

## **POLITICAL INSTABILITY AND HEALTH SERVICES IN UGANDA, 1972-1997**

**BAKAMA BERNARD BAKAMANUME**

Department of Geography,  
Texas A&M University  
E-Mail: bakama@acs.tamu.edu

### **ABSTRACT**

Uganda inherited a socialized medical services system from the British colonial rule. The government through the ministry of health is the main provider of health services in the country. Besides the government, missionary health organizations also provide health services in rural and urban areas of Uganda through cost sharing. Socialized medicine provision is influenced by several factors. The most important factors affecting provision of socialized health services are the prevailing economic and political conditions in the country. This paper examines the relationship between health services provision and political instability in Uganda in the last 25 years (1972-1997). It is argued that political instability and lack of proper planning on the part of the government(s) contributed to the decline in health services. The resurgence and emergence of old and new diseases is one of the indicators of inadequate health services. Malaria, upper and lower respiratory diseases, and measles prevalence and incidences show an upward trend; the out-migration of medical personnel is also indicative of the less than attractive working conditions prevailing in the country. This paper contributes to the literature and calls for the reshaping of priorities in the developing countries' health research, funding, and decentralization of the health sector.

*Keywords: Political instability, health services, Uganda*

### **INTRODUCTION**

Problems related to the relationship between health service provision and political instability are well illustrated by recent events in Africa. At a recent conference of the African Health Ministers in Sun City, South Africa (September 1-5, 1997), the state of health in 46 African countries was assessed. The report from the African World Health Organization (WHO) Regional Office dealt with the implementation of two resolutions adopted: (1) the strategy on HIV/AIDS and sexually transmitted diseases (STD) prevention and control in Africa; (2) the issue of health and peace. The report also called for the implementation of national programs as part of a regional strategy on AIDS prevention. The report emphasized conflict hot spots and peace initiatives and their implications for health provision (Samba, 1997).

Dr. Samba, the Director of Africa's WHO Regional Office, noted that it was a mixed year for the office. The persistence of conflicts and the breakdown of law and order had placed formidable obstacles to health care development. The fighting in Brazzaville, Congo, had caused the relocation of WHO offices and personnel to another country. The realization of the important connection between political instability and health (Ityavyar, 1992; Rosenberg, 1988) reflects insights and calls for redirecting health research funding and policies.

The theory of disorder and decline is well documented for the inner-city neighborhoods in the developed countries. It is argued that when rising levels of disorder prevail -- when broken windows, uncollected garbage, presence of youth gangs, prostitution are tolerated -- this signals that

residents are less concerned about the neighborhood conditions (Skogan 1990; Wallace and Fullilove, 1991, Wallace, 1993). Wallace has eloquently documented that urban decay, housing abandonment, fire, and withdrawal of municipal services are closely associated with the rapid spread of AIDS among inner-city minority populations (Wallace, 1993). The relationship between social and political disorder and disease spread has been closely examined in the developed countries. However, despite the decline in civility in developing countries associated with political disorder, instability and/ or civil wars; similar studies have not been pursued in the developing world. The relationship between political instability and decline in social services such as health care in Africa has not been examined critically (Ityavyar, 1992). For example, Smallman-Raynor and Cliff (1991) argued that AIDS infection in Northern Uganda was associated with the civil war in that part of the country, but, the link between political instability and endemic diseases has received scant attention.

To fill the void, this paper examines the relationship between health services and political instability in Uganda between 1972 and 1997, and presents a general model for understanding the effect of political instability on health conditions and services. Three fundamental questions guide the analysis: (1) How have health services been influenced by political conditions? (2) What are the characteristics of a health service system in politically unstable regions? (3) Could the health crisis in Uganda (for example, high infection rates of AIDS, high incidence of preventable diseases) be partly a product of the poor health conditions resulting from political instability in the country?

## **MEDICAL SERVICES IN UGANDA**

Uganda has what is called socialized medicine. The government through the Ministry of Health provides seventy five percent of the medical care in Uganda. Non Governmental Organizations (NGOs) handle twenty five percent of the medical care. These include missionary hospitals, African Medical Research Foundation (AMREF), and such organizations as The AIDS Support Organization (TASO), World Vision, CARE, the Red Cross, and private clinics (Wood, 1985). To understand the trends in health service provision, it is necessary to examine the history of medical services in Uganda.

### ***Years of Medical Health Prosperity***

Although the analysis is concerned with the period 1972 - 1997, the first two years fall within the period that has been identified as one of medical health prosperity (Dodge and Wiebe, 1985; Alnwick, Stirling, and Kyeyune, 1985; Scheyer and Dunlop, 1985). The decision to use 1972 as the baseline date is based on the fact that the first elected government of Uganda was overthrown in 1971.

