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Accessibility to Basic Healthcare Services and Its Implications on Maqasid Al-Shariah: A study of Muslim Community in Uganda

[1]Umar Ahmed (PhD), [2]Mustafa, Omar. M.(PhD),
[3]Ahamad Faosiy Ogunbado (PhD).
Islamic Business School (IBS), College of Business, (COB), University Utara Malaysia (UUM), Sintok, 06010, Kedah, Malaysia.
Kulliyah of Economics & Management Sciences, International Islamic University Malaysia, 50728 Kuala Lumpur Malaysia.
Islamic Business School (IBS), College of Business, (COB), University Utara Malaysia (UUM), Sintok, 06010, Kedah, Malaysia.

Abstract: *This study examines the effect of accessibility to basic healthcare services on the welfare of Muslim community in Uganda and thus maqasid al-shariah. The study has used a survey, where questionnaires were distributed to 350 respondents. Descriptive statistic and factor analysis were used in the data analysis. The findings reveal that lack of physical factors such as poor public healthcare services, inadequate human resources and poor healthcare infrastructure; inability to afford private healthcare services; and inappropriateness in terms of low public allocation, high corruption in public healthcare sector and use of personal savings rather than health insurance scheme are the most significant factors that affect accessibility to basic healthcare services to majority of muslim community in Uganda. These negatively affect their welfare and thus the very basic elements of Maqasid al-Shari'ah, i.e. to protect life, remove hardship and improve social welfare. This study suggests that Muslim community in Uganda should explore the possibility of using waqf-based models such as cash waqf and waqf shares scheme to raise fund for the construction of waqf hospitals and centers. Waqf models are successful in some Muslim countries like Malaysia, where the use of corporate waqf model increases the accessibility of affordable and high quality healthcare services to Muslim community in particular and societies at large. This study is a pioneering work that examines the effect of accessibility to basic healthcare services in Uganda and its implications for Maqasid al-Shariah.*

Keywords: *Accessibility, healthcare services, maqasid al-shariah, Muslim community, Uganda.*

I. Introduction

Starfield (2001) defines access to healthcare services as the perceptions and experiences of people to their easiness in reaching to health services or health facilities in terms of location, time, money and ease of approach. Accessibility to healthcare services makes society healthier and raises their earning capacities (ILO, 2008). Good health is one of the main determinants of economic growth and a component of well-being of the population (Scheil-Adlung *et al.,* 2006). In addition, good health has positive impacts on school attendance, employment and human capital development (Lamiraud *et al.,* 2005). Better health means much higher survival rates for infants and children, which raises GDP per capita by increasing the ratio of workers to dependents. Better health among adults increases labour force participation and improves the productivity of those who are at work (ILO, 2008). These together have significant positive impact on sustainable economic growth and social development. Thus, improves social welfare (Victor, 2004) which is one of the main objectives of *shariah* (Al-Ghazali, d.1111 CE).

However, Uganda's healthcare performance is still ranked among the worst in the world (WHO report, 2009). Uganda is a landlocked country in East Africa with total population of 34.9 million and its population growth rate is 3.03 % (UBOS, 2014). It is still a low income developing country ranking 161 on the Global Human Development Index in 2012 (HDI report, 2013). The resources available for healthcare are less than required to deliver the National Minimum Health Care Package. Households continue to carry a heavy burden with a high out of pocket expenditure on healthcare services which constitute 42% of their total expenditure (WHO, 2014). According to Uganda ministry of health annual report (2013), the amounts of investments (human resources and finances) for health from the government continue to be below the Health Sector Strategic and Investment Plan (HSSIP) targets which were already below the globally recommended targets. Financial investment in health by the government shows a further decline over the years from 9.6% in 2009/10 to 7.4% in

2012/13. These indeed, affect the very basic elements *Maqasid al- Shari'ah*, i.e. protection of life, removal of hardship and improvement of social welfare.

