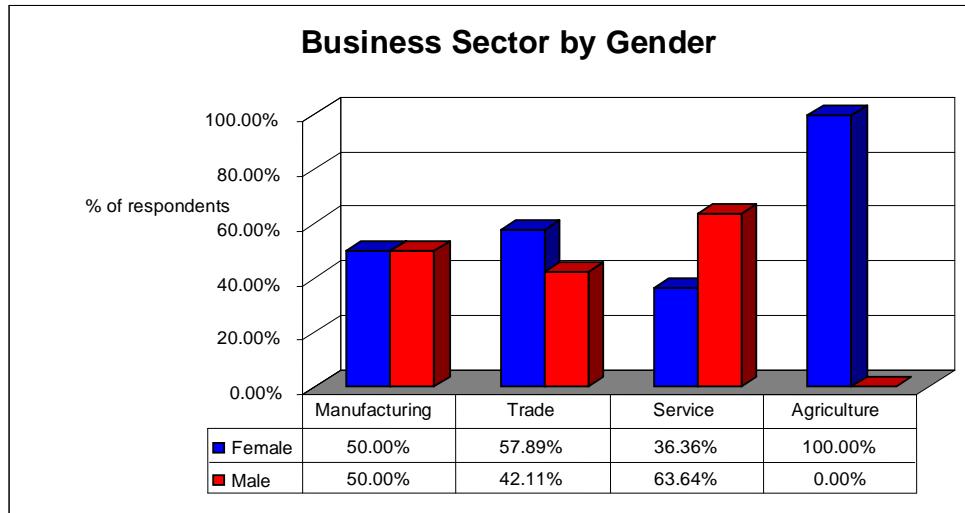


Figure 6 below shows the breakdown of the business sector by gender. As the table demonstrates, there are more men engaged in trade activities than women. Sixty percent of women engaged in trade activities compared to 40% of men. 100% of those engaged in agricultural activities are women. All respondents are from Jinja.

**Figure 6: Business Sector by Gender**



A detailed business sector profile is presented in Figure 7, Business Sector Profile, below.

**Figure 7: Business Sector Profile**

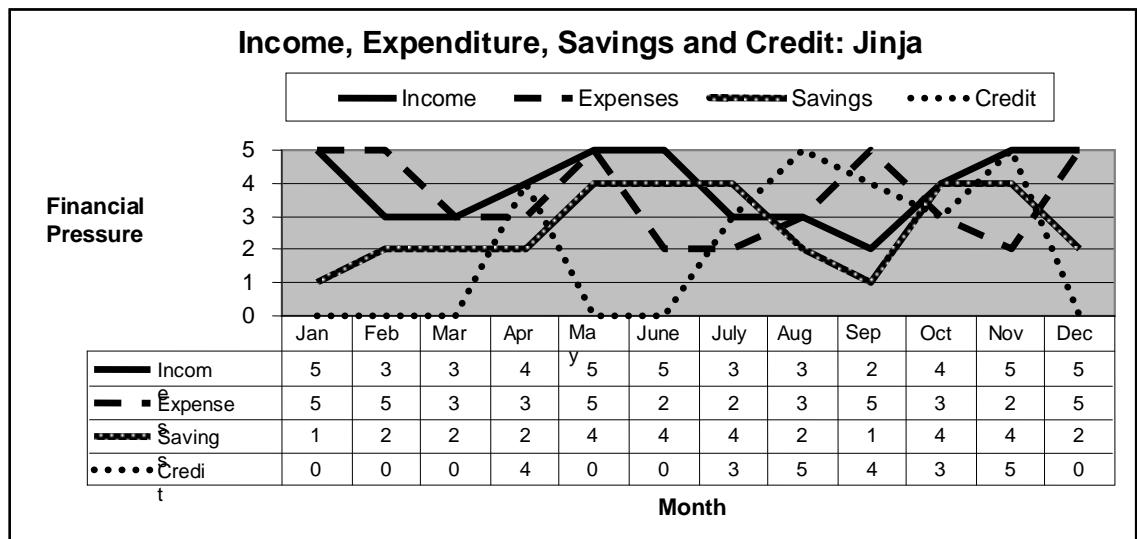
| BUSINESS PROFILE                 |           |             |           |             |           |             |            |             |
|----------------------------------|-----------|-------------|-----------|-------------|-----------|-------------|------------|-------------|
|                                  | LIRA      |             | JINJA     |             | MBARARA   |             | Total      |             |
| No. of Respondents*              | #         | %           | #         | %           | #         | %           | #          | %           |
| <b>Business Sector</b>           |           |             |           |             |           |             |            |             |
| Manufacturing                    | 1         | 2%          | 0         | 0%          | 1         | 5%          | 2          | 2%          |
| Trade                            | 47        | 80%         | 32        | 72%         | 15        | 68%         | 94         | 75%         |
| Service                          | 11        | 18%         | 6         | 14%         | 6         | 27%         | 23         | 18%         |
| Agriculture                      | 0         | 0%          | 6         | 14%         | 0         | 0%          | 6          | 5%          |
| <b>Category Total</b>            | <b>59</b> | <b>100%</b> | <b>44</b> | <b>100%</b> | <b>22</b> | <b>100%</b> | <b>125</b> | <b>100%</b> |
| <b>Business Sector by Gender</b> |           |             |           |             |           |             |            |             |
| <b>Manufacturing Total</b>       | <b>1</b>  | <b>100%</b> | <b>0</b>  | <b>100%</b> | <b>1</b>  | <b>100%</b> | <b>2</b>   | <b>100%</b> |
| Female Manufacturing             | 0         | 0%          | 0         | 0%          | 1         | 100%        | 1          | 50%         |
| Male Manufacturing               | 1         | 100%        | 0         | 0%          | 0         | 0%          | 1          | 50%         |
| <b>Trade Total</b>               | <b>47</b> | <b>100%</b> | <b>33</b> | <b>100%</b> | <b>15</b> | <b>100%</b> | <b>95</b>  | <b>100%</b> |
| Female Trade                     | 26        | 55%         | 18        | 55%         | 11        | 73%         | 55         | 58%         |
| Male Trade                       | 21        | 45%         | 15        | 45%         | 4         | 27%         | 40         | 42%         |
| <b>Service Total</b>             | <b>11</b> | <b>100%</b> | <b>5</b>  | <b>100%</b> | <b>6</b>  | <b>100%</b> | <b>22</b>  | <b>100%</b> |
| Female Service                   | 6         | 55%         | 1         | 20%         | 1         | 17%         | 8          | 36%         |
| Male Service                     | 5         | 45%         | 4         | 80%         | 5         | 83%         | 14         | 64%         |
| <b>Agriculture Total</b>         | <b>0</b>  | <b>0%</b>   | <b>6</b>  | <b>100%</b> | <b>0</b>  | <b>0%</b>   | <b>6</b>   | <b>100%</b> |
| Female Agriculture               | 0         | 0%          | 6         | 100%        | 0         | 0%          | 6          | 100%        |

|                  |   |    |   |    |   |    |   |    |
|------------------|---|----|---|----|---|----|---|----|
| Male Agriculture | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
|------------------|---|----|---|----|---|----|---|----|

### 5.3. Income and expenditure patterns

The Income and Expenditure tool provides information on income and expenditure variations throughout the year. After an in-depth discussion on sources of income, expenditure, credit and savings clients are asked to use bottle tops to show various levels of pressure during each month of the year. Financial pressure in the graphs refers to the level of financial pressures throughout the year. This tool gives an indication of how credit and savings can respond to these financial pressures. The information gathered through this tool is not in monetary terms. Twenty (20) respondents were interviewed and the tool was used in all three research areas. Figure 8 below shows the Income and Expenditure trends for Jinja, Figure 9 and Figure 10 show the Income and Expenditures for Lira and Mbarara. A detailed discussion follows each of the figures.

**Figure 8: Income, Expenditure, Savings and Credit in Jinja**



#### Income

The peak periods for high income in Jinja are from April to June and from October to January. Between April and June the majority of income comes from selling farm produce such as beans, vegetables, and maize. From October to January the income comes from selling coffee beans, and from selling cattle i.e. goats, pigs and goats. These products are in high demand during the Christmas season. February and March, and July through September are months of little or no economic activity. Businesses have low sales and there is little produce to sell. During this time farmers are busy preparing for the first growing season (April to June). During the months of low income people sell the produce that was stored during peak months (October to January). Many

people also have a vegetable garden from which they can sell produce during the months of low income.

### Expenditure

January, February, May, September and December are the months of highest expenditure in the households. The pressure is high during these months due to school fees, which pose one of the highest financial pressures on most households. Expenditures are high in December mostly because of preparations for the festive season. Most of these expenses are met from business profits or individual savings. In this period clients will borrow from ROSCAs and MFIs for business purposes.

### Savings

High months for savings are April through July and October and November, low months are December to March and June to July. Savings are usually done in cash or in-kind (agricultural produce such as maize, or livestock) and informal groups. The savings amounts in informal groups will range from Ush 2,000 (\$USD 0.40) to Ush 10,000 (\$USD 2) per week. Cash savings around October and November are used for school fees and in-kind savings during the same period are meant for consumption smoothing in the households. Savings increases in February and March (from Ush 200,000 (\$ USD 40) to Ush 2,000,000 (\$USD 400)) when stored produce is sold.

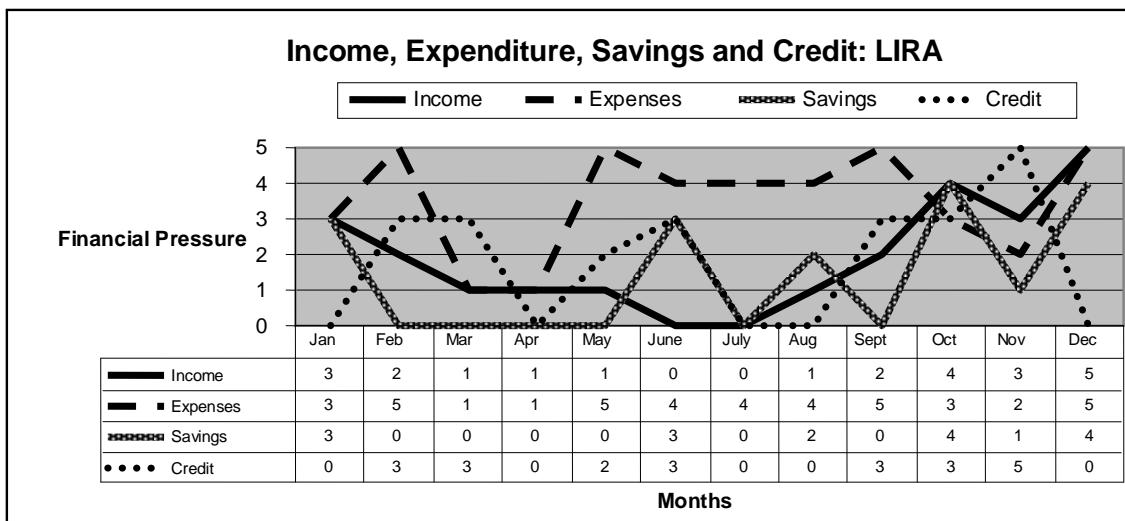
### Credit

The need for credit is highest in April and from July through November. In April credit is needed for business, and for meeting school fees in May. Credit in July and November is also used for business. Apart from borrowing from FINCA for business purposes, clients borrow from PRIDE, U-trust, UML, Post Bank, Feed the Children, sub-county funds, and Women's Groups.

### *Health financing in Jinja*

In order to cope with the financial pressure of sickness (during the months of low income) clients in Jinja will borrow from friends and family. The amounts borrowed are usually small and are just enough to enable people to respond to the emergency needs. If illness occurs during the months of high expenditure clients will look for treatment with known health providers who can offer services on credit. Clients do not save specifically for medical expenses. In the case of an emergency, clients will borrow from individuals such as money lenders or family and friends.

**Figure 9: Income, Expenditure, Savings and Credit in Lira**



### Income

High income months in Lira are October to January with the peak in December. These are the months when the harvest is most plentiful and the produce is sold at a good price. In this period, both farmers and traders are doing well. Major crops include beans, maize, millet, rice, sorghum and sesame seed. Low income months are March to August. This is a period of low supply of agricultural produce in the community. Because of this, there is a generally low level of economic activity and traders have no customers. Only a few traders who deal with essential household commodities, like sugar and salt have business. During the months of low income, savings are used. During the harvest some food is stored for the months of low income.

### Expenditure

School fees present the greatest financial burden to clients in Lira, because the school fees usually need to be paid in a lump sum. The high expenditure months are May to September, and December to February. Food shortage occurs during June and August therefore food consumption presents the highest expense. In order to meet these costs, clients borrow from MFIs and use the loans. Expenditure in December is mainly due to the festive season, and money is used from savings accumulated throughout the year. In January, the expenditure is high because people are building new houses and any savings accumulated in December is used for meeting building costs in January.

### Savings

Like in Jinja, clients in Lira have two forms of savings. They save in-kind and in cash. Savings in December and January are mainly from farm stock which is sold in June. Savings range from Ush. 200 000 (\$ USD 40) to Ush. 1,000,000 (\$ USD 200). The savings are used for school fees, health care, and food. Families will also use savings to meet cash requirements such as medical

expenses. Clients who save in cash mainly save in MFIs or in ROSCA's. Clients in Lira mentioned that they save in a group called "Love is Peace."

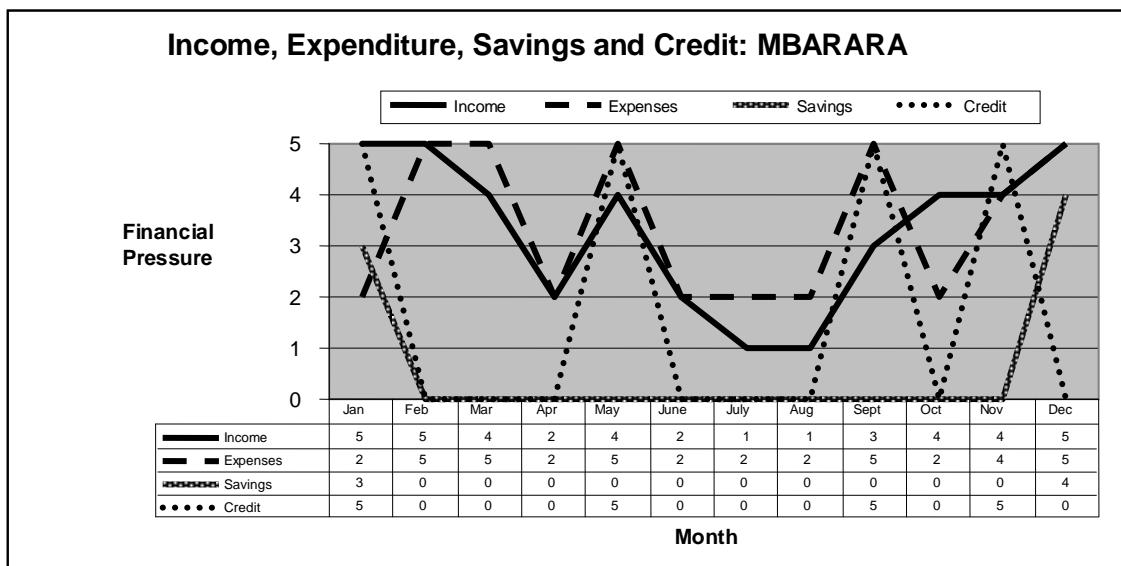
## Credit

Loans taken in February and September are used towards school fees. Traders take loans in September to reinvest in their business to prepare for Christmas. In June, loans are used for buying seeds and preparing land for the upcoming farming season. Loans in November are used for buying extra produce. Apart from borrowing from FINCA, clients borrow from PRIDE, Post Bank and MED-Net. The main reasons to borrow during the months of low income are to pay school fees, meet medical expenses, and to purchase food.

### *Health financing in Lira*

In the case of sickness during the months of low income, clients will go to Lira Referral Hospital or to a private clinic, if affordable. In order to pay for medical expenses clients will divert FINCA business loans, or will borrow from friends and family. In July and August, health expenditures are high because Malaria is at its peak. Clients borrow from friends and family to cover these expenses, and draw down savings, if available. Clients did not report borrowing from MFIs for health related expenses.

**Figure 10: Income, Expenditure, Savings and Credit in Mbarara**



## Income

The major sources of income are farm produce like beans, millet, bananas and vegetables. In December, incomes are at their peak because both farmers and businessmen are making high profits due to the needs of the festive period. People buy new clothes, shoes, and food, while others marry and hold parties. The income around April is from short-term crops like beans and

vegetables. Incomes are not so high this month. In Mbarara, the agricultural calendar has a strong influence on the trading calendar. The second growing season ends in March and April, this is the time when there is barely anything to sell from the farms. Likewise the businesses also feel this low activity and thus make very little income. June to August is another low income period for the same reason. During this period, people use the following coping mechanisms: they stock up on farm produce especially grains for use in the low periods. For short-term needs like emergencies, people use their savings. Some people resort to ROSCAs and some buy household necessities on credit (from shopkeepers with whom they have good relationship).

### Expenditure

During February, May and September expenditures are high due to school fees. The expenses incurred in November-December are mainly for preparation for the festive season, the money is spent on new clothes, food, housewarming parties and marriages. In order to meet these expenses clients use business profits, savings (either cash in a bank/MFIs or in-kind e.g. animals or produce). When in-kind savings are used in the low months, they provide enough income for a household to be able to manage other costs. ROSCAs are also used to enable members to access lump sums for either business or paying for some pressing needs like education and sickness. Loans from individuals are used to meet short term financial needs – amounts involved can be Ush 5,000 (\$USD 1) – 50,000 (\$10USD). Loans from MFIs are not used to pay school fees directly, the money is first invested in business and the incomes from these businesses can be used to clear outstanding school fees for children.