It is generally accepted that health care decline began in 1972 soon after the first political instability of 1971. It is, therefore, important to briefly review the period after independence in 1962. A Ministry of Health was created just before Uganda's independence. The ministry of health replaced the colonial medical department that was responsible for medical services in the country during the colonial era.

The new independent government and its ministry of health had an ambitious program to build 22 hospitals with 100 beds each (Uganda Government, 1972). This was undertaken immediately. The country's economic prosperity between 1962 and 1971, during the first tenure of President Obote, facilitated the achievement of this ambitious health program (Scheyer and Dunlop, 1985; Ogot, 1997). The economic gains were reinvested in the economy through health, education, and transportation. Scheyer and Dunlop observed that:

The situation in Uganda provides poignant evidence both of strength of health and development linkages and the importance that a national development strategy must ultimately invest in health improvements (Scheyer and Dunlop, 1985: 25).

An evaluation of the medical services in Uganda, reveals that between 1962 and 1973, the country had very good medical services (Kawuma, 1997; Scheyer and Dunlop, 1985). It also had a well-trained medical personnel group deployed in different parts of the country. Makerere Medical School provided a steady flow of young, enthusiastic hard working doctors. Most of these doctors spent about two years in a rural setting before returning to Makerere for graduate work (Kawuma, 1997). The medical service department was well managed, and it offered excellent services (Scheyer

and Dunlop, 1985).

Mulago hospital served as a national referral hospital and a university teaching hospital. It was considered the best hospital outside South Africa and Zimbabwe (Hall and Langlands, 1975). The hospital had outstanding foreign and local born doctors and specialists (Langlands and Hall, 1975). Due to the country's economic prosperity, the ministry of health had the resources to provide drugs and medicines, and all patients were treated within Uganda (Kawuma, 1997).

The country had four recognized health care service types: (1) primary health care centers and clinics; (2) secondary health care – district hospitals; (3) tertiary health care – general referral hospitals; and (4) quaternary health care – two national referral hospitals. There were regional referral hospitals throughout the country. The role of health in Uganda's development was one of high priority. The country's planning strategies had health services and education as one of the three important development goals (Scheyer and Dunlop, 1985; Uganda Government, 1972; Uganda Government 1977).

In terms of hospital beds per population, persons per doctor, and health care service efficiency, 1962 to 1972 was a period of medical prosperity. During the era of public health prosperity, private clinics were very few (Langlands and Hall, 1975; Kawuma, 1997). The private clinics generally served a section of the population who did not want to wait in lines at government hospitals and clinics (Kawuma, 1997). This era of self-sufficiency and prosperity gradually came to an end when some of the specialists began leaving the country because of government economic policies, and political instability.

#### ***Political Instability and Years of Medical Health Service Decline***

In 1971, Idi Amin, the army commander overthrew President Obote's government. The following year (in 1972), Amin expelled the Ugandan Asians from the country. This created a vacuum in all sectors of society especially in commercial, health, and education (Kajubi, 1985). The departure of the Ugandan-Asian population represented the first major wave of out-migration of health professionals. It was also the beginning of the health crisis syndrome in Uganda. The later decline in health services in Uganda reflects the poor economic performance of the country, and increasing political insecurity and instability (Kawuma, 1997). The deterioration in medical services was described as follows:

Uganda is a unique case in this regard, because the developments in its health services system and its people's health status during the past three decades show evidence of cumulative and synergistic interaction of health and development – firstly, in progressive advancement, and then, since 1971, in steady deterioration of social and economic well-being, culminating in the war of 1978-79 (Scheyer and Dunlop, 1985: 25).

The departure of the Ugandan-Asian population had other effects. It triggered a decline in national domestic production, which was to continue for more than a decade. As productivity declined, export earnings dropped considerably, causing unstable economic conditions in the country (Dodge and Wiebe, 1985; Jamal, 1991; Wallman, 1996). On the political front, Amin's execution groups, such as the Intelligence Unit, were busy at work. The killings, high inflation, low pay, neglect of the hospitals due to lack of funds, and mismanagement were some of the factors, which led to the departure of many health professionals. The government white paper of 1975 noted this problem, but it was ignored by the government that had commissioned the study (Kawuma, 1997).

In 1974, Amin's government placed a ban on private medical practice. This further eroded the health service profession. More physicians left the country, even after the ban was lifted to allow non-government doctors to practice. The Ministry of Health brought in doctors from Egypt and the former Soviet Union to help resolve the shortage (Scheyer and Dunlop, 1986; Kyemba, 1977). Upcountry hospitals felt the impact of the government policies more than urban hospitals (Williams, 1985).

In 1979, a combined force of Ugandan exiles with the help of the Tanzania Defense Forces forced Amin out of power. There followed a period of numerous government changes. There were three different governments in 1979. President Yusuf Lule became the first leader after the fall of Idi Amin. He was removed from office by an in house coup after three months. His replacement, President Godfrey Binaisa, had been an attorney general in the first Obote government (1962-1970).

