

Final Draft - Seminar Paper

## Section I

Throughout history, health care services have continually progressed due to vast improvements in medical knowledge and technology. Life expectancies continue to rise throughout various areas around the world as a result of these revolutionary changes. Despite the advancements made in medicine, lack of availability of resources and access to health care remains a prominent issue for virtually every nation. The problem no longer lies with trying to develop effective medical service, but rather how these services are to become easily available to all people. Shortages in health care providers, medical supplies, equipment, and pharmaceuticals are increasing, which places a great amount of strain on the global health care system.

Several factors contribute to the paucity in medical services around the world, and population growth is one of major driving forces. With a current population of roughly 6.6 billion, the international public and private health care sector is predicted to be short at least 400 million healthcare workers (Garret 1). Furthermore, there are approximately 20.09 births for every 1,000 people and the world average life expectancy is 65.82 years (The World Factbook). With such a high birth rate and relatively long life expectancy, it is no wonder that there are simply not enough health providers or supplies to treat this massive global population. According to the Journal of the American Medical Association, by 2020 it is predicted that the United States alone could be short 800,000 nurses and 200,000 doctors (Garret 1). As health care is necessary for human survival, these frightening figures illustrate the severity of this global trend.

In addition to population growth, economic issues also contribute to insufficient

health care. For the most part, developing countries experience the largest disparities in modern medicine due to the fact that their weak economies inhibit their potential for improvement. Out of the world's population of nearly six billion, at least two billion people live in poverty (Kelleher and Klein 61). In regards to health care, this population suffers from more diseases and has lower life expectancies because available and accessible medicine is lacking in these regions. Africa is perhaps suffering the most due to its high incidence of HIV/AIDS. Sub-Saharan Africa has the highest population affected with the HIV/AIDS epidemic, but their overwhelming poverty and growing population fails to provide enough medical care. In 2001, faculty at Harvard University conducted research and estimated that fewer than 40,000 HIV/AIDS patients in sub-Saharan Africa were receiving antiretroviral medications even though the region has approximately 25 million individuals infected with the virus. Furthermore, it was estimated that at least 600,000 of those without medication need immediate care in order to survive. Conditions have slightly improved since 2001, but not enough to make significant progress. These poorer areas not only suffer from the situation in their own countries, but the disparities in health care of wealthier nations also have an impact on their circumstance. Laurie Garret, writer for Foreign Affairs, comments that "as the populations of the developed countries are aging and coming to require even more medical attention, they are sucking away local health talent from developing countries. Already, one out of five practicing physicians in the United States is foreign-trained." She is referring the frequent migration of doctors from developing countries to the United States, United Kingdom, Canada and other industrialized nations because the working conditions in these regions exceed those of their home countries. If this continues to be

the response, it seems likely that eventually the majority of healthcare professionals in wealthy nations will be individuals from poorer countries which will only enhance the desperate needs of the developing world (Garret 1).

Tackling all of these issues involved with the global health system continues to be a daunting task for countries around the world. However, the battle differs between industrialized nations and developing countries. In most wealthy countries, solving the issue seems to be more focused on finding ways to provide the millions of uninsured individuals with medical coverage in order to promote equitable and affordable access. There are ongoing debates between liberals and conservatives regarding the implementation of universal health care policy, which some view as the ultimate solution. Universal health care revolves around the concept of social insurance which means that government will mandate contributions into social insurance systems by all citizens, including fees for medical services (Bodenheimer 1). Liberals remain strong advocates of this health care system, arguing that it would increase accessibility for many individuals by providing insurance to those who previously lacked it. Opposing conservatives argue that this health program would be too similar to socialism and that people would become “more dependent on hand-outs, expanding the clumsy hand of regulation, and hobbling individual choice” (Menzel 1). Despite the controversy, there are several nations that offer different forms of universal health care policies including the United Kingdom, Canada, Australia, and Germany to name just a few. However, even these nations experience internal conflicts regarding this socialized health system. While universal health care guarantees all individuals medical coverage, it also dramatically inflates patient flow. As a result, many people in the UK and Canada must

be put on long waiting lists for medical procedures, surgeries, and even check-up appointments. In 2006, it was estimated that nearly 900,000 people had to wait to be admitted into one of the National Health Service Hospitals in the UK, and the patient overload has caused at least 50,000 cancellations of operations per year. In Sweden, wait times for surgeries range from 25 weeks to a year (Tanner 1). This has prompted several debates over whether or not this type of health care system improves or worsens conditions. In 2005, Canadian Chief Justice Beverly McLachlin said that “access to a waiting list is not access to healthcare” (Tanner 1).