II. Research Questions

On the basis of these research backgrounds, this study attempts to answer the following research questions:

1. What is the perception and attitude of Muslim community on the accessibility to basic healthcare services in Uganda?
2. What are the most significant factors that affect their abilities to access basic healthcare services?
3. How does the accessibility to basic healthcare services affect Muslim community social welfare & hence *Maqasid al-Shari'ah*?
4. How can the accessibility of Muslim community to basic healthcare services be improved, given the fact there is a low public spending on healthcare sector?

III. Literature Review

Maqasid is the plural form of the word *qasd* which means purpose, aim, objectives of an action (Kamali, 2008). *Maqasid* comprise the wisdom and knowledge behind rulings and objectives of particular actions. While the term *Shariah* literally means 'way to water' (the source of all life), a straight path to be followed and signifies the way to Allah (Dusuki & Abdullah, 2007). Hence, *Maqasid al-Shari'ah* represents "the objectives and the rationale of the *Shari'ah* (Dusuki & Bouheraoua, 2011). It encompasses all aspects of life, political, social, economic, religion and cultural, etc.

The definition of the objectives of *Shari'ah* has been provided by various Muslim jurists, including reknown Muslim jurists such as al-Imam Ghazali, al-Imam al-Shatibi, Ibn Ashur, etc. For instance, Ibn Ashur (1998) defines the *Maqasid al-Shari'ah* as to preserve the social order of the community and ensure its progress by promoting the well-being and virtue *(Salah)* of human beings. The virtue of human beings consists of the soundness of their intellect and the righteousness of their deeds, as well as the goodness of the things of the world in which they live that are put at their disposal. Al-Imam al-Ghazali (d.1111 EC) was of the view that the main objective of *Shari'ah* is to promote the social welfare of the people. It is unanimously agreed among the Muslim scholars that the primary goal of *Maqasid al-Shari'ah* is to serve the interest of all human beings and protect them from harm (Dusuki & Bouheraoua, 2011).

Generally the rationale behind *Maqasid al- Shari`ah* is to benefit the individual and the community at large and hence *shari'ah* is designed to protect these benefits and facilitate improvement and perfection of the conditions of human life on earth. The Qur'an is expressive of this when it singles out that the most important purpose of the prophet hood of Muhammad (peace be on him) is to bring mercy to all mankind. The Quran says: "We have not sent you but a mercy to the mankind" (21: 107). The *Shari'ah* seeks to establish justice, eliminate prejudice and alleviate hardship. It also seek to promote cooperation and mutual support within the family and the society at large (Kamali, 2012).

Furthermore, al-Imam al-Ghazali classifies the components of social welfare into three-levels or hierarchies: Necessities, Complements and Embellishment. Necessities *(Dharuriyyat)* comprise all the activities and things that are essential for the preservation of five essential elements for good social and individual life: faith, life, intellect, posterity and property. Whatever insures safeguarding these fives elements serves the public interest and is desirable. Al- Shatibi (d.1380 CE) like Al-Ghazali (d.1111 CE) regards these five elements as the basis for *Maqasid al-Shari'ah* (Al-Ubaidi, 1992). In the absence of the proper preservation of these five essential elements, it would be difficult to ensure order and prosperity for mankind (Mustafa, 2006). Faith (al-Din) for instance, allows the individual to elevate himself spiritually above his animalistic desires, as it controls his excess desire for wealth and sacrifice the surplus for the welfare of the less privileged members of the society (Mustafa, 2006). According to Chapra (2000), faith is put first because it provides the worldview which tends to influence the whole human personality. Faith provides the moral filter which injects meaning and purpose into the use of resources, and also the motivating mechanism needed for its effective operation.

