Gendered Health Care Coping In Northern Uganda: What Are The Gender And Equity Considerations In Post Conflict Health System Strengthening?

Sarah N. Ssali1, Robert Byabasheija12, Pallen Mugabe1, and Justine Namakula1. Makerere University- ReBUILD Consortium1, UNICEF Uganda2

Background

Health and health care are a right, yet they continue to elude many in conflict and post conflict situations. While the gendered nature of war and its aftermath are well known, humanitarian and post conflict health system reconstruction continues to focus on infrastructural development. The assumption is that once the facilities exist, anyone should be able to access health care equally and equitably. This ignores the multiple challenges and costs women, men, girls and boys have to negotiate when required medicines are not available or when they are referred for costly investigations. This research documents the gendered nature of household coping with health care costs in Gulu District, northern Uganda.

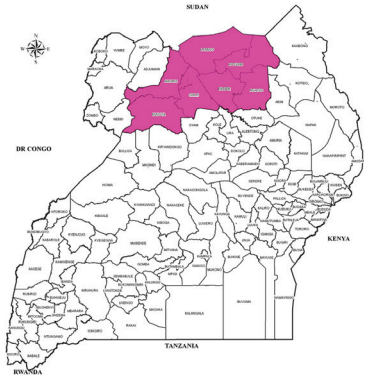
Study Objectives

General:
To understand the extent to which gender is a factor in post conflict health systems

Specific:
To understand the nature of post conflict health reconstruction
To document the gendered nature of health needs in a post conflict setting
To ascertain the gendered nature of opportunities and challenges to accessing health care in a post conflict setting.

The study Area - Acholi Sub Region

General:
Map of Uganda
Showing the Acholi Sub Region.



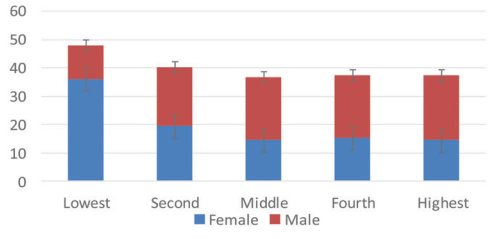
Methods

- 410 randomly selected households. Data analysis was done using STATA; The data from the quantitative survey, a poverty proxy survey, was used to select the poorest of the poor households to subject to life history interviewing. . Wealth index for the data was computed using the principal component analysis method and five quintiles were obtained.
- 47 life history interviews with household heads from the 4 villages (rural and urban mix)
- 16 key informant interviews with health providers and opinion leaders, purposively selected.
- Qualitative data was analysed using Atlas ti and Excel software packages.

Findings

1. Gender, age and marital status were key proxy indicators for poverty. Female household heads who were older and widows were more likely to be poor than their married counterparts and male household heads. Female household heads were more likely to be subsistence farmers, without animals, unemployed and without a wage. From the figure below, female household heads predominated among the lowest wealth categories, whiles males predominated among the highest wealth categories.

Fig 1: Wealth Index distribution by gender



2. While post conflict reconstruction initiatives emphasised rebuilding infrastructure, most households emphasized the direct constraints to health care access such as transport and financial constraints. For example, female household heads mentioned ability to pay as their main challenge in accessing care (14%) more than their male counterparts.

3. With the exception of maternal health, other services are provided with no regard to gender differences. The Emphasis on Maternal health obscures other household health needs which women need to meet as household heads. For example, only females household heads who mentioned heart problems and HIV as illness challenges in their households.

4. Women's strategies for paying required mobilizing money after the patient was ill, which could potentially delay seeking health care. Most female household heads paid the medical bills by engaging in casual work, selling farm produce, and using their savings, while their male counterparts' strategies were using their salaries, selling animals, and casual labour. Only women reported begging, charity organizations, diverting money from their small scale businesses and selling alcohol, while male household heads were more likely to borrow money and not their female counterparts.

Strategies for Paying for Household Health Needs	Gender				Grand Total	
	Female		Male			
	Freq. (n=483)	%	Freq. (n=142)	%	Freq. (n=625)	%
Income from Casual Work	100	20.7	20	14.1	120	19.2
Used Salary	30	6.2	45	31.7	75	12.0
Sold Produce	66	13.7	6	4.2	72	11.5
Sold Animals	27	5.6	45	31.7	72	11.5
Used Savings	51	10.6	0	0.0	51	8.2
Helped by Relatives	42	8.7	6	4.2	48	7.7
Begging	46	9.5	0	0.0	46	7.4
Income from Business	36	7.5	0	0.0	36	5.8
Charity Organisation	22	4.6	0	0.0	22	3.5
Borrowed money from relatives	4	0.8	12.0	8.5	16	2.6
Brewed and Sod Alcohol	11	2.3	0	0.0	11	1.8

5. Ability to pay as a major consideration for where to seek health care was more of a challenge to female household heads (accounting for 14% of mentions) compared to 4% of male household heads' mentions.

Reason for Health Facility Choice	Gender				Grand Total	
	Female		Male			
	Freq. (n=102)	%	Freq. (n=49)	%	Freq. (n=151)	%
Severity of Illness	28	20.7	14	28.6	42	27.8
Perceived Quality of Care	18	17.6	10	20.4	28	18.5
Ability to Pay	14	13.7	2	4.1	16	10.6
Free Health Care	6	5.9	6	12.2	12	7.9
Advised by Others	7	6.9	0	0.0	7	4.6

Key Lessons

1. Gender Matters: Gender and age interplay to mediate households' livelihood strategies, which affect health and well being, as well as strategies and ability to cope with emerging health care costs.
2. There is need to focus beyond infrastructural development, to put in place policies and processes to enable equitable access to health services.
3. Boosting livelihoods, especially of the poor and of female headed households, should be a priority of any post conflict reconstruction.
4. There is need to provide free or highly subsidized, good quality health care for all.
5. Any form of post conflict reconstruction needs to mainstream gender in its policies, plans and processes.

ReBUILD Consortium

UKaid from the British people