Assessment of the Determinants of Health Services utilisation in Urban Areas: Case study of Mbale municipality, Uganda

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Abstract
While health service utilization is a key indicator of health service delivery which many countries seek to improve, low health service utilization patterns characterize many urban settings in developing countries with a grave impact on the community. One such urban setting is Mbale Municipality in Mbale district, Uganda. A cross sectional descriptive study was carried in five wards of Mbale Municipality on the ninety-three (93) respondents. The study aimed at investigating the determinants which influence utilization of health services in urban areas. The information was collected using questionnaires and semi structured interviews. The study findings showed that the procurement process resulted in delayed and inadequate supply of essential drugs and medical equipment' supply. Understaffing is high and untimely funding was also reported. Poor medical ethic or code of conduct of the health workers and negative perceptions of the community towards health services and health staff were cited as other influencing determinants to health services utilization in urban areas. In view of these findings, the authors propose a review of the procurement system to ensure timely and adequate supply of drugs and medical equipment, recruitment of more health staff, continuous professional development (CPD) of health workers in medical ethical code of conduct in handling patients, sensitization of the community to build trust on health workers, and sharing of responsibilities by couples while taking care of patients in admission.

Index Terms- Determinants, Health services utilization, urban areas, Mbale, continuous professional development

1.0 Introduction and Background.

Health service utilization is one of the key health systems indicators (World Health Organisation, 2005). While developed countries have made advances to improve the level of health services utilization, developing countries are putting in place institutional and structural modalities to enhance the level of health service utilization patterns among the nations. It is important to note that poor utilization of health services impacts on the community worldwide especially in developing countries. The impact of this state of affairs is responsible for high rates of morbidity and mortality in developing countries (Vega.C & Beker.P, 2007). Poor utilization of health services is when people ignore the use of health services which are offered by trained medical personnel in the health facility, instead they go for other means of treatments like traditional herbalists, TBAs and witchdoctors among others which are not recommended and would instead cause danger or harm to people's health. Accounts given from several studies show that low utilisation of health services in urban areas could be linked to human and material resources; for examples; poor distribution of human resources, and low staff moral due to poor remuneration (Synellakis & Arudo.P, 2008), and over dependence on untrained personnel in primary health facilities where only 34% of the established positions are filled by qualified staff (WHO Africa Regional office, 2008) pose major structural problems to the effective implementation of health programmes. Another study in Mozambique indicated that missed opportunities and inappropriate timely use of health services like immunization substantially reduces coverage. An average of 85% of children aged 12-23 months have child health cards but only 53% of the children have completed immunization and among children them, of whom only 11% were fully immunized.

There was also evidence that 81% have visited a health facility with preventive services and were legible or able for health services especially preventable services but they had not received any attention or support. (WHO Africa Regional Office , 2008). There was a remarkable increase in the proportion of villages with trained village health teams (VHTs), according to the survey done in 2010 in Uganda in line with expansion of health services to the additional 18 new districts; the Medical Officers, however are well below the WHO minimum target of 23 health workers per 10000 population, Uganda had only 15 health worker per 10000 i.e.0.36 Doctors, 0.71 clinical officers, 2.8 nurses and 1.4 midwives per 10000 population respectively. This has led to great reductions as well as improper utilization of health services in the country as a result of delay to attend to the clients, congestion and tiredness of health workers hence poor utilization of health services. (Ondoa & Lukwago, 2011)

Another study conducted in Northern Uganda in Agago district indicates that, human resources and essential drug supply in health situation is critical, in November 2008, only 51% of the approved staff positions at both national and district level were filled and likewise to the drug supply, only 34% of the essential drugs were supplied in time but the stocks still remain inadequate. The situation is worse in conflict, rural and hard to-reach-areas and this is due to reasons like insufficient training capacity for health workers with the right mix of skills to meet the needs of the patients in the district, low remuneration, delay and inadequate supply of drugs and poor working conditions in the public and Private not for profit (PNFP) sectors including housing (MOH, 2009).