Preserving life requires the provision of all the basic needs such as food, healthcare, clothing, shelter, transport, and education for survival and protection against harm (Chapra, 2000; Ogunbado, 2011). Abu Zaharah (1997) sees the intellect as a public property and not a private one. So intellect must be preserved in such a way that it is an asset for the society and not a liability. The mind must be fed with proper and useful information so as to provide social benefits. Anything that will corrupt and intoxicate the intellect must be avoided, as it increases social costs. Meanwhile posterity or progeny is preserved in order to safeguard human

species. This is done by protecting and strengthening the family institution and combating any activities such as adultery that will undermine the welfare of this institution. Wealth is preserved through investment and entrusting it in the hands of just and productive person. It should be used for economic development, investment in public goods and for equitable distribution of income so as to raise the living standard of the haves not (Mustafa, 2006; Ogunbado, 2011).

Complements *(Hajiyyat)* comprise all activities and things that are not vital to the preservation of the five objectives of *Shari'ah* but really are needed to relieve or remove impediment and difficulties in life (Nyazee, 1994). Ibn Ashur (1998) defines *hajiyyat* as activities or things which Muslim community needs to improve their wellbeing and must manage them in an effective ways. For instance, *waqf* eases the difficulty faced by the destitute and the poor in addition to promoting social welfare of Muslim communities at large. In fact, if *waqf* is not instituted, Mosques could not be solely built and sustain on *Zakat* fund as it is designated for other social causes besides *fi sabil Allah*. Poverty - stricken people who have no access to education, healthcare, daily sustenance, etc. would not expected to be a part of productive and meaningful citizens among the *Ummah* (Ibn Ashur, 1998). Indeed, the Prophet's (PBUH) concern on the welfare of the *Ummah* is the very reason that he encouraged his companions to create *awqaf* to meet various social needs of Muslim communities and societies at large. Embellishments *(Tahsiniyyat)* include activities and things that go beyond the limit of convenience. More specifically, it includes matters that adorn livelihood (Abu Zaharah, 1997). Going beyond refinement into self-indulgence is considered *mafsada* (disutility) for the individual and society alike and is strongly disapproved (Belarbi, 1992). Of course, due to changes in one's lifestyle one may move certain activities or things from one level to another. Al- Shatibi considers necessities, which are at the highest level of *maqasid*, as an overriding objective of *al-Shari'ah.* In case of a conflict between the private and societal goals, the latter prevails (Abu Zaharah, 1997). On the basis of the underpinning theory of *Maqasid al-Shari'ah* and social welfare, this study examines the effect of accessibility to basic healthcare services on *Maqasid al-Shari'ah*. The next section examines research methodology that will be used for data collection and analysis.

IV. Research Methodology

This study has used self-administered survey for data collection. According to Burns and Bush (2000) a survey is a suitable method for collecting data about attitudes and opinions. It also allows quantitative analysis to be conducted in the testing of inferences and also permits generalisation of findings. The process of questionnaire development began with an extensive analysis of literature on factors affecting accessibility to healthcare services which include consumer choice to healthcare services, costs of healthcare services, ability to pay for healthcare services, quality of public healthcare services, right to basic healthcare services, public sector allocation for healthcare and overall consumer satisfaction. Vicki-Ann (2013) argues that accessibility to health services are affected by physically factors, affordability factors (economic accessibility), appropriateness and acceptability. For instance, Vicki-Ann cited in 2008 National Aboriginal and Torres Strait Islander Social Survey (NATSISS) found that about 26% of Indigenous people aged 15 and above living in non-remote areas of Australia had difficulty accessing health services. The main reasons cited were long waiting times, services not being available when needed, difficulties with transport and health-care costs.

According to James (2006), provision of basic health services in developing countries has been measured by indicators of health care spending, resources (personnel and facilities), access, and utilization, as well as by maternal and infant program. World Health Organization cited that the social and economic environment, the physical environment, and the person's individual characteristics and behaviours are significant determinants of health care services. For instance, higher income and social status are linked to better accessibility to health care services. Thus, the greater the gap between the richest and poorest peoples in the society, the greater the differences in accessibility to health care services. Moreover, low education levels are linked with poor health, more stress and lower self-confidence. Effects of physical environment such as safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. As the WHO Commission on Social Determinants of Health has argued, inequality is a major cause of poor health, and hence of disability. Similarly, greater support from families, friends and communities is linked to better accessibility to good healthcare services.

