Opinion

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Striking Observation of the Discrepancies between the Rural and Urban Healthcare Services Delivery: the Need to Bridge the Gap between Urban and Rural Areas of Uganda

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Introduction

The notable disparities in healthcare delivery between urban and rural areas in Uganda, as exemplified by the unequal distribution of healthcare resources between urban centers such as Kampala and rural regions like Luuka district, underscore the urgent need for equitable and comprehensive healthcare services across the entire nation. (Birabwa, et al. [1,2]). Uganda operates a decentralized healthcare framework comprising both national and district tiers. The health system of Uganda is structured into two main tiers: the national level encompasses national referral hospitals, regional referral hospitals, as well as semi-autonomous bodies such as the Uganda Blood Transfusion Services, Uganda National Medical Stores, Uganda Public Health Laboratories, and the Uganda National Health Research Organization (Lutwama, et al. [3-5]) At the district level, the healthcare structure is further elaborated. The bottom tier of the district-oriented healthcare system comprises Village Health Teams (VHTs), a volunteer network of community health workers. These dedicated individuals primarily offer health education, preventive measures, and basic curative services at community level, marking the initiation of level 1 health services. Following this, there is the health Center II, an outpatient facility managed by a nurse, and designed to cater to a population of around 5000 individuals at parish level (Jeppsson, et al. [4,6]). Progressing to the subsequent level, is health Center III (HCIII), designed to serve a population of 10,000 people. HCIII expands upon the services offered at HCII by incorporating inpatient care, simple diagnostics, and maternal health services. These operations are overseen by a clinical officer. Above HCIII stands the health Center IV, which is under the administration of a medical doctor. In addition to encompassing all the amenities provided at HCIII, HCIV also offers surgical interventions. It has the additional mandate to offer blood transfusion services and comprehensive emergency obstetric care, further elevating its capabilities (MOH, et al. [4]). Sustainable Development Goal 3 focuses on ensuring healthy lives and promoting well-being for all at all ages by 2030 (Micah et al., et al. [7,8]). Access to quality healthcare services is a fundamental human right, crucial for the well-being and development of any society (Morudu, et al. [9,10]). The SDG declaration emphasizes that to achieve the overall health goal, we must achieve universal health coverage (UHC) and access to quality health care. No one must be left behind (WHO, 2017). However, this is not the case in many developing countries like Uganda.

Urban advantage vs. Rural struggles

Between June and mid-August 2023, I was assigned to an internship as a mandatory component of my academic obligations in pursuit of a master's degree in public health Monitoring and Evaluation. This attachment led me to collaborate with the KCCA/CDC Urban Health Project, wherein I was stationed at Komamboga Health Center III. Situated within Kawempe Division of Kampala, Uganda›s capital city, Komamboga HCIII is located in the Health Sub District of Kawempe Division with a catchment population of 44,450 people (Bampabwire, et al. [11]). On August 17, 2023, during the health facility performance review meeting that I passionately attended, a striking interesting observation came to my attention, the health facility has four doctors actively contributing to patient care. This diverse medical team includes 2 doctors managing HIV treatment, a general practitioner, and a pediatrician. This level of medical expertise and specialized care is a testament to the advantages that urban centers, especially the capital city, enjoy. Conversely, in rural areas like Luuka district, the disparity is staggering. A population exceeding a quarter of a million people is served with just two doctors, one predominantly in an administrative role as the District Health officer and another the In-charge HCIV, the highest-level facility in the district. The World Health Organization (WHO) provides essential guidance on the doctor-to-population ratio as a key indicator of a healthcare system›s capacity. According to WHO›s recommendations, a benchmark of approximately 1 doctor per 1,000 people is suggested as a practical reference for ensuring basic health services. This ratio serves as a foundational guideline, emphasizing the fundamental principle of accessible and high-quality healthcare for all (Bossert, et al. [6,12]). The doctor-to-population ratio, as delineated by WHO, underscores the core objective of guaranteeing comprehensive and excellent healthcare accessibility. This ratio signifies the intricate equilibrium between the availability of healthcare professionals and the healthcare requirements of the population. As an illustrative example, consider Kamamboga Health Centre III, designed to cater to a population of 44,450 people. This facility currently benefits from the expertise of four doctors who actively provide extensive treatment care to patients. In contrast, Luuka district, encompassing a population of 260,000, is served by merely two doctors. One of these doctors predominantly assumes administrative responsibilities as the District Health Officer, while the other fulfills the role of In-charge of Health Centre IV, supported by just 32 healthcare workers at the facility, and is also responsible for overseeing the operations of 8 Government Health Centre IIIs and 20 Government Health Centre IIs. These disparities in doctor-to-population ratios exemplify the significant challenges faced by healthcare systems in less urbanized regions, further emphasizing the importance of aligning healthcare workforce distribution with population needs. By adhering to WHO›s doctor-to-population ratio recommendations, healthcare authorities and policymakers can strive for a more equitable and effective healthcare delivery system, ensuring that every individual, regardless of their location, receives the medical attention they deserve.