In the low expenditure months (April, June to August and October), there is generally enough food to sustain households.

### Savings

December and January are the months in which the highest savings are accumulated. Like in Lira and Jinja, people in Mbarara save in kind and in cash. These savings are used for paying school fees in February and meeting the most pressing needs like rent and taxes that are demanded around that time. Clients who save in cash said that the savings in this period can range from Ush 200,000 (\$USD10) to Ush. 3,000,000 (\$USD600). The savings are sometimes taken to the bank, or put into a ROSCA.

### Credit

Loans in January, May and September are used for business needs and for paying school fees. Loans in November are used for business purposes.

People borrow from MFIs (e.g. FINCA, PRIDE, UGAFODE, SACCOs, U-Trust) and some banks like Centenary Bank.

### *Health Financing in Mbarara*

People in Mbarara also borrow from friends and relatives for emergencies such as sickness – the amounts borrowed are usually small (e.g. Ush20,000 – 50,000) and repaid in a few days' time. If

income is low and people fall sick, they will seek those health providers who give them services on credit. Loans from individuals are taken for emergencies like sickness.

In summary, the findings from Income, Expenditure, Savings and Credit show that client incomes are dependent on the agricultural calendar in all three geographic areas. Expenses are high throughout the year. However, the greatest peaks are in February, May, and September due to school fees. Savings can range from as low as a few dollars to a few hundred dollars. Expenses are also higher in the rainy season when malaria is more prevalent. The rainy season is from March to November; however the peak of the rainy season is from July to September. December, January, and February are considered the dry season. When incomes are high, people are more likely to save. People save in two major forms: in-kind and in cash. The savings accumulated in December and January are mainly used for later in the year when incomes are low. Savings in October are usually used to recapitalize business in November after the low income season. There are two key periods when business loans are needed in Mbarara, the first period is from April until June, and the second period is from August until November. During these periods people usually need money for working capital i.e. buying additional stock for business. In January, April and May loans are also needed for school fees. In the case of any emergency, such as a health emergency, business loans will be diverted towards emergency needs.

In order to cope with medical expenses, clients in all three areas will borrow from individuals i.e. money lenders, family and friends. Clients do not plan for medical expenditures but rather deal with these expenses as they occur. Clients borrow from money lenders for emergency needs. They will also seek medical attention in clinics where they can obtain service on credit.

**Figure 11: Picture of Income, Expenditures, Savings, and Credit PRA Season with FINCA Clients**



## 5.4. Wealth Ranking

Researchers used a simple Wealth Ranking tool to learn about wealth, poverty and vulnerability among FINCA's clients. This information has been translated into client segmentations presented in Figures 12, 13, and 14 below for Lira, Jinja and Mbarara. In total twenty (20) clients were interviewed with this tool.

In Wealth Ranking a researcher asks participants to categorize members of their community according to wealth status. The wealth status goes beyond financial and physical assets and usually includes social relations and human assets (e.g. number of family members, education level, good health etc). In this study, clients in Jinja and Mbarara distinguished four economic categories in their communities: rich, not so poor, poor, and very poor. Clients in Lira, did not distinguish between not so poor and poor, and therefore decided to have only three economic categories as shown in Figure 12 below. It is important to keep in mind that the classifications presented reflects the opinions of FINCA clients, and as such may be different from the classification FINCA uses for the clients (e.g. set of economic indicators). Given that this was qualitative research, and given the time limitations for the research, a detailed analysis of socio-economic status of FINCA's clients was not possible nor was additional validation of the findings. To get a more detailed analysis of client segmentation, the consultant recommends an in-depth analysis of client records and loan applications. For example, to create a more detailed socioeconomic profile, FINCA can randomly sample a number of clients from all three areas i.e. Jinja, Mbarara, and Lira and analyze stored data in the database. This, of course, assumes that FINCA collects economic information on clients: type of assets, asset value, average income etc.

### Lira

Out of all three research areas Lira appeared to be the poorest. For example, having a bicycle in Lira is seen as a sign of wealth, whereas in Jinja a rich person is the one who owns a car. It can be observed that the very poor in Lira are the most vulnerable among the three economic categories. Given that poor have no ability to borrow, it can be concluded that FINCA clients belong to the "rich" and "not so poor" category even though clients did not specifically say to which category they belong. All three groups are equally susceptible to all health risks, and there is no difference between different segments. However, the response to health risks is what differentiates these groups. The rich can afford good care, and will visit private clinics in the case of sickness, while not so poor will be able to use private clinics only if they can afford to, poor will use private clinics only if they cannot receive help in government facilities, however they will be highly indebted as a result. This shows that all these groups need different financial products. For example, poor probably need insurance products the most; however they probably will be least able to afford it.

In Lira, clients estimated that on average they spent between Ush.5000 (\$USD1) to Ush.150,000 (\$USD30) on various health expenses per month. These costs can be higher depending on sickness, for example if a household has an HIV/AIDS infected family member. In the case of Malaria, for example, the monthly health costs can go up to \$USD100. It is important to note that clients do not keep records of their health expenses hence these figures can be understated or overstated given the frequency of illness in the community.

**Figure 12: Client segmentation in Lira**

| Customer group Indicators                | Rich         | Poor           | Very Poor               |
|--|--------------|----------------|-------------------------|
| Average gross household income per month | \$40 - \$125 | Less than \$30 | Unable to secure income |
| Average no. of                           |              |                |                         |

| Customer group Indicators                           | Rich  | Poor   | Very Poor   |
|---|---|--|---|
| household members                                   | 7   | 7  | 7   |
| Type of housing structure                           | Permanent structure (cement or mud)   | Permanent (mud)  | Non permanent structure (huts or similar)                                     |
| Assets (other than transportation assets)           | Land or house   |  | None  |
| Level of education                                  | Primary and Secondary education   | Primary  | Uneducated  |
| Business type                                       | Agriculture (cows, oxen or goat farm)<br>Trader (agricultural produce) or larger Grocery store  | Agriculture  | Unable to secure income, at times may do some seasonal work                   |
| Means of transportation                             | More than one bicycle<br>Motor vehicle (however not common)   | None<br>Walks usually  | None  |
| Financial capabilities                              | -Ability to borrow against assets (usually individual loan)<br>- Ability to send children to school<br>- Can respond to a financial need immediately e.g. access to savings, borrowing, sale of assets etc. | -Limited ability to borrow against assets (usually group loan)<br>- Ability to send children to school - however in time of financial crisis may need to withdraw them<br>- Has limited ability to respond to a financial need | - Unable to borrow<br>- Low or no ability to respond to a financial need      |
| Human assets  | Looks healthy and can afford to look after him/herself and the family   | Looks healthy  | Person does not look health and clean, usually wears torn clothes and sandals |
| Key health risks                                    | Malaria<br>HIV/AIDS<br>Hypertension<br>TB<br>STD  | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD   | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD                                  |
| Health provider used in times of sickness           | Private clinics   | -NGO clinics<br>- Government health centers<br>- Private clinics (if affordable)   | Government health centers   |
| Coping mechanisms used in times of financial crisis | -Savings<br>- Community support<br>- Self insurance<br>- Loans<br>- Borrowing from friends and family   | - Limited Savings<br>- Community support<br>- Borrowing from friends and family  | - Friends and family<br>- Sale of small household assets                      |

Note: Clients in Lira did not distinguish between Not so Poor and Poor, hence only 3 categories are included.

### Jinja

Jinja is better off than Lira. Average household income is significantly higher in Jinja than in Lira. In Jinja clients estimated that a rich person makes up to Ush.1,000,000 (\$200) per month. As in Lira there is no difference among health risks and the rich can afford good care, and will visit private clinics in a case of sickness, while the not so poor will be able to use private clinics only if they can afford to, and poor do not use private clinics at all.

In Jinja, clients estimated that on average they spent between Ush. 5000 (\$USD1) to Ush. 200,000 (\$USD40) on various health expenses per month. If more than one family member falls sick in a month, these costs can be double. In some instances clients mentioned that costs can go up to Ush.400,000 (\$USD200) in a case of malaria for example. It is important to note that clients do not keep records of their health expenses hence these figures can be understated or overstated given the frequency of illness in the community.

Clients in Jinja indicated that the majority would belong in the not so poor and poor category.

### Mbarara

In Mbarara clients are well off compared to Lira and Jinja. A rich person in Mbarara can generate a monthly gross income of \$USD625, while not so poor person can generate between \$USD180 and \$USD300. A rich person can send their children to expensive private schools, while a not to poor person can afford educating their children up to the university level. Clients in Mbarara indicated that a majority would belong to the not so poor category.

There seems to be a sharp difference between not so poor and poor categories in that a poor person in Mbarara is one that struggles to meet basic needs such as food. In Jinja however, a poor person can afford food for daily needs. A very poor person in Mbarara is destitute, and extremely vulnerable i.e. (s)he has no household assets (in Jinja and Lira, a poor person has some household assets), (s)he does not have a permanent place to live and may sleep on a street. A poor person in Mbarara usually has a struggling business, however (s)he has difficulties in borrowing since (s)he has very limited assets to put as collateral.

In Mbarara, some private clinics are owned by government employees hence rich people prefer private clinics. The services in private clinics owned by government officials are subsidized according to the respondents. The not so poor use private clinics, health centers (government owned) and hospitals. The poor and very poor groups use government facilities. In Mbarara, clients identified HIV/AIDS as the biggest risk in the community due to sexual practices. However, for clients Malaria and TB are also among key health risks for all segments.

On average, clients estimated spending Ush.100,000(\$USD20) to Ush. 400,000 (\$200) for health expenses per month, depending on the type of illness in the family. As aforementioned, clients do not keep records of their health expenses; hence these figures may be understated or overstated given the frequency of illness in the community.

**Figure 13: Client segmentation in Jinja**

| Customer group Indicators                           | Rich  | Not so Poor   | Poor  | Very Poor   |
|---|---|---|---|---|
| Average household income/month                      | \$USD150 - 200  | \$USD80 - \$120   | \$USD20 - 60  | \$USD10   |
| Average no. of household members                    | 4 - 5   | 5   | 6   | 6   |
| Type of housing structure                           | Permanent structure (cement)  | Permanent (cement)  | Permanent (mud)   | Some form of permanent house but very modest  |
| Assets (other than transportation assets)           | Buildings (residential and commercial)  | House   | Chicken (100)   | Not specified   |
| Level of education                                  | Primary and Secondary education   | Primary, some secondary   | Primary   | Uneducated  |
| Business type                                       | Wholesale   | Medium size shop (retail)<br>May also rent  | Market Vendor (sells vegetables and chapattis at the market)  | Unable to secure income, at times may do some seasonal work   |
| Means of transportation                             | Motor vehicle   | Motor vehicle<br>Mini bus   | Mini bus<br>Bicycle   | Walks<br>Bicycle  |
| Financial capabilities                              | - Ability to borrow against assets (usually individual loans)<br>- Ability to send children to school<br>- Can respond to a financial need immediately e.g. access to savings, borrowing, sale of assets etc. | - Ability to borrow against assets,<br>- Has enough money for survival<br>- Has limited ability to respond to immediately respond to a financial need | - Limited ability to borrow against assets (usually group loan)<br>- Can afford food for the day<br>- Cannot respond immediately to financial needs | - Unable to borrow<br>- Low or no ability to respond to a financial need<br>- Cannot afford basic necessities |
| Human assets  | Looks healthy and can afford to pay for anything he/she needs   | Looks healthy   | Does not look healthy   | Not specified   |
| Key health risks                                    | Malaria<br>HIV/AIDS<br>Hypertension<br>TB<br>STD  | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD  | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD  | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD  |
| Health provider used in times of sickness           | Private clinics   | -NGO clinics<br>- Government health centers<br>- Private clinics  | -NGO clinics<br>- Government health centers   | Government health centers   |
| Coping mechanisms used in times of financial crisis | -Savings<br>- Community support<br>- Self insurance<br>- Loans<br>- Borrowing from friends  | - Savings<br>- Informal groups<br>- Loans<br>- Borrowing from friends and family  | - Limited savings<br>- Community support<br>- Sale of small household assets<br>- Borrowing from  | Friends and family  |

| Customer group Indicators | Rich       | Not so Poor | Poor               | Very Poor |
|---------------------------|------------|-------------|--------------------|-----------|
|                           | and family |             | friends and family |           |

**Figure 14: Client segmentation in Mbarara**

| Customer group Indicators                 | Rich   | Not so Poor   | Poor   | Very Poor   |
|---|--|---|--|---|
| Average household income/month            | \$USD 625  | \$USD 180 - 300   | Not specified  | Not specified   |
| Average number of household members       | 4 - 5  | 4 - 5   | More than 5  | More than 5   |
| Type of housing structure                 | Permanent structure (cement)   | Permanent (cement)  | Permanent (mud)  | No house, sleeps on the street  |
| Assets (other than transportation assets) | Buildings (residential and commercial)   | House   | Chicken (100)  | Not specified   |
| Level of education                        | Secondary education  | Primary, some secondary   | Some primary, Uneducated   | Uneducated  |
| Business type                             | Large farm with 300 cattle<br>Has a large business   | Agriculture, raises cattle (has less than 300)<br>Can operate a retail shop   | Market Vendor (sells vegetables and chapattis at the market)   | Unable to secure income, at times may do some seasonal work                                 |
| Means of transportation                   | Motor vehicle  | Motor vehicle<br>Mini bus   | Bicycle  | Walks   |
| Financial capabilities                    | - Ability to borrow against assets (usually individual loan)<br>- Ability to send children to school<br>- Can respond to a financial need immediately e.g. access to savings, borrowing, sale of assets etc. | - Ability to borrow against assets,<br>- Has enough money for a good life<br>- Has ability to respond immediately to a financial need | - Unable to borrow due to limited collateral<br>- Can afford food for the day<br>- Cannot respond immediately to financial needs | - Unable to borrow<br>- Cannot support a family<br>- Not able to respond to financial needs |
| Human assets                              | Looks healthy and can afford to pay for anything he/she needs<br>Has many friends  | Looks healthy   | Not specified  | Not specified   |
| Key health risks                          | Malaria<br>HIV/AIDS<br>Hypertension<br>TB<br>STD   | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD  | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD   | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD  |

| Customer group Indicators                           | Rich   | Not so Poor   | Poor  | Very Poor                 |
|---|--|---|---|---------------------------|
| Health provider used in times of sickness           | Private clinics  | -Government health centers<br>- Private clinics                                 | Government health centers   | Government health centers |
| Coping mechanisms used in times of financial crisis | -Savings<br>- Community support<br>- Self insurance<br>- Loans | -Savings<br>- Informal groups<br>- Loans<br>- Borrowing from friends and family | - Community support<br>- Sale of small household assets<br>- Friends and family | Friends and family        |

## 6. Risks and Risk Coping Strategies

In order to understand what kinds of risks FINCA clients face, the research team asked the respondents to identify and rank risks which impose the greatest financial burden on their households. This was done to assess whether sickness represents a severe economic pressure, and if so, how it compares to other risks that households face. Twelve (12) respondents were interviewed and the tool was used in Jinja and Lira. The findings are presented in this chapter.

### 6.1. Risks faced by FINCA clients

The clients surveyed in Lira and Jinja face a variety of risks.<sup>6</sup> These risks result from the types of economic activities clients operate, household conditions, seasonality patterns, and life-cycle events. While many risks faced by clients create significant social distress (for example, stigmatization in the case of sickness), the majority of risks cause great economic losses which are perceived by the participants as disastrous for the family. The most severe economic risks are those that impact a household's ability to generate income, i.e. loss of productivity due to sickness, or those that cause a significant loss of assets such as a business theft.

The figure below summarizes the results from clients surveyed in Lira and Jinja. Death was the most significant risk across both areas while other risks had gender and place related variations (the group in Jinja was comprised entirely of men, while the group in Lira was comprised of women only).

**Figure 15: Ranking of the Risks**

| Type of Risk        |          | Ranking of Severity per area |      |
|---------------------|----------|------------------------------|------|
| Area                |          | Jinja                        | Lira |
| <b>Overall rank</b> |          |                              |      |
| 1                   | Death    | 1                            | 1    |
| 2                   | Sickness | 3                            | 3    |
| 3                   | Theft    | 1                            | 4    |
| 4                   | Accident | 5                            | 2    |

<sup>6</sup> The research team did not survey risks in Mbarara because of the limited number of groups organized by FINCA's Mbarara branch, hence the Focus Group Discussion (FGD) on risks was omitted.

|   |                                    |               |               |
|---|------------------------------------|---------------|---------------|
| 5 | Business risks                     | 4             | 8             |
| 6 | Fire                               | 6             | 7             |
|   | Environmental changes <sup>7</sup> | 5             | Not mentioned |
|   | Child kidnapping                   | Not mentioned | 5             |
|   | Divorce/Separation                 | Not mentioned | 6             |

### *Death*

Death was identified as the most severe risk by both groups. Death has a great impact on the family because it is usually unpredictable and requires large lump sums of cash. In Jinja, for example, in the case of death, the family may spend between \$USD 63 and \$USD 375 for transportation, food for mourners, and purchasing of a coffin. In the case of the death of the head of the family, the long-term impact will be even greater and is usually seen as a significant decrease of family income or total loss of household income. While death imposes the greatest economic stress on the family, both groups considered death not to be very frequent in the communities (clients estimated that there is one death per five households per year).