Most women in Uganda deliver in their homes assisted by relatives or Traditional Birth Attendants (TBAs) with no formal midwifery training, and some pregnant women visit TBAs for antenatal care as well 67-70%. TBAs are members of the community with no formal training, however, they tend to have limited knowledge on the risk factors and dangers signs of complications related pregnancy. It's a belief that women tend to have more equal relationship and socially acceptable dialogue with TBAs compared to biomedical trained midwives, hence many mothers continue to deliver at home with the help of untrained attendants whom they trust (Cindy, 2004). Cultural beliefs and practices often lead to self-care, home remedies and consultation with traditional healers in rural communities. Advice of the elderly women in the house is also very instrumental and cannot be ignored. These factors result in delay in treatment seeking and are more common amongst women, not only for their own health but especially for children's illnesses. Family size and parity, educational status and occupation of the head of the family are also associated with health seeking behavior besides age, gender and marital status. However, cultural practices and beliefs have been prevalent regardless of age, socio-economic status of the family and level of education. They also affect awareness and recognition of severity of illness, gender, availability of service and acceptability of service. Gender disparity has affected the health of the women in Pakistan too by putting an un-rewarded reproductive burden on them, resulting in early and excessive child-bearing. This has led to 'a normal maternity' being lumped with diseases and health problems.

Throughout their life cycle, gender discrimination in child rearing, nutrition, health care seeking, education and general care make a woman highly vulnerable and disadvantaged. At times, religious misinterpretations have endorsed her inferior status. For her, limited access to the outer world has been culturally entrenched in the society, and for the unmarried, the situation has been even worse, even if it is just a matter of consulting a physician in emergency (Babar.T.S & Hatcher.J, 2004).

Prevailing cultural beliefs among most people in Uganda tend to lead to self-care and consultation of traditional healers which in turn leads to delays in seeking appropriate health care, these is compounded by lack of physical accessibility of health facilities as still a significant proportion live more than 5kms radius from nearest health facilities. In addition to this, civil strife as was the case in northern Uganda, people's ways of living such as pastoral communities and changing lifestyle (e.g. eating unhealthy diet and sedentary living) impacts on the health of the people in Uganda. It's evident therefore, that the major determinant of health in Uganda includes the low level of literacy, poor sanitation, cultural belief, physical accessibility, uptake of risking behavior and prevailing poverty (MOH, 2010).

Approximately 60% of Uganda's population seeks care from traditional complementary medicine practitioners (TCMP) (e.g. herbalists, traditional bone setters, traditional birth attendants, hydro-therapist, spiritualists and traditional dentists) before visiting the formal sectors. TCMPs are available in both urban and rural areas even if

the service provided are not consistent and vary widely. Many traditional healers remain unaffiliated. Most TCMP have no functional relationship with public and private health providers. This results into late referrals, poor management of various medical, surgical, obstetric condition and high morbidities and mortalities. Non-indigenous traditional or complimentary practitioners such as the practitioners of Chinese and Ayurvedic medicine have emerged in the recent years, a regulatory bill and policy framework for TCMPs is awaiting cabinet approval and it's essential to establish functional Relationship between the TCMPs and the rest of the health sector (MOH, 2010; Kyomugisha.H, 2009).

With regard to attitude of health workers, observation of the most health workers reveal reduced commitment which results into little attention to professional standards. Some of the negative consequences are increased late coming and absenteeism of staff. In some cases, the public has lost confidence in health workers (Kyomugisha.H, 2009). Men play a paramount role in determining the health needs of a woman. Since men are decision makers and in control of all the resources, they decide when and where woman should seek health care. Women suffering from an illness report less frequently for health care seeking as compared to men. The low status of women prevents them from recognizing and voicing their concerns about health needs. Women are usually not allowed to visit a health facility or health care provider alone or to make the decision to spend money on health care. Thus, women generally cannot access health care in emergency situations. This certainly has severe repercussions on health in particular and self-respect in general of the women and their children. Despite the fact that women are often the primary care givers in the family, they have been deprived of the basic health information and holistic health services. In Pakistan, having a subjugated position in the family, women and children need to seek the permission of head of the household or the men in the family to go to health services. Women are socially dependent on men and lack of economic control reinforces her dependency. The community and the family as institutions have always undermined her prestige and recognition in the household care. The prevailing system of values preserves the segregation of sexes and confinement of the women to her home. Education of women can bring respect, social liberty and decision-making authority in household chores (Cindy, 2004).

