Author's response to reviews

Title: Private and Public Health Care in Rural Areas of Uganda

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Private and Public Health Care in Rural Areas of Uganda
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Onama and Birger Carl Forsberg

Dear Sir,

Many thanks for your mail dated May 12, 2010 on the article above. We appreciate the serious work done by the reviewers and yourself. In the following we respond to the points raised. Many of them have been considered in the attached revision of the paper. In addition to the revised article file we also attached a slightly improved version of figure 1.

With regard to the major point made by yourself and Reviewer 2 (BM) on the originality of the work we have reviewed the literature available on similar work in Uganda and concluded that our study is the first comprehensive description of the total private sector in rural districts in Uganda. No other community based study covering several districts has been published. The findings of the study are in line with expectations but the study advances our knowledge on the scope and potential of the private sector in Sub-saharan Africa. In line with this conclusion, we have inserted a sentence at the beginning of the discussion section to underline the role of the study in the context of health systems research in Africa.

We have dealt with the other major comment by reviewer 2 that “it is not always clear whether comments in the discussion section are conclusions from the study or from other studies” by seeking to mark clearly what are our study findings and what are general conclusions brought into the discussion. We have supported this discussion with several new references to studies from Uganda including several of those suggested by reviewer 2.

With reference to the comment by
Reviewer 1 (DM)
The reviewer in his second paragraph wishes to know the purpose or justification of the study. This is provided in paragraph two of the Introduction section. We state that Uganda is at the stage of promoting and even formalizing linkages between public and private health care systems, but knowledge on the private sector providers is limited. Lower down in the same paragraph we explain that most studies have commonly tended to target specific categories of health providers, mostly public, rather than looking at the full spectrum of providers. We point out that “...in order to expand the knowledge base for planning and policy making there is a need to identify all types of health care providers in the community and to quantify the fraction of clients that each type attends to.”

District selection:
The districts were selected purposefully and the text has been modified accordingly.

Numbers of public facilities selected:
One needs to differentiate the “mapping” exercise from the health facility survey. The 19 public facilities that are mentioned in the first paragraph of findings (availability), were identified during the “mapping” exercise. Mapping of providers was a total count of all health care providers in defined areas and it was done for the purpose of obtaining the relative frequency of providers. The mapped area was smaller than the study area. As is reported in the opening paragraph of the Findings section, the mapping listed 19 public and 445 private facilities. Mapping was a simple count of different types of facilities.

With regard to the health facility survey, which is described in the (methodology) paragraph just before findings, the health facilities that were assessed were sampled from the whole study area for detailed study and comprised 22 public and 60 private facilities. A minor revision of the paragraph on the methodology of the health facility survey has been made to clarify the facility sampling.

Self treatment
For clarity we have added a definition of self treatment in this section on page 8, which states as follows: “Self treatment is when a person decides what medicine to take without advice from a health worker. Even when one purchases the medicine from a drug shop or pharmacy it remains self treatment if he or she decides what to buy and how to use it”.

Differences in health seeking behaviour by age
We did not analyze this by age. This is because exact age was not recorded for every respondent. As is described in the methods section, we separated adults from children below 15 years old but the children’s responses were provided by their parents. This was because in most instances the parents would have made the treatment decision for the child.

Urban rural differences
All our study participants were essentially rural-based as is indicated in the title and described in the methods section. We recruited from villages that generally include both traders and peasants and the difference between these two was obtained from bivariate analysis. We therefore did not analyze by urban or rural residence.

Choice of provider
It is clear that most people selected a provider balancing proximity, cost and technical skills. The data implies that serious illness would more likely be taken to public or PNFP facilities where technical skills for such conditions seem to be believed to be best. This comes out in the discussion section.

Quality of care information
For clarity, the quality of care tool was designed for assessing formal facilities, which are expected to have diagnostic equipment. This clarification has now been included in the last paragraph of the methods section titled “Health facility survey”. In the last paragraph of the findings section titled “quality of health care”, the last sentence has been modified to read that the assessment tool would have scored informal units very low because none of them had basic equipment.

Self treatment and severity of illness
We fully agree that staying away from work may sometimes be due to a mild illness but this should normally be an exception rather than the rule. We believe that only a few persons in a rural community like the one studied would be at risk of being misclassified because of this as the majority are self-employed or engaged in the informal sector.

We also agree that self treatment does not mean lack of health care. What we actually said is that it “could reflect poor access to health care”. The sentence has been slightly reworded into “While partly due to mild illness, this could also reflect inadequate access to health care.”

In addition to all the changes mentioned plus a few more we have worked to improve the language in the article. We hope our thorough work on the revision will be to yours and the reviewers’ full satisfaction and that the article now will be accepted for publication.

Yours respectfully,

Birger C Forsberg and co-authors