### *Sickness<sup>8</sup>*

The most distressing aspect of sickness is the frequency of malaria both in Lira and Jinja. While there are other ailments present in the community [See Chapter 7], the predominate sickness, and the one creating the most financial stress, is considered to be malaria. Due to its unpredictability and frequent reoccurrence, malaria poses a great economic risk to the family because of both the immediate need for cash for treatment and the income loss due to a decrease in productivity. Given this urgency, a family will immediately dispose of any available asset. Sickness affects a family's ability to generate income, thus negatively impacting the overall economic wellbeing of the family. Respondents identified the costs of treatment as a major contributor to economic pressures. It is interesting to note that men ranked sickness as their number one risk, while women in Lira ranked it only as the fourth most important risk. This could be explained by the fact that women in Lira save in informal savings groups hence sickness is not considered to be as much of a financial risk.

### *Theft*

Theft has a great impact on a household because it is difficult to replace stolen assets, especially if the assets were used for productive purposes and were the primary source of income. Theft in the business was considered a greater economic stress than theft in the household. Theft in the business is particularly devastating for those who have taken a loan from an MFI or a bank, and as a result of a theft will experience problems with loan repayment. Men in Jinja claimed that theft is a very common occurrence, while women in Lira claimed that theft is not so common in this area.

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<sup>7</sup> The environmental changes, child kidnapping, and divorce/separation were not ranked since only one group mentioned these risks; however the risks are discussed in the report.

<sup>8</sup> Detailed discussions about sickness follow in the report.

**Figure 16: Market in Lira, Uganda**



### *Business risks*

Business risks were identified by both groups as very common. Three business risks in particular were mentioned: loss of electricity, increase in rent and eviction. Loss of electricity is extremely common and negatively impacts daily revenues. Increase in rent and eviction have negative impacts on income streams, causing greater expenses to a business.

### *Fire*

Fire was identified as a risk that causes significant income and property losses. However, fire is not frequent in Lira or in Jinja and therefore participants did not perceive fire to be a significant risk in their communities.

### *Environmental changes*

Respondents mentioned that weather conditions are an important risk for farmers and fishermen since changes in weather patterns (heavy rains and floods, for example) negatively influence farmers' income flows. However, environmental changes did not place a great economic pressure on respondents since none of them were farmers.

### *Child kidnapping*

In Lira, women highlighted child kidnapping as a risk that causes great emotional stress to the family. This risk may be due to Lira's location. Lira is located in Northern Uganda and it is considered by Ugandans to be the "last safe town" from the Lord's Resistance Army.

### *Divorce/Separation*

Women in Lira mentioned divorce/separation as a major risk in their lives. According to the participants it is common for husbands to abandon their wives in Lira. Divorce causes great economic stress to women since the economic burden of running a household becomes the sole responsibility of the woman.

### **Summary**

The findings of this study were not significantly different from findings in the 2002 study "Assessing the Demand for Microinsurance in Uganda," by Grace Sabageni. Findings in 2002 identified a number of risks organized into three categories: risks faced in course of a business, risks faced in daily life and risks faced by the community. In that study, death, sickness and theft were perceived as major risks in a household; still in 2007 the same three risks are perceived as the key risks by the poor.

Death, theft and sickness are the top three sources of significant risk and economic pressure on FINCA clients' households. While sickness was not ranked as the key risk in a household, it was identified as a risk that causes significant financial hardship for a family on a regular basis. Sickness has special characteristics when compared to other risks faced by FINCA clients due to the frequency of occurrence (especially in a case of malaria), the need for immediate attention, and the immediate need for large sums of cash. All these factors make sickness a major economic burden for a family.

There are various risk-coping mechanisms that FINCA clients turn to once the risk occurs. These strategies are discussed in the next section.

## **6.2. Risk coping mechanisms**

The risk coping mechanisms described below outline the key risk mitigation strategies used by FINCA clients when a risk occurs. FINCA clients mostly rely on community support and the sale of assets on hand whenever any risk occurs. Clients do not have specific strategies in place for specific risks (e.g. sickness), but rather deal with the risks as they arise and, as a result, many

risks become emergencies for a household. Respondents usually combine strategies based on the financial need and their financial ability. For example, they may belong to an informal savings group and they may also save in-kind.

Risk coping strategies can be divided into precautionary strategies and loss management strategies. Precautionary strategies are actions people take before a risk occurs, like self insurance and savings (cash and in-kind). Loss management strategies are actions that people take after the fact. These include reallocation of household income, sale of assets, purchasing of goods and services on credit and borrowing. Figure 17 outlines different strategies used for the top three risks.

**Figure 17: Risk Coping Strategies**

| Risk     | Risk coping strategies |                        |                |                        |           |
|----------|------------------------|------------------------|----------------|------------------------|-----------|
|          | The most common        |                        |                | The least common       |           |
| Death    | Community support      | Sale of Assets         | Borrowing      | Reallocation of income |           |
| Theft    | Reallocation of income | Borrowing              | Sale of Assets | Using savings          |           |
| Sickness | Sale of Assets         | Reallocation of income | Using savings  | Treatment on credit    | Borrowing |

### **Precautionary Strategies<sup>9</sup>**

#### *Self- insurance*

The most common self-insurance strategy among the respondents is diversification of income sources. In trade, for example, clients will trade a variety of goods so that the risk of income loss is minimized. None of the clients mentioned having formal property or theft insurance. A few clients, however, did mention having health insurance with Microcare Uganda. While self-insurance is an important risk mitigating strategy for the respondents, its effectiveness is limited because the amount of a loss is usually much higher than the self-insurance mechanism in place. If a person does not have a variety of mitigation strategies in place, such as savings and/or borrowing, self-insurance independent of other mechanisms is not of great help to a household. For example, if a client diversifies her income source and she falls sick, diversification of income sources may not be helpful if she is unable to work for a certain period of time or if a sick person is the only income earner in the family.

#### *Savings*

Both groups considered savings as one of the main precautionary measures for risk management for all the reported risks. There are three major ways of savings: savings in-kind (mostly in livestock, and at times in larger assets), formal savings (opening a savings account with an MFI or a bank), and savings in social groups (known as *circle* in Lira, or *nigina* in Mbarara).

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<sup>9</sup> Strategies used for health risks are discussed in detail in chapter 8.3 Coping Mechanisms

*Savings in-kind* (i.e. non-cash savings) is more prevalent in rural and semi-urban areas such as Lira, where people mostly save with goats, chickens, or bicycles. For example, at the time of getting a loan, a certain amount of the loan will be used to purchase a goat that can be easily sold in the event of an emergency. There are two main reasons why respondents save in-kind: a) saving in-kind can be converted to cash very fast, (the respondents considered the disposal of in-kind assets to be a much shorter process than accessing a savings account with an institution) and b) it is difficult for poorer respondents to save the high amounts needed to open a savings account in a bank. While savings in-kind is a very popular method of risk management among respondents, it can also be an extremely costly method. For example, in the case of malaria, a client may need to purchase medication that costs \$6. To raise the cash to pay for the medication, an asset may be sold at \$30. The remaining balance may be used for consumption purposes, leaving the client without an asset or any cash. Strategies used for health risks are discussed in detail in Chapter 8.

*Formal savings* are a common precautionary method in urban areas. Those respondents that save usually save in more than one institution, for example a client may have savings accounts with FINCA and with another bank in the area.

*Saving in social groups* is a common strategy in all areas<sup>10</sup>. Usually savings groups are gender specific. Men tend to save for purchasing larger assets, while women tend to save for emergencies such as sickness, death and the like. Research showed that savings groups are an important financial coping mechanism in times of emergencies. However, despite the popularity of savings groups, the groups are not considered to be an effective risk management strategy. This is because the accumulated savings are usually insufficient to cover the emergency need, cash may not be available when needed, and the funds usually cannot cater to multiple emergency needs.

## **Loss management strategies**

### *Community support*

Community support during a time of crisis is one of the most common strategies to mitigate risks, especially in times of a death in the family. Community members will help by contributing food, labor, and money or in any other way they can. Community support is common both in urban and rural areas.

### *Reallocation of household income*

Reallocation of household income is one of the most common loss management strategies, especially in times of sickness. Households usually reprioritize spending and decrease food consumption.

### *Sale of assets*

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<sup>10</sup> Savings groups make defined in cash or in-kind contributions on a regular basis based on the agreement with all group members at the time of the group formation. The contributions are then distributed on a weekly basis to members. If a member of the group has an emergency the contributions will then go to that member.

Sale of assets is a common risk mitigation strategy. Particularly in times of sickness, smaller household assets will be sold to cope with costs associated with an emergency. In extreme cases, if all other strategies have failed, mortgaging or selling land will be used as a risk mitigation strategy. Sale of assets was considered the worst mitigation strategy for respondents because assets often have to be sold below market value due to the rapid need for cash. Furthermore, households may dispose of needed productive assets, leaving the household with a reduced capacity to generate income. In addition, the value of the asset may be higher than the cost of the emergency and the remaining money from the sale of the asset may be used for consumption purposes. The sale of assets in times of emergency often leaves a household in a more vulnerable position, as the asset in many instances is hard to replace and/or may be crucial for household survival.

#### *Purchasing goods and services on credit*

Purchasing services on credit is the most common loss management strategy in times of sickness. Clients will seek medical services from those health service providers they know and trust, and who are willing to offer medical care on credit. The strategy is effective only when a client has a pre-existing relationship with a health care provider.

#### *Borrowing*

For the majority of respondents, borrowing is an important loss management strategy but is also considered the least preferred strategy. Borrowing from family and friends is common, as well as from formal institutions. Borrowing from money lenders was common in cases of sickness. Borrowing from friends and family is the preferred way of borrowing because the money is normally interest free; however, family and friends may lack cash in times of need. Borrowing from formal institutions such as MFIs or banks is a common loss management strategy. Borrowing from institutions, however, becomes problematic when clients already have a loan and are restricted in the additional amount they can borrow. Moneylenders are widely used in all surveyed areas. While respondents understand that moneylenders are a very costly option they will still borrow from moneylenders in a time of pressing emergency (either because of inability to borrow from a formal institution or lack of access).

### **Summary**

Respondents in surveyed areas use numerous precautionary and loss management strategies such as self insurance, savings in-kind, and borrowing. The research found that most of these strategies are costly or inadequate, especially in times of sickness. The effectiveness of these strategies in relation to health risks is discussed in Chapter 8.

This section shows that illness is one of the major risks facing client households. When illness leads to death in the family, especially death of the breadwinner, the financial pressure on the household is at its greatest. Illness impacts households financially in two ways: increased medical costs and loss of income. Existing coping mechanisms are insufficient to protect households from the negative financial impacts of risks. In particular, precautionary strategies available to households are inadequate.

## **7. Health Risks faced by FINCA clients**

The most stressful aspect of medical risks for respondents is the lack of financial resources available to access quality health care. This chapter discusses the most common health risks faced by FINCA clients at different life stages, seasonal patterns of diseases, and the overall economic burden of illness on clients [See Figure 23]. In order to gain information about health risks, two research tools were used, namely Seasonality of Diseases and Health Care Financing. Forty-six (46) respondents were interviewed. Health Care Financing (N 34) was used in all three areas, and Seasonality of Disease (N 12) was used only in Lira and Jinja.

### **7.1. Key diseases identified by FINCA clients**

In the overall ranking of risks, sickness was ranked as the second most important in terms of economic burden on the household. Sickness has many negative impacts on the household which are summarized in the Figure 20. Inability to generate income is the greatest negative impact that can result from sickness. This will negatively affect a clients' family, their household, and the community at large. In order to understand what kind of health risks FINCA clients face, and the subsequent financial impacts, the research team asked respondents to identify and rank health risks which cause the most severe pressures to their households.

#### *Malaria*

Malaria is a leading public health concern in Uganda [See Figure 24]. The 2006 Ugandan Demographic and Health Survey found that only 34% of Ugandans own a mosquito net and only half of these own an insecticide treated net (ITN). Urban households are twice as likely to own a mosquito net compared to rural households (61% compared with 29%)(MoHU, 2007). Malaria is a leading cause of infant, child, and adult morbidity and mortality in Uganda. Children under five and pregnant women are at the highest risk of malaria infection. Pregnant women infected with malaria are at risk of spontaneous abortion, low birth weight, and stillbirth. Malaria may seriously affect a child's future, causing, for example, neurological after-effects and impaired learning ability.

Malaria is a year-round environmental health threat in Uganda with severe negative socio-economic impacts. Malaria patients are often bedridden and incapable of carrying out normal daily activities. This causes considerable loss of income and places a heavy burden on the family, health system, and society as a whole. A recent study conducted by WHO (2002) found that the prevalence of malaria infection is substantially higher among the poorest populations. Poor families live in dwellings that offer little protection against mosquitoes and they are less able to afford insecticide treated nets.

*"Malaria mosquitoes are developing resistance; it is not easy to treat the malaria as it was before." FGD participant, Mbarara, Uganda July 2007*

Respondents reported owning, on average, one or two mosquito nets. Children often sleep on the floor without a mosquito net, thus being more exposed to mosquitoes compared to other family members (average family size 7). In Jinja, participants mentioned that early treatment for malaria is not given to children since parents have difficulties recognizing malaria symptoms.

Malaria is a constant threat to a household and respondents reported that malaria can occur once per month in a family. The frequency of malaria makes it financially difficult to manage [See Figure 24]. This makes malaria the greatest financial burden to the family among all the diseases ranked. When malaria strikes the need for money is immediate. However, due to lack of financial resources and lack of knowledge, people in the researched areas often delay seeking care until the illness is severe, or resort to partial or inadequate treatment (i.e. using treatment that is affordable but less effective<sup>11</sup>); as a result, treatment costs become higher, and the disease itself can be fatal.

*"Malaria can kill the victim if not treated fast." FGD participant, Mbarara, Uganda July 2007*

In instances where a head of family has malaria, the financial burden is even greater because apart from covering the costs of medication, the family will also have less income available.

*"If the head of the home dies, the family takes a long time to recover and sometimes the children will stop going to school." FGD participant, Lira, Uganda July 2007*

The respondents considered the treatment and prevention of malaria to be expensive. Malaria treatment consumes a large portion of the household budget. Respondents estimated that households spend between \$USD 2 to \$USD 50 for medical-related expenditures per month. In order to treat malaria, one will incur the costs of laboratory tests, consultancy fees and medication. While there are regional variations in costs, the costs to treat malaria range from as low as \$USD 15 in Lira to as high as \$USD 125 in Mbarara. The costs of treatment will depend on where the treatment is sought (i.e. private clinics or government hospitals), as well as on the type of medications used to treat the patients. In Lira, transportation costs were mentioned as a major cost associated with sickness, while in all other areas transportation was not mentioned. This is because in Lira many clients seeking health care come from remote rural areas where transportation is less available.

The high costs associated with malaria are also related to the type of medication administered for treatment. While medical care is free in government hospitals, drugs like Artenam and Coartem are not always available; hence patients need to buy them in private pharmacies or clinics.