Traditional and alternative maternal health practices, traditional medicines are commonly used in pregnancy and birth in Uganda. The indigenous system of medicine has persisted for a long time and still continues partly because of inadequate modern medical services and inadequate drugs in health facilities. Some of this medicine has been found to be remedies by particular groups of Uganda for many years, yet others have been found to be dangerous, containing highly toxic elements. It's believed that certain childhood disorders such as congenital malformation and tumors may be due to toxic or carcinogenic constituents present in herbal medicine taken during pregnancy [(MOH, 2010; Kyomugisha.H, 2009; Galabuzi.C, et al, 2009).

In a study done in Mbarara district, it was found that 73% of women used traditional medicine when they were pregnant women with their last child. Reasons women gave for taking herbs during pregnancy include cleaning the baby, preventing STDs, preventing miscarriage and stomach upset associated with pregnancy, and to soften or widen the birth canal during labor, women often take herbs to ease and quicken the child birth. Herbs taken during labour include those with toxic properties (constricting the uterus) from biomedical point of view; such drugs can be associated with risk of rapture of the uterus-a potential life-threatening complication. These herbs have also been used to terminate unwanted pregnancies. Several local cultural groups have traditional practices related to child birth with varying degrees of perceived risk by biomedical health providers. This is a common cause of clients –provider conflict in labour wards as providers may blame women for their use of potentially dangerous herbs. The safe motherhood assessment survey of 1995/6 also showed that traditional birth attendants use local herbs to mother before labour. During birth and in the postpartum period, the most commonly prescribed herbs were those that are perceived to stimulate labour contraction (50%),'relax' the pelvic bones (29%) and those that prevent miscarriage, the little research has investigated the effects of various herbs on maternal processes (Kyomugisha.H, 2009, Galabuzi.C.et al, 2009)]. The reproductive health program in Uganda has implemented a strategy to train TBAs in the conduct of safe birth, including identification of complication and proper referral behaviors. A number of TBAs have been train by Ministry of Health and NGOs through such effort. The certificate obtained by TBAs boosted the community perception of TBAs as alternative to trained attendants at

birth. Unfortunately, recent evaluations have found a persistence of poor referral and delivery practice from the TBAs. In part this is because they will not receive the same payment from a referral case than from a successful delivery, which provides incentives to delay referral as long as possible and attempts to manage complication on their own. There has also been no obvious change of maternal mortality resulting from TBAs training interventions (Ssengobe. et al, 2004).

In regard to government policy, strategic policy formation in all health care systems should be based on information relating to health promoting, seeking and utilization behavior and the factors determining these behaviors. All such behavior occurs within some institutional structure such as family, community or the health care services. The factors determining the health behaviors may be seen in various contexts: physical, socio-economic, cultural and political. Therefore, the utilization of a health care system, public or private, formal or non-formal, may depend on socio-demographic factors, social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic and political systems environmental conditions, and the disease pattern and health care system itself. A main driver for the health seeking behavior is the organization of the health care system. In many health care systems, there is tension between the public and the private health sector. The private health sector tends to serve the affluent; thus, the public sector resources should be freed for the poor. A dynamic cooperation, either formal or informal, between the two sectors is a must but the private sector is rarely taken into account in health planning scenarios. The public and private sector may complement or substitute for each other. There are very often resource mixes with doctors working in the public sector also establishing their own private practice. Features of the service outlet and confidence in the service provider also play a major role in decision making about the choice of health facility. The relationship of factors affecting health seeking behavior on use of health services in the developing world including Pakistan, encompassing public as well private sector (Ebanyat.F, 2002).