President Binaisa was removed from power by a military commission in 1980. Later that year President Obote was elected to power for the second time.

The rate at which governments changed did not allow for stable civic conditions to return. Such conditions are necessary for rebuilding the country’s infrastructures including medical services. In 1981, Museveni (now the President of Uganda) went into the bush and started a guerrilla war (Civil War 1981-1986) against the government of President Obote. He claimed that the 1980 elections were rigged. The civil war fought from 1981 to 1986 was another blow to social service provision in the country. With the unstable political conditions health services continued to decline. Since 1986, there has been some stability in most parts of the country. This marginal level of political stability has facilitated the rebuilding of the country’s infrastructure. The two era of medical services in Uganda – medical prosperity, and era of health decline are summarized in Table 1 below.

**THE HEALTH CRISIS SYNDROME**

Figure 1 shows a model of the health crisis syndrome, which is affected by natural and human events. The model is a modification of Grove’s famine syndrome model. Natural events include drought, flooding, and unknown natural conditions. Drought results in shortage of food, and malnutrition, especially among children. This may lead to lower health status of a population. Flooding causes crop loss, disruption of drainage systems resulting in poor sanitary conditions, and loss of communication and transportation. Disruption of drainage systems and poor sanitary conditions are often associated with declining health conditions, and outbreaks of diseases such as cholera, and dysentery. The break down of transportation often isolates rural areas in terms of service provision.

Table 1. Time Line: Relationship Between Political Changes and Health Services

| POLITICAL ERA                    | MEDICAL CHANGES  |
|----------------------------------|--|
| 1962                             | Establishing the Ministry of Health  |
| 1966-67                          | Second Five Year Plan, Emphasis on Health  |
| 1972 Expulsion of Ugandan-Asians | Reduced Health Manpower – departure of Asian doctors and other medical professionals |
| 1973                             | Lack of essential drugs , Ugandan and foreign doctors depart                         |
| 1974 Ban on Private practice     | More doctors left , Government imported in Egyptian and Cuban doctors                |
| 1975-79 Political Instability    | Further decline in medical services  |
| 1980s Civic War                  | Decline of medical services, resurgence of old diseases                              |
| 1990s                            | Some improvement in health services  |