*"I have just been treating my son of malaria, but it has cost me Ush 50,000 (\$USD 31) for the 3 days he has been sick." FGD participant, Lira, Uganda July 2007*

<sup>11</sup> Less effective treatment refers to treatment that does not involve artimisinin combination therapy (ACT) but rather resorts to Quinine and Cloroquine

**Figure 18: Reasons for High Costs of Different Diseases**

| Sickness | Reasons for High Costs of Disease   |
|----------|---|
| Malaria  | Occurs frequently, affects all family members, present throughout the year  |
| HIV/AIDS | Cannot be cured, medication is expensive, loss of productivity, causes opportunistic diseases (TB, malaria, etc.) |
| TB       | High costs of medication, opportunistic disease, loss of productivity   |
| Typhoid  | High cost of treatment, difficult to detect   |

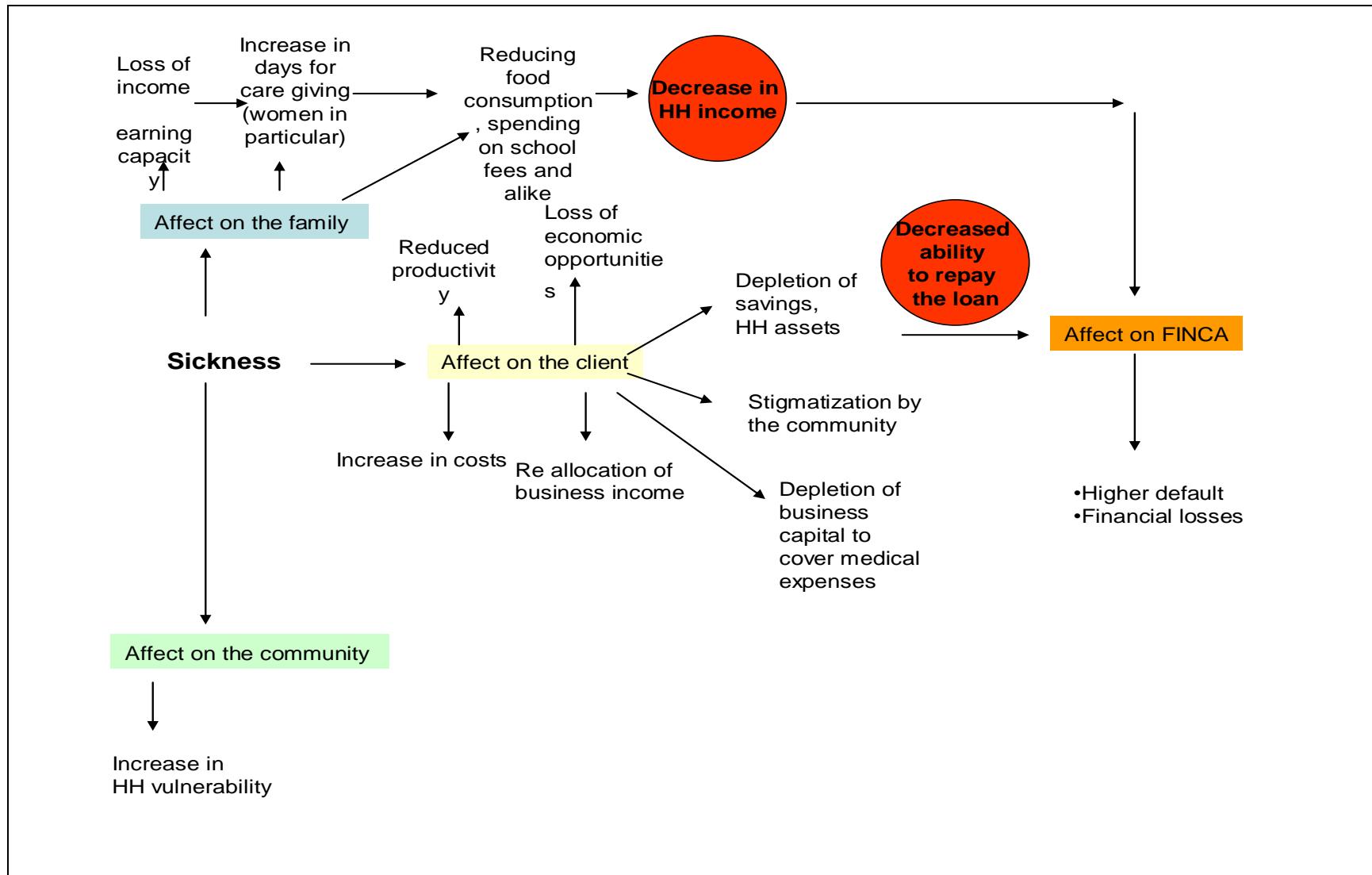
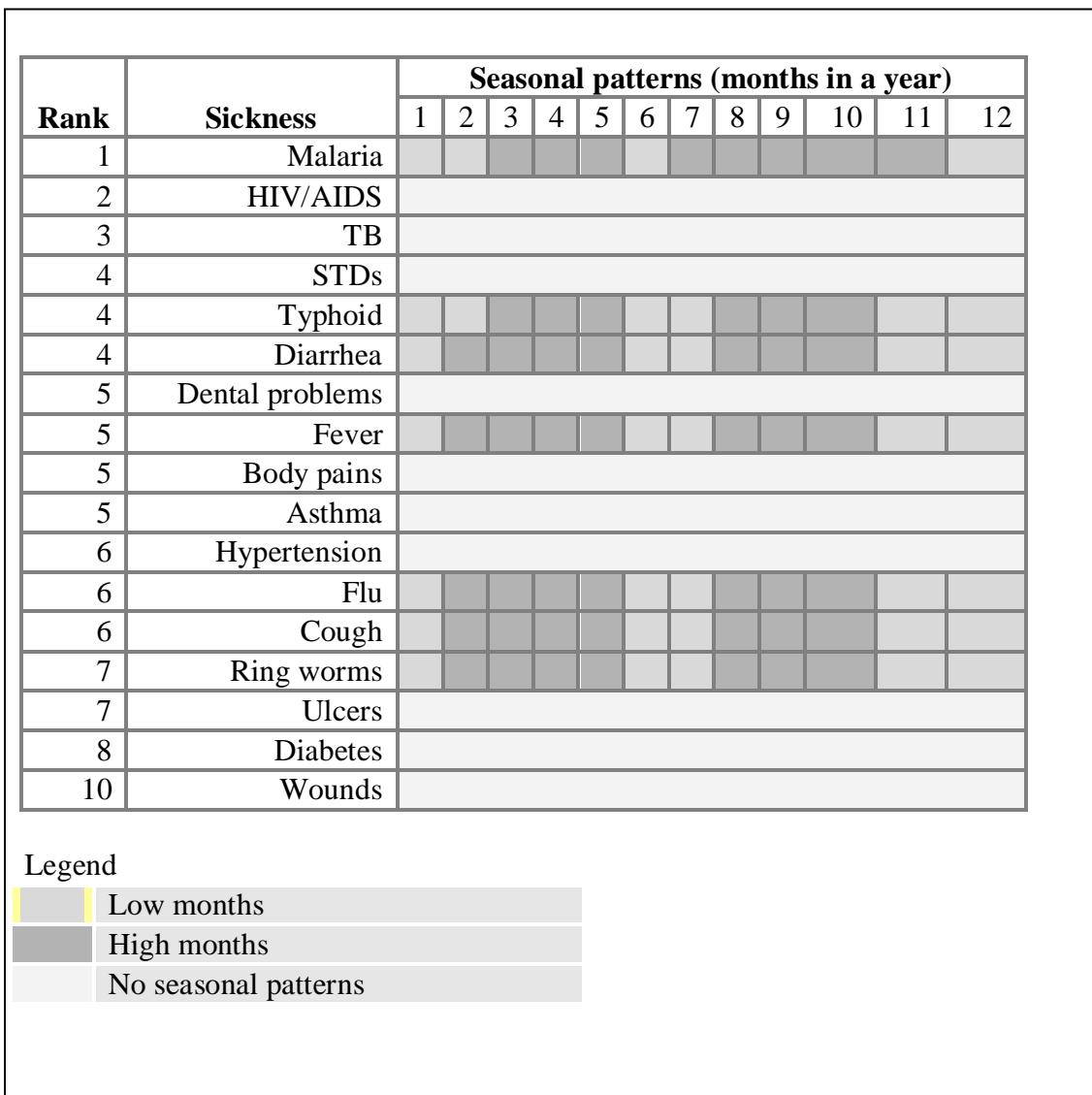


Figure 19: Impact of illness on FINCA clients

**Figure 20: PRA Session on Seasonality of Diseases**



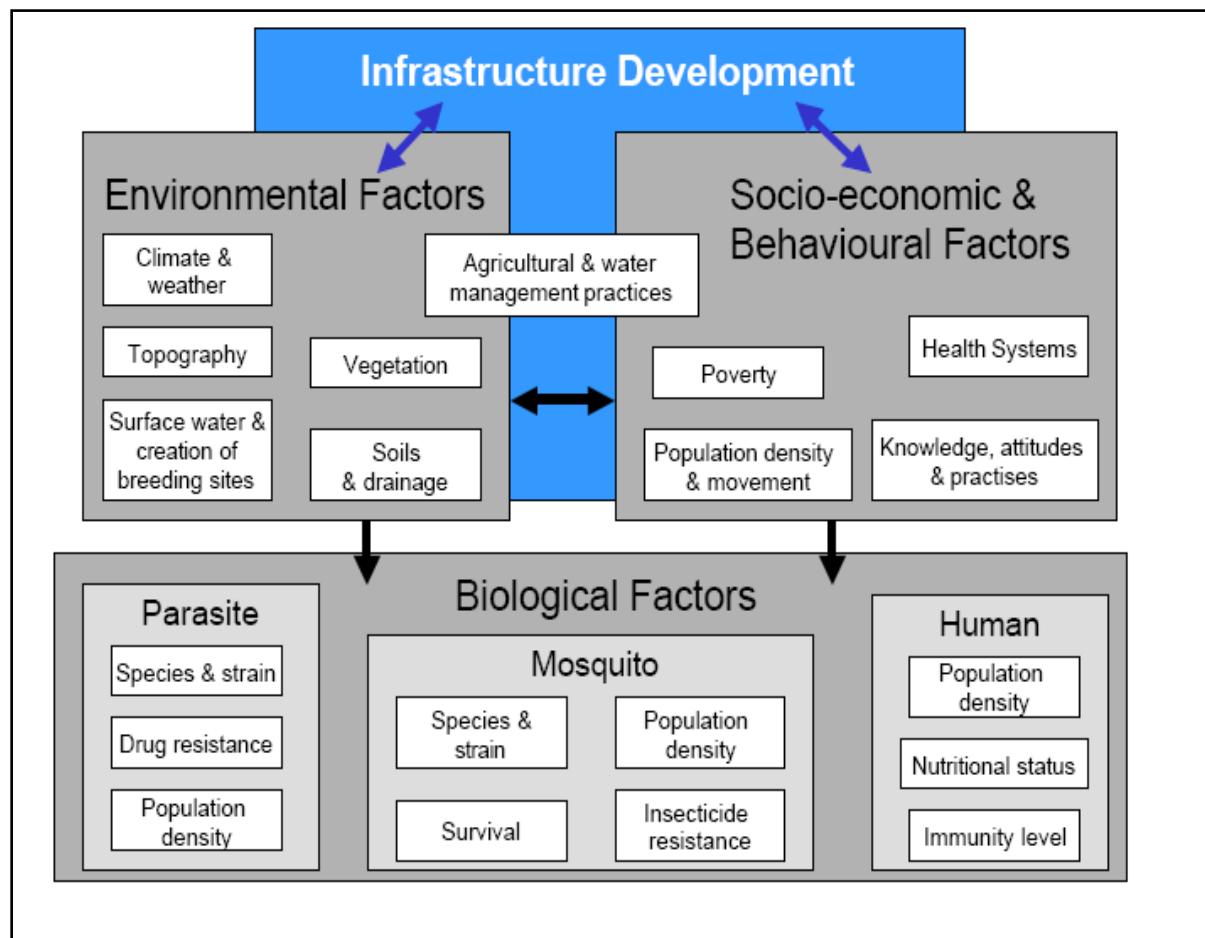
**Figure 19: Sickness Ranking and Sickness Seasonality Patterns**



**Figure 22: Sickness Seasonality Patterns**

Malaria and HIV/AIDS are the most serious diseases in the community given their occurrence, high number of deaths, and the costs of treatment. Malaria is present throughout the year; however, incidence of malaria is the highest from April to June and in August. Malaria affects mostly children. Usually malaria affects more than one person per family. HIV/AIDS is constantly present throughout the year and the respondents did not identify any specific seasonal patterns of the disease. STDs are present throughout the year, and usually more than one family member is affected with an STD. The peak time of the year for typhoid is May to August, since these are the rainy months. Flu, cough, and diarrhea are present throughout the year, but are more frequent during rainy months. Diseases like asthma, hypertension, and body pains do not have seasonal patterns and are present throughout the year.

**Figure 23: Causes of Malaria**



Source: World Bank, 2004

**Figure 20: Malaria Costs in Selected Areas**

| Treatment                                       | Monthly costs range in \$USD | Area    |
|---|------------------------------|---------|
| <b>Mosquito nets (one time costs)</b>           |                              |         |
| Mosquito nets                                   | 5 to 6                       | Jinja   |
| Monthly treatment of the net                    | 1                            | Jinja   |
| Mosquito nets                                   | 12                           | Mbarara |
| <b>Drugs</b>                                    |                              |         |
| Coartem   | 9 to 13                      | Jinja   |
| Fansidar, quinine, cloroquine                   | 6                            | Lira    |
| Artenam   | 9                            | Lira    |
| Artenam   | 10 to 12.5                   | Mbarara |
| Fansidar quinine, cloroquine                    | 2                            | Mbarara |
| <b>Overall treatment</b>                        |                              |         |
| Drug, consultation fee, bed if needed, lab test | 125                          | Mbarara |
| Drug, consultation fee, lab test                | 13 to 16                     | Mbarara |
| Drug, consultation fee, lab test                | 19 to 31                     | Jinja   |
| Drug, consultation fee, lab test                | 2 to 31                      | Lira    |
| <b>Other</b>                                    |                              |         |
| Single Lab malaria test                         | 2                            | Jinja   |
| Consultation fee                                | 2                            | Lira    |
| Transportation costs                            | 1 to 3                       | Lira    |

### HIV/AIDS

HIV/AIDS is one of the most pressing health issues confronting Ugandan society (SIDA, 2000). As a result of the high prevalence of HIV/AIDS (e.g. 1.7 million people were affected with HIV in 1997), the government has adopted a policy of “openness” towards HIV/AIDS and established many HIV/AIDS control programs in the early 90’s. WHO reports that various special efforts undertaken by the government have shown visible changes in HIV/AIDS prevalence, as well as changes in sexual behavior nationwide. Despite these changes, the respondents in selected areas perceive HIV/AIDS as very prevalent in the communities.

*“HIV/AIDS has become common like malaria.” FGD participant, Jinja, Uganda, July 2007.*

Respondents in our research ranked HIV/AIDS as the second greatest health risk and the one that causes greatest financial pressure on a household, especially in Mbarara where

HIV/AIDS was perceived as a greater risk than malaria. This is because HIV/AIDS causes long-term financial pressure to the family, as well as significant stigmatization in the community. Therefore HIV/AIDS was perceived to have greater negative consequences for an individual compared to malaria. Respondents said HIV/AIDS is very common in all three areas and it affects those who are sexually active i.e. ages 15 to 45 [See Figure 27].

When it comes to HIV/AIDS, people in the community do not easily accept the fact that they have contracted the disease. In most cases, they claim that they have been bewitched, and often wait for a long time before seeking treatment. This contributes to a higher cost of treatment.

HIV/AIDS is expensive to treat because it is incurable. Medications are expensive and needed for life. Estimated antiretroviral therapy (ARV) treatment costs ranged from \$USD 31 to \$USD 150 as shown in Table 8. While ARV medications are provided for free in government hospitals, respondents claimed that medications are not always available in hospitals, and therefore patients are forced to buy them in private clinics. ARV medications are available on the “black market” and can reach costs of \$USD 30-60.

**Figure 21: Costs of ARV Treatment in Selected Areas**

| Treatment          | Monthly Costs range in \$USD |
|--------------------|------------------------------|
| <b>ARV Drugs</b>   |                              |
| Mbarara            | 94                           |
| Jinja              | 31 – 150                     |
| Lira               | 31 – 60                      |
| Government clinics | free                         |

The indirect effects of HIV/AIDS are experienced by individuals, families, and the community. Nearly 80% of those infected with HIV in Uganda are in the economically productive and reproductive age range between 15 and 45 years old (SIDA, 2007). HIV/AIDS causes lower productivity, and therefore negatively impacts household income. HIV/AIDS patients also require specific care so family members will spend significant time caring for the sick, thus neglecting their other roles.

In Jinja, for example, loss of productivity (due to HIV/AIDS) was seen as a major medical risk. Loss of productivity impacts economic security of a household because the disease requires long term care. In Lira, HIV/AIDS was perceived as one of the greatest health risks. However, in terms of immediate financial pressure, HIV/AIDS was considered not so risky because it “*takes time to develop*”; its impact is not immediate as with malaria. Despite this belief, the respondents were aware that HIV/AIDS poses a

greater financial burden to the family once the disease develops; hence negative financial impacts are felt long term.

HIV/AIDS additionally poses great risk because it causes many opportunistic diseases such as cough, tuberculosis, and diarrhea which contribute towards higher costs of sickness.

#### *Tuberculosis (TB)*

In Uganda, TB prevalence and mortality is on the rise (TB/Leprosy Programme Survey 2002). In 2002, 40,000 TB cases were reported in Uganda, representing an increase of 13% compared to 2001 (STD/HIV/AIDS Surveillance report, 2003). In an interview with a key informant from Lira, the research team found that TB is very common in Uganda; the doctor estimated that 68% of Ugandans are exposed to TB bacteria. While TB was mentioned as a health risk in only a few FGDs, health authorities in Uganda consider TB as one of the major public health concerns. It should be mentioned that women in all groups considered TB to be a health risk while men did not. This may be because women, being the caregivers, are more knowledgeable about diseases. TB causes a great financial stress in the household since the costs of treatment are rather high, ranging between \$USD 30-50 per month. While malaria causes frequent financial pressures, TB causes prolonged financial pressure to a household because TB takes longer to treat and an infected person cannot work for a significant period of time [See Figure 29].

#### *Sexually Transmitted Diseases (STDs)*

STDs are reported as common in all three areas. Men in particular mentioned syphilis as a key problem in all three areas. Women, on the other hand, said that STDs are prevalent since the use of condoms is low in the areas, especially in Mbarara. STDs are often the cause of stigmatization and as a result, many will wait to seek medical care. In such instances, the disease progresses, since patients prefer to self-treat STDs, into an advanced stage which makes it more difficult and more costly to treat. It is sometimes the case that patients do not recognize the symptoms and as a result they seek medical care too late. In Jinja for example, participants mentioned that STDs are associated with HIV/AIDS, hence seeking medical care is difficult for fear of stigmatization. Once symptoms are obvious and medical attention is sought, the financial pressure is immediate: money is needed fast.

#### *Typhoid*

Typhoid is a health risk; however, it does not occur commonly. Typhoid is difficult to detect since symptoms presented are very similar to malaria and patients are often treated for malaria as a result of misdiagnosis. As typhoid progresses it becomes more difficult and more expensive to treat. The costs of medications are often very high and unaffordable for the patients.

#### *Diarrhea*

Diarrhea is very common throughout Uganda and dehydration from severe diarrhea is a major cause of childhood mortality (UNDS, 2007). Diarrhea is common in children of all ages and is usually linked to polluted water or lack of access to clean water. Because diarrhea is a water-borne disease it has a high rate of infection and can affect more than one family member at the same time. A UNDS survey shows that 25.8% of all children surveyed had diarrhea in the two weeks preceding the survey (2007). The costs of treatment are not high: oral rehydration salts (ORS) cost less than \$1 and tablets cost less than \$2. Female respondents considered diarrhea as a major health risk even though it does not pose a great financial pressure on the family. Dehydration from diarrhea is a major cause of childhood mortality in Uganda, thus this condition generates significant emotional stress.