In the years after independence that is 1962-1971, Uganda had good health policy and good health was achieved, but it began to deteriorate due to lack of support from NGOs and community participation to health except religious organizations but NRM government has begun the reconstruction and rehabilitation of health services. In 1980-1990, UNICEF was seen an alternative. Since 1990 NRM government has given priority to the improvement of health status of Ugandan. A number of subsequent policy documents and the successive national development plan (NDP), it has set forth that the provision of health services aims at the attainment of a good standard of health by all people in Uganda. The policies that the government had pursued over the years have had direct impact in improving health status of Ugandans, although health status remains poor. There has been significant improvement between 1991-1995 but it keeps on reducing and it indicated by infant mortality rate 127 -97 per 1000 birth, mortality rate 203-147 under 5 years per 10000 birth and maternal mortality 506 per 10000 in 1995 (Ebanyat.F, 2002). Even though an essential medical equipment' list has been drawn, problems exist relating to procurement delay and luck of fund. Most facilities and equipment are in a state of disrepair and lack of transport is the major handicap especially in newly created districts. Rehabilitation of the buildings and maintenance of medical equipment are irregularly done and many health facilities remain uncompleted or poorly done. Staff accommodation in hard to reach areas remain a big challenge and it's a major reason for low staff number. The existing infrastructure is insufficient to ensure that the core functions of the health sectors are carried out (Jitta.J., et al, 2008). Distance is a problem in the utilization of health services. There is poor access and poor quality of health care still persist with only 49% of the population living with 5 kilometers or walking distance of a health care facility and only 42.7% of the parishes have some form of health facility (Nambozo.J, et al., 2001). The increase in the number of districts over the last decade has overstretched the capacity of the Ministry of Health to manage the district to the edge. Although the recent report shows that 72% of the household in Uganda lives within 5 kilometers a health facility (public and PNFP), Utilization is limited due to poor infrastructure, lack of drugs and other supplies and the storage and low motivation of human resource in the public sector (Zaramba.S, 2005).

In Uganda, approximately only 40% of the population uses the health services properly much as the government has done a lot to improve on health services delivery in the country by strengthening and supporting the available health systems e.g. building health facilities at all parish level, up grading health centers to hospital and referral hospital (Ondoa & Lukwago, 2011). WHO with the Ugandan government have contributed towards Health services in all parts of the country. However, all their efforts have not succeeded and this has led to disabilities, high mortality and morbidity rates. The possible causes of these could be linked to limited resources i.e. both human and material resources, Culture and attitude, Government policies and many others. The Uganda National minimum health care package has been developed for all levels of the system, and services are supposed to be based on the health care package (MOH, National Health Policy- Reducing poverty through promoting people's health, 2009). In 2000, OPD utilization was considered a key output indicator for monitoring utilization of health services in the country during the baseline data collection for the health sector strategic plan. For both government and NGOs health services, OPD utilization was found to be only 40% per capita at all level and age groups. A five years target has been set at 60%.the trend in the past four years has been similar, although there appeared to be a slight improvement in 1999. Unfortunately, low rate of OPD utilization continues to be observed in the current year due to a number of factors. Most notably the essential drugs stock out in many health units across the country. This calls for a review of health policies to reflect realities in the lower health facilities with the introduction of health sub-districts in 2000, it is hoped that services will be fully utilized by the communities (Katungi.P.Y, 2001). In Mbale district, no study was done on utilization of health services although, the District Health Office report for the financial year 2010-2011 revealed that only 57% of the population is utilizing the available health services in Mbale Municipality (DHO, 2014). This study was conducted in Mbale Municipality, Mbale with the view of establishing the determinants which influence poor utilization patterns of health services in urban areas despite the government efforts to improve health services. Mbale Municipality is the urban center and main town of Mbale district, it has a regional referral hospital and number of hospitals and health centers both public and privately –owned and yet it's still faced with poor utilization rates of health services by the community around. Specifically, this study sought to investigate the influence of low level both of human and material resources (i.e. personnel's and drugs), to assess the effect of attitude and Culture and to establish effectiveness of government policies on the utilization of health services or facilities in Mbale municipality, Mbale district.