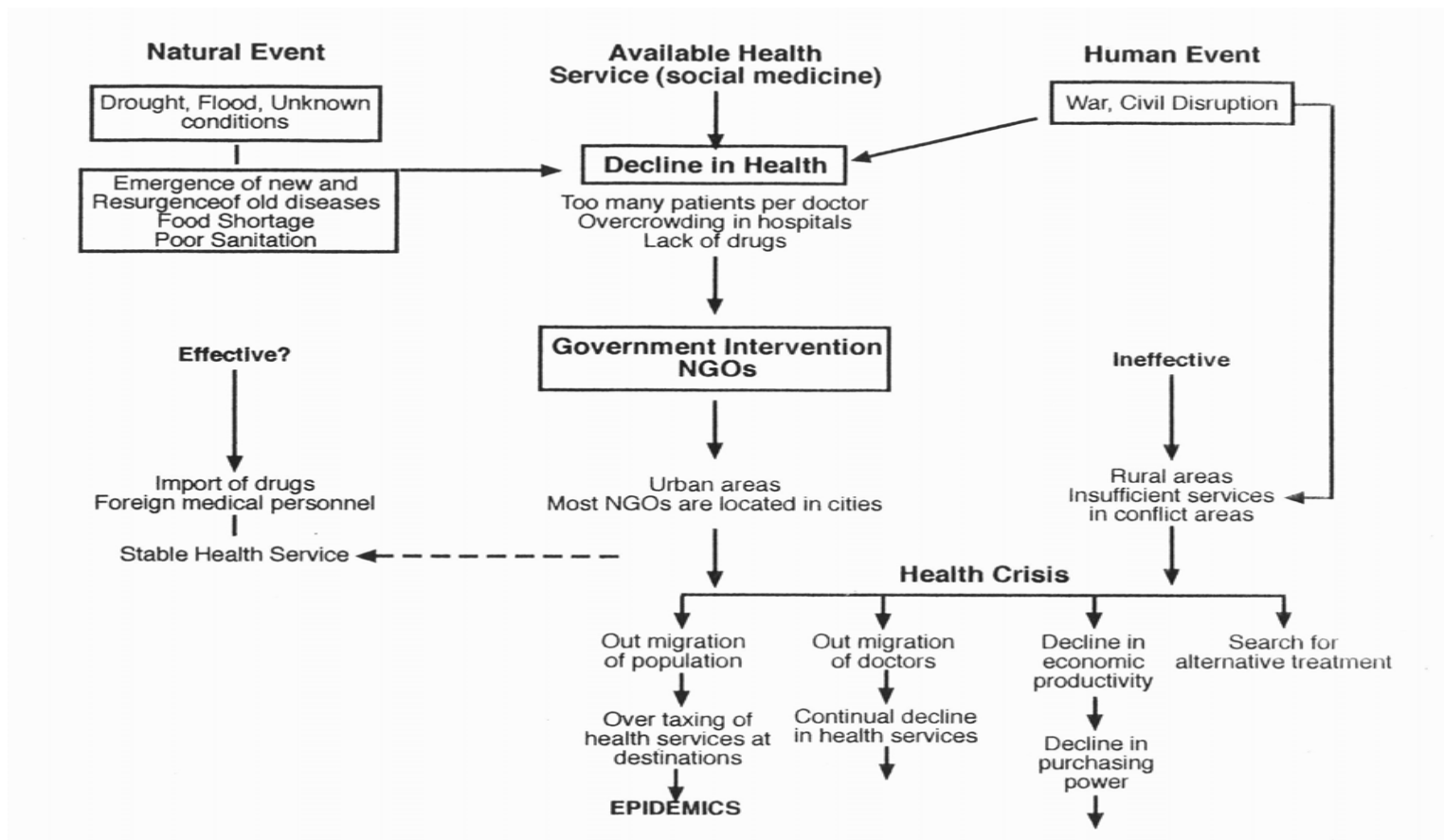


Figure 1. A Model of Health Services, Disease Infection, and Politics: The Health Crisis Syndrome<sup>1</sup>  
 Source: Modified from A. T. Grove's Famine Syndrome Model (1988: 210).

On the other hand, human events such as war, civil disruption directly affect health conditions in a country. Civil wars directly affect the level of health services provided in an area. There are insufficient services in conflict areas and rural areas. The government, which is the major health provider, has limited funds in terms of resources because of expenditures for the war or conflict effort. In urban areas, government health services are easily supplemented by Non Government Organizations (NGOs). The NGOs are less visible in rural areas. Medicine and health services have been called a 'tool of political rule' (MacLeod, 1988). The level of effective medical provision is directly related to the political consolidation of political rule (Good, 1991; MacLeod, 1988; Bell, 1993).

The health crisis syndrome is characterized by at least three of the four conditions. The first condition is out migration of the general population from the affected areas. War or civil disruption causes forced relocation or displacement of people. The displaced persons place an increasing burden on the health services at the destination points. This leads to decline in health services at the destination places. If the situation is not resolved it may lead to epidemics. In conflict areas, the fighting often causes disruption or complete cut-off of services and assistance for the people left behind or the displaced persons.

The second condition of the health crisis syndrome is out migration of medical professionals. Uganda has seen its share of the brain drain. Neighboring countries such as Kenya, Tanzania, Zambia, and prosperous countries like South Africa and Zimbabwe have benefited from the exodus of health workers from Uganda. The departure of medical personnel leads to a further decline in health services.

The third condition of the health crisis syndrome is the decline in productivity. The areas of conflict gradually decline in economic productivity. As economic productivity declines the purchasing power of a region and country is reduced. The ability to purchase medical equipment and drugs is further eroded by decline in economic well being, and inability to pay good salaries and wages to health professionals. The health services in a socialized medicine system become sub-standard with the decline in economic productivity.

In the absence of a solution to the health service crisis, more private practices are established to supplement earnings of poorly paid medical professionals and to fill the vacuum left by socialized medicine. The increase in number of private health services and rising costs of modern health care will force the people to search for alternative medicine. The alternative medicine includes private medicines and native healers. The search for alternative health care/medicine is the fourth characteristic of the health crisis syndrome. It is a reality that an epidemic condition may occur if the alternative health services do not cure the diseases.

#### **APPLYING THE HEALTH CRISIS SYNDROME MODEL TO UGANDA**

In this section an attempt is made to show how the health crisis syndrome applies to Uganda. The political instability in Uganda discussed earlier in the paper is a necessary condition for the health crisis syndrome. One of the consequences of political instability and a characteristic of the health crisis syndrome is the disruption of the health services. For example, health immunization drives are often compromised by conflicts. During a recent polio immunization drive in Uganda, the areas of political conflicts in northern Uganda were less successfully covered (Monitor, 1997; New Vision, 1997). In section below, I discuss the resurgence of old diseases, doctors' flight from Uganda, refugee crises, use of alternative medicine, and AIDS infection.

##### ***Resurgence of Old Diseases***

The resurgence of old diseases is a condition that is closely tied to inadequate health services and the near collapse of the medical service. A Ugandan Government report stated that:

Health standards have deteriorated over the past decade. Among the reasons for this are untreated water supplies, inadequate sanitation and poor nutrition. These deficiencies give rise to waterborne and water related diseases and low resistance to other diseases. Reduced immunization programmes and falling standards of primary health care have compounded the problem (1982: 81).