The pressing economic issues facing underdeveloped countries deny these regions the option of universal health care; therefore policies and reform constitute an entirely different realm of debate. Unlike industrialized nations, third world countries have the obstacle of poverty to deal with. Since poverty generates most of the health care problems, reform is commonly directed towards economic development. However, there are different opinions on how to approach economic development. Some policy-makers promote economic growth and industrialization. Proponents of this strategy argue that in order to fix problems associated with poverty, such as insufficient health care, developing countries must undergo industrialization in order to improve their economy which will eliminate most of the issues. On the other hand, others feel that fulfilling basic-needs in order to improve the lives of individuals now rather than later is more appropriate (Kelleher and Klein 66, 99). In an article of the British Medical Journal, the authors analyze the current reform efforts in Africa and make arguments regarding these two approaches. The article emphasizes how global corporations donate money towards medications, hospitals, and other health related ventures with the intent to provide

immediate relief so as to enhance Africans' quality of life by fulfilling their medical needs. The authors argue that while these efforts are beneficial, increasing foreign aid and debt relief will have little effect on alleviating the health care crisis if not coupled with other developmental efforts. They continue to argue that industrializing Africa's economy would ultimately fulfill health care goals by improving poverty conditions. The article states, "Across Africa, liberalisation of trade has increased displacement of local industry by large and international concerns, and couples with agricultural subsidies in rich countries, depressed commodity prices. African states must be allowed to control the pace of liberalisation and guide development to allow for a more balanced and fairer economy" (Sanders, Todd, and Chopra 757). Clearly, the authors' emphasis on trade and the economy reflects their support for economic growth versus fulfillment of basic needs. As this article exhibits, the differing opinions regarding development have the potential to create conflicts between policy-makers and reformists, making it hard to successfully make improvements in developing countries.

Overall, disagreements in approaches to health care solutions only prolong the issue at hand, which is why the health care system continues to be an issue around the world. While the circumstances may vary between wealthy and poor nations, one cannot argue that lack of availability and accessibility to health care is a widespread, global trend affecting all individuals.

## Section II

The weaknesses in global health care system not only have a tremendous affect on individuals in need of care, but it severely impacts workers in the health care profession. Countries face challenges such as worker shortages, skill mix imbalance, poor

distribution, negative work environment, and weak knowledge base. In the poorer countries, the paucities in health care create debilitating conditions plagued by epidemics, out-migration, and lack of funds (Chen 1). All of these circumstances have an influence on all aspects of the health care sector, including medical practitioners. The health care system in Uganda, a country located in East Africa, closely fits the mold of this global crisis. Medicine in this country undoubtedly reflects its crippling economic situation which directly impacts the health institutions, practitioners, and overall profession in the area.

With a population of 26 million, Uganda continues to be one of the most populated countries in Africa. The nation has been battling poverty for years, and therefore lacks the ability to expand and prosper as an industrialized nation. The per capita income in Uganda is only \$280 which makes this country one of the poorest in the world (Uganda: Country Brief). Currently, 38% of Uganda's people live below the national poverty line. Additionally, 23% of children under the age of five suffer from malnutrition and nearly 40% of the population does not have access to a sanitary water source (Uganda at a Glance). Studies have shown that the population increases in Uganda by about one million every year (Wakabi 1). This steady growth in addition to the poverty conditions places a considerable amount of strain on the health care system. As with other areas around the world, Uganda suffers from considerable shortages within their health care system. The doctor-to-patient ratio in the area is 1:28,000. While this obviously creates most of the issues, the most prominent obstacle to accessing medical care is poor infrastructure. Transportation and communication are lacking in Uganda which makes it nearly impossible for citizens to gain access to medical services. Over