Nine characteristics that measures accessibility to healthcare services in Uganda were identified from the literature and incorporated into the questionnaires. These characteristics are consumer choices, quality of public healthcare services, consumer accessibility to private healthcare, costs of private healthcare services, mode of payment for healthcare services, conditions of public healthcare services, right to basic healthcare services, public sector allocation on healthcare and overall consumer satisfaction. The questionnaire was designed based on the Likert scale, which consists of statements that express agreement and disagreement of the respondents

toward the object of interest (Sekaran, 2003). The Likert scale is easy to develop and also easy for the respondents to answer question and is reliable (Emory, 1985). Hence, the nine characteristics were measured on some form of a Likert-type scale (e.g. 1= strong agree to 4= strongly disagree). The questionnaires were then distributed to a sample of 350 respondents out of which a total of 300 were collected as valid and complete. The questionnaires were distributed to the Muslim population across the central, southern and northern Uganda. Respondents were classified by gender, age, marital status and education level. Statistical tools used for analysis is descriptive statistics and factor analysis were used.

V. Results and Discussion

The results are presented in the form of percentage and descriptive statistics. The demographic results reveal that the majority of the respondents were middle-aged, married, male and with some form of high qualification. Meanwhile for the descriptive statistics, the mean scores range from maximum of 2.934 to a minimum of 1.459 regarding the respondents' agreement on each characteristic. The standard deviation scores range from maximum of 0.967 to a minimum of 0.590, revealing that most of the responses were clustered around disagrees to strongly disagree on most of the statements.

Table 1: Perception of Muslim Community in Uganda on Accessibility to Healthcare Services

Items	Measurement Scale	Percentage	Mean	Std Dev.
1. Consumer Choice	1.Government hospital/health centre	50	1.55	0.59
	2. Private hospital/ health centre	45		
	3.Pharmacy/shop	5		
2. Quality of public healthcare services	1. Improved	14	2.478	0.73
	2. Not changed	24		
	3.Worsen	62		
3. Access to private healthcare services	1. Easy to somewhat very easy	39	2.66	0.830
	2. Difficult to somewhat very difficult	61		
4. Costs of private healthcare services	1. Agreed to somewhat strongly agreed	94	1.46	0.632
	2. Disagreed to somewhat strongly disagreed	6		
5. Modes of payment for healthcare services	1. Use Personal saving	64	1.63	0.967
	2. Borrow money	18		
	3. Sell valuable goods	10		
	4. Health insurance	8		
6. Improvement in public health	1. working very well	6	2.753	0.698
	2. Needs minor changes	23		
	3. Needs major changes	62		
	4. Not working at all	9		
7. Right to basic healthcare services	1. Agreed to somewhat strongly agreed	90	1.52	0.759
	2. Disagreed to somewhat strongly disagreed	10		
8. Public expenditure on healthcare	1. Too much	9	2.278	0.827
	2. Too little	68		
	3.The right amount	8		
	4. I don't know	15		
9. Consumer satisfaction with public healthcare services	1. Satisfied to somewhat extremely satisfied	27	2.934	0.642
	2. Dissatisfied to somewhat extremely dissatisfied	83		

The results in Table 1 shows that respondents have wide choices for healthcare services in Uganda, as half of the respondents (50%) were frequently using public hospitals and healthcare centers whenever their family member fell sick, 45% used private hospitals and clinics, and only 5% bought drugs from pharmacies or shops whenever they fell sick. Standard deviation result of 0.590 indicates that most of the responses were distributed between public hospital/healthcare centers and private hospitals/clinics. In other words the results generally show that consumers in Uganda have choices for healthcare services. This particular findings substantiates a study done by Partners for Health Reform plus (PHRplus) in 2006 in collaboration with the Public- Private Partnership for Health (PPPH) Desk of the ministry of health, where it is found that the number of Private Healthcare facilities in the country accounted for 46% of the total healthcare delivery system. A total of 9,500 health professionals were estimated to be working exclusively in the private sector, including more than 1,500 doctors i.e. almost 40% of total health workers in the country.