One of the resurging preventable diseases is Malaria. Malaria now kills about 80,000 people annually in Uganda (Kiyonga, 1997). The rise in malaria infection has been accompanied by a rise in

other diseases such as tuberculosis (TB). Malaria, acute upper respiratory infection, and acute lower respiratory infection have been the leading diseases in the country since 1991 (Ministry of Planning and Economic Development, 1997).

Three out of four children in the world suffer from one of five preventable conditions: acute respiratory infections (especially pneumonia), malaria, diarrhea, measles, and malnutrition (WHO, 1997). These are sometimes called diseases of poverty. Malnutrition is a condition that often accompanies conflicts and decline in agricultural production. The decline in agricultural/economic production is associated with political instability in Uganda. The three leading diseases in Uganda are malaria, upper and lower respiratory infections. The health status in Uganda shows that three of the five preventable diseases that WHO lists are present in the Ugandan situation. Probably, it is safe to argue that we have a condition of health crisis in the country.

### ***Medical Profession Migration***

One of the direct impacts of political instability on health services in Uganda has been out migration of medical personnel. Uganda has been one of the major source areas of trained doctors. There is no official figure on how many doctors have left the country, but it is well known that Uganda's brain loss started in the Amin era of 1971-79. As discussed earlier, the departure of the Ugandan Asian community had an impact on health care provision in Uganda. In later years, Ugandan born doctors left the country in search of greener pastures -- better economic conditions.

The brain drain was due to several push factors: (1) medical professionals (like most Ugandans) left because they were afraid for their lives; (2) the high and rising economic inflation in the country; and (3) the decline or demise of the hospitals and other health facilities.

Figure 2 shows the estimated number of medical doctors who migrated (Kawuma, 1997; Ministry of Health, 1991). Massive out-migration has accompanied periods of serious political instability. Three periods in particular need mentioning. The first period was 1972-73. This was a period of out-migration by mainly Ugandan Asian health professionals. The periods between 1975 to 1979 and 1982 to 1985 represent the out migrations of health professionals because of insecurity and economic reasons. By 1979, there were fewer doctors than in 1965 to 1968 (See table). The number of registered and licensed doctors declined throughout the 1970s, starting with the massive out-migration of Ugandan Asians in 1972-73. There is no data on traditional health healers who have migrated out of Uganda. These health service providers are included with the general refugee population.

### ***The Political Refugee Crisis***

Uganda is one of the few countries in Africa that has been a source area for refugees as well as a destination (UNHCR, 1996; Woods, 1996). The country has its own internally displaced persons (internal refugees), and it is a destination for refugees from Sudan, Rwanda, and Democratic Republic of Congo. The refugee population has added a pressing burden on an already poor health service (New Vision, 1998). The regional conflicts in the Great Lakes area have further eroded an already inadequate health service.

The northern and northwestern parts of Uganda are conflict areas. Rebels of the "Lord's Army" have been fighting the government in these areas since 1991. To contain the rebel activities in northern Uganda, the government has established protected villages (camps) for the internally displaced. Poor sanitation and ill preparedness to deal with so many people have resulted in many deaths, especially of children, in these camps. Food shortages are common (Onyango-Obbo, 1997). The critics of government policy allege that the protected villages are "Nazi-type camps." The local Acholi leaders argue that the camps will prolong rather than end the war.

Besides the protected villages, there are other camps that have been established to accommodate internally displaced persons. Riki camp in Arua is one of the camps. This temporary resettlement camp has experienced water shortage due to lack of boreholes, suffered shortage of latrines, and initially lacked a health facility (Acidri, 1997). Some of the internally displaced persons have moved to the southern districts, where some are squatters.

The refugee camps or village of displaced persons are places of high disease infection rates (Onyango-Obbo, 1997). Cholera infection has been closely associated with large camps of the