50% of hospitals are located in urban areas, where only a reported 11% of the population lives. The other 89% of Ugandans must travel miles to the nearest facility (Knudsen 254-255)

In 1992, the Canadian Physicians for Aid and Relief which is a program providing communities in need with better access to health care, based one of their projects in Uganda. Dr. Virgil Onama, a participating physician, describes the working conditions Moyo Hospital in Northern Uganda as severely insufficient. The facility lacks an x-ray department and has no laboratory. The water supply comes from bore holes located outside of the hospital which can only be retrieved by walking from the hospital to these areas. These conditions present health care institutions and their practitioners with a large obstacle since services remain limited by these unfortunate circumstances. The Ugandan government does provide the hospital with food and medicine supply for the patients, but it is only enough for an estimated 100 patients. Unfortunately, the patient load usually exceeds 250 patients or more, creating shortages in food, medicine, and hospital beds. The hospital also lacks sterile needles and gloves which put health care workers at great risk since most of the patients are HIV positive. Dr. Onama also explains that the first two years he worked at this hospital he did not receive a paycheck. He eventually made U.S. \$175 per month which was not much more than the average salary for that time. He was also the only doctor there during his first year, and only 15% of the staff members were trained medical professionals. By 1997, five years after Dr. Onama had arrived at the hospital, there were a total of four doctors which was still five short the amount required by government regulations (Gallagher 1) Despite these harsh conditions, Dr. Onama continued to work there and encourages other physicians to join

the program. After all, most doctors go into the field of medicine to help people and countries like Uganda tremendously benefit from such programs.

Another physician, Dr. James K. Tumwine who is an associate professor of Pediatrics and Child Health at the Makerere Medical School in Uganda, offers his insight into Ugandan hospitals as well. In 2004, he published an article in *Health, Policy, and Planning*. In his article he discusses a memorable workday at the hospital, illustrating the working conditions and the overwhelming disadvantages. Upon arriving at the hospital at 5:00 am, after an emergency phone call, he finds seven children convulsing due to a combination of mushroom poisoning and cerebral malaria. A family is also there, grieving the death of their six year old daughter. They traveled nearly 300 km to the hospital, and sadly they have no transportation to take the body home. Fifteen children are undergoing blood transfusions, eight have severe pneumonia, five more have severe dehydration from diarrhea, and four suffer from malnutrition. In addition to the overwhelming patient load, Dr. Tumwine describes his frustration towards the lack of supplies. He writes, “The staff has had to deal with all these problems with very limited resources” (246). Medication shortages are the most common problems. The hospital often runs low on quinine and ceftriaxone which are treatments for cerebral malaria and meningitis. Parents often become discouraged when they discover that their children cannot receive the proper treatment. Unfortunately, the increasing patient load continues to create shortages in medications, supplies, and equipment. Dr. Tumwine also explains that organizations do provide donations and loans towards the Ugandan health care system, but the revenue base is very small (246). Despite the horrid working conditions Dr. Tumwine, along with a few other physicians, continues to provide care in the hopes

that they can make a difference utilizing the resources they have. Working in developing countries, like Uganda, puts greater pressure on the health care workforce which affects the overall disparities in health care of the area.

These two accounts of the health care system in Uganda demonstrate the country's harsh conditions as it relates its economic instability. Even though the articles were written at different times (1997 and 2004), the content of each provides very similar accounts. This resemblance reveals the fact that Uganda has not made any vast improvements in its health care system over the past several years. Even now, three years after the last article was written, the conditions still remain the same making it hard for physicians to complete their work successfully.