**Figure 22: Life Cycle Profile PRA Session with FINCA Clients**



#### *Dental problems*

Women in Jinja identified dental problems as a major health concern but there was no mention of dental concerns in any other areas. This is mostly because FGD participants in Jinja experienced recent dental problems that required large sums of cash and have therefore identified dental problems as a key issue in the family.

#### *Fever*

Fever is not considered as a major health risk among the respondents, however it is very common and it is usually result of other diseases such as malaria or diarrhea.

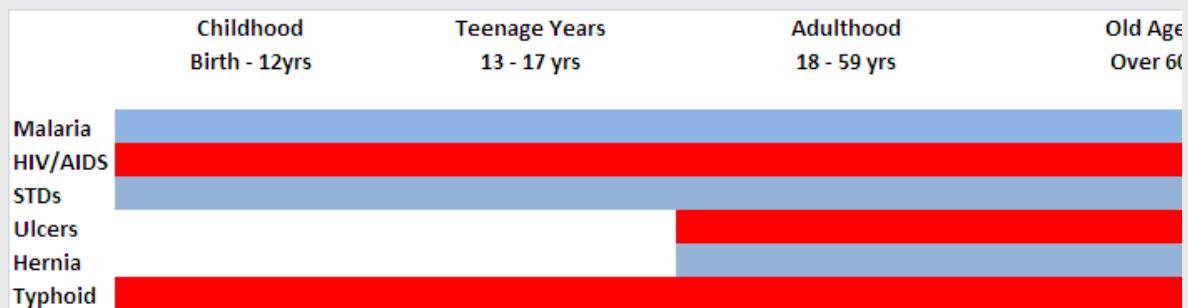
#### *Body pains*

Body pains were not considered a severe sickness, but rather, an effect of other sicknesses. Participants noted that these pains usually cause discomfort which can be alleviated with pain relief medications. The medication most commonly used is Panadol

which costs between \$1 to \$3 depending on the quantity of medication and the remoteness of the location.

**Figure 27: Health Life Cycle Profile**

Participants grouped life stages into four categories. These are: Childhood (birth to 12 years of age), Teenage years (13 years to 17 years), Adulthood (18 years to 59 years) and Old Age (over 60 years). An overview of the disease profile during each life cycle is presented in the figure below. To gather information about the Life Cycle Profile, 9 respondents were interviewed in Lira and Jinja.



**Childhood:** During childhood, malaria is the most common disease, followed by HIV/AIDS, and STDs both in Jinja and Lira. While malaria is present throughout one's life, it was reported to be most common during childhood. Respondents commented that early malaria treatment is not given to children since parents have difficulties recognizing the symptoms, which are often mistaken as milk teething pain. Respondents commented that children usually sleep without a mosquito net and are therefore more exposed to mosquitoes compared to other family members. HIV/AIDS and STDs are transmitted from an infected mother to a child during birth. Additionally, children who are affected with HIV/AIDS are more prone to severe malaria due to a compromised immune system.

**Teenage years:** Participants mentioned that people become infected with HIV/AIDS during their teenage years, but that the disease manifests itself during adulthood, hence adulthood is when the disease is predominately diagnosed. HIV/AIDS is most prevalent during teenage years and adulthood because these populations are sexually active and many people do not use safe sexual practices.

**Adulthood and Old Age:** STDs are common during adulthood. For example, participants in Jinja estimated that 80% of community residents have an STD, in particular, syphilis. The participants contributed the high incidence of STDs in this life stage to extra-marital sexual behavior and also unsafe sexual practices that exist in the community. STDs are more common in this population because adults and the elderly (in Jinja) are likely to change sexual partners very frequently and the chances of contracting the disease are subsequently higher. In both areas, the participants said STDs are present also in childhood due to parent to child transmission. Ulcers and hernias were mentioned by the participants as common during adulthood and old age. Participants attributed this to the poor life habits such as smoking and inadequate nutrition. Participants in Lira commented that typhoid is rare and it usually occurs in adulthood, but it can occur at other stages in life as well.

### *Asthma*

Respiratory illnesses were not mentioned as a major health threat by the respondents. Acute respiratory illnesses such as asthma, however, are major causes of mortality, and are considered major health risks in Uganda by the Ministry of Health (MoHU, 2007). It is likely that respondents may not be familiar with medical names of certain diseases, but frequent reports of cough may be a symptom of respiratory diseases.

### *Hypertension*

Participants referred to high blood pressure as “*rich man’s disease*.” High blood pressure reduces one’s capacity to engage in productive work and therefore it lowers the income in a household, especially if the breadwinner is affected with high blood pressure. While high blood pressure is not very common in the community, it causes significant pressure since pills have to be taken on daily basis. One of the participants commented that the tablets cost \$3 and need to be taken daily for 3 months.

### *Cough and Flu*

Flu and cough were mentioned as common, but were ranked very low since participants did not perceive flu and cough to be a great health risk. In Jinja, for example, cough is very common among children and the medications can be expensive if coughing is persistent. While cough and flu may cause some discomfort, the respondents considered that a person can go on with their daily routine. Treating a cough is not expensive, but if left untreated for a significant period of time the costs can significantly increase.

### *Ring worms*

Ring worms were identified as a problem in Lira only, mostly because Lira is a poorer area when compared to Jinja and Mbarara. Ring worms mainly affect children and are not seen as a major health threat since the disease is easy to treat.

### *Ulcers*

Ulcers were seen as a minor disease in Mbarara; however, ulcers were not considered to pose a great financial or health risk to a household.

### *Diabetes*

Diabetes was mentioned in Jinja and Mbarara as a problem, but respondents said the disease is not common in the area.

### *Other*

Brucellosis is a common disease in Western Uganda. The disease is caused by drinking un-boiled milk. The disease is common during the dry season and it affects all ages equally.

## **7.2. Preventive measures used by FINCA clients to avoid sickness**

The type of preventive measures against sickness used by FINCA clients depends on availability of funds, level of education, and overall knowledge about the available illness prevention methods. In the areas where health education is provided by the government, the knowledge about diseases and subsequent prevention methods is higher compared to areas where no education is offered.

In the case of malaria, the most common preventive measure is a mosquito net. Many clients said that they use an ITN. While clients claimed that mosquito nets are the most common preventive measure against malaria, the Ugandan Demographic and Health Survey from 2006 shows that the percentage of households with at least one mosquito net is rather low: 23.1% in Southwest region; 41.5% in the North; and 27.8% in the East Central region respectively [See Figure 29]. Therefore, there is still significant room for financial products and services related to mosquito nets. Respondents mentioned that mosquito nets are expensive, ranging from \$USD 5 to \$USD 12, but that they are viewed as a necessity. Purchasing a sufficient number of mosquito nets can be an especially high cost for a large household.

In addition to the mosquito nets, respondents reported using coils. Coils, however, are a less preferred method due to side effects such as coughing.

**Figure 23: Key Malaria Indicators for Selected Regions**

| Malaria indicators   | Region    |       |              |
|--|-----------|-------|--------------|
|  | Southwest | North | East Central |
| Percentage of households with at least one mosquito net (treated or untreated) | 23.1%     | 41.5% | 27.8%        |
| Percentage of households with at least one ITN                                 | 11.3%     | 28.8% | 10.8%        |

*Source: MOH, Uganda Demographic and Health Survey, 2006*

Although respondents reported using condoms to protect against HIV/AIDS and STDs, women commented that the usage of condoms is not very common. This is because women have less bargaining power when it comes to sexual protection, hence many women cannot demand the use of condoms (Mosser, 1997). Other prevention methods mentioned by the participants included educational seminars provided by the government.

In order to ensure that water is drinkable, people will boil water and use water chlorine tablets; this strategy is used to prevent diarrhea. Poorer households are less likely to use these prevention methods. A common preventive method for skin rashes is usage of herbal treatments such a Neem tree and aloe vera. Neem tree has antimicrobial properties and aloe vera is used as a skin ointment. Additional preventive methods against sickness involve boiling milk, washing hands, and participating in health awareness workshops organized by the government.

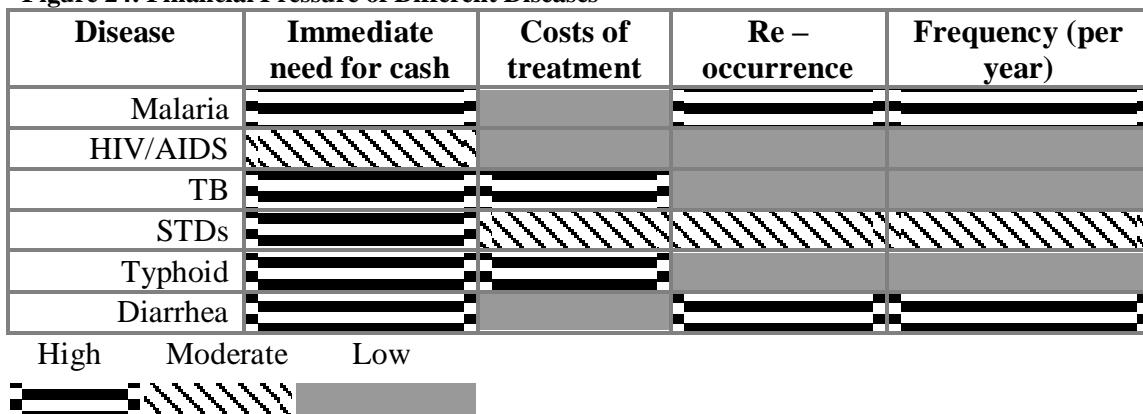
### 7.3. Financial pressures of different diseases

Medical costs have the potential to plunge households into poverty. Recent research by Whitehead et al. shows that the likelihood that poor households are able to move out of poverty diminishes when confronted with sickness-related expenses (2001). FINCA clients face great constraints in accessing health care, especially in rural areas such as Lira where clients incur costs additional to the direct treatment costs (e.g. transportation costs).

The focus of discussion with the participants was mainly on financial pressure caused by the key diseases they identified. The Health Care Financing tool was used to gather information on various financial pressures, as was the Life Cycle Profile tool. In total, 43 respondents were interviewed. Health Care Financing was used in all three areas, while the Life Cycle Profile was used in Jinja and Mbarara only. In this research, financial pressure was defined as the urgent need for a lump sum of cash. The research team also looked into financial pressure caused by frequency of diseases and their reoccurrence, as well as the overall costs of treatment. Figure 30 presents financial pressure associated with the top six diseases.

On average, the study found that a family of 7 will spend between \$USD 5 and \$USD 30 per month on medical expenses. Given the fact that average household income is between \$USD 63 and \$USD 250, medical expenses present a significant proportion of household expenditure<sup>12</sup>.

**Figure 24: Financial Pressure of Different Diseases**



<sup>12</sup> This is a rough estimation of income and expenditure among the respondents.

One of the major contributors to higher medical costs is the fact that people wait to seek medical care (further discussed Chapter 8). When clients go to see a doctor their disease is usually in an advanced stage, hence it is more complicated and more costly to treat.

Different diseases pose different financial pressures on FINCA clients. HIV/AIDS and malaria cause the greatest financial pressure in all researched areas; the participants ranked the financial pressure of these diseases as 5 out of 5.<sup>13</sup> Costs associated with HIV/AIDS are related to increased food costs, high costs of laboratory tests, and high costs of ARV medications. In order to avoid high medication costs, people will sometimes resort to local herbalists, where costs of treatment are less compared to clinics (See Figure 33). The additional advantage of local herbalists is the possibility of in-kind payment, usually in a form of a goat or chickens.

The financial pressure of STDs was ranked as 3 out of 5.<sup>14</sup> STDs involve both partners; hence the treatment costs are doubled, contributing additional financial pressure. Due to stigmatization associated with STDs, many people will choose to self treat STDs and in such instances they will spend between \$USD 5 and \$USD 10 on drugs and ointments which are usually not effective [See Figure 29].

While government facilities are free, FGD participants mentioned that many service providers require a bribe to administer health services. Additional fees can make health services unaffordable and can include, among others things, fuel fees, service fees, and bed fees.

#### **Case Study 1: Health Risks According To Health Service Providers in Lira**

The health risks in Lira identified by Dr. Jimmy Odaga are malaria, respiratory infections, worm infestations, HIV/AIDS and tuberculosis. Malaria affects all residents of Lira; however, children are more susceptible to malaria. Worm infestations and diarrhea are common, especially among children, due to lack of access to clean water and lack of proper hygiene. Pneumonia in children is very common and also very frequent. Tuberculosis is very common in the area due to the high exposure to tuberculosis bacteria. Sexual and gender based violence is also common in the area.

#### **Case Study 2: Health Risks According To Health Service Providers in Jinja**

Common diseases in Jinja identified by Dr. Kasuti Edward are malaria, respiratory infections (pneumonia and common cold), and diarrhea (in children mostly). Anemia in children is commonly a result of malaria, as are worm manifestations. Tuberculosis is not so common in the area but the doctor noted that there has been an increase. Women suffer from inflammatory diseases such as urinary tract infections. Sickness is more common during the rainy season, especially in the case of malaria. Sanitation and access to clean water are a problem in the area, and cause diarrhea and other water-borne diseases.

<sup>13</sup> 5 being the highest and 1 the lowest pressure

<sup>14</sup> 5 being the highest and 1 the lowest pressure, hence 3 is moderate

**Figure 30: Costs of Treatment for Other Diseases**

| Diseases                        | Treatment                             | Costs in USD  | Place   | Source              |
|---------------------------------|---------------------------------------|---------------|---------|---------------------|
| Coughs                          | Locally produced syrup                | 1 to 2        | Jinja   | Pharmacy            |
|                                 | Imported syrup                        | 3 to 6        | Jinja   | Pharmacy            |
|                                 | Syrup at local herbalists             | 6             | Jinja   | Local herbalists    |
| Consultation fee                | Per a visit                           | 2 to 25       | Mbarara | Private clinic      |
|                                 | Per a visit                           | 2             | Lira    | Private clinic      |
|                                 | Per a visit                           | 2             | Jinja   | Private clinic      |
|                                 | Blood test                            | 2             | Jinja   | Private clinic      |
| TB                              | Any                                   | Free          | Mbarara | Government          |
|                                 | Drugs                                 | 31.25 to 50   | Jinja   | Private clinics     |
|                                 | Transport and drinks for the patient  | 6             | Jinja   | Government          |
|                                 | X ray                                 | 50            | Jinja   | Private clinics     |
| STDs                            | Drugs and consultation                | 15            | Jinja   | Private clinics     |
|                                 | Injection                             | 3             | Mbarara |                     |
|                                 | Drugs and creams                      | 6.25 to 9     | Jinja   | Self medication     |
|                                 | Treatment                             | 15 to 44      | Jinja   | Private clinics     |
| Diarrhea                        | Syrup at local herbalists             | 9             | Jinja   | Local herbalists    |
|                                 | Injection syphilis                    | 15            | Lira    | Private clinic      |
|                                 | syphilis treatment                    | 31            | Jinja   | private clinic      |
|                                 | Tablets                               | 5             | Jinja   | Self medication     |
| Dental                          | Rehydration salts                     | 3             | Jinja   | Self medication     |
|                                 | Tooth removal                         | 4,000 – 5,000 | Jinja   | Private clinics     |
|                                 | Tooth removal                         | free          | Jinja   | Government hospital |
|                                 | Anesthetic tip                        | 1             | Jinja   | Government hospital |
| Typhoid                         | Lab diagnosis                         | 4 to 8        | Lira    | Private clinics     |
|                                 | Treatment                             | 31            | Lira    | Private clinics     |
| Ring worms                      | Pills                                 | 1 to 4        | Lira    | Pharmacy            |
| Brucellosis                     | Lab test                              | 1 to 3        | Mbarara | Private clinics     |
|                                 | Treatment                             | 200           | Mbarara | Private clinics     |
| Measles                         | Treatment                             | 12.5 to 50    | Jinja   | clinics             |
| Skin diseases                   | Ointment                              | 1 to 4        | Jinja   | clinic              |
|                                 | Household expenditure for family of 7 | 50 to 62.5    | Jinja   |                     |
|                                 | Household expenditure for family of 7 | 25            | Lira    |                     |
| Monthly health care expenditure |                                       |               |         |                     |

## **Summary**

From a poverty perspective, health issues are the greatest risks faced by the poor. According to a Ugandan National Household Survey conducted in 2006, disease prevalence in Uganda increased from 29% to 40% between 2002/03 and 2005/6 (MoHU, 2007). The top ten diseases causing morbidity and mortality (all age groups) are: malaria, HIV/AIDS, tuberculosis, acute respiratory infections, diarrheal diseases, malnutrition, anemia, intestinal infections, trauma/accident, and skin infections (WHO 2001). Malaria is endemic in all parts of Uganda and is also a leading cause of mortality, especially among the children. Apart from the diseases mentioned above, Uganda is also facing increased problems with non-communicable chronic diseases such as hypertension, diabetes, and heart disease.

In the next chapter we will discuss health seeking behavior, the financial impact of illnesses, and coping mechanisms of FINCA clients.

### **Case Study 3: Health Risks According To Health Service Providers in Mbarara**

The most common diseases in Mbarara, according to registered nurse Biacika Lilybit, are malaria, hypertension, diabetes, and brucellosis. HIV/AIDS is also very common in the area. Malaria is more common in the rural areas surrounding the town.