2.0 Materials and Methods.

This study was a cross-sectional descriptive study involving the collection of both qualitative and quantitative data for analysis. The study was conducted in Mbale Municipal Council, an urban setting which is the main town of Mbale district, a district located in Eastern region of Uganda, with a half of the study population chosen being women of child bearing age i.e. age between 20-45, men and health workers. The study was conducted from parish to parish and finally to the village/cells level where the respondents were selected for interviews. The key study variables were availability of the health workers, attitudes of the health workers, culture, community perceptions regarding health workers and government policy. Ninety-three (93) respondents including women of child bearing age between 20-45 years and men being the decision makers in the home, health workers were also interviewed as key informants (KIs) The Kish and Leslie (1965) formula was used for estimating the sample size (Leslie, 1965). $n=z^2pq/d^2$ (z=1.96 at 95%, Where n= Sample size, d=precision of study set at - or + 10% , z=Confidence interval=1.96 or 95% (confidence interval = C.I.) p=Proportion of the study = 60% while q=(1-p). See distribution in table 2.1 below.

Table 2.1 Distribution of respondents interviewed

Age group (years)	Number of respondents (No.)
≤20 men and women	18
21-30	20
31-40	25
41 and above	30

Total	93

Source: Primary data, 2015

Nine (9) health facilities were visited during the study in order to interview the health workers who were key informants during the study and also to assess the availability of the health workers, drug and medical equipment supply to the health facilities.

Table 2.2: showing the hospital and health facilities visited

Level of Health facility	Government	Privately-owned (PFP[1]/PNFP[2])	Total
Hospital	01	01	02
Health Centre III	05	00	05
Medical Clinics	00	02	02
Total	**06**	**03**	**09**

Source: Primary data, 2015
Key: PFP1-Private for Profit
PNFP2-Private not for Profit

The selection criteria of the respondents was divided into two; inclusion and exclusion criteria. The inclusion criteria was based on utilisation patterns and therefore all women of the child bearing age were interviewed because they are the most affected especially during pregnancy, vulnerable and they take care of sick children as well as adult who are sick, men were also included because they are the discussion makers in a home and elders as the technical advisers in a home on cultural issues, while Children below 15 years were not included because they don't make decisions on what health care should they take but their health care is determined by their parents. The district and the division were purposively selected; the wards (parishes) and villages (cells) were selected using multi stage system of study. The actual wards studied were Namatala, Nkoma, Busamaga, Mooni, and Malukhu wards. The households and respondents were selected using systematic random sampling. Semi structured interviews were used during data collection, while pre-tested semi structured questionnaires with standardized close-ended and open-ended questions, and to ensure a high data quality, research assistants were carefully selected and trained carefully for three days on the interviewer techniques and a pilot study was also conducted to improve on the quality of the test items. Permission to conduct the study was obtained with the help of an introductory letter from school of hygiene Mbale to the relevant authority within the district that is the District Health Officer (DHO) who issued a forwarding letter to Town Clerk, Hospital administrator and Medical Superintendent, and In-charges of Health facilities in Mbale Municipality. To access the community, an authority letter was issued by the Town Clerk to various Area local council one chairpersons permitting the researcher to carry out the within the area. Respondents and LC I Chairpersons were assured of confidentiality of the information collected. Ms. Excel was used to analyze the data and descriptive statistics were presented inform of tables, pie charts and graphs. A report of the results of the study was shared in feedback meetings, and a workshop with the Municipal authorities and other stakeholders.

3.0 Results and Discussion

A total of 93 respondents were interviewed from the five parishes of Namatala, Nkoma, Busamaga, Mooni, and Malukhu of which 69% were community members consisting of women of child bearing age, men and local leaders while 31% were health workers. See table 3.1 below:

Table 3.1: Category of respondents Respondent

Respondent	Frequency (n=93)	Percentage (%)
Community members	64	69
Health workers	29	31

Total	93	100

Source: Primary data, 2015

Findings on socio-demographic characteristics are presented in table 3.2 below.

