



## INJECTIONS AND SELF-HELP: RISK AND TRUST IN UGANDAN HEALTH CARE

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**Abstract**—The paper draws upon research material collected during a one year long ethnographic study on injection use and a WHO funded Injection Practices Research Project, which were both carried out during 1992/1993. The paper examines the changing trends in injection use and practices in the context of the Ugandan health system and in relation to popular views about risk and trust. Generally, people mistrust injections provided at government health institutions and prefer to gain access to injections as symbolic tokens of healing through personal contacts and private ownership of injecting equipment. It now appears that the use of this Western biomedical technology is widespread at all levels of the health care system; needles, syringes and injectables are readily available in homes for use by families and untrained providers. In other words, the injection technology has been domesticated and personalized. The Giddens (1990) framework [Giddens, A. (1990) *Consequences of Modernity*. Stanford University Press, California.] concerning modernity, trust and risk is applied to understand the motivations behind these processes. The basic argument is that the weakening of state institutions of health care has been accompanied by a loss of trust in the treatment offered there. In addition, the massive anti-AIDS education campaigns which have warned people against the dangers of sharing unsterilized needles, have reinforced existing mistrust in public health facilities and induced families to seek care from people they know and using injecting equipment over which they have personal control. The paper concludes that changing the current injection practices in Uganda will necessitate a change in the organization of public health institutions. © 1998 Elsevier Science Ltd. All rights reserved.

**Key words**—injection practices, health systems, Uganda, domestication, personalization, therapeutic relations, risk perceptions and trust

### THE PROBLEM

One of the most popular forms of therapeutic administration in Uganda is the injection (UEDMP, 1990; Glenthoj, 1991; Whyte, 1991; Birungi and Whyte, 1993; Kafuko *et al.*, 1996). Injection use is abundant at all levels of the health care system, both public and private; among formal and non-formal providers, among trained and non-trained providers, in hospitals, health centers, private clinics and homes. On average 7 out of 10 treatments made by formally trained providers at established health facilities include an injection (Birungi *et al.*,

1994). This is far above the national desired level of injection prescription of 15% which was stipulated by the Uganda Essential Drugs Management Programme (UEDMP, 1990). Over 95% of all the injections prescribed are chloroquine, procaine penicillin fortified (PPF) and crystalline penicillin. The high level of morbidity in the country which features malaria as the top cause of illness, followed by acute respiratory infections, encourages the over-use of injections\*.

The use of injection therapy in Uganda has been under government jurisdiction. The Pharmacy and Drug Act of 1970 made it illegal for any person to own a syringe for injection (Uganda Government, 1970). It states "...no person shall have in his possession without lawful excuse, the proof wherein shall lie on him, any syringe designed for injection" (The Pharmacy and Drug Act, 1970, p. 1116). Although the recent National Drug Policy and Authority Statute 1993 (Uganda Government, 1993) does not explicitly state the law on injections, there are strong intentions from the National Drug Authority to restrict its use (Chairman NDA, personal communication). In effect, injection use is still formally restricted to biomedical experts.

However, perceptions of risk and trustworthiness have made lay people more autonomous in control-

\*Here injection use is incorporated to treat symptoms and the categorization of symptoms supports the common use of injections. In Lusoga, the language of the fieldwork area, the term *omusudha* is used to describe malaria and sometimes conditions under acute respiratory infections. It includes "fever of cough", "fever of cold", "fever of the chest" and "fever of the brain". Symptoms such as runny nose, joint pains, fatigue, cough, high temperature, chills and loss of appetite are all referred to as *omusudha*. Since injections are the preferred treatment for malaria and acute respiratory infections, injections are the treatment choice for many symptoms. It is also believed that injections deliver medicines directly into the blood stream and they are best for diseases such as malaria and acute respiratory infections that "move in the blood".

ling their health care and have opened new dimensions in the use of injections (Birungi and Whyte, 1993). It now appears that this Western biomedical technology is becoming more and more dependent on local social relations and personal ownership of injecting equipment. Findings of a WHO study carried out in two regions of Uganda, show that 63 and 83% of the 360 households visited in Busoga, Eastern Uganda and in Ankole, Western Uganda, respectively, owned needles and syringes. In the same study, it was noted that there was growing mistrust of government health care as a source for injections. For instance in Busoga, in the 359 households where an injection was ever administered, 35% of them had received their last injections at government units, 36% were given in private clinics and the remaining 28% were received from informal providers and at home. In Ankole, it was noted that less than a quarter of the last injections had been given in a public institution. In 358 households where an injection was ever administered, 47% received their last injection at a private facility, 23% at a government facility and 30% were received from informal providers and at home.

