‘I wish I had AIDS’ - three periods in Uganda's health system

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Statistics would be one way of describing the changes in Uganda’s health care system over the years since Independence. Infant mortality has fallen, from 120 per 1000 live births in 1969 to 76 in 2006, greatly helped by the immunization programme administered through biomedical institutions. The number of health units has expanded tenfold from 413 in 1969 to 4,450 in 2010.

But the challenges have also grown exponentially. Sheer numbers of sick people have multiplied. The population in 1969 was 9.5 million, in 1991 it was 16.7 million, and this year it is projected at 33 million.

But in this brief essay, I will mostly leave numbers aside and describe transformations by sketching three periods in Uganda’s composite health care system, as I came to know it through ethnographic research projects.

The First Decade

Hodi! Hodi! The call of someone at the door late at night, wanting help to take a sick person to the health centre.

When we first did ethnographic fieldwork in Uganda, starting in early1969, my husband and I learned about the biomedical health care system as a side effect of having one of the two cars in the county.

Several times a week we were called to bring very ill children and women in difficult labour to the government health centre 14 km away, or in more critical cases, to the nearest hospitals, government or Catholic, in Tororo and Mbale, 40 and 56 km distant.

Sometimes we came back with corpses in the car – of those whom biomedicine could not help.

Independence was only seven years old and the new state was present in everyday life through the system of poll tax, administrative chiefs, agricultural officers, and not least, government primary schools and health facilities.

It was a time when civil servants constituted the fortunate rural salariat, whose standard of living was better than that of their neighbours. Their salaries were paid so regularly that our school teacher neighbor used to say that she loved February because she got her salary two or three days earlier than in other months.

Free care and medicine in supply

Looking back to those post-independence times before Amin, there was a positive disposition towards biomedical care, despite what were, in retrospect, grave shortcomings.

Health workers were at their posts and care was free. There was almost always medicine in supply, although the variety was very limited.
We remember how people going to the health centre used to beg bottles from us, because gentian violet was so commonly dispensed for all skin problems, and patients had to bring their own containers.

The health units were heavily used and there were queues of people waiting. In fact, the average number of attendances per person per year was as high as, or higher than, it is now.

Distances were great, especially for hospital care, and the one ambulance in the county was difficult to access. By 1970, an important improvement was in sight; with support from Britain, 22 rural district hospitals were being constructed all around the country, including in our local trading centre, Busolwe.

**Composite health care system**

Health care in Uganda has always been provided through a composite system. People tend to think of medical pluralism in terms of the contrast between institutionalized biomedicine and the informal provision of ‘traditional medicine’, similar to the opposition between conventional and alternative medicine in Europe.

This was always too simple a division, even in the early days, and these categories have become even less useful fifty years on.

My own first research was about the management of misfortune, and mostly concerned rituals to appease spirits, and ‘African medicine’ to counteract sorcery. These were intermixed with healing practices from the Arabian Peninsula, brought by traders early in the colonial era.

There were important differences between treatment by family rituals and treatment by the use of medicinal substances from the bush, or Pemba, or a Muslim specialist. Even biomedicine was pluralistic in that it was a very different phenomenon at Mulago, the national hospital in Kampala, and at the small rural health posts.

When I returned to Uganda in 1989 to carry out research on the use of medicines, the variation within biomedicine had become far more striking.

During the time of the ‘regimes,’ from 1971 to 1986, the government health services deteriorated radically. Salaries were inadequate and severely delayed; staff was often absent.

As one health worker explained: ‘They pretend to pay us and we pretend to work.’ Medicines were in short supply at the government units, and one common ‘survival strategy’ for government health workers was to open small clinics and drug shops.

**Medicine shops**

In the trading centre of Busolwe, there were 26 medicine shops even though the hospital was practically next door. When health workers were on duty, or occupied with other survival strategies, others, often unqualified in medical work, minded their shops.

These sources of health care, close by and open long hours, were, and still are, major sources of treatment in Uganda.
The ‘folk practitioners of biomedicine’ popularized manufactured pharmaceuticals, although they were severely criticized by health authorities for selling ‘prescription-only’ drugs, and for availing medicines without making a proper diagnosis.

Ironically, as donors began to support rehabilitation of the health sector, they reached out to ‘traditional healers’ as being embedded in ‘the community’, but almost never worked with the local sellers of pharmaceuticals who were community-based by almost any definition.