Table 3.2: Summary of the social demographic characteristics of the respondents

| *Variable*	Frequency (n=93)	Percentage (%)
Age		
Female	58	62.0
Male	35	38.0
Total	**93**	**100.0**
Age group (years)		
≤20 men and women	18	19.0
21-30	20	22.0
31-40	25	27.0
41 and above	30	32.0
Total	**93**	**100.0**
Marital status		
Single	07	07.5
Married	86	92.5
Total	**93**	**100.0**
Level of Education		
Primary	41	44.1
Secondary	29	31.2
Tertiary	12	12.9
University	07	07.5
Uneducated	04	04.3
Total	**93**	**100.0**

Source: Field data, 2015

Findings on table 3.2 above are on the three key social demographic variables that is sex, age, marital status and level of education. Out of the 93 respondents, a majority (62%) were males while only 38% were females. The ages of the respondents were varied with majority being within the age of 41 years and above with a proportion of 32%, followed by 31-40 with 27%, 2130 with 22% while the least were those 20 years and below who had only19%. On the issue of marital status, a majority i.e. 93% reported to be only married while only 7% said they were single. The greater proportion of married respondents gives a true picture of this part of the country where early marriage is common and the couples tend to have children as early as possible so that knowledge about the importance of health services such as antennal care, maternal care and immunisation is high, these findings are in agreement with those of (Bour, 2004) who observed that marital status was a key determinant of health services utilisation in Kumasi metropolis of Ghana.

The findings on the level of education showed that the majority of the respondents i.e. 95.7 % had undergone a form of education training (that is primary, secondary, tertiary, and university) , this is typical of urban areas because of easy access to a number of available educational institutions, In fact Mbale municipality is a number of educational institutions ranging from nurseries, primary schools , secondary schools, tertiary and vocational and universities because of this urban populations therefore tend to have a generally good level of knowledge and experience of health services provided in the areas, due to the fact that they might need health care for themselves hence low level of awareness can be as a determinant of utilisation of health services in urban areas.

Findings on the availability of health staff compared to the patients available are given in the figure 3.1 below;

**Figure 3.1: Showing health workers to patient ratio**
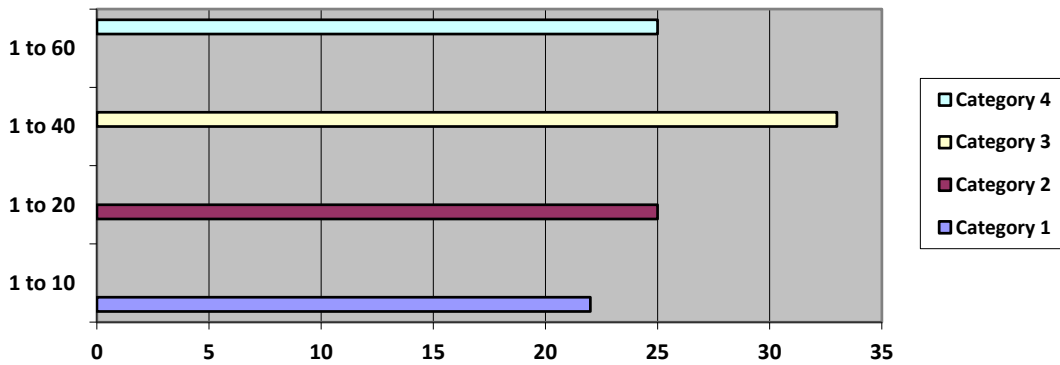
Source: Field data, 2015

The findings show that a majority of the respondents, 32 (34%) stated that the ratio of a health worker to patients corresponds to 1 to 40, implying that (one) 1 health worker handles 40 (forty) patients a day. A high health worker to patient ratio is a sign of inadequate staffing. Inadequate staff in health facilities is a multifaceted problem linked to political, economic, social and a number of other reasons (Manzi.F., et al., 2012), this has grave consequences such as low productivity, absenteeism, low staff morale, and poor supervision. In adequate staffing also results into long waiting time for patients before they are attended to /seen by a clinician resulting into loss of interest by the patients. These findings are similar to those of (Oche.M.O. & Adamu.H, 2013; WHO, 2001) who observed the amount of time a patient waits to be seen is one of the factors which affects the utilisation of health care services. Patient perceive long waiting times as a barrier to actually obtaining services and keeping patients waiting unnecessarily can be a cause of stress for both the patient and doctor.