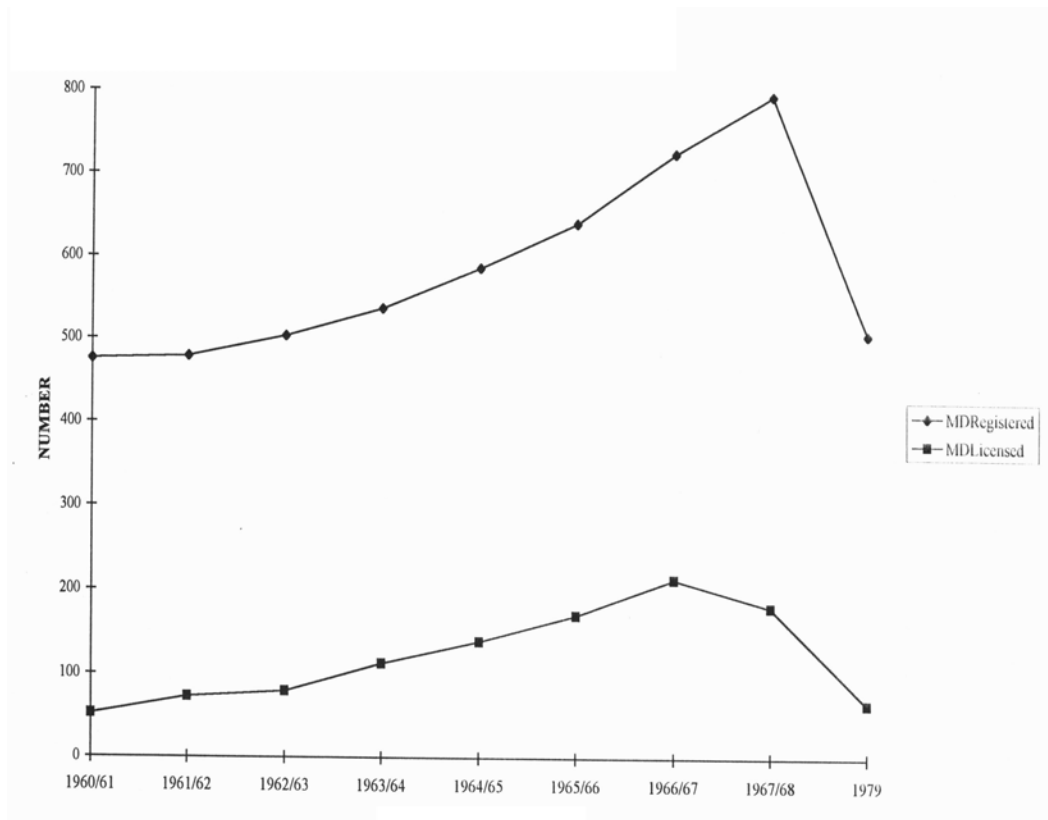


Figure 2. Doctors in Uganda, 1960-1979.

Sosource: Ministry of Planning and Economic Development 1997. *The Republic of Uganda 1997: Statistical Abstract*, Entebbe: Government Publishers.

displaced people and refugees. In these camps sanitary conditions are inadequate and infectious diseases are common.

### **Alternative medicine**

There is a growing call for alternative medicine. The search for alternatives is a product of existing conditions: (1) western style public medicine is inadequate – drugs are not available, hospitals are overcrowded, referral hospitals are now primary care regular hospitals, and there is a general lack of funds; (2) private clinics are very expensive for most people; (3) there is ongoing brain drain as medical professionals continue to leave the country; and (4) AIDS/HIV infection rates have prompted the questioning of western (biomedical) medicine. There are several clinics and traditional doctors who are at the forefront of the search for alternatives. For example, Wallman (1996), discussed the role of traditional healers in Kamwokya, Kampala, Uganda.

The Uganda government policy is to harness the resources of the traditional sector. It is recognized that traditional healers are closest to the people (Wallman, 1996). More than two thirds (70

percent) of the births in the country are assisted by traditional birth-attendants (TBA) (Wallman, 1996). It is also being accepted that traditional healers may be useful in the treatment of chronic diarrhea, herpes Zoster in AIDS patients (Wallman, 1996). It is, however, too early to make any sustainable conclusions about alternative medicine. The health crisis syndrome diagram does not indicate a path for this alternative. But if alternative approaches do not provide relief to overtaxed medical services, the consequences will still be epidemics.

Home treatment is a common response to most illnesses in all parts of the world. The household becomes the locus of health service because household chores such as cooking, washing clothes, keeping the home clean are part of household health management; and because some diseases commonly treated in homes are sexually transmitted diseases and illnesses thought to be brought about by witchcraft (Wallman, 1996). In Uganda, people have realistic expectations of their government health service, and tend to use it only as a last resort (Berman et al. 1994, Whyte, 1991). Home treatment is the first step in health service provision. Whyte (1991) wrote that:

In the face of continuing high morbidity, people are taking health care in their own hands and are pleased to find the tools they think they need available in shops and markets (cited in Wallman, 1996: 144).

Whyte argued that the rise in lay medicine was the product of the collapse of the formal system. The author also noted that there was privatization of the health service from institutional setting to acquiring of medicine to treat themselves.

One of the emphases at present is to decentralize the medical system. Decentralization may cut down the bureaucratic tape and also help stream line health service in out laying rural districts. Although the government is busy selling off other properties, it has yet to sell the hospitals. Will the government attempt privatization of health services? Most policy analysts view decentralization as an immediate partial solution (Lockhart, 1996). A complete solution has to involve the political questions and situation.