Ironically, the findings reveal that sixty two percent of the respondents (62%) acknowledge that the quality of public healthcare services has worsened over the past years and only fourteen percent of the

respondents (14%) agree that the quality of public healthcare services has improved over the past years. Mean result of 2.478 reveals that there is general consensus among the majority of the respondents on the poor quality of public healthcare services. This shows that half of the respondents have no choice but to visit public healthcare services despite poor quality services. This finding is consistent with a study conducted by the World Bank and Uganda Ministry of Health in 2009 which found out that absenteeism is the largest waste factors in the public health sector in the country, which was estimated at the cost of Ushs 26 billion per annum. In addition, health workers have bad attitude to patients and the patients were left at their mercy. This reduces effective utilisation of healthcare services; as health workers often do not feel accountable to society and often neglect the patients. Moreover, leadership and management of human resources are also weak at all levels (WB and UMOH report, 2009). All these factors led to poor quality of public healthcare services. Furthermore, Julie, et al. (2011) study revealed that most of public hospitals and health centers across the country have a chronic shortage of beds, drugs and medical personnel, confirming a recent verdict by the Anti-Corruption Coalition of Uganda that "service delivery and general care is almost not there in public healthcare sector.

To make matter worse, most of the respondents (61%) agree to somewhat that it is very difficult to obtain healthcare services from the private hospitals or health centers and only 39% of the respondents said it was easy to somewhat very easy to access private healthcare services. Mean result of 2.659 reveals that there is general consensus among the respondents that indeed, it was difficult to somewhat very difficult for the majority of the people to access private healthcare services. Standard deviation result of 0.830 indicates that most of the responses were distributed between difficult to very difficult, with very easy being the least. According to the ministry of health report (2008), households are charged exorbitantly for private healthcare services and this makes private healthcare services inaccessible for the majority of the needy and the poor. The report added that medicines are 3-5 times more expensive in the private sector compared to the public sector. For many people, medicines in the private sector are not affordable and this constitutes a major obstacle to households accessing medicines. This is confirmed by this study, as an overwhelming majority of the respondents (94%) agree to somewhat strongly agree that healthcare costs in private sector are very high and the majority of the people cannot afford to get decent healthcare services. Mean result of 1.46 reveals a strong consensus among the respondents that the costs of private healthcare services are too high to the majority of the people. Standard deviation result of 0.632 indicates that most of the responses were distributed between agree and strongly agree, while strongly disagree being the least.

Sadly, the study demonstrates that health costs is one of the main obstacle to wealth accumulation, as the majority of the respondents (64%) use their personal saving for paying their medical bills. Eighteen percent (18%) borrow money to pay for their medical bills, 10% sell household items/farm produce & animals/ valuables to pay for healthcare bills and only 8% had health insurance. Standard deviation result of 0.967 further indicates that responses were widely distributed between mode of payment for healthcare services, and use of savings received the most responses and health insurance the least. Indeed, this finding substantiates by UBOS households survey (2010), where in Uganda; households spend about 9% of their income on healthcare, despite the fact that public healthcare services are free of charge. Yet, there is very limited coverage for private health insurance and there is no National Health Insurance Scheme (NHIS), which is supposed to cater for the majority of Ugandans. Thus, health expenditure remains high for most households, forcing them to use their personal savings, borrow money or sell their household items including valuables to pay for healthcare services.

In relation to public healthcare facilities, the majority of the respondents (62%) believe that the public healthcare facilities needs major changes and with relatively high mean 2.753; there is a strong consensus among the respondents that there is urgent need for major changes in public healthcare facilities. These findings substantiate the argument put forward by the Director General of Health Services (DGHS), Dr. Ruth Achieng that healthcare problem in the country is mainly due to ethical erosion. There is a need for a major overhaul of the healthcare system as a whole from human resources to infrastructures; and that may require over Ushs. 2.6 trillion to upgrade public hospitals and healthcare centers across the country (Achieng, 2011).