Results on the availability of the medical equipment are shown in the **fig.3.2**
Figure 3.2: Showing the availability of medical equipment
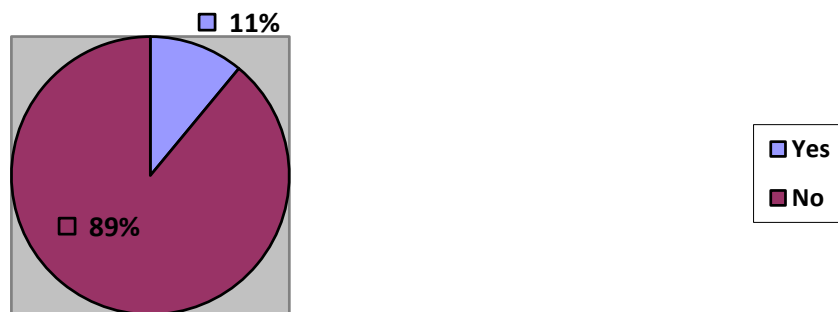
Source: Primary data, 2015

Responses from twenty-nine (29) health workers on the availability of medical equipment in the health centre the showed that a majority (89%) of the health facilities do not have all the required medical equipment while only 11% of the respondents said they have medical equipment in the health units, this health workers from the Private hospitals and health facilities, implying that government hospitals and health facilities are poorly equipped.

Regarding trend of supply of essential drugs to health facilities and the time Intervals these take place, table 3.3 below shows the frequency and time intervals.

Table 3.3 showing supply intervals of drugs to health facilities

Variable	*Frequency (n=9)*	*Percentage (%)*
Monthly	01	11
Every two months	06	67
Every three months	02	22
After three months	00	00
Total	**09**	**100**

Source: field data, 2015

From the nine (09) health facilities, the findings in table 3.3 above show that the that majority of the respondents 6/9 (67%), reported drugs are supplied after every two months yet quantities of drugs supplied are inadequate and in most cases they are not essential drugs while the remaining proportion (33%) reported that the drugs are supplied in more than three months indicating that there is inadequate supply of essential drugs moreover with a lot of delays from the National Medical stores which could due to procurement delays, transport and logistical challenges to get drugs and other medical equipment from the National Medical store to the lower facilities and corruption , This finding in similar those of Nambozo.J, et al., (2001) who observed that though an essential drugs and medical equipment list had been drawn, there were other exiting problems related to procurement delays and lack of funds. The situation is rendered so bad by the fact that most facilities and equipment are in a state of disrepair and lack of transport, it implies that governments are meeting the requirements of the Abuja declaration and Maputo declaration where governments agreed to allocate 15% of the budgetary funding to health (WHO, 2001; WHO, 2008)].

Results regarding perceptions of the community towards health services offered at hospital and other health facilities are given in figure 3.3 below;

Figure 3.3: Reasons for poor perception towards health services offered at health facilities.

Reasons for poor perceptions towards health services
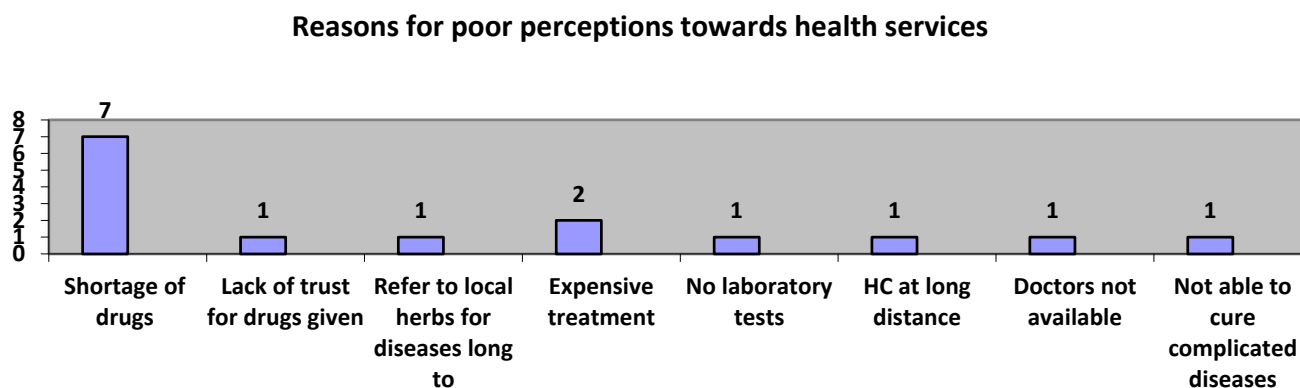
Source: Primary data, 2015.