Socialized medicine is very vulnerable to political instability. For socialized medicine to work well political stability is necessary. Given the political instabilities of countries such as Uganda, it may be fair to suggest that the socialized health care system inherited from colonial rule does not work well. The policy implication is that health care should be decentralized if the objective is to reduce vulnerability to political instability.

## **POLITICAL STABILITY AND HEALTH CARE**

The relationship between health and politics is most evident in the fight against AIDS in Uganda. After reaching a peak in 1992, the AIDS/HIV infection rate has declined. Uganda has been cited as the only country in Sub-Saharan Africa where the infection rate of AIDS is declining (ACP, 1997; WHO, 1998). The decline is most evident in the southern part of the country, which enjoys some stability. The Ministry of Health and organization such as The AIDS Supports Organization (TASO) have been responsible for the declining rates (ACP, 1997; WHO, 1997, Anonymous, 1997).

The recognition of the connection between politics and AIDS has been very rewarding for Uganda, and for the southern part of the country. Figure 3 shows the AIDS rates for 1991 and 1996 for various places in the country. The areas within the peaceful southern part have experienced a decline in AIDS rates, while the northern areas have rising rates.<sup>2</sup>

The government intervention in the fight against AIDS has proved very beneficial for several reasons: (1) The government openness with regards to AIDS disease has brought in research funds, equipment for screening blood and testing for HIV; and helped establish effective control agencies such as AIDS Control Program (ACP), and Uganda AIDS Commission (UAC). (2) The ACP, UAC and TASO have been effective in educating the population about AIDS, and documenting statistics on AIDS/HIV infection. (3) On another level, the church's objection to condom use and advertisement of condoms promotion was resolved through the government's ability to bring the church and AIDS/HIV prevention agencies together.

The government appointed a retired bishop to the chairmanship position of the Uganda AIDS Commission. The government appointed the Right Reverend M. Kawuma, the position in 1993. (The