Since access to basic healthcare services is a basic human right, it is interesting to notice that an overwhelming majority of the respondents (90%) agree to somewhat strongly agree that everyone has right to a medical treatment that might save his or her life regardless of the costs and individual ability to pay. Yet the majority of the respondents (68%) believe that government is spending too little for public healthcare. Standard deviation result of 0.8271 further demonstrates that the responses were widely distributed among the alternatives, with most responses clustered around too little and least around the right amount. According to WHO (2008), concern about equity in healthcare services arises because health is universally accepted as a merit good, and each individual is entitled to basic healthcare services regardless of ability to pay. In health care markets, the equity issue is manifested by widespread public subsidization or direct provision of health care. The case for health subsidies is particularly strong because evidently, an individual needs some minimum amount of healthcare services to survive (Grossman, 2004). Last but not least, Table 1 reveals that the overwhelming majority of the respondents (83%) were not satisfied to somewhat extremely dissatisfy with

public healthcare services, and only a minority of 27 % were satisfied to somewhat extremely satisfied. Considering relatively high mean 2.943 there is a strong consensus that most of the respondents were dissatisfied to somewhat extremely dissatisfied with public healthcare services in Uganda. Standard deviation result of 0.642 indicates that most of the responses were distributed between not satisfied and extremely dissatisfied with extremely satisfied being the least. They cited several reasons for their dissatisfaction, which include: rampant corruption, embezzlement of healthcare fund, discrimination, increased absenteeism and inefficiency of the public healthcare workers. In addition, lack of resources in public healthcare sector led to under staffing and under paying of health workers. Furthermore, public healthcare facilities are dilapidated, and there are limited numbers of healthcare centers. There are few and outdated functioning medical equipment and machinery such as x-ray, scanning and theatre facilities in referral hospitals. Moreover, drugs are limited in public healthcare facilities and sometimes patients are forced to buy medicines in private sector at high prices. In addition, the per capita doctor to patient is too high and this increases waiting lists in public healthcare facilities.

Furthermore, factor analysis is conducted to determine the most significant factors that limit accessibility of the respondents to basic healthcare services. Vicki-Ann (2013) categorized these factors into physical accessibility factors, affordability factors, appropriateness factors and cultural acceptability. To test the factorability of the data, the Kaiser-Meyer-Olkin (KMO) and Bartlett's test of sphericity are used. The former measures sampling adequacy while the latter is a test of sphericity. Bartlett's test of sphericity is a statistical test used to examine the hypothesis that the variables are uncorrelated in the population (Vaus, 2002). Table 2 presents the results of the statistical tests which support the use of factor analysis as the KMO value is 0.794 and Bartlett's Test of Sphericity also significant (0.000).

Table 2: KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.794
Bartlett's Test of Sphericity	Approx. Chi-Square	171.361
	df	36
	Sig.	.000

Table 3: Rotated Component Matrix of Accessibility to Basic Healthcare Factors

Items	Factor 1 Physical Accessibility	Factor 2 Affordability	Factor 3 Appropriateness
Poor Quality of public	.459		
Private Inaccessibility	.678		
Poor Public facilities	.715		
Overall dissatisfaction	.577		
Cost of Private healthcare		.672	
Equity		.759	
Public allocation		.487	
Healthcare choice			.851
Mode of Payment			.383
Eigenvalue	1.854	1.232	1.170
% of variance	29.23	14.36	13.69
Cummulative %	29.23	43.59	57.28