### Section III

As the health care system remains a burden across the world, health care workers in all different countries are forced to practice medicine and provide care despite the deficiency in equipment, supplies, medications, funding etc. These shortages challenge medical professionals as the population continues to grow leaving the international doctor to patient ratio in declination. Providers of health care all over the world face overwhelming obstacles as they attempt to become effective providers amidst all the chaos. Epidemics and disease continue to be on the rise which increases international pressure to develop health systems that fulfill the needs of the global population with equal justice, quality, and financial protection (Frenk 1). While the circumstances in each country vary, each nation experiences some sort of impact from this global trend which in turn affects medical personnel worldwide.

In response to these poor conditions, doctors and other health care providers are

migrating to different areas of the world in search of better opportunities. Since the global health care system is short millions of workers, these individuals do not have a hard time finding a place to go, but as a result there is a severe imbalance in concentrations of doctors. For instance, the United States and the United Kingdom seem to be receiving most of the migrant physicians. In 2003, the UK registered a little more than 11,000 health care professionals from sub-Saharan Africa. It is estimated that for every doctor leaving the country, Africa loses U.S. \$184,000 towards health care (Katikireddi 1). Sadly, this situation is common to many nations especially developing countries, which leaves these areas with an even higher deficit in health practitioners.

According to recent statistics, nearly 350 million people in India live on less than a dollar per day which classifies the country as having the world's largest concentration of poor. Nearly half of the children living in India suffer from malnutrition (Waldman 1). These conditions create overwhelming health concerns as India's economic instability fails to provide its citizens with adequate medical service. Similar to Uganda, the working conditions in India make it close to impossible for physicians to treat their patients. In response, most medically-trained Indians have been fleeing to wealthier countries in hopes of something better. This migration has been casually nicknamed the "brain drain" and it has created a significant shortage in health care workers. Almost 60,000 practicing physicians in the United States, United Kingdom, Canada, and Australia originally come from India. This figure represents nearly 10% of the registered physician population in India. As a country with severe economic problems and increasing population, this small percentage creates large deficiencies in India while it simultaneously helps buffer the shortages in these receiving nations (Mullan 1).

Fitzhugh Mullan, a medical professor at George Washington University as well as editor of *Health Affairs*, traveled to India in the spring of 2006 to observe the nation's health care system. Aware of the frequent migration of Indian physicians, Mullan took notice to the disparities in both the private and public health sectors in the country. He interviewed many citizens in order to get insight on their views on the matter. While some residents feel that the "brain drain" is beneficial to newly trained doctors, others thought that it is insulting to have so many of its nation's physicians leave for other parts of the world. Mullan explains that the government has acted upon the physicians' responses by creating appealing laws to keep young doctors close to home. Economic and immigration policies have also been revised to attract non-resident Indian physicians back to the country (Mullan 1).

Furthermore, based on his observations and interviews, Mullan devised his own policies for both India and countries receiving the most Indian immigrants which he feels would improve India's current shortage of doctors. He first suggests increasing public sector investment and investment in primary care medicine, two areas that India's government tends to neglect in regards to funding. India's medical sector lacks laws for hospital accreditation, practice standards, credentialing for health professionals, and prescriptions. Mullan feels that these aspects of the medical sector need to be regularized through law, as it is in many other countries. By doing so, physicians might feel more comfortable practicing medicine here reducing the migration rate. As far as policies for recipient nations such as the U.S., U.K. and Canada, Mullan argues that the shortage of doctors in these countries shows that medical schools in the West are underinvested. Increasing the number of physicians in training to equal the amount needed would lessen

the demand for physicians, and therefore prevent foreign doctors from migrating to these areas. Programs for physicians studying abroad should “feature leadership training focused on transferring medical leadership skills for the purpose of returning to India” (391).

On the other hand, not all physicians’ reactions have been migration. Some Indian doctors have remained in their home country in order to help with efforts towards improving India’s health care. For example, Dr. V.K. Raju is founder of the Eye Foundation of America and co-founder of Srikirana Eye Institute in rural India, his homeland. While still working in the U.S., Dr. Raju has made several trips back and forth to India since 1977 in order to provide free corneal transplants as well as to train other Indian physicians the art of ophthalmology. He also created an exchange program in which has received more than 200 physicians from the UK, U.S. and Canada. With an estimated 15 million blind people, India has greatly benefited from Dr. Raju’s program. The program is funded by several corporations allowing free service to be available. The eye institute is fairly successful due to support from native physicians as well as doctors from around the world. In addition to Dr. Raju’s dedication, Dr. Chandra Sankurathri has also made a significant contribution to the program. Even after receiving Canadian citizenship, Dr. Sankurathri returned to India to join the efforts of preventing blindness and restoring poor sight for those in need (Corathers 18-20). Dr. Raju and Dr. Sankurathri are examples of two physicians who, instead of abandoning their home country in response to the poor health system, felt the need to help improve the lives of the people in their homeland.