**Figure 31: Waiting Room Government Hospital**



## 8. Health Seeking Behavior, Health Providers and Coping Mechanisms

This section of the report describes the health seeking behavior of respondents in the selected areas. In order to gather information about health seeking behavior, health providers and coping mechanisms three tools were used. These were the Health Care Seeking Behavior tool, Health Care Matrix tool and Health Care Financing tool. The total number of respondents was 72. The tools were used in all three areas, apart from Mbarara where only the Health Care Matrix and Health Care Financing tool were used.

### 8.1. Health Seeking Behavior of FINCA clients

FINCA clients were asked about the different types of health care they sought when sick.

**Figure 32: Health Seeking Behavior and Reasons Why Sought**

| Rank | Health service      | Cost of treatment | Opportunistic costs <sup>15</sup> | Quality of care | Proximity | Trust |
|------|---------------------|-------------------|-----------------------------------|-----------------|-----------|-------|
| 1    | Drug shops          | ✓                 | ✓                                 | ✓               | ✓         | ✗     |
| 2    | Health workers      | ✓                 | ✓                                 | ✓               | ✓         | ✓     |
| 3    | Churches            | ✓                 | ✓                                 | ✗               | ✓         | ✓     |
| 4    | Clinics             | ✗                 | ✗                                 | ✓               | ✗         | ✓     |
| 5    | Hospitals           | ✓                 | ✗                                 | ✗               | ✗         | ✓     |
| 6    | Herbs               | ✓                 | ✓                                 | ✓               | ✓         | ✓     |
| 7    | Traditional doctors | ✗                 | ✓                                 | ✗               | ✓         | ✓     |

Legend

|   |                        |
|---|------------------------|
| ✓ | Reason why visited     |
| ✗ | Reason why not visited |

*Delaying seeking health care*

A common strategy in coping with illness among FINCA clients is ignoring illness all together (ignoring the disease<sup>16</sup>). The study found that clients, especially the poorer ones, delay seeking health care until the illness is severe. The delay is caused by two main factors: an inability to cover costs of medical treatment; and a lack of knowledge about sickness severity. This leads to greater medical complications as well as to higher costs of treatment.

<sup>15</sup> Refer to time spent in travel, time spent in waiting for a treatment, and like costs

<sup>16</sup> For further discussion about the phenomenon of ignoring disease among the poor refer to Sauerborn, R. Adams et al. (1996). Household strategies to cope with illness. Social Science and Medicine, 43, 291 – 301.

### *Self medication*

Another common strategy among FINCA clients is self medication, especially in the case of STDs and even malaria. Self medication may include application of available drugs at home (regardless of its suitability for the disease, for example a common drug used for malaria in Panadol), use of homemade medicine (for example herbal medicine) or purchasing drugs at a local drug store. People resort to self medication for several reasons: they are not aware of the risks of self medication; they cannot afford hospital treatment; home medicine is free; no additional costs are incurred; proximity to the place of living (in the case of a drug store). Respondents said that drug stores are usually located in the area where they live, which make drug stores more accessible than hospitals or health centers and therefore more preferable as a treatment.

*"In the village people will buy drugs like Panadol, and if Panadol does not help then they will go to the doctor. If money is not enough they will get half of the treatment and the sick one will not get better." FGD participant, Lira, Uganda, July 2007*

### *Traditional healers/herbalists*

Clients do seek help from traditional healers/herbalists. It was noted, however, that this practice was not very common among the respondents. Respondents perceived traditional herbalists as more expensive since payment is usually made with goats and/or bulls. Respondents said that a few community members visit traditional healers/herbalists as a last resort "*when modern medicine has failed;*" however, other research in Uganda shows that Ugandans do use traditional healers/herbalists more than reported (Makerere University research, 2006).

### *Spiritual healers, churches, and pastors*

In Lira, respondents ranked the church as the first place they go to when sick. However, churches are sought mostly for reassurance, and not necessarily for medical reasons. Reasons for visiting church are: no paperwork, no queues, free service and the hope pastors give to patients.

### *Home of Health Workers*

In Jinja, seeking health care from health workers is a common practice. Individual health workers stock medicines at home and privately treat patients. Health workers are usually the first contact for the patients in many communities, especially rural ones. They are preferred because they can be accessed at any time, they are a part of the community, thus they know patients well and the services are low cost in terms of transportation and access costs (such as consultancy fees).

### *Formal health providers (clinics, hospitals and the like)*

Despite their socio-economic differences, the majority of respondents visit formal health providers when sick, and recent research in Uganda shows that 56%<sup>17</sup> of sick persons seek formal health care (Makerere University Institute of Public Health, 2006). The type of formal health institution people seek depends on their socio-economic level. For example, those who are poorer seek public care since it is free and will resort to private clinics only if a treatment is not available in a government hospital. Those who are better off seek health care in private clinics [See Figure 33]. In Lira for example, patients will first go to the private clinic because clinics are reported to be much closer than the government hospitals and they provide higher quality services. If treatment at the clinics fails, then people will resort to the government hospitals, often because they are in need of a medical specialist.

## **8.2. Health providers in selected areas**

This section of the report presents findings from the Focus Group Discussions and the In-Depth Interviews with Health Service Providers in selected areas.

Health Care providers in Uganda can be categorized into several groups: public and private (private health sector in Uganda can be broadly categorized into Private for Profit (PFP) and Private Not-for-Profit (PNFP) providers); governmental and non-governmental, trained and untrained, modern and traditional; and formal and informal [refer to general merchandise shops and traditional healers] (MoHU, 2007). See Attachment 2.

In 1993, the Ugandan government implemented a health decentralization policy with the intention of moving public resources closer to the beneficiaries at the local level, as well as to improve service delivery (SIDA, 1999). As a result of this decentralization policy, the health responsibilities in Uganda are divided between the Ministry of Health and the Ministry of Finance at the national level, and the Health Services office at the District level. The basic strategy for health care in Uganda is defined as primary health care, meaning that a minimum package of public health care and clinical services are to be provided to all Ugandans. This reform of the health care system resulted in a new classification of health units based on services they offer. These are Health Centre (HC) I, II, III, and IV.

- HC I operates at the community level; a trained health worker can treat basic health issues such as fever
- HC II has outpatient services only, such as provision of drugs and basic primary care, and is headed by a nurse
- HC III has the services of HC II including clinical officers and surgery and acts as a referral facility for HC IV
- HC IV has surgery, inpatient services and outpatient services (source key informant, Lira Referral Hospital, Uganda 2007)

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<sup>17</sup> Sample size = 1097

There are four key aspects<sup>18</sup> in determining where people seek health care; these factors can be summarized as: Availability, Accessibility, Affordability and Acceptability.

- *Availability* refers to geographical distribution of health facilities and pharmaceutical products
- *Accessibility* refers to transportation, roads, and similar infrastructure
- *Affordability* refers to treatment costs for the individual, family, and household, both direct (costs of treatment) and indirect (e.g. bribes, transportation and opportunistic, time)
- *Acceptability* refers to cultural and social distance, such as characteristics of health providers, their behavior, gender norms, etc.

All these factors were considered when discussing health care providers with FINCA clients as presented in Figure 34 below.

**Figure 33: Usage of Health Care Services by Different Groups**

| Health Care Service Provider | Rich  | Not so Poor | Poor | Very Poor | Women | Men |
|------------------------------|-------|-------------|------|-----------|-------|-----|
| Hospitals                    | **    | ***         | **** | *****     | ****  | *** |
| Health Centers               | *     | ***         | **** | *****     | ***** | *** |
| Private Clinics              | ***** | ***         | **   |           | ***   | *** |
| NGO Clinics                  | *     | *           | *    |           | *     |     |
| Herbalists                   | ***   | **          | ***  | ***       | ***   | **  |
| Midwives                     |       | **          | **** | *****     | ***** |     |
| Drug shops                   | ***** | ***         | ***  | **        | ***   | *** |

*Note: Stars (\*) indicate places of usage when sick for different socio-economic group. A higher number of stars indicate greater usage, while lower number indicates low usage. If the box is empty it means the socio-economic group is not using a provider.*

We can observe from Figure 33 that hospitals are mostly used by the very poor, poor and women, while private clinics are mostly used by the rich and not so poor. When a person falls sick in a household, the decision on where to treat their illness falls on the man, i.e. he will decide how much will be spent; women, however, are caregivers in all areas. The study showed that this is not true if a woman is a head of a household and if she has her own source of income. In this case, the decision on where to go for a medical care will be made by the woman.

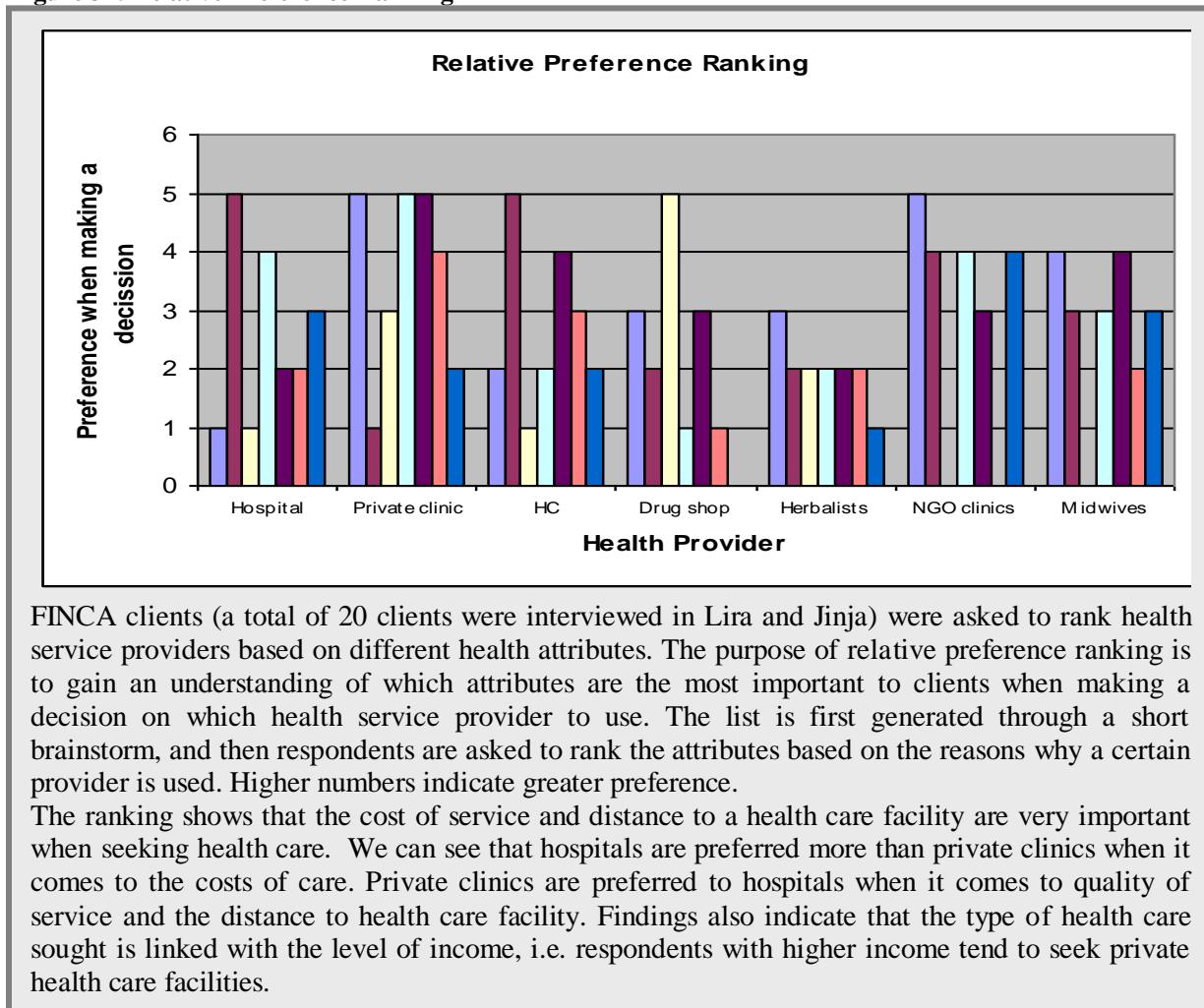
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<sup>18</sup> Muela, Ribera and Nyamongo (2003): “Health-seeking Behavior and Health System response”

In order to access health services, respondents in our research usually have to pay in cash, so called “out-of-pocket payments,” which makes accessing health care more difficult for the poor. Figure 34 shows relative preferences based on different health attributes in the selected areas.

Some health care providers interviewed have other payment options such as credit (refer to Figures 41, 42 and 43 for detailed analysis of Health Providers in Jinja, Lira, and Mbarara) or insurance. In Uganda, as in many other developing countries in Africa, out-of-pocket payments are a very common way of financing health service providers (McIntyre et al., 2005). Other forms of health funding include: tax funding, donor funding, user fees, and health insurance.

**Figure 34: Relative Preference Ranking**



### *Hospitals*

Hospitals are usually reserved for the poor clients of FINCA because the services in the hospital are free and often the poor have no other option. Hospitals are often the most

accessible health facility for the clients from rural areas, who are usually poorer compared to clients in urban areas. Hospitals are generally associated with a poor quality of service because of low availability of drugs and long waiting times. Not so poor and rich people will use hospital services if they need to see a specialist.

*“Hospitals are known to have a very long waiting time which the rich cannot tolerate.”*  
*FGD participant, Jinja, Uganda, 2007.*

The research team visited government hospitals in Jinja and Lira [See Figures 41 and 42]. Key informants mentioned that the hospitals are usually understaffed, and the available medical and financial resources are low, particularly in Lira.

Despite the fact that hospitals are free, patients do incur unofficial costs while seeking health care in government hospitals. These costs can include bribes and gifts for medical staff. Usually these are extended to receive faster service. The research team estimated that these unofficial costs can range from a few dollars to much higher amounts depending on the urgency of the medical problem. In Mbarara, for example, participants identified waiting time as one of the biggest problems in accessing health care in government facilities. On the other hand, the fact that Makerere University Hospital is in Mbarara was seen as an advantage by the respondents due to the availability of qualified doctors.

*“Doctors are underpaid and not many people want to be a doctor. If you work in an NGO clinic you can get paid \$USD 937 while you work in a hospital and you get \$USD 312 and no money for transportation. The infrastructure is weak; structures are there only in name. In a day there can be 250 patients, and it is only me and another doctor in this hospital.” Key Informant, Lira, Uganda, July 2007*

The findings show that women use hospitals more than men. This may be linked to the type of care women are seeking (maternity care) as well as to the fact that women are generally poorer than men.

*“Men have money, they want good services and these are not in a hospital. Women do not control family finance and cannot choose to go to a private clinic.” FGD participant, Lira, Uganda, July 2007*

### *Private Clinics*

Private clinics are the most popular health service providers in all the selected areas; however, their quality and services (services available, drugs available, medical staff, etc.) vary throughout the researched areas. Private clinics are used by all socio-economic groups but the rich and not so poor use private clinics more than the poor. The main

reasons given for using private clinics are the quality of service and timeliness. The study found that even the poor would be willing to pay more in exchange for faster service. In Mbarara, for example, the following clinics were mentioned as the ones used most frequently by the respondents: Mayanja Memorial Clinic, Nursing Home Clinic, Rwabyoma Clinic, Tropical Clinic, Children's Clinic, Deo Clinic – general practitioners, and Diagnostic Centre. Mayanja Clinic is considered to be the best in the area; it was also reported as the most expensive by the respondents.

Private clinics are also more popular because of their proximity, especially in areas where transportation is limited such as Lira. The poor and not so poor cannot afford private clinics; however, when services are not available in the hospitals they will resort to a private clinic. The poor and not so poor usually use NGO-owned clinics where there are other payment options besides cash. Male respondents in our research use private clinics more than women because men control family finances, but they also reported that they do not fall sick as frequently as women and children.

#### *Health Centers*

Health care centers were not very popular among the respondents. The centers are usually considered substandard because, according to the participants, there is no qualified medical staff in HC I and II, hence the health care centers are perceived as a “*waste of time*.”

#### *Traditional healers/herbalists*

The findings show that herbalists are less expensive than formal clinics. While services provided by traditional herbalists may not cure the disease, some clients will still opt to use their services due to the lower cost. The use of traditional herbalists is also related to some cultural beliefs in the areas we visited; one commonly held belief is that traditional herbalists cannot overdose the treatment while doctors can. Respondents with more education or those with more money do not use traditional herbalists.

*“It is difficult to take pills, but it is very easy to drink herbal medicine as it tastes like tea.” FGD participant, Mbarara, Uganda, July 2007*

While the research found that traditional doctors are widely present in the community, respondents did not perceive them as very useful. In Lira, for example, traditional doctors were associated with exorcism and ritual murders.

#### *Midwives*

Midwives were mentioned as important health care service providers by women in Jinja and are considered trustworthy. From the discussions it appeared that using a midwife is very common in the areas, as is home delivery.

## ***Health Services Matrix***

The research team visited health providers in all three areas. In total, 25 health care providers were visited during the research. The list of key informants is provided in Attachment 2.

The research team visited both private and public health care facilities in the researched areas. The team's objective was to visit the clinics that are most often used by FINCA clients. The research team visited as many clinics as possible given the time constraints. The findings show that government hospitals in Mbarara are better stocked and better equipped compared to hospitals in Jinja and Lira. Private clinics visited were of all shapes and sizes, there was no uniformity as to the type of services clinics offer, available staff, and facilities. In general the private clinics in Lira were in worse condition than those in Jinja and Mbarara. Clinics in Lira were poorly stocked, doctors were not available, and the facilities were usually run down.