As shown in figure 3.3. above the reasons for poor perception towards health services offered are varied and indicate that health facilities cannot solve all their health problems are not the same. However, the majority of the respondents, 42/93 (45%) reported that lack of essential drugs availability for treatment at the health facilities and the fact that health workers do not give sufficient, quality and quantity drugs and services to cure their diseases. It is interesting to note that the opinions of the respondents varied depending on social economic levels in that those form lower income level gave favorable opinions regarding the health workers as compared to their counter parts from a higher income level. This view is in agreement with Cartwright.A., (1964) who in her study on the utilisation of health services found that the middle- and high-income class patients were highly critical on the kind of services provided by the health facility and complained of specific issues like privacy and wanted screen as opposed to the other patients from lower income classes. Another study, Solome.K, et al., (2009) emphasized the influence of the perceptions of community members in the utilisation of health services. The key reason could be due to the fact that patients from high- and middle-income class are more exposed and highly knowledgeable about the quality of services which they should receive for a health facility as opposed to their counterparts from the lower income class.

Regarding the community responses on the attitudes and behaviors of the health workers which can be a barrier to accessing health services from health facilities. The results are shown in the table 3.5 below;

Table 3.5: below Show how health workers handle patients when they come for health needs/care.

Variable	Frequency (n=64)	Percentages (%)
Handle with care	44	69.0
With rude language	18	27.5
Not very quick	02	03.5
Total	**64**	**100.0**

Source: Primary data, 2015

Responses from community members showed that 69% of them positively asserted that they were treated with care when being handled by health workers. However, health care handling and care is still problematic as indicated by one third of the respondents i.e. 20/69 (31%) who reported complains about being treated with rude language or not quickly helped by health workers. Such a proportion is very high when taking into account that all health workers are trained to follow the medical code of ethical conduct, which includes treating patients promptly and with care. The fact that patients are not treated with enough care or promptly is most probably a consequence of the lack of adequate staffing in the health facilities, leading to delays in the response capacity of health workers towards patients. (Kiwanuka.S.N., et al., 2011), noted the attitudes of health workers was one of the key barriers to health services utilization.

A majority of the health workers (65%) noted that nature and implementation of government policy in one way or the other influence the utilization of health services, the effect of poor policy implementation results into delays and supply of drugs.

4.0 Conclusions

The conclusions drawn from study findings showed that poor and long government procurement process resulted in delayed and inadequate supply of essential drugs and medical equipment supply, this could be addressed by reviewing procurement system and putting in place modalities to reduces bureaucracy. In order to address the under staffing in the health units or hospitals leading to poor handling of patients by health workers by health workers, the Government of Uganda through Ministry of Health should recruit more health staff. Timely and adequate funding by government to facilities to address inadequacy of medical equipment for diagnosis, investigation, testing and other examination for appropriate treatments due to lack of funds and little support from

the government for health departments. Other government actions needed to improve health services utilization are review of government drug procurement policy and organise on-going or continuous training of health workers in medical ethic or code of conduct in handling patients. Finally, the researcher encourages the community to be sensitized to build trust on the medical attention given by the health workers, and couples need to be encouraged to share responsibilities while taking care of patients during admission.

5.0 Acknowledgements

6.0 Funding

7.0 Competing interests

None declared

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