Despite the generous services provided by these two men, India continues to lack

sufficient medical care. The poverty conditions create such challenges within medical care, and eventually efforts need to be directed towards economic development in order to build a strong health system. It is safe to assume that as long as shortages within health care exist, Indian doctors will respond (and other professionals from developing countries for that matter) by continuing their migration to the wealthier nations who are also in need of their services.

The current situation in Uganda almost mirrors the conditions in India. Both countries are considered third world, and their health care services experience comparable deficiencies. Like India, many Ugandan physicians have responded to the poor conditions in medicine by moving out of the country while a select few continue to practice in their homeland. In addition to native physicians returning to the country to provide care, Uganda seems to receive a significant amount of American doctors that offer charitable medical services. Stephanie Van Dyke, hospice volunteer and current medical student at Albany Medical School, built a health clinic in Ddegeya village in Uganda with \$35,000 that she inherited from her late grandmother. When school is not in session, Van Dyke along with two other U.S. physicians, a nurse, and several fellow students from Albany Medical School spend their time in this village providing Ugandans with different medical services (Crowley 1). Another group of physicians from Texas are also active helpers in Uganda. This passed winter, Dr. Tyron Kamar along with 17 other fellow health care professionals, made a humanitarian trip to Mbale, Uganda to provide medical services to the people of this rural village. The trip was organized under Mercy Trips Healthcare Outreach, a newly founded organization (Courtesy 1). This charitable group organizes various trips to poor countries in order to help provide health care

services to the developing nations around the world.

While most developing countries experience the so-called “brain drain,” physicians in some industrialized nations are also migrating to other areas in response to the poor health care system. One of the more recent incidences occurred in Germany, which is located in central Europe. Germany is Europe’s leading economy and it is the fifth largest economy in the world. Despite Germany’s apparent status as a wealthy nation, the health care system remains flawed. As a result, many doctors have reacted by going on strike or threatening to leave the country. The problems seem to lie with poor working conditions that most physicians feel grants them the right to higher paying salaries. Germany’s hospitals have 3,000 unfilled positions collectively which places a huge burden on ensuring equitable care (Tzortzis 1). Consequently, the doctor to patient ratio remains insufficient which forces the currently employed health care providers into working overtime in order to provide the growing population with the care that they need. In response to these conditions, German doctors have gone on strike or moved out of the country. Nearly 12,000 German physicians have migrated to the United Kingdom. Last spring, nearly 2200 health care professionals from Charite University Hospital in Berlin stopped working to protest grueling overtime hours and pitiful salaries. It is estimated that German physicians work nearly 8500 hours in overtime per month excluding the time that they are on call, and 90% of those hours go unpaid for (Chapman 1229). These harsh conditions tremendously impact physicians and other health professionals, and in the long run the patients suffer as well. German physicians are also responding by joining other industries such as pharmaceutical companies. If these conditions continue to prosper, the number of individuals attending medical school may decrease and

physicians will either continue to travel to other areas or pursue different careers.

Overall, the circumstances in Uganda, India, and Germany represent some of the major flaws in the health care system of areas all around the world. These three nations, along with many others, endure drastic shortages in medical care such as lack of medications, supplies, equipment, and most importantly trained physicians which affects availability and access to medical services. These three countries also show that most health care workers respond to this global crisis by migrating to other areas, causing a severe imbalance in health care providers. As availability, access, and working conditions for doctors, nurses, and other providers continue to be poor, the deficits in the global health care system will only increase in future generations.

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