The main method of financing private clinics is cash. Some clinics offer services on credit to their clients however this is not a common practice. Apart from cash payments, some clinics have access to government funding; NGO clinics, for example, can lower the costs of their services because they can purchase drugs at subsidized rates. A few of the clinics that were visited collaborate with health insurance providers such as Microcare; this collaboration was viewed as favorable for the clinics.

## ***Health Care Providers in Jinja***

In Jinja, the government hospitals we visited face chronic funding shortages which greatly affect the quality of service the hospitals can provide, according to Dr. Kasuti Edward. Government facilities are usually lacking medical staff, and many doctors work in two institutions at the same time. One of the major costs for patients is the cost of an overnight stay; given the high cost, many patients opt to stay overnight only if it is absolutely necessary. An overnight stay only includes the cost of the bed, and does not cover the costs of food or drink. The cost of a bed can be \$USD 5-6, but the addition of food and drink can double this cost. The respondents in this research did not talk about bed fees as expensive mostly because they consider bed fees as a part of overall treatment. However, if a case of malaria becomes complicated and overnight stay is needed, respondents considered bed fees extremely high.

Private clinics in Jinja have collaborations with larger employers, where employees can access health care when needed and costs are covered at the end of the month by the employer. The employer recovers the costs from the employee by collecting a monthly deduction from the employee's paycheck. Like in Lira, the quality of private clinics also varies. The Muvule Medical Centre, for example, was in very bad condition; the building was run down and there were no facilities or beds available and the pharmacy was almost empty. Vithi was interested in partnering with FINCA in offering a special financial package of health services for FINCA clients. The manager, Mr. Afzaal, was interested

in developing an exclusive package for malaria treatment for FINCA clients. All the health providers that the research team visited stressed that malaria caused the most financial pressure to the family. They estimated that if an average family size was 6 people, then 4 would need malaria treatment each month. The health care providers also noted that sanitation is very poor in the area, which contributes to incidence of malaria. It needs to be noted that medications used for malaria treatment vary from clinic to clinic. Some clinics still use Quinine to treat malaria. Quinine will significantly lower the costs of treatment; however, in many cases it will not be effective.

**Figure 35: Delivery Room, Government Hospital, Jinja**



**Figure 36: X-Ray Machine, Vithi Clinic**



**Figure 37: Surgery Room, Vithi Clinic, Jinja**



### *Health Care Providers in Lira*

Health clinics visited in Lira are in very poor condition as a result of inadequate facilities, low availability of drugs (especially in government clinics), and a shortage of doctors. At the time of our visit to Aboka Health Centre for example, we observed more than 50 people waiting to see a doctor, and there was only one doctor available. In all clinics visited, apart from the government hospital, doctors were not available. The research team visited other clinics in the area; however, no qualified staff was available to provide any information about the clinic. Private clinics in Lira are worse than clinics in Mbarara or Jinja. However, there is a great variation in the quality of service among private clinics in Lira. Some clinics like Ronam (which is very popular among FINCA clients) have no drugs and very poor facilities, while other clinics offer a higher standard of care. This is mostly because Lira is poorer than Mbarara or Jinja, and costs of service in Lira are actually cheaper than in other two places. The doctor we spoke to said that doctors are scarce, overworked and underpaid. When the research team asked whether the institutions would be interested in potentially partnering with FINCA, all the clinics were interested in such an option. Their greatest concern was lack of cash among their patients, and therefore lack of income for the clinics [See Figure 42]. We asked whether they would be interested in offering services through a credit scheme with FINCA and all the institutions were interested.

**Figure 38: Laboratory Unit, Ronam Clinic, Lira**



**Figure 39: Pharmacy Unit, Downtown Medical Clinic, Lira**



### *Health Care Providers in Mbarara*

The research team observed that clinics in Mbarara are in better condition than clinics in Jinja and Lira. The clinics in Mbarara are better organized and better stocked with medication; even the government hospitals are superior to those in Lira and Jinja. This may be because Mbarara is the second largest town in Uganda so the area experiences greater capital inflow than the other locations. All the clinics serve various socio-economic groups, although the majority of patients in all three areas are women. Health care providers in Mbarara identified major obstacles to seeking health care in Figure 44. As was the case in Jinja, health care providers were most concerned with patients' inability to pay for services rendered. We asked whether they would be interested in offering services through a credit scheme with FINCA and all the institutions were interested in potentially partnering with FINCA.

**Figure 40: Mbarara Community Hospital**



**Figure 41: Health Care Providers in Jinja**

| Clinic Name  | Type of Institution | Services Offered   | Opening Hours | Type of Patients                           | Average Number of Patients/ Day   | Type of Payment Method   | Costs of Treatment  | Obstacles to Health Care  |
|--|---------------------|--|---------------|--|---|--|---|---|
| <b>Mpumudde Health Centre</b><br>Met with Dr. Kasuti Edward              | Government HC IV    | Outpatient/ inpatient, antenatal care, gynecology, surgery, laboratory | 8am to 5pm    | All socio-economic groups, rural and urban | Usually the number of patients is high since HC IV is a referral institution for other health providers | Free   | Free  | Lack of government funding hence the services are of a poor quality |
| <b>Bunawona Health clinic</b><br>Met with Belcor Anita<br>Enrolled Nurse | Private Clinic      | Outpatient, inpatient  | 24 hours      | All socio-economic groups, rural and urban | Large number of patients since this is considered a high quality clinic according to the nurse          | Payment in cash, credit accepted at times, usually in smaller installments | Malaria costs can range from Ush 15,000/\$USD 9.78 to Ush20,000/ \$USD 12.50 including medications and consultation. Lab test for malaria cost Ush1,500 (\$USD 0.94) Costs for overnight stay are Ush10,000 (\$USD 6.25) per night however a deposit of Ush40,000 (\$USD 25) is needed ahead. Overnight costs include bed only. | Inability to pay for services, lack of knowledge about diseases     |

| Clinic Name   | Type of Institution   | Services Offered  | Opening Hours                                       | Type of Patients   | Average Number of Patients/ Day | Type of Payment Method  | Costs of Treatment   | Obstacles to Health Care  |
|---|---|---|---|--|---------------------------------|---|--|---|
| <b>St. Balikudembe</b><br>Met with Martha Nalkenge Clinical Officer | Private Clinic  | Outpatient, inpatient, minor surgery                            | 8am till 7pm  | All socio-economic groups, rural and urban   | 50 – 75                         | In cash, collaboration with companies. When needed, some costs will be written off in cases where a patient is very poor        | Malaria costs around Ush 30,000 (\$USD 18.75) if a patient is admitted, however, the clinic does not allow overnight stays   | High costs of service for patients  |
| <b>Muvule Cresten Islamic Medical Centre</b> met with Martha Akubo  | Private Clinic (at the time of our visit the clinic just re-opened) | Outpatient, inpatient, counseling, psychotherapy , lab services | 8 am till 6 pm, however has a doctor/ nurse on call | All socio-economic groups; however, mostly from rural areas due to affordability of services | 10                              | Cash only   | Costs of malaria Ush 6,500-15,000 (\$USD 4.06-9.38). However, malaria treatment involves chloroquine only. Consultation fee and lab is around Ush 1,000 (\$USD 9.38)   | Drugs are not always available when needed for patients. For rural people transportation can be a problem at times so medical services are not sought |
| <b>Vithi Clinic</b> met with Doctor Moses Mosana                    | Private clinic (HC IV)  | Outpatient, inpatient, surgery, gynecologist, dental services   | 24hrs   | All socio-economic groups and patients, mostly come from urban areas                         | 25-30                           | Payment in cash, collaboration with Microcare, collaboration with larger companies, credit payments available on rare occasions | Malaria costs are Ush10,000-15,000 (\$USD 6.25-9.38) and include drugs and lab test (however, treatment involves chloroquine). Malaria costs for a child are Ush5,000-10,000 (\$USD 3.13-6.25). If other malaria drugs are used, | Lack of cash by the poor to pay for services (estimated 40% of patients can afford services, 60% cannot)  |

| Clinic Name   | Type of Institution | Services Offered   | Opening Hours | Type of Patients   | Average Number of Patients/ Day | Type of Payment Method  | Costs of Treatment  | Obstacles to Health Care                       |
|---|---------------------|--|---------------|--|---------------------------------|---|---|--|
|   |                     |  |               |  |                                 |   | cost are Ush50,000 (\$USD 31.25) and above.   |  |
| <b>Ripon clinic</b><br>met with Tucime Sheila                                       | Private Clinic      | Antenatal and postnatal care, x-ray, breast surgeon, gynecologist, radiologist | 8am to 5 pm   | All socio-economic groups from both rural and urban areas  | Up to 75                        | Majority of people pay in cash, but, the clinic allows credit payments, especially when costs of treatment are high. The clinic has collaboration with large employers in the area. | X-ray costs are between Ush15,000-50,000 \$USD 9.28-31.25. Malaria treatments for children (ages 12-15) cost Ush12,000-15,000 (\$USD 7.50-9.38), depending on the drug. In adults, malaria treatment can cost Ush 20,000/\$US12.50. | Lack of financial capacity to pay for services |
| <b>The National Medical Centre (Ahimbisibwe)</b><br>- met with nurse Pierson Ampire | Private Clinic      | Small operations, general practitioner, inpatient services, overnight stay     |               | Mostly people from urban areas. All socio-economic groups. | 5 to 8                          | Payment is cash or credit   | Malaria costs Ush 20,000 (\$USD 12.50) for drug treatment.  | Various  |

**Figure 42: Health Service Providers in Lira**

| Clinic Name   | Type of Institution | Services Offered  | Opening Hours                     | Type of Patients                                      | Average Number of Patients/Day   | Type of Payment method   | Costs of Treatment   | Obstacles to Access Care   |
|---|---------------------|---|-----------------------------------|---|--|--|--|--|
| <b>Ronam Health Care Clinic</b><br>Met with Mr. Otim Kalwe, Laboratory Technician | Private Clinic      | Lab, dental, outpatient and in patient services, minor surgeries        | 24hrs                             | Mostly serves very poor people                        | 20-30  | Cash & credit. Noted that if people pay in full at time of treatment the clinic will give a discount. Some support from Medical Aid Uganda?? | Malaria and anemia drugs are expensive. Drugs Ush 5-6,000 (\$USD 0.01-3.75), lab Ush 500-1,000 (\$USD 0.31-0.63) | Lack of money for transport and often have to beg for transport  |
| <b>Downtown Medical Clinic</b><br>Met with Peter Somwe, Medical Assistant         | Private Clinic      | Outpatient, inpatient, antenatal care, gynecology, surgery, laboratory  | 24hrs                             | Poor and not so poor, most clients are women          | 10   | Always in cash   | Malaria treatment: drug Ush10,000/\$USD 6.25, lab Ush2,000/\$USD 1.25, consultancy fees Ush 3,000 (\$USD 1.88)   | People don't have enough money. Suspicious of western medicine. Transport. Lack of education. Traditional doctors.   |
| <b>Aboka Health Centre</b> Met with Dr. Jimmy Odaga                               | Government HC IV    | Outpatient, inpatient, midwife, referral facility, surgery, operations, | 7am to 4pm, has an emergency unit | Poor mostly, however serves all socio-economic groups | 820 clients want to be seen, outpatient-120-150, antenatal clinic 50-100 | Free   | Free   | Popularity of traditional healers and traditional birth attendants. Lack of beds, no electricity, little knowledge of disease symptoms. Illiteracy. Poverty. Transportation, roads in bad condition. |

**Figure 43: Health Care Providers in Mbarara**

| Clinic Name   | Type of Institution  | Services offered   | Opening Hours  | Type of Patients  | Average Number of Patients/day | Type of Payment method                         | Costs of Treatment  | Obstacles to Access Care   |
|---|--|--|--|---|--------------------------------|--|---|--|
| <b>Mbarara Community Hospital</b> Met with nurse Biacika Lilybit        | Private clinic but NGO owned   | Antenatal and postnatal care, x-ray, gynecologist, radiologist, lab        | 9am to 5pm for outpatients services, however has an emergency unit | Serve very poor, rural people mostly women and children | 50                             | Cash, at times services are offered on credit. | For overnight stays, costs can range Ush6,000-10,000 (\$USD 3.75-6.25). Malaria costs can range Ush 6,000- 60,000/ \$USD 3.75-37.50 | Costs of care for the poorer clients are a problem, lack of knowledge about the diseases           |
| <b>Mayajna Memorial Hospital</b> Key informant did not want to be named | Privately owned by a member of the government so receives government funding | All hospital services  | 8am to 5pm, with doctor on call in a case of emergencies           | Better off, usually with government connections         | 25                             | Not known, the research team assumes cash      | The person we talked to did not want to provide costs of care in the facility   | For better off there are no barriers; for poor usually cost is greatest barrier to health care.    |
| <b>Surgical Centre</b> met with Mugame Rashid Medical Officer           | Private clinic   | Outpatient and inpatient services  |  | Better off  | Record not available           | Cash   | Malaria from Ush10,000-800,000 (\$USD 6.25-500) if an overnight stay is needed  | For the poor, costs are the greatest problem   |
| <b>Kakoba Division</b> Key informant did not want to be named           | Government HC III  | Outpatient and inpatient services, no specialists available, minor surgery | 8am to 5pm   | Rural and urban, all economic groups                    | Not known                      | Free   | Free  | Lack of knowledge about sickness, bad sanitation and living conditions, especially in rural areas. |

### **8.3 Coping Mechanisms for Medical Expenditures**

In this chapter we examine what coping mechanisms FINCA clients use to deal with medical costs. This section is focused on only financial coping mechanisms. Financial coping mechanisms refer to all of the financial strategies households undertake to manage the costs of health care before and after sickness. The information was gathered using the Health Care Financing tool, and 34 respondents were interviewed. The tool was implemented in all three research areas.

In Chapter 6 “Risks and Risk Coping Strategies,” we discussed risk coping mechanisms for all risks faced by a household; in this chapter a more in-depth discussion is provided about health risks coping strategies and their effectiveness in covering medical expenses.

*“For health, people look for money when someone is sick, they do not budget for sickness.” Key informant, FINCA Lira, Uganda July 2007*

#### *Borrowing from money lenders against personal assets*

When sick, an individual will borrow using his or her personal assets as security as a method of last resort. This method is effective if a household has enough value in assets to borrow against. The sickness has the potential to reduce the family income and hence loan repayments may become an issue for the borrower and the institution or moneylender. Collateral requirements are common when borrowing from moneylenders. The respondents were aware that borrowing from moneylenders is extremely costly (e.g., in Jinja people will borrow from moneylenders at rates as high as 50% per month) but considered that the money is available fast with little hassle.

#### *Diverting business loans for medical expenses*

It is common in all three areas to divert some part of a business loan towards covering medical costs. The respondents found this strategy effective if sickness happens at the time of the loan disbursement. However, if the sickness does not happen in the time of disbursement the loan is less likely to be diverted. Furthermore, the respondents reported that a small part of the business loan will often be used to purchase a small asset such as radio or a goat that can easily be converted into cash in time of an emergency such as sickness.

#### *Relying on family and friends to cover medical costs*

Social support of family and friends is of extreme importance in times of sickness. Friends and family not only help by providing cash, but will also help by contributing food or by providing care for a sick person. While this method is very important among the respondents, the respondents said this method is only effective if a family member or a friend has something to contribute.

*“It is difficult these days to borrow from friends or other business people when sick.” FGD participant, Jinja, Uganda, July 2007.*

In all of the three researched areas, people use business income and business inventory as a way of paying for medical expenses when they occur. While this is a convenient method, it is rather costly for the respondents. This is because selling business inventory in the event of an emergency usually means that cash is needed urgently, and thus the stock may be sold below market price. Furthermore, using business capital as a way of paying for medical expenses usually disrupts the business stability and may cause a collapse of the business. This causes even greater problems to the individual and the affected household. Using business income is a less preferred strategy among the respondents, and it is considered as only partly effective due to possible long-term negative impacts.

#### *Sale of livestock and small household assets*

People chose to save in animals or small household assets because in the time of an emergency need such as sickness, these can be easily transferred to cash. In instances where illness is prolonged, e.g. HIV/AIDS, the family may sell land or another large asset if all other assets have been sold. The sale of an animal is a good strategy only in cases where animals were actually bought with an emergency purpose in mind, so that the family does not have to dispose of necessary animals intended for food. Despite the fact that animals can be converted into cash easily, at times animals have to be sold below market value due to an emergency need. In Mbarara, clients reported that a goat, fruit, or vegetables can be sold within 30 minutes, and thus the respondents felt that they do not need to save in cash or keep cash in their houses to cover the costs of medical expenses or other emergencies.

#### *Belonging to informal savings scheme*

Informal savings schemes are common insurance methods in all three areas. It appeared as if every respondent in this research belonged to some sort of informal group. These groups function like ROSCAs (refer to Case study 2 and 3). Self selected individuals come together and contribute a small amount of money on a regular basis. These contributions are then distributed to the members in times of need, but not necessarily a health need (however there are many variations from group to group). Despite its popularity, the strategy does not fully cover the costs of medical care because the accumulated amount is usually not sufficient to cover all expenses. Informal savings groups, however, are important coping mechanisms for all community members because they offer valuable social support.

#### *Reallocation of household income towards medical expenses*

Reallocation of household income was a common strategy used by the respondents. The study found that in times of a health emergency it is common to reallocate the cash intended for food towards medical expenses. In Lira, it was reported that people may ration food for an extensive period of time to cope with medical expenses.