Equity in Healthcare

Healthcare is a fundamental right, irrespective of one›s geographical location (McDavid, et al. [13]). It is the responsibility of governments and relevant stakeholders to ensure that every Ugandan, whether residing in the capital or a remote village, has equitable access to quality healthcare services including People with Disabilities. The current state of affairs raises pertinent questions about resource allocation, infrastructure development, and policy implementation. Bridging the gap between urban and rural healthcare services requires a concerted effort from policymakers, health authorities, development partners, and communities alike.

Impact on Healthcare Access

The implications of such disparities in healthcare service delivery are profound. Urban residents benefit from a multi-faceted approach to healthcare, where specialized services are readily accessible. In contrast, rural residents face limited access to essential medical expertise, leading to delayed diagnoses, inadequate treatment, and ultimately, compromised health outcomes. The scarcity of medical professionals in rural areas contributes to a vicious cycle, as individuals might be discouraged from seeking timely medical attention due to the long distances and inadequate services available. These disparities in doctor-to-population ratios exemplify the significant challenges faced by healthcare systems in less urbanized regions, further emphasizing the importance of aligning healthcare workforce distribution with population needs. By adhering to WHO›s doctor-to-population ratio recommendations, healthcare authorities and policymakers can strive for a more equitable and effective healthcare delivery system, ensuring that every individual, regardless of their location, receives the medical attention they deserve.

Recommendations for Change

The allocation of healthcare resources should reflect the the recommended World Health Organization patient doctor ratio putting into considerations of the healthcare needs of each region, as disease burden, and local contexts. Strategies should be devised to incentivize healthcare professionals to work in rural areas, including offering scholarships, loan forgiveness programs, and improved working conditions. Utilization of technology to bridge geographical gaps by implementing telemedicine initiatives and regular health camps in underserved areas can go a long way to support bridging the gap. Encourage community involvement in healthcare planning and decision-making to ensure that local needs are accurately represented.

Conclusion

Discrepancies in healthcare services delivery between urban and rural Uganda are not only a reflection of geographical disparities but also a human rights concern of access to quality care for all that demands urgent attention. The service imbalances is reflected by the bad health outcomes and low life expectancy in rural communities

compared to the urban areas. Addressing this imbalance requires a comprehensive approach that encompasses policy changes, resource allocation, and a collective commitment to providing equitable access to healthcare services for all Ugandans. Only through such efforts can we truly realize the vision of a healthier and more prosperous nation, regardless of where individuals reside.

About Sande Slivesteri

Sande Slivesteri is a permanent resident of Luuka District, a Social Science Researcher at the Medical Research Council/Uganda Virus Research Institute and London School of Hygiene & Tropical Medicine Uganda Research Unit, and a master's degree candidate of Public Health Monitoring and Evaluation at Makerere School of Public Health, Kampala, Uganda.

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