In fact, biomedicine was becoming pluralistic; it had grown alternatives within itself. At the same time, biomedicine became a model for some specialists who called themselves ‘traditional’ and began to commercialize their services and products.

**Structural adjustment**

In the early NRM years, it seemed that all the problems besetting the Ugandan health care system stemmed from the political instability that began with Amin’s coup. But many other African countries were also struggling to provide health care for their populations in the face of widespread economic difficulties in the 1980s.

It was the time of the structural adjustment programmes, when public services such as government health care were to be ‘rationalized’. Policies like the Bamako Initiative, which introduced user fees, were tried out as ways to finance health services.

Uganda’s version of these more general developments was unique because they came close on the heels of the years of political instability.

The NRM never made user fees official policy and slowly through its first ten years, it improved salaries for health workers.

**Public-private mix-up**

Yet government health facilities never regained the good image they had before 1971 and staff continued to find ways of supplementing their incomes through private sale of medicines and services.

The notion of a ‘public-private mix’ in services was popular in the period of structural adjustment. What happened in Uganda with the proliferation of small private clinics and drug shops, is better described as a ‘public-private mix-up’ where government and private health care were deeply entangled, each dependent on the other.

The Essential Drugs Programme, heavily supported by Denmark, was a major pillar in the rehabilitation of health services during the first NRM period, and it presaged the significant role that donors would play in the ensuing years.

**Focus on AIDS**

The era of AIDS was beginning in the first years under Museveni. From the outset, he addressed the epidemic explicitly and opened the door for many donors and NGOs, often with somewhat different programmes.
‘Let a thousand projects bloom!’ seemed to be the welcoming attitude. But it was not until after the turn of the millennium that possibilities of treating AIDS, and not just trying to prevent it, brought the epidemic fully into the health care system.

Of course, AIDS patients had been filling hospitals and patronizing healers of all kinds, but very few could afford the antiretroviral treatment that actually controlled the virus.

Uganda was well positioned to take advantage of treatment programmes because of its exemplary leadership in awareness and prevention.

Between 2004 and 2006, the U.S. President’s Emergency Programme for AIDS Relief (PEPFAR) and the multinational Global Fund to Fight AIDS, Tuberculosis and Malaria supported a massive roll-out of free antiretroviral therapy (ART). Other donors joined as well.

By 2009 it was estimated that donors provided 93% of funding for the AIDS response, while the Uganda government contributed 7%. The USA alone gave over 80% of the funds for HIV/AIDS activities.

There has been controversy over the way in which the extreme, almost exclusive, focus on AIDS has distorted health care in Uganda.

Government health workers were drawn away from other functions to run AIDS care within their units; some took better paying jobs with non-government AIDS organizations.

**AIDS treatment revolutionary**

In either case, donor support to AIDS activities meant allowances for outreach, workshops and seminars, providing another way for health workers to supplement their salaries. It also meant training, supervision, better equipment, and a generally reliable supply of the medicines for ART.

In the context of actually existing health care, AIDS treatment is revolutionary. For no other disease is chronic treatment provided so fully and systematically.

Screening is widespread; more people know their sero-status than their blood pressure. Patients, referred to as ‘clients’, are enrolled in a treatment programme to which they belong.

They do not shop around here and there for treatment, as is often the case for other chronic conditions. They are given counseling, and even though dialogue is not always according to the ideals of HIV treatment programmes, it far surpasses the brief communication offered in connection with other kinds of health care.

**“I wish I had AIDS”**

In many ways, the response to AIDS provides a model for prevention, diagnosis and treatment of other chronic conditions such as cardio-vascular diseases and diabetes, predicted to become major health problems in the coming years.
But thus far, donors have shown little interest in these and government is only just beginning to put them on the agenda. As several diabetes patients have remarked, ‘I wish I had AIDS.’

As was the case for AIDS before treatment was available, herbal medicine fills a gap. For the few who can afford it, there are nutritional supplements for ‘lifestyle diseases’ from Chinese and South African multi-level-marketing firms.

And there is Ugandan ‘natural’ medicine, commercially produced and marketed.

**Changed expectations**

Fifty years on, the composite health care system continues to change. What is seldom recognized is that people’s expectations about treatment have also transformed over the years, as they have become familiar with more and more medicines and equipment, and have been exposed to a plethora of donor funded health care projects.

It is also ironic—and of some concern after 50 years of independence—that the health system of today is far more dependent on external support than it was in 1969 when I first lived in Uganda.

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