Table 3, shows there are three factors with an eigenvalue greater than 1 (1.854, 1.232 and 1.170). This initial analysis therefore resulted in a three-factor solution. That is, 9 items were reduced to three factors. Each Factor explains a particular amount of variance in the items. In this case, Factor 1 explains 29.23%, Factor 2 explains 14.36% and Factor 3 explains 13.69%. Together these three factors explain a total of 57. 28% of the variance. According to Vaus (2002), the more variance that is explained by the factors, the better the factor solution and the more comfortable the study is in reducing the initial 9 items to three factors. The results reveal that physical factors such as poor quality of public healthcare services, poor public healthcare facilities and inaccessibility to private healthcare services led to overall dissatisfaction among the general masses and that significantly affect accessibility to basic health care services in Uganda. In addition, unaffordability to private healthcare services due to high cost of healthcare services and belief of the people that basic healthcare services is a human right irrespective of their ability to pay also significantly affect the ability of the people to access basic healthcare services. Lastly, inappropriateness is the third factor that affects accessibility to basic healthcare services. Inappropriate public allocation to healthcare sector, corruption and use of personal saving and selling valuable assets to finance healthcare rather than using insurance scheme greatly limits the ability of the majority of the people to have access to basic healthcare services

VI. Conclusion and Suggestions

The study has identified that lack of physical accessibility factors such as poor public healthcare facilities; unaffordability and inappropriateness are the most significant factors that affect accessibility to basic healthcare services in Uganda. In general, the majority of Ugandans rely on the public healthcare services, despite the poor quality because they cannot afford private healthcare services. The costs of private healthcare services are exorbitant and this makes private healthcare services inaccessible to the majority of the people. Yet public sector spending on healthcare remains low and there are no national health insurance scheme. Citizens are left with no choice but to use personal savings and sell their valuable assets to pay for their medical bills. These results in overall dissatisfaction among the general masses, increase burden to the majority of the people and affect their social welfare and thus *Maqasid al-Shari'ah.*

Sen (2000) proposes two pathways model to increase the provision and accessibility of healthcare services to the society. The first route is through rapid economic development; where a nation raises the level of its real per capita income and this gives its society high purchasing power so that they can afford to buy high quality healthcare services. At the same time, a high income nation can afford to provide better quality and affordable healthcare services for all citizens. Indeed, "Asian Tigers" that include South Korea, Hong Kong, Taiwan, Malaysia and Singapore are successful in increasing longitivity of their people using this pathway. The second pathway to increase accessibility to healthcare services is through, a 'support-led' or social support programmes. This is where individuals, corporations, charitable organizations, religious and non-religious affiliated NGOs providing healthcare services to the poor and the needy section of society through donations, payment fees and investment. Today, the second pathway has contributed significantly in providing healthcare services to the poor and the needy in both developed and developing countries. For instance, in the United States, nonprofit organizations still account for over half of the hospital care, 45 percent of the outpatient clinic care, and nearly 30 percent of the nursing home care. They thus form a vital part of the nation's health care delivery system and have demonstrated durability in the face of rather dramatic recent changes (Salamon, 2015). In Malaysia, *Waqaf An-Nur* Corporation (WANCorp) adopted corporate *Waqf* model which enables the corporation to provide healthcare *s*ervices to the poor and the needy through chain of its clinics known as *An-Nur Waqaf* Clinic and Hospital *Waqaf An-Nur* (JCorp annual report, 2013). At the end of 2011, WANCorp owns and operates 16 branches of *An-Nur Waqaf* Clinic, 4 dialysis centres, and one *waqaf* hospital managed by KPJ Healthcare Bhd. In addition to using its own resources, WANCorp also receives cash donations and in kinds donations, such as medicine, dialysis machines, and medical equipment from the community members and also corporate donors. By 2011 *An-Nur Waqaf* clinics and hospital managed to treat more than 765,000 patients from various ethnic groups and religious backgrounds with only a nominal charge of RM5 for each treatment. All *An-Nur waqaf* clinics are equipped with dialysis machines to cater for the needs of patients at subsidized rates. In some cases, for deserving patients, the services are given free of charge. Therefore, this study suggests that Uganda Muslim community should adopt *waqf-based* models such as cash *waqf* and *waqf* shares scheme to raise fund to finance construction of *waqf* hospitals and clinics that can provide affordable and good quality healthcare services to the community at large.

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