#### *Free drugs provided by the government*

In a case of HIV/AIDS or malaria, the Very Poor or Internally Displaced Persons (IDPs) can access free medicine through hospitals. This coping strategy is effective only if drugs

are available. The low availability of drugs in hospitals is a common problem in all three areas.

### *Labor for medical expenses*

In some cases, people are forced to provide cheap labor to raise money for medical expenses. This practice was reported as common in Lira but not in Mbarara and Jinja. For example, a sick person can go to a local commercial farmer and ask for a loan towards costs of treatment. The loan is then repaid in the form of labor provided to the farmer. This strategy is effective, but very costly for clients. Usually there is no written agreement on how many hours of work or the type of work a borrower will do as loan repayment. In many instances, people are exploited and therefore the costs of sickness become even higher.

### **Case study 4: Women's Informal Savings Group**

Mary is a client of FINCA and she belongs to a women's savings group in Lira. The group collects money every Sunday (\$USD 1) and jointly deposits the money in the bank. The money is used at the end of the year to buy clothes, food or other smaller items. Mary belongs to the savings group because she said it is difficult to deposit a dollar in the bank and saving with a group gives her an opportunity to accumulate savings. At the end of the year, everyone gets an equal amount. Mary says that rules are strict in the group. She belongs to the group because it helps her to save and provides social support as well.

We asked Mary whether her group has any specific savings mechanisms for sickness. Mary's group does not have any mechanisms, but she said that there are groups that have specific savings contribution in case of sickness. In her group, if someone falls sick, women call for an emergency meeting where everyone contributes what they can.

*"Members in a group are people you know, they will help you if you fall sick."*

### *Savings*

Where and when available, people will use their savings to cover medical expenses. In Mbarara, respondents mentioned having more than one savings account, i.e. they may save with FINCA but they also have a savings account in another institution. Where sickness happens frequently, savings are not very effective coping mechanisms since the amount of medical expenses usually exceeds the amount held in savings.

### **Case study 5: Men's Informal Savings Group**

Samson is a client of FINCA and he belongs to the Marwa group. In this group men meet every night for a drink: the rule is that if one drink is a dollar he needs to save a dollar too. While there are variations to this rule, Samson said this is a general idea. The group members will meet on daily basis and contribute the agreed amount. The money is banked every day by the Treasurer in a joint savings account. Everyone knows how much each person contributed. Samson said this practice is part of the transparency in the group. There are two rules in his group: no withdrawal until the end of the year and obligatory purchase of a larger asset (TV, car, fridge, lock up shop etc). Samson said that the no withdrawal rule enforces discipline among men while purchasing of large asset provides savings for the future. There is a \$60 registration fee at the time of joining. The money can be withdrawn in December because this is usually when expenditures are high. We asked Samson whether the group makes any specific savings contribution; if someone falls sick or dies the group will meet immediately and everyone will contribute \$10-15. When we asked Samson why men decided to form this group he said that group creates solidarity, it helps men control expenses – “*if money is in the pocket it gets spent fast*”– and it helps men purchase a larger asset for their household.

### *Borrowing from formal institutions*

Respondents borrow for medical emergencies; borrowing, however, is the least preferred option among the respondents because it is perceived as the most costly option. The fear of “*not getting better and still having a loan to repay*” was very common among the respondents. In addition, respondents said that borrowing from formal institutions for sickness, especially MFIs, is rather difficult because it is hard to qualify for a new loan if one has other outstanding loans.

### **Summary**

The study found that the majority of respondents do not have specific health coping mechanisms, e.g. savings for health or health insurance, but rather treat health as any other household emergency. This fact, for example, brings an opportunity to offer clients education on health care financing (further explored in Chapter 10).

While clients have many coping mechanisms in place, these mechanisms are often costly for the clients and do not cover overall medical costs. However, the findings suggest that while clients are aware that their coping mechanisms are costly, they are not necessarily unhappy with the systems in place. They are not necessarily looking to replace their current systems but instead would consider variations to their current practices. For example, clients would prefer to borrow from an MFI in a case of sickness rather than from moneylenders. The biggest advantage of current practices is the speed at which cash can be secured for medical expenses, regardless of how ineffective or costly. Findings suggest that clients are able to access cash faster from traditional coping strategies than they can from savings accounts.

## **9. Barriers to Obtaining Health Care and Health Financing Gaps**

This chapter presents the findings related to obstacles to health care access for FINCA's clients. The respondents were asked to identify major barriers to obtaining health care in their respective communities. The obstacles to health care are organized into four categories: availability, accessibility, affordability, and acceptability. As described in Chapter 8, these four key aspects determine where people seek health care. In order to gather information about barriers to health care the Health Care Seeking Behavior tool was used. Eighteen (18) respondents were interviewed. Clients were interviewed in Jinja and Lira.

### **9.1. Obstacles in accessing health care**

#### *Availability*

- Unavailability of doctors was mentioned as one of the major barriers to obtaining health care. Specialists are not available in the majority of clinics in Lira and Jinja, but in Mbarara this is not considered an obstacle to health care.
- Lack of drugs was mentioned as a specific barrier to obtaining health care, particularly at government hospitals.

#### *Accessibility*

- Lack of transportation is a major obstacle to health care access in Lira, although it is not an issue in the other areas. In Lira, both the costs of transportation as well as its availability were mentioned as a problem for the community. Lira is a rural area where transportation services are limited or non-existent.
- Distance was mentioned as a major obstacle for accessing health care in Lira because of the rural nature of the area and the long distances to access health care.

#### *Affordability*

- FGD participants said that high health care costs are prohibitive; they mentioned consultation fees, in particular, as one of the major barriers to obtaining health care. In Mbarara, respondents mentioned that the costs of drugs are manageable since some drugs can be obtained free of charge from government hospitals. In Jinja, costs of services were also identified as a major obstacle to health care, where private hospitals were mentioned as the most expensive of all health care providers. The largest treatment costs included buying medical supplies (plasters, etc.), bed fees, food if admitted, and costs of operations for specific illnesses.
- The findings show that people often do not seek medical care because they have limited financial resources. People who have low incomes usually have already prioritized money for other purposes so medical expenses become emergency expenses.

### *Acceptability*

- Sickness has negative connotations and people are stigmatized when sick. As a result many will wait until the sickness becomes severe, which contributes both to an increase in costs and in health impacts.

*“Sick people are segregated by the society and will find it difficult to do normal business with other people because of the fear that they will die soon.” FGD participant, Mbarara, Uganda, July 2007*

- Participants had negative opinions of public health workers. They said that public health workers treat patients badly, which drives people away from the government hospitals. In Jinja, participants mentioned that customer service improves if a health worker is bribed.
- People may have the wrong perception or lack specific knowledge; therefore they do not seek adequate treatment.

*“The government introduced a community ambulance which spends most of its time in Kampala, and when you are lucky to get one for the patient, they ask you for the money to buy fuel.” FGD participant, Lira, Uganda, July 2007*

### *Summary*

The research findings show that many FINCA clients face constraints and challenges in relation to obtaining health care. The most significant factor for those seeking health care is having the cash to afford health care services. The barriers to obtaining health care increase when we consider other indirect costs associated with care, for example transportation costs. The other key obstacle to obtaining health care is the availability of trustworthy and qualified health workers. Quality, however, appears to be a secondary consideration when clients are seeking health care.

## 10. Conclusions

### 10.1 Introduction

The purpose of this study was to explore the demand for health protection services by FINCA clients in Uganda. It was anticipated that the study would result in an understanding of which health protection services clients need and how FINCA can address the financial concerns of clients related to health expenditures.

### 10.2 Summary of Findings

The findings show that FINCA clients face a variety of health risks and use a variety of coping mechanisms to manage these health risks. FINCA clients identified malaria, HIV/AIDS, and tuberculosis (TB) as sources of significant financial pressure on their households. Sickness creates two types of financial costs: the cost of actual treatment, i.e. direct costs; and the loss of income from not being able to work, i.e. indirect costs. The research found that most FINCA clients preferred private health care providers due to the better quality of service and availability of drugs. Public health facilities are preferred because services are free or low cost. As is found in other countries, access to health care is determined by socio-economic status. Clients with higher levels of income usually have access to better quality services (i.e. private clinics), while poorer clients use public facilities (refer to Figure 45 Usage of Health Providers per Client Segment)

**Figure 43: Usage of Health Providers per Client Segment**

|  | Area    | Rich   | Not So Poor                                  | Poor   | Very Poor                                    |
|--|---------|--|--|--|--|
| <b>Key health risks:</b>               |         | Malaria<br>HIV/AIDS<br>Hypertension<br>TB<br>STD | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD                 | Malaria<br>HIV/AIDS<br>Diarrhea<br>TB<br>STD |
| <b>Health provider used when sick:</b> | Lira    | Private clinics                                  | N/A  | NGO clinics<br>Government<br>Private clinics (if affordable) | Government                                   |
|  | Jinja   | Private clinics                                  | NGO clinics<br>Government<br>Private clinics | NGO clinics<br>Government                                    | Government                                   |
|  | Mbarara | Private clinics                                  | Government<br>Private clinics                | Government health centers                                    | Government health centers                    |

Note: In Lira, there was a “Not so Poor” group.

The findings show that FINCA clients rely on a number of coping mechanisms to deal with health risks. These mechanisms include: insurance (formal and informal), savings, and borrowing. Most of these strategies were found to be inadequate as they do not cover the full cost of medical treatment. At the time of this study, it appeared that while

sickness was a very pressing financial problem, the coping mechanisms in place were considered effective by respondents regardless of the high cost of these mechanisms (e.g. borrowing from moneylenders). Borrowing from formal and informal sources to cover medical expenses is seen as the least preferred option by respondents. Respondents considered it risky to borrow for medical expenses as there is no guarantee that a patient will recover; therefore the loan repayment is at risk. The inability to repay a loan due to sickness was seen as a major constraint to borrowing to cover health care expenditures.

The findings of the report reveal that sickness becomes a financial emergency in the household, similar to school fees and death. Cash, therefore, is needed very quickly to cover medical expenses and, depending on the sickness, may be required for an extended period of time. Medical expenses were identified as a key expenditure in a household due to their frequency and recurrence. The coping mechanisms currently used by clients are not adequate to cover these frequent costs. There is a subsequent need for a financial product that provides security for a household over an extended period of time (e.g. health insurance).

The aim of this report was to focus on the health seeking behaviors of clients, and not on their level of biomedical knowledge. The research team, however, noted during discussions with health care providers and clients that one of the key obstacles to seeking appropriate health care was the lack of knowledge among the respondents of diseases, symptoms, and treatments. Health education, therefore, is needed among FINCA clients.

The research shows that 100% of respondents saved formally and/or informally. Clients do not save specifically for medical expenses but rather for general emergencies. As sickness is considered a financial emergency, savings are often used to cover medical costs. Savings are an important mechanism to building assets within a household. Therefore, it is costly to use savings for medical emergencies, as this practice reduces the assets within the household. If savings are depleted, the household is left more vulnerable.

## **Attachment 1: List Key Informant Interviews**

Fabian Casi – CEO, FINCA  
Barbare Awai – Administration Officer, FINCA (Lira)  
Stephen Alekhe – Credit Officer, FINCA (Lira)  
Otim Kalwe – Laboratory Technician, Ronam Health Centre (Lira)  
Peter Somme – Medical Assistant, Downtown Medical Clinic (Lira)  
Margret Olong – FINCA Client (Lira)  
Dr. Jimmy Odajo – Aboka HC IV (Lira)  
Annent Sampe – FINCA Client (Jinja)  
Anonymous – Jinja Hospital HC III  
Sajjabi Sula – Administration Officer, Amber cont  
Dr. Jume Muweja – Muvule Cresten Islamic Medical Centre HC III (Jinja)  
Dr Kasuti Edward – HC IV Chikamaigo, Mpumudde (Jinja)  
Matho Akulo – Psychiatric Clinical Officer, Muvule Cresten Islamic Medical Centre  
Belcor Anita – Enrolled nurse, Bunawono Health Clinic (Jinja)  
Mathe Nalkenge – Clinical Officer, St. Balikudeute (Jinja)  
Makaire Fredrik – Project Manager, Save for Health  
Dr Moses Mosame – Vithi Clinic (Jinja)  
Maicike Lilybit – Nurse (Mbarara)  
Mugabe Rashid – Medical Officer, Surgical Centre  
Kajiro Egit – Kakola Division HC III  
Tusime Shielo – Ribon Chira, National Medical Centre (Jinja)  
Pierson Ampine – Nurse  
Dr. Mulindue Doo – Mbarara Nursing Home

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## **Attachment 3: Health Sector in Uganda**

Private Not-for-Profit (PNFP) institutions can be categorized into facility based and non-facility-based providers. A majority of the PNFPs in Uganda are founded and run by religious organizations, while a few are owned and run by NGOs or other philanthropic organizations. The majority of the facility-based PNFPs are religion-based, falling under three umbrella organizations: the Uganda Catholic Medical Bureau (UCMB), the Uganda Protestant Medical Bureau (UPMB) and the Uganda Muslim Medical Bureau (UMMB). The bureau together own 78% of the 490 PNFP health units in the country, while the rest fall under other humanitarian organizations and community-based health care organizations (MoHU, 2002). The non-facility-based PNFPs comprise the majority of local and international organizations working in the health sector, commonly referred to as NGOs. These PNFPs work with counterparts such as the government, facility-based PNFP providers, private practitioners, and local communities. Their focus is in areas ranging from social awareness and advocacy to more specific aspects of service delivery. The area of emphasis tends to conform to agency expertise, such as special disease programs, technical assistance, training, capacity building, emergency and relief services and mainstream service delivery. The non-facility-based PNFP providers include local ones such as the Uganda Red Cross and international ones such as AMREF, CUAMM, OXFAM and SCF (MoHU, 2002). The facility-based PNFP sector has a large infrastructure base comprised of a network of hospitals and health centers. It accounts for 42% of the 108 hospitals in the country, and 28% of the 1617 lower level units in the country with a considerable percentage of these units located in rural areas (MoHU, 2002). The partnership between public and private sectors has led to strong government support of PNFP hospitals. Some of the PNFPs have even been contracted to carry out public roles including supervising lower level public facilities.

### ***The Private for Profit Sector***

According to the government (MoHU) definition, the private for-profit sector encompasses all cadres of health providers in the clinical, dental, diagnostics, medical, midwifery, nursing, pharmacy and public health categories who provide private health services outside the public, PNFP, and the traditional and complementary medicine establishment (MoHU, 2002). This definition includes only the formal private providers and, unfortunately, it completely excludes the informal providers. Similarly, Odedo, in a study of PFPs in Uganda, broadly categorizes PFPs into: medical clinics, dental clinics, drug shops, and maternity homes (2001). Of these, drug shops account for the largest proportion of all facilities in the private health sector. The study shows that this is true of all districts except Kampala, which has more clinics than drug shops on record. This study however, only gives a picture of the legal PFPs since it is largely a review of records found at the Uganda Medical and Dental Practitioners Council, the National Drug Authority and District Medical Offices countrywide. Some studies in the country, however, have shown that most PFP facilities have no professional license to practice (Orach, 2001). This could be attributed, at least in part, to the fact that although the laws to regulate private practice are in place, their enforcement is poor (Konde-Lule et al., 1998). A report by the government of Uganda states that the private health practitioners mainly provide primary level services with limited secondary level services. A few urban units offer tertiary and specialist care (MoHU, 2002). Okello et al. (1997) and Nuwagaba (2001) found that private health providers mainly offer general curative services. The

services include: treatment of common ailments such as malaria, colds, STDs, and pneumonia. Okello et al. (1997) found that the range of services provided were generally similar across the clinics and did not vary significantly in relation to the qualification of the clinic managers. Specialists, general doctors, medical assistants (clinical officers), nurses, and all others were virtually all providing the same range of services.

### ***Informal providers***

Informal providers thrive in situations where formal providers, whether public or private, are scarce or not easily accessible. They generally operate outside of the law but since they are filling a gap in service delivery, they tend to become very popular in the areas where they operate. They appear in many forms and include shop-keepers, village health workers, trained health care workers who offer services in their homes, and unqualified persons who operate illegal facilities (of various kinds). It also includes mobile health care providers, of a wide range of competencies, who commonly travel between villages and in market places to provide health services. In this study traditional healers were categorized as informal providers.

### ***Traditional Healers***

A traditional healer is one who is recognized by his community as a healer, and uses indigenous knowledge handed down from generation to generation to alleviate diverse forms of human suffering. A study conducted by THETA showed that traditional healers acquire their knowledge over years, mainly through apprenticeship. Some of the healers were trained directly by healers while others became healers through other means like possession by spirits, as reported in 51% of the cases. The main traditional healing practices described include spiritualism, herbs, bone setting, traditional birth, and “false teeth” extraction. Although witchcraft was mentioned among the practices, all healers dissociated themselves from it. The study revealed that the main proportions by type of healing practice are: herbalists (42.2%), spiritualists (44.9%), bonesetters (33%), and traditional birth attendants (12.3%) (THETA, 2001)

### ***Other Systems of Traditional Medicine***

Of late, a number of non-Ugandan traditional medicine systems have been introduced into the country. These include the Chinese and Ayurvedic systems practiced in China and India respectively. Other systems like Reiki, Chiropractic, Homeopathy, and Reflexology are among later practices introduced into the country (MoHU, 2002). There has as yet not been any move, on the part of government, to make any of these systems a partner with the public health care system.