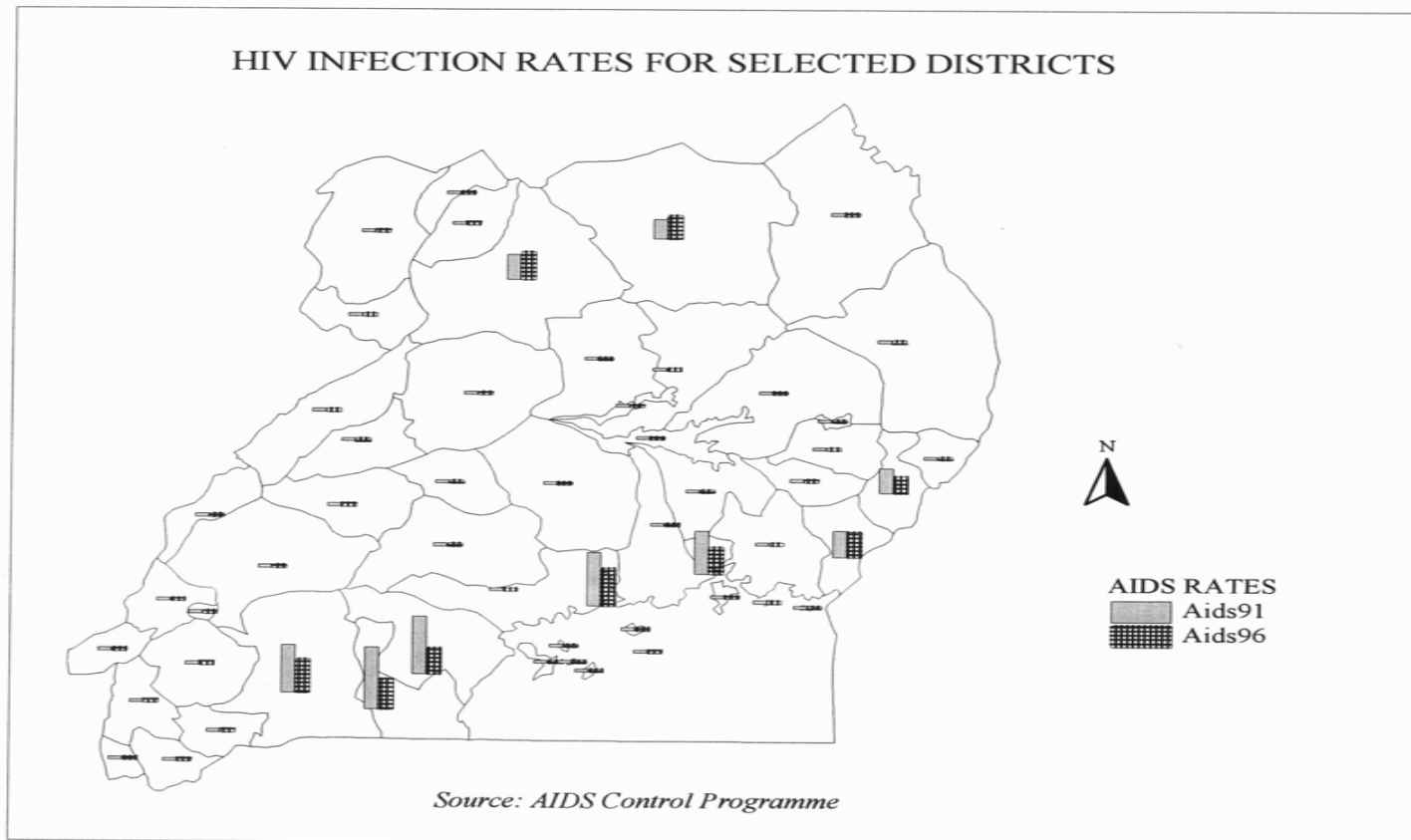


Figure 3. HIV Infection Rates for Selected Districts.  
 Source: AIDS Control Program 1997. *Surveillance Survey Reports*. Entebbe: Government Printer.

bishop died last year.) The appointment helped to diffuse the differences between the church and the Ugandan AIDS Commission. The decline in AIDS rate is partly a product of the efforts by government and organization such as TASO.

The government realizes its weakness in dealing with AIDS infection at a national level. It is trying to implement its AIDS management activities at the district level. Lockhart, 1996 states:

By comparing data collected at the district level, we can detect more precisely those factors which may determine the present and future impact of AIDS in a specific area... (Lockhart, 1996: 20)

The government recently announced a door to door testing for AIDS/HIV. This is a grass-root approach to AIDS/HIV infection. While the house to house testing may be opposed by Human rights advocates, it shows the decentralization approach to the AIDS problem. The AIDS example does require an element of central government intervention because the resource needed may not be easily available at local level. Indeed decentralization of the health system does not necessarily mean that central government will have no input at all. It is rather a recognition of the fact that preventable diseases require local intervention. The AIDS Control Program in Uganda can remain in place but the administering of the health and monitoring of AIDS has to be at the local level. A strong district level health system rather than central government is in a better position to deal with local conditions. For example, in the United States we have state departments of health and the Center for Disease Control, National Institutes of Health and other federal agencies. The health status of a region is the responsibility of the local health agencies that are familiar with the local condition.

## **CONCLUSION**

In this paper, I have presented a theoretical framework for understanding the health crisis in politically unstable areas. I have argued that in the face of political conflicts, governments cannot meet the demands of socialized medicine. Inability to provide an adequate health system has resulted or will result in a health crisis syndrome. Also, I have applied the model to the Ugandan situation from the 1970s to the present time. There are certain characteristics that reflect the health crisis syndrome in this case study. There has been not only a massive out-migration of people, but also in-migration of refugees. The influx of migrants from outside and within the country has placed more stress on the health service system. Disease incidences and prevalence have been on the rise, while out-migration of health professionals still continues today.

The decline in economic productivity, and the fight against rebels are conditions which fuel the continuing health crisis syndrome. The governments' fighting to curb instability have no capability to meet the bare minimum health requirements of the population. The NGOs are not in a position to pick up the responsibility. Since the majority of the population has no financial source to afford private health services, alternative medicine is the option open to the people. The population is now turning to traditional healers and other alternative medicine. This is not yet an approved alternative.

This paper calls for the reshaping of priorities in the developing countries' health research agendas, funding, and decentralization of the health sector. One of the possible approaches to the problem of health service provision is through decentralization. However until some of the political problems and conflicts are addressed, the health crisis syndrome will continue in the conflict areas.

## **ACKNOWLEDGEMENT**

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## **ENDNOTES**

<sup>1</sup> There are some disease exceptions which may not fit the model being described. The case of sleeping sickness is a good example. Order and stability may be viewed as a cause of high prevalence of sleeping sickness. Langlands (1961), in a study of tsetse flies, recognized the high prevalence

associated with decrease in burning of bushes. He concluded that enforcing the regulation on bush burning resulted in the growth of bushes, a habitat for wild animals, which acted as hosts for the disease. The disease affected the cattle economy and the health of the people. To the contrary the nomadic way of life and burning of bushes facilitate the growth of new shoots for the cattle was also a method in tsetse fly control.

<sup>2</sup> The critics and some of the opposition members of the government have accused the government of using AIDS as a weapon to fight the civil war in the north (BakamaNume, 1997). They claim that the government has deliberately deployed HIV infected soldiers in the north. While it is true that the army like other mobile professionals has generally higher rates of HIV/STD infection than the general population, it is probably not true to suggest that the government has used AIDS warfare (BakamaNume, 1997).

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