This paper looks at the changing trends in injection use and practices in relation to perceptions of risk and trust. In order to understand people's motivations, the framework developed by Anthony Giddens (1990) concerning modernity, institutions and trust is applied. The basic argument is that the weakening of state institutions of health care has been accompanied by a loss of trust in the treatment offered there. In addition the massive anti-AIDS education campaigns which have warned against the dangers of sharing unsterilized needles, have reinforced existing mistrust of government health facilities and moved families to seek care from people they know and only using injection equipment over which they have personal control. The paper draws upon research material collected during a one year long ethnographic study on injection use in Busoga, Eastern Uganda and also on research materials collected during an Injection Practices study funded by WHO, which was carried out in 1992 in Western and Eastern Uganda.

\*During Amin's regime (1971–1979), policies such as the economic war led to a big decline in the country's economy. The growth in gross domestic product (GDP) is reported to have fallen from 4.8 to –1.5%. The Obote regime that followed was characterized by political instability and could not rescue the economy.

†A situation analysis report by UNICEF (1989) shows that the ratio of physicians to the population halved in the past 25 years from 1:11,000 in 1965 to 1:28,000 in 1991. Mburu (1984) in his study based on 15 rural health centers found that nursing aides were the largest cadre: 3 health centers had one, 4 had three and 8 had five or more nursing aides.

#### THE UGANDAN HEALTH CARE SYSTEM

In the 1960s, Uganda was considered to have one of the best health care systems in Africa (Dodge and Wiebe, 1985). It had a comprehensive institutional referral system, from numerous rural dispensaries, through health centers, maternity units, district and regional hospitals, to a national referral hospital. These health units were run by trained biomedical professionals. Additionally, private medical services provided by missionaries and an insignificant number of private clinics run by licensed medical practitioners complemented government services. Medical services were free at government units and those provided in private units were relatively cheap. Injection use was almost entirely restricted to these facilities. Hence, although there exist anecdotal data indicating that untrained neighborhood "needle-men" provided injections in their communities, the scale of this informal activity was confined.

Presently, the context of injection use has changed. During the 1970s and 1980s, Uganda suffered political disruption and a precipitous decline in the country's economy\*, leading to a decrease in government expenditure on health care and to a breakdown in the health care system (MOH, 1992). Government could not afford to provide free drugs, maintain adequate supervision of health workers or pay health workers a living wage. Many health professionals left the country†. Immunization programs broke down; only the mission health facilities that continued functioning reasonably. This scanty and nearly non-functional health care system gave rise to a number of new local solutions. There was a proliferation of private oriented health care providers, such as unlicensed private clinics, drug shops and home providers (Health Policy Review Commission, 1987; Whyte, 1991). Subsequently, confidence in the public facilities was undermined, since proliferation was normally accompanied by changes in morals and values of medical practitioners. Obbo (1991) observed that the structural changes that occurred in Uganda in the 1980s led to a number of macro and micro changes, one of the most significant micro changes was that professionals could only survive by ignoring their standard ethics. Survival strategies of government health workers included opening drug shops, putting up clinics, treating patients at home, misappropriating drugs and medical equipment for personal gain and introducing informal charges on services which were originally free (USAID, 1980; Banugire, 1987, 1989; Whyte, 1991).

By the middle of the 1980s donors began to mount special programs to revitalize the Ugandan health care system. Two major vertical programs were initiated: the Uganda Expanded Programme for Immunization and the Uganda Essential Drugs Management Programme (UEDMP). Through the

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